

# **Multi-annual program**

## **Content**

<b>Summary of the program</b>	<b>2</b>
<b>Part I: The Policy Research Centre for Welfare, Public Health and family</b>	<b>7</b>
1. Presentation of the members of the consortium	7
2. The actors and organs of the policy research centre	9
3. Resources	12
4. Valorisation	19
5. Consultation and participation	20
6. Quality control	21
<b>Part II: Description of the multi-annual program</b>	<b>22</b>
1. Mission, objectives and tasks of the policy research centre	22
2. Structure of the multi-annual program	24
3. Back-ground of the multi-annual program	25
4. Content of the multi-annual program	40
5. Summary of the projects	103
6. Suggestions for focused research and advice	125

## Summary

### **Proposal for funding: “Policy Research Centre for Welfare, Public Health and Family”**

**K.U.Leuven-UGent-VUB-KHK**

**2007-2011**

In May 2006 a call for proposals was launched for broad, multi disciplinary and integrated research in the expanding policy field of Welfare, Public Health and Family. The attached proposal for a Policy Research Centre for Welfare, Public Health and Family (Flemish Acronym: SWVG) is a response to this call from a group of researchers. The mission of the SWVG is to conduct research in order to support the Flemish Minister for Welfare, Health and Family in developing a powerful, innovative, effective, inclusive and integrated policy. The SWVG will realise this mission through a coordinated and multi disciplinary scientific approach, enabling the analysis, understanding and tackling the complexity of the actual welfare, health and family problems.

## Part 1: the consortium

### *1.1 The partners*

The consortium unites of experts affiliated to three Flemish universities (Catholic University of Leuven, Ghent University, Free Brussels University) and one Flemish college (The Catholic Superior College of the Kempen). The promoters form a multi disciplinary and inter disciplinary group of experts guaranteeing a broad expertise in the policy area of health and welfare. Geographical issues were part of the decisions in setting up the group of promoters. Given the scale and complexity of the challenges in Brussels, the promoters considered it as crucial to involve a partner having expertise in the administrative complexity of this area and being able to act as a gateway to information and decision makers in Brussels.

The 9 promoters and their partner found each other for this proposal partly based on natural synergies, rooted in earlier collaborations and partly through discussions and exchange of plans for this call for proposals. The development of a common vision and shared framework for policy oriented research in Flanders within an international context was given high priority and was considered as an important challenge. This consortium not only groups professors considered as “established values” in policy oriented research in the welfare and health sector but also “young potentials” bringing to the consortium new and innovative ideas and being an important option for a planned second five year plan for the SWVG.

The partnership of The Catholic Superior College of the Kempen in the consortium aims mainly at guaranteeing the input and the throughput from and to professionals working in the field and to the training of professionals in the welfare and health sectors.

*1.2. The consortium as Policy Research Centre for Welfare, Public Health and Family in Flanders*

A key point in the proposal is the interaction between the different parts of the proposed program. Following options were taken for an optimal functioning of the Policy Research Centre:

The establishment of a broad network of expertise: apart from the 9 professors, promoters of the consortium, also 28 experts and a formal research network are involved in the projects. Each expert represents in his area of academic expertise, broad research groups involved in ad hoc international networks. These research groups bring to the consortium their experience, expertise, research projects, master thesis and other conceptual work, making this available for the government.

An academic setting oriented towards undergraduate and permanent training and development of know-how bringing differentiation in the potential for this consortium.

A longitudinal research program adding to the ad hoc expertise new data, crucial analysis of bottlenecks and global legal discussion themes. This specific part of the policy research centre is focussing on delivering elementary data not only in function of a coherent policy but also to provide the necessary input for the planned research projects and the harmonisation of the research plans.

Six to ten carefully selected regions, with a local multi disciplinary panel, will be integrated in the consortium. They will be the preferential partners for delivering data, acting as pilot regions for innovations and providing essential field knowledge. The “region” will be crucial in the future organisation of the welfare and health services. Cooperation, coordination and integration of the work of all involved professionals will be key concepts in delivering care in the future. The option to involve regions in the work of the consortium guarantees the necessary knowledge of the actual work on the field and gives insight in implementation possibilities and problems.

A performative central secretariat guarantees efficient communication and coordination and direct access to the expertise for policy makers.

## Part 2: the program

The text of the call for proposals reflects the size, the complexity, the “sectorisation” and the lack of coherence in policy oriented research for welfare, health and family. To guide the reader through the text, the proposal starts with a mission statement and an overview of the actual challenges of the policy area, the underlying intentions and general ideas of the proposal, followed by the description of 3 broad research programs and the approach taken within each of the programs.

*2.1. Working within changing policy areas*

To select priorities for their research, the researchers started to make an overview of the actual societal trends having undoubtedly an impact on policy as well in Flanders as internationally. Following topics are covered:

- demographic trends including increasing ageing and rising costs for care
- economic and socio-cultural changes in the field of labour, gender relations and the weakening of traditional institutions
- a trend towards globalisation and “glocalisation”
- trends in lifestyle and health risks
- institutional changes such as from “government” to “governance”, the growing importance of efficiency and effectiveness, the impact of European policy and the open cooperation method
- innovations in the working field as: the development of new visions on care, quality of life as a multi dimensional outcome measure; the focus on inclusion, participation and empowerment
- the socialisation of care
- the attentiveness for the accessibility of services
- trends in the “learning organisation”

Based on these trends, the priorities of the minister as mentioned in the call and know how of the researchers, a common plan for the SWVG was written.

*2.2 Sub themes within a global framework*

Schematically the SWVG consortium groups projects related to three programs, covering three populations and involving services as well in the welfare and the health sector. The health sector includes as well preventive and curative approaches. Each project is situated within several cells of the grid described below.

Focus	Target groups			Services		
	Program	Youth and family	Adults	Older people	Welfare	Public Health
					Prevention	Curative
1. Indicators and monitoring						
2. Evaluation and interventions						
3. Legal and institutional framework						

### *2.3. Three coherent programs*

Despite the availability of several registrations and databanks there is still a lack of data going beyond sectors, mapping data concerning users of care and their use of care. This essential information on the cost of care and service delivery is lacking for the moment.. This conclusion was the starting point for Program 1. The Policy Research Centre is aiming to tackle this problem. The first phase of the program consists of a gap-analysis. This implies the production of a comprehensive overview of all existing research data banks, administrative data and registration data. This overview will enlighten the overlap of data and gaps in data and will make clear which information is still needed. The second phase comprises the setting up of a cohort study of children and their families and of panels of users of care. These panels will be surveyed repeatedly about their use of care and services, their appreciation of the services, the quality of the care, their quality of life and other indicators. By means of repeated surveys of panels of people with a specific profile (parenting problems, relational problems, poverty, mental health problems, depression, dementia) long term information is obtained concerning their search for care and the delivered care, providing essential information for the planning of services. These panels will be organised in min 6 to maximum 10 regions. The regions will be selected taking into account factors relevant for the Flemish health and welfare policy.

In program 2 the SWVG will respond to actual efficiency and effectiveness problems. Also this program provides a status questionis. Within the same regions of program 1 a survey concerning priorities in health and welfare services will be organised for all actors involved (users of care, health and welfare professionals and administrators of services, members of the local community and decision makers). Also an overview of evidence based methods and instruments to enhance the quality of care will be put together. Finally, the researchers will implement and evaluate–based on well defined selection criteria – evidence based practices in the regions. A repeated survey of the panels will provide information on the impact of the innovations on the well being of the users.

A specific objective of program 2 is the establishment of a “health and welfare economic research cell” conducting economic evaluations of the delivery of services in the health and welfare sectors. This cell will bring together welfare and health economists aiming at enhancing the potential for economic expertise in these sectors and making this expertise available for policy makers as well for ad hoc as for long term projects. In the past, economic evaluations were only popular in the heath sector, the new cell of expertise will introduce efficiency and effectiveness studies of care trajectories in the welfare sector.

The third program ‘Legal and institutional framework’ adopts an integrative approach towards the organization of social care and public health. Both institutional, managerial and legal aspects of social care and public health will be addressed in this program.

A first legal approach serves a double purpose. On the one hand it allows for legal benchmarking of research findings formulated within the other two programs. Consequently, a legal test could be implied in translating results for policy purposes in those programs. For instance, the integration of social and health care services and the delineation of the concepts of social and health care, necessarily implies a legal analysis of constitutional issues of competence. Also with regard to services provision in the region of Brussels, a constitutional background has to be taken into consideration.

On the other hand, the organization of care services increasingly invokes problems of a legal nature, as for instance in relation to confidentiality and the processing of personal data, the legal position of persons lacking legal capacity, patient mobility and liability. Legal solutions are more frequently solicited and analyses are made to check whether existing legal concepts and instruments should be redirected and/or adjusted to meet specificities of a social and health care environment. As a result, the third program explicitly aims to build a sound legal framework in order to enable a faster response to certain knowledge gaps.

A second institutional approach ensures a novel view of the existing structures of policy implementation in the field of social care, public health and family. Through a supply chain management perspective and bottom-up approach, the third program aims to enhance the efficiency and effectiveness of policy implementation.

## **Part I**

### **The Policy Research Centre for Welfare, Public Health and Family**

#### **1 Presentation of the members of the consortium**

The policy research centre implies an extensive group of experts. They are members of different Universities and a school for higher education. The distribution is as follows:

K.U.Leuven - 23 members + 4 promoters

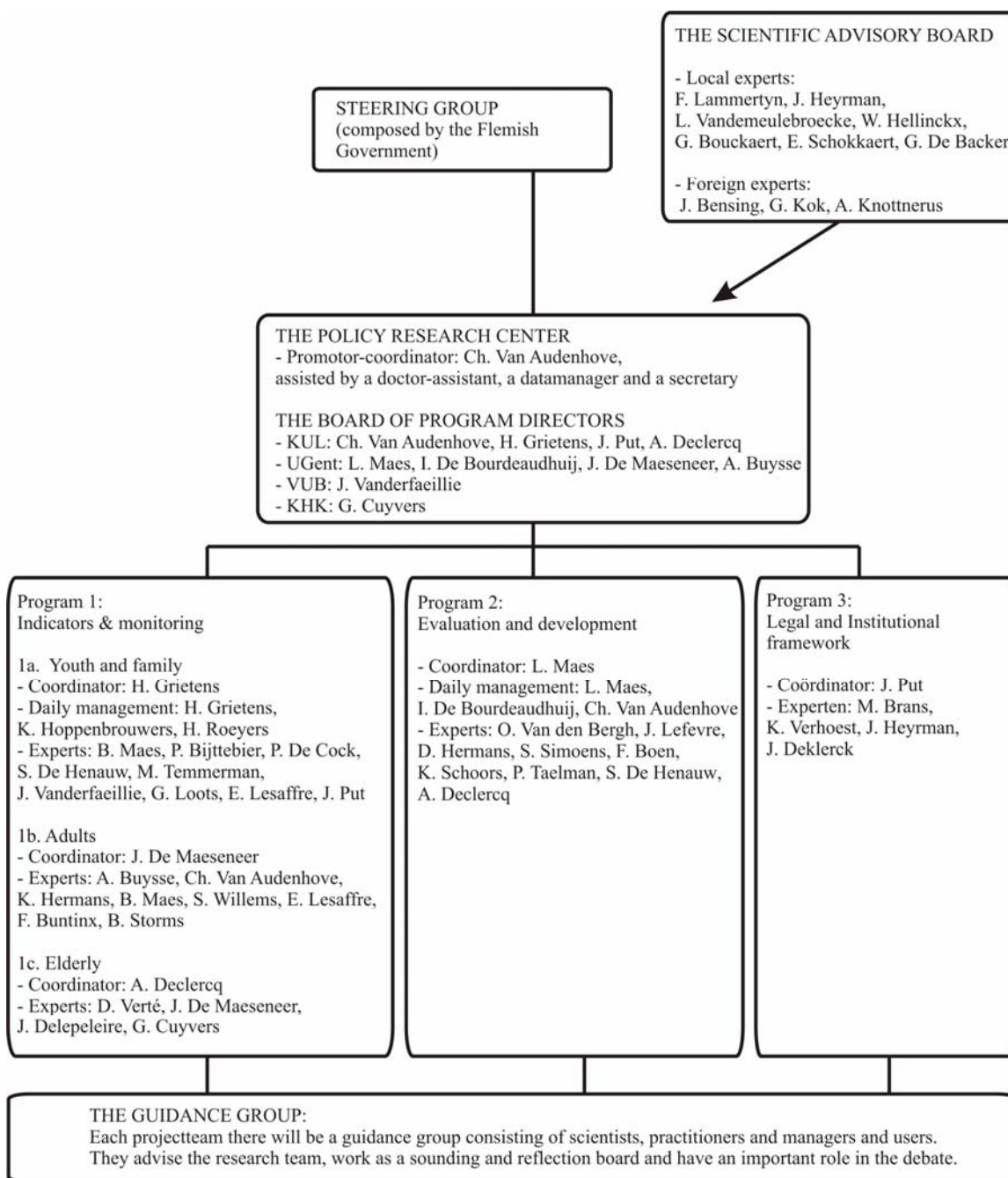
UGent - 6 members + 4 promoters and the Scientific Research Community Health and Welfare of UGent

VUB - 2 members + 1 promoter

KHK - 1 member + 1 promoter

To guarantee a focused and efficient management of the policy research centre, the participation and the involvement of each member is organized in a limited number of functions and taskforces. They are presented in the following scheme.

By governance of the Flemish minister  
of Welfare, Public Health and Family



## 2. The actors and organs of the policy research centre

The main actors and organs of the policy research centre are:

### 1. *The steering group*

Is composed by the Flemish government

Makes a yearly contract with the policy research centre

Oversees compliance with the contract

### 2. *The promoter-coordinator of the policy research centre*

Is the contact person for the policy research centre and for the steering group of the policy research centre

General representation of the policy research centre

Bears final responsibility of the policy research centre

President of the board of directors

Responsible for the coordination between the research programs

Responsible for the coordination between the basic activities of the policy research centre (research programs, ad hoc research proposals and valorisation of the policy research centre)

Assisted by a doctor-assistant

### 3. *The board of program directors*

Meets every month and in the starting period more often

Is composed by the promoters of the policy research centre and the representative of the partner:

K.U.Leuven:

Prof.dr. Ch. Van Audenhove, Prof.dr. H. Grietens, Prof.dr. J. Put, Prof.dr. A. Declercq

UGent:

Prof.dr. L. Maes, Prof.dr. I. Debourdeaudhuij, Prof.dr. J. De Maeseneer, Prof.dr. A. Buysse

VUB: Prof.dr. J. Vanderfaeillie

KHK: Dr. G. Cuyvers

### 4. *The scientific advisory board*

Consists of foreign and local experts

Meets once a year to advice the global functioning of the policy research centre

Local experts: (to be invited) Prof.dr. F. Lammertyn, Prof.dr. J. Heyrman, Prof.dr. L. Vandemeulebroecke, Prof.dr. W. Hellinkxs, Prof.dr. G. Bouckaert, Prof.dr. E. Schokkaert, Prof.dr. G. De Backer

Foreign experts:

Prof.dr. J. Bensing,

(to be invited:) Prof.dr. G. Kok, Prof.dr. Knottnerus

### 5. *The program management*

Each program will be managed by a team of professors composed by (principally all) promoters of the policy research centre and other experts. For program 1 this is organized for each subgroup apart.

One member of the board of directors is coordinator of the program and the daily management is the responsibility of a limited group of experts.

#### *Program 1*

- Youth and family

Coordinator: Prof.dr. H. Grietens

Daily management: Prof.dr. K. Hoppenbrouwers, Prof.dr. H. Roeyers

Experts: Prof.dr. B. Maes, Prof.dr. P. De Cock, Prof.dr. P. Bijttebier, Prof.dr. S. De Henauw, Prof.dr. G. Loots, Prof.dr. E. Lesaffre, Prof.dr. M. Temmerman, Prof.dr. J. Vanderfaeillie, Prof.dr. J. Put

- Adults

Coordinator: Prof.dr. J. De Maeseneer

Experts: Prof.dr. S. Willems, Dr. K. Hermans, Prof.dr. E. Lesaffre, Prof.dr. F. Buntinx, Prof.dr. Ch. Van Audenhove, Prof.dr. B. Storms

- Elderly:

Coordinator: Prof.dr. A. Declercq

Experts: Prof.dr. J. De Maeseneer, Prof.dr. D. Verté, Prof.dr. J. Delepeleire, Dr. G. Cuyvers

#### *Program 2*

Coordinator: Prof.dr. L. Maes

Experts: Prof.dr. J. Lefever, Prof.dr. F. Boen, Prof.dr. O. Van den Bergh, Prof.dr. K. Schoors, Prof.dr. P. Taelman

#### *Program 3*

Coordinator: Prof.dr. J. Put

Experts: Prof.dr. M. Brans, Prof.dr. K. Verhoest, Prof. J. Deklerck, Prof.dr. J. Heyrman

### 6. *The guidance group*

For each project team there will be a guidance group consisting of scientists, practitioners, managers and users. They advise the research team, work as a sounding and reflection board and have an important role in the debate.

7. *The secretariat*

The secretariat will be managed by the coordinator, offers logistic and administrative support for the policy research centre manages the means of the secretariat and the Policy Research Centre valorisation and supports the financial management of the Policy Research centre.

The policy research centre will realise its mission in a multi-annual program that consists in four major parts:

1. Three mutually linked research programs
2. Ad hoc research and advice
3. The general valorisation of the policy research centre: platforms, publications, website and annual report or yearbook
4. The secretariat: support of the coordinator, administrative organisation, the data management and the financial management

*The research programs of the policy research centre*

Program ‘indicators and monitoring’ aims at the exploration of existing data banks and the gathering of new longitudinal data which will lead towards information about the trajectories and the use of care of users through different sectors. This program is the most elaborate of the policy research centre. It will be a basis for both program 2 and 3. Besides it will gather a large amount of information over a large number of sectors and the collection of longitudinal data requires this investment in program 1.

Program 2 ‘evaluation and development’ aims at the optimalisation and evaluation of the services in curative and preventive sectors of health and welfare. The development of innovative methods in care and service delivery and in policy interventions will lead towards a better quality of care and service delivery and to a better cost-efficiency.

Program 3 ‘juridical and institutional framework’ aims at the integration of these innovations in policy and organisation of health and welfare services.

The interaction between the three programs of the policy research centre is well organised by the structure of the programs. Most of the projects will be part of different programs. The same researchers will work in different programs.

All the themes and research aims that are mentioned in the call for proposals will have their place in the multi-annual research program of this consortium.

### 3. The resources

Estimation of personnel assignment

Research programs:

Budget: 350.000 euro research personnel

Program1: 7 FTE

Program 2: 2 FTE

Program 3: 1,5 FTE

Total 10,5 FTE

Working: 80.000euro

0,5 FTE for administrative support UGent: 23.000 euro

Rest: 57.000 euro working costs to distribute over three universities a ratio of personnel: 32.000 euro/22.000 euro/3000euro

Ad hoc projects and advice:

Budget: 235.000 euro

4 FTE working coasts included

A fixed budget of 4810 euro consisting of 4710 euro for personnel and 100 euro for working, in particular, well motivated cases more than 100 euro can be delivered for working.

The 4710 euro is a means of loan costs for a researcher with a normal contract with 2 years of seniority calculated for 2007 and 2011 (via SAP)

Calculation for ad hoc projects:  $235.000 / 4810 = 48,8$  months gives 4 FTE pro year

58.000 euro working and 177.000 euro personnel

Central policy research centre working and secretary: 3FTE (director, data manager en secretariat):

190.000 euro

182.000 euro

8.000 working costs

Overhead 10%

85.500 euro

**Sum: 940.000 euro**

Multi-annual program

3.1. Budget according to cost categories

In euro	2007	2008	2009	2010	2011
<b>Total budget</b>	<b>940.000</b>	<b>940.000</b>	<b>940.000</b>	<b>940.000</b>	<b>940.000</b>
Overhead 10%	85.500	85.500	85.500	85.500	85.500
Workings costs	332.200	145.200	145.200	145.200	145.200
Detail working costs:					
- projects					
- ad hoc research	79.700	79.700	79.700	79.700	79.700
- management	57.500	57.500	57.500	57.500	57.500
- Set up of the policy research centre	8.000	8.000	8.000	8.000	8.000
	187.000				
Costs for contracting (total)	-	-	-	-	-
Costs for contracting to partner X	-	-	-	-	-
Costs personnel	522.300	709.300	709.300	709.300	709.300
Total					
Detail personnel costs :					
Researchers	203.300	350.300	350.300	350.300	350.300
Ad hoc research	177.000	177.000	177.000	177.000	177.000
Management	142.000	182.000	182.000	182.000	182.000

*3.2. Budget for tasks and assignments*

In euro	2007	2008	2009	2010	2011
<b>Total budget</b>	<b>940.000</b>	<b>940.000</b>	<b>940.000</b>	<b>940.000</b>	<b>940.000</b>
Overhead 10%	85.500	85.500	85.500	85.500	85.500
Research programs	243.000	430.000	430.000	430.000	430.000
Ad hoc research	234.500	234.500	234.500	234.500	234.500
Central working	190.000	190.000	190.000	190.000	190.000
Set up of the policy research centre	187.000	--	--	--	--

During the first working year the costs for the set up and the funding of the policy research centre are foreseen. These are non recurrent costs for basis equipment like pc's printers, development of the website and utilities for the secretary. Besides we expect the distribution of the budget to be equally distributed over the following years.

*3.3. Budget for participants in the policy research centre and partner*

In euro	2007	2008	2009	2010	2011
<b>Budget incl. overhead 10%</b>	<b>940.000</b>	<b>940.000</b>	<b>940.000</b>	<b>940.000</b>	<b>940.000</b>
K.U.Leuven	255.200	255.200	255.200	255.200	255.200
UGent	195.800	195.800	195.800	195.800	195.800
VUB	22.000	22.000	22.000	22.000	22.000
KHK	Pm	Pm	Pm	Pm	Pm
ad hoc research*					
via K.U.Leuven:	155.000	155.000	155.000	155.000	155.000
via UGent:	103.000	103.000	103.000	103.000	103.000
Central working and valorisation of the policy research centre via K.U.Leuven	209.000	209.000	209.000	209.000	209.000

\* Ad hoc research by the VUB and by the KHK will be financed by the budget of K.U.Leuven or UGent.

Multi-annual program

KU.Leuven	2007	2008	2009	2010	2011
<b>TOTAL budget inclusive overhead and ad hoc questions</b>	<b>410.200</b>	<b>410.200</b>	<b>410.200</b>	<b>410.200</b>	<b>410.200</b>
<b>Budget personnel + working</b>	<b>255.200</b>	<b>255.200</b>	<b>255.200</b>	<b>255.200</b>	<b>255.200</b>
Real budget	232.000	232.000	232.000	232.000	232.000
Overhead	23.200	23.200	23.200	23.200	23.200
- working					
HT administration	--	--	--	--	--
Working	32.000	32.000	32.000	32.000	32.000
Starting costs	60.000	--	--	--	--
<b>TOTAL working</b>	<b>122.000</b>	<b>32.000</b>	<b>32.000</b>	<b>32.000</b>	<b>32.000</b>
- personnel					
Start 1 Jan	33.000	33.500	33.500	33.500	34.000
Start 1 Jan	33.000	33.500	33.500	33.500	34.000
Start 1 April	28.000	33.500	33.500	33.500	9.000
Start 1 April	28.000	33.500	33.500	33.500	9.000
Start 1 Sept	9.000	33.000	33.000	33.000	28.000
Start 1 Sept	9.000	33.000	33.000	33.000	28.000
Extension wp					58.000
<b>TOTAL personnel</b>	<b>140.000</b>	<b>200.000</b>	<b>200.000</b>	<b>200.000</b>	<b>200.000</b>
<b>Ad Hoc questions total personnel and working</b>	<b>155.000</b>	<b>155.000</b>	<b>155.000</b>	<b>155.000</b>	<b>155.000</b>
Real budget	140.900	140.900	140.900	140.900	140.900
Overhead	14.100	14.100	14.100	14.100	14.100
<b>Establishment of the policy research centre</b>	<b>209.000</b>	<b>209.000</b>	<b>209.000</b>	<b>209.000</b>	<b>209.000</b>
Real budget	190.000	190.000	190.000	190.000	190.000
Overhead	19.000	19.000	19.000	19.000	19.000
- personnel					
Post-doc	68.000	68.000	68.000	68.000	68.000
Data manager	34.000	68.000	68.000	68.000	68.000
Secretariat	40.000	46.000	46.000	46.000	46.000
Working	8.000	8.000	8.000	8.000	8.000
Establishment policy research centre	40.000	-	-	-	-

Multi-annual program

UGent	2007	2008	2009	2010	2011
<b>TOTAL budget inclusive overhead and ad hoc questions</b>	<b>298.900</b>	<b>298.900</b>	<b>298.900</b>	<b>298.900</b>	<b>298.900</b>
<b>Budget personnel + working</b>	<b>195.800</b>	<b>195.800</b>	<b>195.800</b>	<b>195.800</b>	<b>195.800</b>
Real budget	178.000	178.000	178.000	178.000	178.000
Overhead	17.800	17.800	17.800	17.800	17.800
- working					
HT administration	€ 23.000	€ 23.000	€ 23.000	€ 23.000	€ 23.000
Working projects	€ 22.000	€ 22.000	€ 22.000	€ 22.000	€ 22.000
Start policy research centre	€ 87.000				

Multi-annual program

---

VUB	2007	2008	2009	2010	2011
<b>TOTAL budget personnel + working</b>	<b>22.000</b>	<b>22.000</b>	<b>22.000</b>	<b>22.000</b>	<b>22.000</b>
Real budget	20.000	20.000	20.000	20.000	20.000
Overhead	2.000	2.000	2.000	2.000	2.000
- working	2.700	2.700	2.700	2.700	2.700
- personnel	17.300	17.300	17.300	17.300	17.300

## **4. Valorisation of the policy research centre**

De valorisation is organized for each program apart and for the policy research centre as a whole.

**For each program** periodical and programmed transfers of knowledge and know how from the policy research centre to the administration will be organized. This type of valorisation will be described in each program.

**The valorisation for the policy research centre as a whole** will be organized in the following way:

### **The organization of a policy platform**

Target group: members of the administration, cabinet and federations of services

Objective: transfer of relevant scientific findings to stimulate the implementation and evolutions in Flanders and to stimulate a benchmarking attitude.

This way of working is closely connected with program 2 and it is to be situated in the context of “learning organizations”.

### **The organization of a platform for practitioners**

Target group: managers and field workers from the sectors, representatives from the administration

Objective: transfer of scientific knowledge and know how, interpretation and feedback, defining of priorities and spearheads for the management of innovations

Practical organization: thematically organised inter-sector reflection days for each target group.

**Information to the larger public**, to fortify the positive image of sectors in welfare and health care, to improve the benchmarking position by organizing seminars, briefings and field visits.

### **The development of a website**

### **The development of an electronic newsletter**

**The development of publications such as a yearbook of the policy research centre** Key-publications will be presented in Dutch and in English in a series-type of edition.

### **The collaboration with the media**

## **5. Consultation and participation**

The way the policy research centre will realize the consultation and participation of the Flemish government and other involved actors, was described under part 4 as an element of valorisation.

Besides the platforms that were mentioned, the policy research centre intends to be the preferential discussion partner for the administration and for the minister by developing support for alternative policy strategies.

Via the organization of the platforms the research results will be distributed on a larger scale. The members of the policy research centre participate in many thematically organised networks and policy working groups. Via these networks the further distribution of know how from the policy research centre will be realized.

The academic members of the consortium are participating in many different international working groups and networks of researchers (see part 4). They will realize the distribution of knowledge in international research forums and they will develop new international contacts that are relevant for Flanders.

Besides this there is the possibility to collaborate with other policy research centres in Flanders. By the involvement of a number of experts and promoters from this consortium in other policy research centres this is already realized for

- The policy research centre for governmental organization Flanders – research line policy
- The policy research centre for governmental organization Flanders – research line governance
- The policy research centre for ‘Sport, movement and health’ 2001-2006

## **6. The system of quality control**

The quality control of the policy research centre will be guaranteed by the organization of a number of actors and organs (cf. supra). Besides this a system of monitoring and reporting will be developed to organize the follow-up of the process in the four parts or working fields of the policy research centre.

For each initiative (research project or valorisation initiative) a standardized system of follow-up will be set up in which all the tasks are mentioned with milestones and products or deliverables.

Each project has a table in which the project leaders can chart eventual changes in the timetable and give additional explanations for deviations or adjustments. Realized and planned actions are mentioned in this system.

The review tables are presented monthly by the project leaders and discussed with the coordinator. During the monthly meetings of the direction committee each initiative is presented. Twice a year these reviews are presented to the steering group.

## **Part II**

### **Description of the multi-annual program**

#### **1. Mission, objectives and tasks of the policy research centre**

##### *1.1 The mission*

The policy research centre's mission is to support the policy of the Flemish minister of welfare, health and family in the development of a strong, innovative, effective, inclusive and integrative policy.

The policy research centre will realize this by a coordinated and multidisciplinary approach that will permit to analyze, to understand and to manage the complexity of the current welfare, health and family problems.

The policy research centre will make the knowledge and know how that it will develop accessible and transferable to the Flemish government.

It will also make the knowledge accessible for other target groups.

##### *1.2 Objectives and intended results of the policy centre*

The policy research centre intends to be a complete answer to the goals that are formulated in the call for proposals that is formulated by the government for the theme of Welfare, health and family.

The general objectives of the policy research centre are:

- The collection, analysis, the opening up of data (also longitudinal data)
- The implementation of (short term) problem-oriented scientific research
- The implementation of policy relevant research that is important for the government on the long term
- The deliverance of scientific consultancy

Specific objectives concerning the policy in the field of welfare, health and family, are:

1. to gain more insight and knowledge about the prevalence and data of target groups
2. to gain insight in the results of care and service delivery in the curative and in the preventive field
3. To give specialized advice in the field of policy, legislation, institutional organization, types of service delivery and networking
4. the development of a knowledge and documentation centre for policy- oriented research

This policy research centre will focus on three target groups in their context: children and youth, adults and elderly people.

The policy research centre will be oriented towards all the sectors the minister of Welfare health and family is responsible for.

Special attention will be directed to the inclusion of socially vulnerable groups.

### *1.3 Tasks of the policy research centre*

- The collection of relevant longitudinal data about needs, expectations and demands of (segments) of the three important target groups, namely children and youngsters, adults, elderly people over the borders of the different care and welfare sectors.
- The opening up of existent data banks and registration systems of services in the policy field of this ministry and to apply a gap-analysis on their usage for policy planning.
- The development of new interventions
- The adaptation, implementation and evaluation of practices, methods that have given proof of effectiveness in research (evidence based practice) in the Flemish policy and organizational context.
- Based on research results to present proposals and to stimulate reflections concerning adaptation of innovation of the policy or the organizational context.
- The development and strengthening of a multidisciplinary national and international network of persons and organizations with expertise in these policy fields
- The set up of a permanent process of exchange, negotiation and collaboration with the minister, the administration and the field with as important objective to offer a scientific basis for policy choices between alternative options.
- To deliver scientific services and consultancy tot diverse actors in this policy field (federations, local governments...).
- The implementation of fundamental scientific research with long term focus
- The organization of the transfer of new insights, instruments, methods via schools for higher education and academic education for professionals in welfare, health and family sectors.

## **2. Structure of the multi-annual program**

The thematic scope of the policy research centre should – according to the call for proposals – be directed to three themes:

1. Research about efficacy and cost-efficacy (E&E)
2. Target groups, needs and demands
3. Specific ad hoc questions

All the sectors and themes that are in the policy field of the minister belong to the action field of the policy research centre.

The policy research centre should start with relevant reviews of international literature and an international benchmarking is required.

The policy research centre will realize its mission in a multi-annual program that consists in four major parts:

1. three mutually linked research programs
2. ad hoc research and advice
3. The general valorisation of the policy research centre : platforms, publications, website and annual report or yearbook
4. The secretariat: support of the coordinator, administrative organization, the data management and the financial management

The research programs of the policy research centre:

1. Program ‘indicators and monitoring’ aims at the exploration of existing data banks and the gathering of new longitudinal data which will lead towards information about the care trajectories and the use of care of users through different sectors.
2. Program 2 ‘evaluation and development’ aims at the evaluation and innovation of the services in curative and preventive sectors of health and welfare. The development of innovative methods in care and service delivery and in policy interventions will lead towards a better quality of care and service delivery and to a better cost-efficiency.
3. Program 3 ‘juridical and institutional framework’ aims at the integration of these innovations in policy and organization of health and welfare services.

### **3. Background of the multi-annual research program**

The field of welfare, public health and family is wide, is growing fast and is changing thoroughly. We will first make an inventory of these changes and the modified concepts related to them. All of this of course also has consequences for policy making. Knowledge about these changes is crucial for a centre directed at the future.

The choices made by the promoters while developing their programs, are inspired by international trends and developments in welfare, public health and the family. The position of Flanders in this context and the growing demand for an effective long-term care and welfare policy is the special angle from which the priorities for the multi-annual research plan of the Centre for Welfare, Public Health and the Family have been determined. Below, we sketch an outline of these.

#### **Introductory problem analysis**

The Centre for Welfare, Public Health and Family (CWPF) intends to play a prominent role in the comprehension, analysis and tackling of challenges society is currently struggling with. At the time the welfare state was build, the supply of social services nicely fitted in with population, family and labour structures. This period was characterized by a compromise, a kind of agreement within primary relationships (the breadwinner model), within the labour market (the dominance of contractual labour based on contracts unlimited in time), within the labour relationships (capitalism with the condition of the safety net of the welfare state), within the structure of social services (private social services, but guided and controlled by the government), within health care (a strongly specialized organizational frame, but aimed a cure) and within politics (democracy, but based on parliamentary representation).

As a consequence of the transition to a post-industrial knowledge economy, this situation of relative peace was disturbed. On the one hand, all kinds of societal changes caused new needs and expectations which the existing services cannot easily answer (changes on the demand side). On the other hand, ideas and convictions on the functioning and interference of the government changed (changes on the supply side). Both evolutions are of utmost importance for the ways in which in future welfare, health and family policies will be shaped. In this part of the proposal, we sketch an overview of the major societal and institutional changes and policy innovations.

#### **1. Demographic changes**

Demographic changes in general and the strong increase in the ageing population along with the decrease in the younger population more in particular, have as a consequence that a continuously diminishing group of active people are responsible for a growing group of inactive people. Our population is ageing, not only because people live longer but also because the number of births

continued to decrease during the last decades. Data on the European Union in 1999 indicate a steep decline in fertility rates in all member countries, often far below the replacement rate of 2.1. This trend started in 1965 and developed very quickly (Deleeck, 2001). Europe moreover is one of the leaders in worldwide ageing. In 2000 21.8% of the Belgian population was over 60 years of age. By 2020 this number will have increased up to 27.3% and by 2050 up to 31.5%. Within the group of elderly people, the proportion of people over 80 grows from 16.75% in 2000 to 20.9% in 2020 and 31.89% in 2050<sup>1</sup>.

Of course, these demographic changes lead to growing and changing demands for care. First, care and living conditions more and more are uncoupled. Elderly people choose to stay at home and to make use of home care services rather than move to residential care (Vanden Boer & Vanderleyden, 2004: 195; Van Meerbeeck, 2003: 69). However, we wish to link this evolution with the fact that over 40% of people over 70 who live at home fall at least once a year. Fractures caused by falling even are the most important cause of death in this population (58% of men and 75% of women). Also, the psychological impact of falls may not be underestimated: fear of falling, loss of self-assurance, fear of losing independence, social isolation and depression (Milisen et al., 2004).

The economic cost of an increase in institutional care moreover is high and unaffordable. Demographic trends, such as the diminishing number of older parents living with a child, rise questions concerning the optimal balance between formal and informal care at a time when the number of professional workers decreases (Audenaert, 2003: 466). The ageing of the population also draws attention to the problems of dementia and the demand for early detection and well-adapted care. At the same time, we should not overlook the large group of elderly people who are still very active. They wish to continue to actively participate in societal life.

## **2. Economic and socio-cultural changes**

Economic and socio-cultural evolutions destabilized two important pillars of the welfare state. The first pillar is the assumption of full employment. Work and more importantly paid labour was very prominent in industrial society. A job was characterized by a full-time contract for an undetermined period of time. As a consequence of the process of post-industrialization, characterized by the transition from a fordistic energy-intensive production system into a post-fordistic information-intensive production system, these assumptions no longer stand (Ferrera et al., 2000). Increasing global capital flows, technological developments and a growing international trade market can be identified as the economic motors of this transition (see below 2.3). People with no or few education are the first victims of these changes. They have a very

---

<sup>1</sup> Federal Governmental Services on Economy, Small and medium-sized businesses, the Self-employed and Energy. Structure of the Population. Available at [http://statbel.fgov.be/figures/d21\\_nl.asp](http://statbel.fgov.be/figures/d21_nl.asp)

hard timing finding jobs, and when they do, the job usually is insecure, of low quality and poorly paid. Low education has become a new social risk, to which society has not yet found an answer.

The second pillar was the traditional division of roles between men and women. Full employment in fact only was full employment for men, since women were expected to take care of the children and the household. Men and women moreover were supposed to engage in a permanent relationship in the form of marriage. Women liberated themselves from traditional role patterns in the 1970s, and went seeking fulfilment of their own needs. Marriage as an institution lost its self-evidence and its permanent duration. Sociologists consider this to be one of the consequences of individualization. This concept includes two phenomena.

The first phenomenon points to the weakening of the influence of all kinds of traditional social categories such as class, neighbourhood, gender, family and nation state. Secondly, individualization draws attention to the growing need for individual citizens to shape their own life course and to continuously make choices. Traditional institutions such as the family, the surrounding neighbourhood, the church, the political party, or the union used to provide some kind of protecting cocoon, which subscribed a more or less self-evident repertoire for the individual. Along with the dissolution of these traditional institutions, things that went without saying in everyday life also disappeared. The more enforcing character of these traditional agents of control vanished. Other phenomena no longer are taboo, for example divorce, sexuality or interfamilial violence. The growing prevalence and complexity of family problems was shown not long ago, when the Centre for General Welfare Work rang the alarm bell ([www.steunpunt.be](http://www.steunpunt.be)).

The increasing changeability, complexity and uncertainty of the life course also brings along more risks. An active way of planning life demands certain cognitive skills – the ability to make, coordinate and execute plans. But because of uncertainty and complexity, life plans can also go wrong. In order to be able to make these choices, the individual needs to dispose of certain resources of help, of a certain amount of capital. This capital however, is not divided equally among the population. Not every individual is able to or even inclined to make choices and to plan his or her own life course. If individuals lack this ability, they risk being confronted with a ‘breakdown-biography’, rather than a biography of choice (Beck-Gernsheim, 1996). This is true for the labour market as well as for family life and education. The central question is how this new form of social vulnerability can be prevented and how the individual and his or her family can be helped to better cope with these now social risks. New methods and techniques of intervention, such as educational support or counselling in divorce, have already been developed, but it cannot be denied that there still is a long way to go.

A higher educational level on average, combined with the process of individualization, also causes changes in the number and nature of needs and demands concerning health care. Patients have clearer convictions about what good care is, and they often gather knowledge through all kinds of sources, such as the internet, patient associations or support groups. Patients with chronic

diseases more and more gather information about their condition through the internet. They demand a more personalized approach and confront their doctors with their knowledge. As a consequence, a gap can develop between the expectations of those who seek help on the one hand, and the supply of health care and medical knowledge on the other hand.

### **3. Globalization and “glocalization”**

Globalization implicates that people are more and more connected across boundaries, in the field of labour and the economy as well as in the field of culture and politics. As a consequence of these networks of interdependence that cross national borders, social phenomena have faster, larger and more frequent consequences at one location on earth than at another. One aspect of this process is represented by the global streams of migration that manifested themselves in a number of phases. The “multiculturalization” of Flanders raises questions about the underlying pattern of Western values in the current welfare, family and health policy. Differences in values and norms, lack of empathy and differences in the reference frames of health professionals and service users can lead to misunderstandings and mutual prejudices. This problem is all the more prominent for migrant people. Western middle-class professionals often do not know how to interact with clients from other cultures, while immigrants themselves are unfamiliar with the Western way of providing care and the Western perception of health (Sannen, 2003). Ethno-specific and ethno-sensitive care no longer is an option, it has become a necessity. Moreover, cultural diversification is broader than mere specialization towards the Turkish or Magreb population.

Another aspect of this change process is glocalization. The 21<sup>st</sup> century will be the century of the city (De Rynck, 2003). The city is becoming the centre of knowledge, technology, communication and power. The city population is characterised by heterogeneity and diversity. It is a meeting point for all kinds of nationalities and cultures. At the same time, a large concentration of socially vulnerable groups and neighbourhoods can be found in these cities. A study by Kesteloot et al. (1986) showed that Flanders and Brussels know 323 neglected neighbourhoods.

### **4. Evolutions in life style and health risks**

There of course also are important trends and changes in the field of health and illness. On the one hand, a number of health risks disappeared during the last century (e.g. smallpox as a consequence of the vaccination policy) and other health risks diminished because of medical progression (e.g. leukaemia, mucoviscidosis and Duchene muscular dystrophy). On the other hand, new health risks came into existence because of pollution and changes in life style.

In Flanders, over 40% of mortality amongst people older than 75 years, can be avoided by changes in life style and an optimally functioning health system<sup>2</sup>.

Obesity and overweight are symptoms of a first problem in life style. Flemish people do not exercise sufficiently, which turns obesity into a major problem: 52% of men and 37% of women are overweight. One out of ten even is obese. The percentage of male labourers with overweight grew from 10 to 14% between 1993 and 2000. In female labourers it increased from 9 to 13%. A second problem is smoking. 30% of mortality among men and 4% of mortality among women can be linked with smoking behaviour. In comparison with 15 other European countries, Flanders scores highest in prevalence of lung cancer. A third alarming trend can be situated in mental health. The health survey of 2004 showed that almost one out of five Flemish citizens is dealing with psychological problems. A subdivision in problems indicates that 20% has sleeping problems, 10% struggles with thoughts about suicide, 8% has somatic problems that can be attributed to psychological problems, 7% suffers from feelings of depression and 5% has feelings of anxiety. The World Health Organization estimates that one out of four Flemish families has a family member with mental problems. Also, the number of suicides is high in Flanders. It is the main cause of death in men between 30 and 40 and women between 25 and 29. These figures subscribe the importance of recovery and rehabilitation as policy priorities. This fits within a community oriented approach of mental health care (see 2.6.4).

Along with the coming into being of new health risks as a consequence of changes in life style, we also wish to point at the medicalization of everyday life. Although medicalization as a concept is less common then it was in the past, it cannot be denied that more and more aspects of daily life have a medical component, such as one's appearance, the body or the education of children.

## **5. Institutional changes**

At the supply side, three major changes can be distinguished. Firstly, the way in which the Flemish government steers society has evolved drastically. These changes can be summarized in the concept of 'governance'. Secondly, society expects the government to give account about its policy realizations in terms of efficiency and effectiveness. Thirdly, the Flemish government more and more is obliged to share its power with the European Union, including social policy and health care.

### *5.1 From 'government' to 'governance'*

In the more public policy oriented literature, a transition from 'government' to 'governance' is mentioned. When taking a closer look at the concept of governance, we see it hides a multitude of

---

<sup>2</sup> Administration of Health Care (Ministry of the Flemish Community). Health indicators 2001-2002. Available at <http://www.wvc.vlaanderen.be/gezondheidsindicatoren>

meanings (Lynn, Heinrich & Hill, 2001). It certainly points at new mechanisms of control and steering and is contrasted with the traditional hierarchical control by government.

This new model firstly points at the large whole of interdependent elements that are part of the 'governance' regime, such as jurisdiction, policy goals, organizational structures, financial streams, administrative guidelines, and broader cultural values and norms. These are not exogenous variables that guide the policy process. They only receive their ultimate meaning during this process. Because of their interdependent coherence, they moreover are difficult to steer and to control. Changes in one system automatically lead to (unintended) consequences in another. As a consequence, it is impossible to identify just one institution that is responsible for the realization of goals. Public, private as well as non-profit organizations all are involved.

Second, the government no longer is in command as a hierarchical superior, but is searching for steering instruments such as networking coordination by network-type mechanisms (negotiating, searching for compromise, drawing agreements, giving incentives, process management with relatively autonomous actors) and market-type coordination systems (the subcontracting of tasks). In view of the specific historical development of the welfare sector in Flanders, and the concurrent institutional complexity, network steering as an intervention principle, offers many possibilities to draw trajectories over the borders and boundaries of organizations. Market-type coordination systems should conduct to a higher efficiency, by installing the possibility of competition, but at the same time it rises questions about justice and fairness, because the accessibility of affordable care of high quality can be endangered.

Third, this paradigm points at the stratification of policies and the interweaving of different levels of policy making (local, regional and national). The local level is closest to the person in need of care and is best situated to assess his or her needs and to react in the most adequate way. The question however is how much room for decision is left for the local level. The most important advantages of the local level are: (1) the possibility to adapt policy to local circumstances and needs; (2) the coordination and mobilization of different actors and services across sectors; (3) the special attention for problem areas; and (4) the development of renewing projects. At the same time however, a strong decentralization also has disadvantages: (1) local initiatives do not suffice to tackle the national or even international span of certain problems; (2) inequalities in policy efforts; (3) the danger of discrepancies between national policies intentions and local policy results; and (4) the duplication of policy activities and a loss of efficiency. This paradigm thus demands special attention for the relation between the local, regional and national actors.

### *5.2. Monitoring, efficiency, effectiveness and justification*

The professionalization of the welfare and health policy was re-interpreted in the second half of the 1990's. In the 1970's, professionalization implied more discretion for the professional (the social worker, the health or care professional, the doctor, ...). Society was convinced that these professionals were most capable at providing high quality within this discretionary space, because

of their particular knowledge and skills. From the second half of the 1990's on, a new definition of professionalization came into being. Professionalization is seen in terms of policy planning, harmonization and coordination of services, control of implementation, accountability and policy evaluation.

Moreover, efficiency and effectiveness gained importance. Not all that is preferable, is affordable. As a consequence, choices have to be made. In the Anglo-Saxon countries, choices are strongly determined by 'evidence'. One prefers those approaches that proved to be effective in scientific research, and through which one can help as much people as possible with as little means as possible. But 'evidence based practice' is not the only possible approach. Scientific knowledge is not available for all kinds of problems, and when it is available, this knowledge not necessarily can guide clear decisions at the individual level. Therefore, a broad interpretation of 'evidence based' policy is a necessity, one that takes account of the specificity of welfare work. Possible examples are the relational aspect of welfare work, the centrality of the interaction between the client and the professional, the plurality of goals, and the partial knowledge about human functioning. This broad approach seeks for an integration of the results of scientific research, clinical expertise in terms of practice knowledge, and expectations and needs of clients and users. For this, the gap between science, policy and practice needs to be tightened and the search for new forms of cooperation between researchers, policy makers and front-line workers needs to continue.

### *5.3. European social policy and the open method of coordination*

On April 20<sup>th</sup> 2004, the European Commission (EC) made an announcement, entitled: "Modernizing social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the open method of coordination". This document shows that the EC thinks that the health care systems in the European Union (EU) and the policies in the different member states are becoming more and more entwined. The growing mobility of patients plays an important role in this evolution. The EC thinks that common problems and challenges in health and health care, asks for a reinforcement of the policy cooperation and policy coordination in the EU. Therefore, the EC is in favour of an introduction of the open method of coordination (OMC) in health care and in long term care. The EC firstly determines the goals the member states should strive for. These goals are translated in a number of numeric indicators. The decisions on the ways in which the member states will realize this goal, are to be taken by the member states themselves. They however have to draw an action plan every two years in which they clarify the concrete way of working and the means available. These action plans then are evaluated by the EC. On the one hand, every member state receives recommendations and points of attention. On the other hand, this way of working promotes the exchange of 'best practices' between different member states. However, these recommendations cannot be enforced. They are thus considered to be 'soft law'. Member states will be obliged to report on their health and care policies. In this way, the EU becomes a

key agent in the shaping of these policies, as the EU already is in labour policy, social protection, pensions and social inclusion.

## 6. Recent policy innovations

A number of innovative concepts were developed in recent national and Flemish research. They should contribute to an innovative, effective, inclusive and integral family policy, welfare policy and health policy. The most important innovations are listed below. In the first paragraph, a new vision on care is developed and the criteria for ‘good care’ are described. In the second paragraph, the importance of ‘life quality’ outcomes is stressed. In the third paragraph, the new attitude towards the target groups is described in terms of inclusion, participation and empowerment. A fourth theme is the socialization of care. Fifth, we see a renewed attention for the accessibility of services. And last, a new vision on front-line workers as knowledge workers and services as ‘learning organizations’ is developed.

### 6.1. *A new vision on care*

The starting point when developing the future framework for long term care, is the determination of criteria for ‘good care’. The specification of the concept of ‘good care’ was one of the aims of the joint action project Biomed II, which focused on the ethical aspects of de-institutionalization in mental health care (Bauduin et al., 2002; van Weeghel, Van Audenhove et al., 2005). Discussions concerning this topic were organized in five European countries (the Netherlands, Belgium, England, Greece and Italy), with participants that represented five groups of people involved: patients and service users, family members, professionals, members of local communities and policy makers. The study shows that a respectful relationship between clients and service providers is considered to be the most important aspect of ‘good care’. Such a relationship was associated with an image of clients as responsible individuals, capable of stating their own opinion and whose experiences and decisions are taken seriously. Good care, secondly, was seen as effective care, adapted to individual needs of clients. Third, good care was defined in terms of local availability and accessibility of services. Ultimately, good care was linked with support for informal carers (family and friends). The researchers concluded that care policy in society needed an ethical evaluation as well as an evaluation in terms of efficiency and effectiveness.

Their recommendations correspond with the vision of Thornicroft and Tansella (1999). Based on a review of literature and clinical and research experience, these two researchers identified nine relevant key aspects for the evaluation of mental care services in society:

1. **Autonomy:** the client should have the possibility to decide independently and to make choices, notwithstanding the presence of problems, complaints or limitations.

2. **Continuity:** services dispose of the ability to gear interventions within and between teams on the short term (cross-sectional continuity) and to streamline contacts in the long term (longitudinal continuity).
3. **Effectiveness:** treatments and services with proved advantages can be applied in daily practice.
4. **Accessibility:** clients can receive care where and when needed.
5. **Comprehensiveness:** horizontal comprehensiveness (reaching all target groups) implies that care is provided over the complete continuum problems and over the broad spectrum of all client characteristics. Vertical comprehensiveness (to offer all basic care a target group needs) can be defined as the provision of all basic components of care and prevention and their use by prioritized target groups.
6. **Justice:** the means are divided evenly and the vision behind prioritizing needs as well as the methods used to attribute means, are clarified.
7. **Accountability:** questions of clients, families and the broad public are answered, since they all have rightful expectations towards the way in which the service needs to take responsibility.
8. **Coordination:** the service has a coherent treatment plan for each individual client. Each plan contains clear goals, with which necessary and effective interventions are coupled. There is a plan for cross-sectional coordination (coordination within a limited period of care), as well as for longitudinal coordination (coordination over a longer period of treatment).
9. **Efficiency:** one strives for a minimal input to become a certain outcome, of a maximum output for a certain level of input.

These principles not only are of utmost importance within mental health care, they are valid for all three policy domains of the CWPF.

### *6.2. Life quality as a multi-dimensional outcome measure*

To measure the effects of services and help, we need to start from a definition of outcomes in terms of life quality (Schalock et al., 2002). It is up to the service system to offer responsive help, assisting people to reach and uphold valued outcomes of life quality. When this is the case, clients evaluate to which level and in what way services contribute to these outcomes, or in the opposite way: whether the outcomes hinder life quality. Outcomes of life quality are measured through a vast range of aspects of life: emotional wellbeing, interpersonal relationships, material wellbeing, personal development, physical wellbeing, self-determination, social inclusion, and civil rights (Felce & Perry, 1996; Schalock et al., 2002). These broad domains are supposed to have general functions, which are subdivided in a variety of indicators or outcomes. This also implicates approaches that exceed sectors, that are integral and that are aimed at target groups (youth, adults and elderly people).

*6.3. A changed vision on target groups: inclusion, participation and empowerment*

Three trends have brought about a new interpretation of the participation of the user, the patient or the client to policymaking. First, partly due to the increased educational level and the increased accessibility of the media, they are more emancipated. The client, patient or user no longer wants to be treated as a passive follower, who resigns to the expertise of the professional. Being able to show ones opinion every four years during the elections is considered insufficient. He or she wants to make his or her voice heard through other canals, preferably on a regular basis. As a consequence, all kinds of new ‘bottom-up’ initiatives arise: neighbourhood committees, consumer associations, patient associations, internet discussion groups, et cetera. Second, the Flemish government goes along with this trend by giving more attention to participation, e.g. the decree on poverty, the framework decree on local social policy and the decree on the participation of elderly people. The voice of the citizen thus no longer is just heard through his or her political representatives, but also through public discussion, consultative and advisory bodies, interactivity through the internet and offices of ombudspersons. Third, the recognition of experiential knowledge of the client, patient or user is growing. His or her subjective perception is no longer neglected, but is considered to be a necessary and valuable addition to scientific and professional knowledge. Policy interventions lose their strength if they do not connect sufficiently with expectations and aspirations of the target group. Moreover, inclusion of people with disabilities and empowerment also are expressions of the changed vision on users and target groups.

Persons with continuing limitations in their physical, mental and social functioning want to lead a life in the community that is as normal as possible. This also demands changes in society. Tolerance towards the deviant and a positive appreciation of the different are currently important points of attention. How can we fight stigma and discrimination and at the same time make sure that people with limitations can take full part in labour, education and recreation? For people with disabilities, this trend is strongly captured with the concept of inclusion, which states that all people together create society, people with disabilities included. People with disabilities do not have to be integrated; they are already part of society. This argumentation can also be used for other target groups of policy.

Empowerment fits in with these trends. Research shows that people with lifelong limitations, people who live in poverty, people with mental problems and immigrants are no longer seen as passive and dependent consumers of care and welfare services that are planned and organized by experts. They can be addressed as experiential experts, and they have the right to organize their own lives and to make choices about the care they need (Pedlar, Haworth & Hutchison, 1999; Ward, 1998). They are more and more ‘empowered’ to express their own opinions, to make choices and to control their life situations and also to search for strengths and to undertake actions necessary for accomplishing their life goals. For services, this implies shifting from system oriented care to person oriented assistance (Holburn & Vietze, 2002). These target groups and their families should thus be involved and be allowed to participate in the planning and the evaluation of their own assistance program. They have to be informed in an open, accurate and

comprehensible way. They have to play a central role and participate actively in all plans and decisions that have an impact on their wellbeing. Also, they need to be allowed to make choices regarding their life and the assistance they receive.

In recent research, we concluded that this is not fully realized (Maes et al., 2001; Maes, Bruynincks & Goffart, 2003). In focus groups and interviews with people with learning disabilities and their parents, a number of bottlenecks were discovered. The people interviewed thought that the service system and the regulations that go along with it (structure, accessibility criteria, modalities) are unclear, not transparent and ambiguous. They lack information and help in their search for the service arrangements they expect. Their participation in the process of determining adequate assistance that is adapted to their needs is far too limited. Many have negative experiences with care workers who showed neither respect nor appreciation for their views or preferences. They think the system is not flexible enough to adapt to their specific needs. Services rather than clients still control the way in which assistance is offered. Biographical research with young assistance beneficiaries points in the same direction (Hermans et al., 2004).

For the user, there is an urgent need for psycho-education and information tools that encourage patients and clients towards self-care, and facilitate and stimulate more participation in processes of choice. As soon as people realize they can still do a lot for their own wellbeing and health, or that there are equivalent care trajectories that possibly have a different impact on their wellbeing, they are prepared to take responsibility for their own choices. In that way, dependency upon care and care workers can be strongly reduced. In spite of the fact that good initiatives have already been developed in Flanders, there still is a long way to go.

#### *6.4. Socialization of care*

Care for target groups such as people with enduring mental problems, people with disabilities, people with Traumatic Brain Injury or elderly people suffering from dementia, continues to shift from residential care to care in small-scale institutions and care in the community. These evolutions represent more than a mere relocation of care from the institution to home. They are accompanied by changes in the culture of care and in the attitudes and methods of the care providers. Informal carers to a growing degree take over aspects of care. We find that there is an increasing need in baseline services for expertise in developing and implementing suitable care forms for these target groups. Flanders is among the leaders in the number of psychiatric hospital beds. A cutback in favour of care in the community is slowed down, among other things because of the division of authority over different ministries.

### *6.5. Accessibility of services*

Accessibility is a phenomenon that is far less simple than it seems at first sight. We firstly want to point out that the concept refers to a reality that is far broader than the merely getting access to a certain service. Accessibility has to do with literally getting in (accessibility in its strictest sense), as well as with usability or with getting an answer to ones questions. We subdivide this process into three phases. The first phase of accessibility concerns the defining of a condition or an event as a problem. Differences between individuals are major in this phase. One identical objectively present emergency situation can be experienced as a problem by some and not by others. The way in which it is experienced as a problem moreover also can vary greatly between individuals. Second, one chooses to seek professional help for this 'problem situation'. For some, this step is easily made. Others choose self-help (or do nothing) because they lack knowledge, because they had bad experiences of heard negative things about certain services or because they feel ashamed to show their impotence. Still others struggle with financial considerations, for example when health care is concerned (Willems, 2005; Vanroelen, Smeets, Louckx, 2004). Third, once people have decided to appeal for a certain service, they still have to gain access. Formal/official as well as informal/unofficial conditions play a role. Last, once admitted, there are differences in the ways people cope with the service, with the demands it poses and with the expectations from staff. The Frame Decree on Local Social Policy, among others, has put accessibility of welfare services back on the agenda. Moreover, methods have been developed that should allow to track down non-take up. However, the current models still presuppose that the person in need in help will take the first step towards a service. Therefore, there is a need for new methods that track down target groups that are hard to reach, and that appeal to them to use the current services.

### *6.6. Front-line workers and the learning organization*

In welfare work and in care, three sources of complexity can be distinguished. A first problem stems from the object of care, being a service user who can hardly been standardized. Every demand for care or help has a unique, individual component. A second source of complexity lays in the scientific foundation of care. Getting an overview becomes an illusion because of the speed of scientific development, along with the fact that the foundations continue to be discussed of contested. Finally, the organizational context of care is also a source of complexity. In many trajectories, a range of professionals is involved, or even a range of organizations. Moreover, there often is a serious time pressure in an environment characterized by limited means. To do this work, one needs professional knowledge and abilities. In that sense, welfare and health professionals are knowledge workers who try to make relevant connections between scientific insights, experiential knowledge, specific information about users and the labyrinth of organizational rules and procedures that characterizes their work. This experiential knowledge is not always easy to make explicit, and therefore is called silent knowledge (Schön, 1983; Argyris & Schön, 1999).

It is dangerous to consider silent and explicit, more formalized knowledge as different and even as conflicting kinds of knowledge. In fact, they are two sides of the same medal. Professional knowledge consists of the precarious interweaving of explicit rules and silent knowledge. To tear these sides apart, or to focus on just one of them at the expense of the other, is too limited a strategy. In view of the rapidly changing society, it is essential that within as well as between organizations, instruments are developed that allow to make explicit silent knowledge and to share this knowledge between front-line workers. In that way, welfare and health organizations can become learning organizations.

## **7. Priorities of the Centre**

This extensive overview clarifies that it is no sinecure to establish priorities for the Centre. Three variables play a major role in this process of choice: the current needs and expectations in view of the changes on the demand side, the policy priorities of the Minister and the expertise of the research team.

In order to pursue a powerful, innovative and effective policy in the domains of welfare, public health and the family, the promoters think a multiple strategy is necessary. This strategy should consist of the following ingredients:

- to disclose existing databases and to define indicators
- to develop panels of target groups in order to map trajectories
- to quickly and effectively track down needs in welfare, public health and the family
- to test innovating interventions, in prevention as well as in assistance
- to develop models that exceed sectors and organizations, in order to counter compartmentalization and in order to develop an integral policy in welfare and health
- to convert these interventions into legislation and to attune them with existing legislation

We want to realize this in three research programs:

1. The program 'Indicators and monitoring' aims at disclosing existing databases and at collecting new longitudinal data, with which the trajectories and the use of care of different types of assistance seekers can be mapped.
2. The program 'Evaluation and development' aims at optimizing the evaluation of the supply of assistance and prevention and at the development, implementation and evaluation of innovative methods and policy interventions that lead to a higher quality of care and of services and to a better cost efficiency.
3. The program 'Legal and institutional framework' aims at integrating these innovations into the legislation and the policy and organization of care and welfare services.

These priorities will be structured by means of three target groups: children and youngsters, adults and elderly people. Within each target group, we aim at determining a number of priorities:

- Children and youngsters: problematic educational situations, habits in eating and exercise

- Adults: people at risk of poverty, people with relational problems, people with psychological problems and people with disabilities.
- Elderly people: participation, needs of care and dementia.

## Bibliography

- Argyris, C., Schön, D. (1999) *Organizational learning II: Theory, method and practice*, Reading, Mass: Addison Wesley.
- Audenaert, V. (2003). Changes in older people's living arrangements in Flanders, 1993-98. *Ageing and Society*, 23, 451-469.
- Bauduin, D., McCulloch, A., Liégeois, A. (ed.) (2002). *Good care in the community. Ethical aspects of deinstitutionalisation in mental health care*. Utrecht: Trimbos-instituut.
- Beck-Gernsheim, E. (1996). *The normal chaos of love*. Cambridge: Polity Press.
- Deleeck, H. (2001). *De architectuur van de welvaartsstaat opnieuw bekeken*. Leuven: Acco.
- De Rynck F. (red) (2003), De eeuw van de stad: over stadsrepublieken en rastersteden. Brussel: Ministerie van de Vlaamse Gemeenschap. Administratie Binnenlandse aangelegenheden, 238 p.
- Felce D., Perry J., 1996, Exploring Current Conceptions of Quality of Life, in: Renwick R., Brown J., Nagler H. (eds.), *Quality of Life in Health Promotion and Rehabilitation*, London, Sage
- Ferrara, M., Hemerijck, A. & Rhodes, M. (2000). *The future of social Europe. Recasting work and welfare in the new economy*. Oeiras: Celta Editora.
- Hardonck S, Vanroelen C, Loucx F (2004). Sociaal-economische gezondheidsverschillen in België: analyse van de gezondheidsenquête 2001. pp.123-146. In:Vrancken J, De Boyser K, Dierickx D, (red). *Armoede en sociale uitsluiting. Jaarboek 2004*. Leuven: Acco.
- Hermans, K., Seynaeve, T., Declercq, A., & Lammertyn, F. (2004). *Aan de rand van de actieve welvaartsstaat. Een socio-biografisch onderzoek naar jongeren en OCMW-hulpverlening*. Gent: Academia Press.
- Holburn, S., Vietze, P. (2002). *Person-Centered Planning: Research, Practice, and Future Directions*. Baltimore, MD: Brookes Publishing Company
- Kesteloot, C., Vandenbroecke, H., Van der Haegen, H. (1996), *Atlas van achtergestelde buurten in Vlaanderen en Brussel*. Brussel: Ministerie van de Vlaamse Gemeenschap.
- Lynn, L., Heinrich, C., & Hill, C. (2001). *Improving governance: a new logic for empirical research*. Washington: Georgetown University Press.
- Maes, B., Bruyninckx, W., Goffart, K; (2003). *Trajectbegeleiding voor personen met een handicap*. Leuven: Acco.
- Milisen K, Detroch E, Bellens K, Dierickx D, Smeulders W, Teughels S, Dejaeger E, Boonen S, Pelemans W. (2004), Valaccidenten bij thuiswonende ouderen: een pilotstudie naar prevalentie, omstandigheden en gevolgen in Vlaanderen. *Tijdschrift voor Gerontologie en Geriatrie*, 35, 15-20.
- Pedlar, A., Haworth, L., Hutchison, P., Taylor, A., & Dunn, P. (1999). *A textured life: Empowerment and adults with developmental disabilities*. Waterloo, ON: Wilfrid Laurier Press.
- Sannen L.(2003), *Drempels naar welzijnsvoorzieningen: de cliënt aan het woord*. Leuven: Hiva.
- Schalock, R.L., Verdugo, M.A. (2002). *The handbook on quality of life for human service practitioners*. Washington DC: American Association on Mental Retardation.
- Schon, D.(1983). *The Reflective Practitioner: How professionals think in action*. London: Temple Smith.
- Thornicroft, G. & Tansella, M. (1999). Translating ethical principles into outcome measures for mental health service research. *Psychological Medicine*, 19, 761-767.
- Van Audenhove, Ch., Van Humbeeck, G., Van Meerbeeck, A. (2005). De vermaatschappelijking van de zorg voor psychisch kwetsbare mensen. Onderzoek, praktijk en beleid. Leuven: Lannoo Campus.
- Vanden Boer L., Vanderleyden L. (2004). Zorg en ondersteuning. In: Jacobs, T., L. Vanderleyden, L. Vanden Boer (red). *Op latere leeftijd. De leefsituatie van 55-plussers in Vlaanderen*. Antwerpen: Garant.
- Van Meerbeeck, A. (2003). *Determinanten voor de instroom in tehuizen voor niet-werkenden*. Leuven: LUCAS
- van Weeghel, J., Van Audenhove, Ch., Colucci, M., Garanis-Papadatos, T., Liégeois, A., McCulloch, A., Muijen, M., Norcio, B., Ploumbidis, D. & Beauduin, D. (2005). The components of good community care for people with severe mental illness. Views of stakeholders in five European countries. *Psychiatric Rehabilitation Journal*, 28 (3), 274-281.
- Ward, L. (Ed.) (1998). *Innovations in advocacy and empowerment for people with intellectual disabilities*. Chorley: Lisieux Hall.
- Willems S (2005). *Socio-economic differences in health: a never ending story? Doctoral thesis*. Gent: Universiteit Gent.

## Overview of the multi-annual research program

### ***Program 1: Indicators and monitoring***

#### 1.1 Family and youth: 0-18 years

- Inventory of basic data with gap-analysis
- Longitudinal research into the prevalence and problem evolution and assistance trajectories of families  
Cohort follow-up 0-3-6 years; 12,000 children

#### 1.2 Adults

- Inventory of basic data with gap-analysis
- Sample of specific target groups, follow-up of indicators and trajectories:
  1. people at risk of poverty
  2. people with mental problems
  3. people with relational problems
  4. people with disabilities

#### 1.3 Elderly people

- Inventory of basic data with gap-analysis
- Specific target groups, follow-up of indicators and trajectories:
  1. elderly people with feelings of unwell being and depression
  2. elderly people with cognitive problems and dementia

### ***Program 2: Evaluation and development***

#### 2.1 Concept-mapping and selected regions

2.2 Family and health behaviour: healthy nutrition and exercise. Multi-component intervention in toddlers and 6 to 9 year olds in selected regions

2.3 A psycho-educative teaching program on stress for preventing stress, fear and depression

### ***Program 3: Legal and institutional framework***

#### 3.1 Legal framework

- Comparative law analysis of basic data: legal texts, jurisdiction, legal doctrine
- Legal protection of the welfare client
- Set of instruments for the government in the welfare sector

#### 3.2 Institutional framework

- Inventory of basic data
- Supply chain management in welfare
- Inter-sector care trajectories

## **4. Content of the multi-annual program**

In this part of the proposal, we give a complete overview of the contents of the three research programs. Summaries can be found in the project index cards in part 5.

### **Program 1: Indicators and monitoring**

#### **Background summary**

In Flemish welfare and health care, there are a large number of registrations that follow-up the functioning of different sectors. The data in these registrations contain a lot of information on the input of resources. The Flemish Regional Indicators yearly summarize these input registrations (among others for elderly care, care for people with disabilities, youth care and general welfare work). However, we dispose over far less data where the users of services, their use of care across services (parallel use of care) and the determinants of that use are concerned. Since 2001, the Flemish government subsidizes the Intego network that registers diseases, illnesses and disorders in selected general practices ([www.intego.be](http://www.intego.be)). Certain parts of care use (laboratories, medication, referring) are mapped by this network. These kinds of indicators are extremely relevant for policy making, since they contain data on the care trajectories and the immediate effects of investments (output). Therefore, there is a need for more insight in the trajectories of certain target groups of assistance seekers in Flanders. To this end, the CWPF firstly wants to make a contribution by the program of ‘indicators and monitoring’. This program differentiates between three target groups or project lines: (1) children, youngsters and families; (2) adults; and (3) elderly people. For each target group, the researchers determine priorities. This selection process will be fully elaborated upon in the description of the three project lines;

For each of the three target groups, there are two phases in the program. The first phase consists of a gap-analysis. This means that all existing scientific databases, administrative data and registration data will be collected and mapped. This should lead to an insight in the information that is already available, in the overlap between data, in redundancy of data, and in hiatuses.

The second phase consists in the collection of data trough panels of care users. At his moment, there are no panels of users of welfare and health care services in Flanders. The existing data mostly consider supply data (number of organizations, number of staff, services rendered), with a limited amount of demand data (number of clients, demographical data on clients and scaling in diverse assessment instruments). For good policy making and for the evaluation of the outcomes of policy, we also need data that only the users themselves can provide: which services do they use and why? Are they satisfied with the services? What do they miss? How do they organize their own care and assistance? What impact does the use of care have on their quality of life? By means of repeated questioning of panels in which people with specific problems (cases)

(problematic educational situations, relational problems, poverty, psychological complaints, depression, dementia), we can study how they search for and receive care and assistance in the long term. This kind of information allows drawing up better plans at the policy level (distribution of resources). We thus aim at repeatedly questioning the same panels of care users in the future, to study the impact of certain policy interventions on the nature of the care use, on the quality of life, on the quality of care and on the satisfaction with care.

These panels will be organized in clearly defined territorial regions. There will be a minimum of 6 and a maximum of 10 regions. These regions will be chosen in a way that they are relevant for the Flemish policy in welfare, public health and the family. This implies that a number of variables will guide the choice: geographical distribution, degree of urbanization, socio-economic situation of the regions and the presence of services within the domains of welfare, public health and the family. This will firstly be inspired by the work of Kesteloot et al. (1996) and Kesteloot & Vandermotten (2001). The atlas of neglected neighbourhoods in Flanders and Brussels from 1996 still stands as a reference for the study of the socio-economic situation of Flanders and Brussels. The more recent study from 2001 focuses on metropolitan districts. It is self-evident that these researchers will be contacted for the selection of the regions. Furthermore, these studies should be supplemented with data on the supply side or the presence of welfare and health services. This is a necessity because there are large differences in Flanders in presence of services at the level of the municipality and the region. We can also see this in the planning process the municipalities currently go through for the execution of the Frame Decree on Local Social Policy. We aim at mapping the landscape of Flemish welfare and health services in a more structured way. The database that is developed by Dominique Verté (see the project line on elderly people), with data on over 100 municipalities will also be of use in this phase. It should be clear that the definition of a 'region' can differ, going from parts of metropolitan districts to a combination of smaller, rural neighbouring municipalities. It is also self-evident that one or two regions in Brussels will be selected.

### **References**

Kesteloot, C., Vandenbroecke, H., Van der Haegen, H. (1996). Atlas van achtergestelde buurten in Vlaanderen en Brussel. Brussel: Ministerie van de Vlaamse Gemeenschap.

Kesteloot, C., Vandermotten, C. (2001). Sociale structuren en buurten in moeilijkheden in de Belgische stadsgewesten. Leuven: Instituut voor sociale en economische geografie.

**Project line 1.1: Families and youth: Health, development, behaviour and education of 0 to 18 year olds: Longitudinal research into the prevalence and progress of problems and assistance trajectories in families**

## **1. Coordination and research groups involved**

Coordinator: Prof.dr. Hans Grietens (Catholic University of Leuven, Centre for family and orthopedagogics).

Ghent University:

Prof.dr. Herbert Roeyers (Department of experimental clinical and health psychology)

Prof.dr. Stefaan De Henauw (Department of social health)

Catholic University of Leuven:

Prof.dr. Karel Hoppenbrouwers (Section Youth healthcare)

Prof.dr. Bea Maes (Centre for family and orthopedagogics)<sup>3</sup>

Prof.dr. Patricia Bijttebier (Research group Psycho diagnostics and Psychopathology)

Prof.dr. Paul De Cock (Section Youth healthcare)

Prof.dr. Emmanuel Lesaffre (Department of social healthcare)

Prof.dr. Johan Put (Institute for social law and youth criminality)

Free Brussels University:

Prof.dr. Johan Vanderfaeillie (Department of orthopsychology)

Prof.dr. Gerrit Loots (Department of orthopsychology)

## **2. Background**

Epidemiological research offers the opportunity to collect data on prevalence and incidence (see in the field of behavioural problems in children and adolescents, for instance Bird, 1996; Crijnen, Achenbach & Verhulst, 1997, 1999; Meltzer et al., 2003; Sawyer et al., 2001). In addition, it offers possibilities to trace evolutions in populations and to study continuities and discontinuities in the development of risks and problems. Finally, data can be gathered on the help-seeking behaviour of individuals and families and on their trajectories in the care system (Verhulst, 1995). In the last decade, we see that in the field of epidemiology more attention is paid to longitudinal and integrative studies. In these studies, cohorts of children are followed from birth on (some studies start to follow-up children before birth) until late adolescence. Different parameters

---

<sup>3</sup> During the academical year 2006-2007 Walter Hellinckx (Centrum voor Gezins- en Orthopedagogiek, K.U.Leuven) and Lieve Vandemeulebroecke (Centrum voor Gezins- en Orthopedagogiek, K.U.Leuven) will participate in the consortium. From the academical year 2007-2008 their successors will be involved.

regarding children (e.g., health, motor development), their family (e.g., family situation, transitions, parenting, stress, coping) and their context (e.g., socioeconomic aspects, living conditions, neighbourhood) are measured at different moments in time. We find examples of studies in the United States, in particular the NICHD Study of Early Child & Care Youth Development (<http://secc.rti.org/home.cfm>), and in the Netherlands, in the province of South-Holland, where recently a long-term study of birth cohorts has started, as well as in Amsterdam, where since January 2003 the Amsterdam Born Children and their Development (ABCD)-Study has started, in which more than 8,000 children will be followed until adulthood. These studies show us how children and families cope with risks and how they benefit from protective factors. Further, the families can be traced that seek and receive help in the event of problems related to parenting, development, behaviour or health, and what may be the benefits of early interventions. As they provide information on the possibilities of early screening and the outcomes of early interventions, these studies are of great importance to policy makers. They also may provide answers to other questions that are relevant to policy makers, for instance on the accessibility of the care system for populations that are difficult to reach, for instance underprivileged families and families from ethnic minority groups.

In Flanders there is so far only a limited tradition of longitudinal research on children's health, development, behaviour and rearing situation. Especially prevalence studies (e.g., by Hellinckx, De Munter & Grietens, 1991, 1993, on behaviour problems in children) were carried out, with a few exceptions, such as the longitudinal research by van den Bergh (2004) into the importance of pre- and postnatal influence on children's stress, health and well-being. The need for such studies is nevertheless high. For when we get more information on where young families and children at risk are to be found, how chronic their risks and what their real needs are, their care may be organized and budgeted in a more efficient way. In this way policy gets a better image of the needs for care in diverse regions.

From epidemiological research we also know that there are children and families with problems that do not reach the care circuit or not on time (i.e. in a stage that an intervention may yield positive results) and that parents' search for help is filtered by many variables (Verhulst, 1995). These refer to child factors (e.g. on the domain of behavioural problems we notice that for externalizing problems, school problems and chronic health problems help is relatively quickly sought), family factors (e.g. the balance of resources and responsibilities in a family, parental functioning) and context factors (e.g. families from ethnic minorities seek help less frequently or later, in some schools certain signs are picked up more quickly) (Zwaanswijk e.a., 2003). The organization of care in itself plays here most probably also a negatively filtering part. Because of its complex structure (also for care workers) and because the client's own initiative and maturity is called on, certain groups do not find the way (e.g. multi problem families, families of ethnic minorities). For others the way to care is blocked because their problems have not been screened or discovered in time (e.g. health and development problems, educational problems, intra familial violence, neglect). Still others on the other hand end up in care (too) soon and become too dependent on care because the supply does not sufficiently emancipate them or make them

responsible. Part of the children and families with problems does evidently not (or not in time) get the help they need. There are indications that the children and families who might most profit from professional help, do not get it in time and that 'who does not ask, is left out' (Baartman, 1996). From a preventive point of view it therefore is important that the problems and needs of vulnerable children and families are sooner identified and mapped, that they are promptly guided to adequate help and that care becomes more accessible for families that are difficult to reach.

Of the situation in Flanders we have in this connection but a fragmentary image. Limited and cross-sectional studies in the framework of Integral Youth care have established that for instance families of ethnic minorities do find the way to care only with difficulty and that young people often only in the period of adolescence are for the first time able to let know the problems they already had for some time (e.g. a teacher or School Guidance Centre-collaborator). There is besides not much insight in the admittance to the different sectors of youth care, nor in the help that is asked for, or the case history of those who are admitted. In the Global Plan Youth care (Vervotte, 2006) too we can find references to these lacunas. In other words scientific research is needed that maps the admittance across the sectors and that studies the case histories of those who are admitted. It is important that in doing so attention is also paid to groups at risk – by this term we mean children and families for whom the access to care is made more difficult, such as the underprivileged or persons from ethnic minorities – and that research is started on young children, for many, if not most, health, behavioural, developmental and educational problems manifest themselves for the first time early in life.

### **3. Objectives**

- Collect data on prevalence of health, developmental, behavioural and educational problems in 0-9-year-olds (and in case of continuation: 0-18-year-olds) from regions that are socio-economically different;
- Gain insight in the factors that in some vulnerable families cause the presence of risks to lead to an escalation of problems and not in other families;
- Assess the needs and real consumption of professional care by parents because of these problems and their determinants on micro, meso and macro level;
- Collect index numbers in voluntary care (networks that are directly and indirectly accessible) on the number of people who are taken care of and the case histories of 0-9-year-olds (and in case of continuation: 0-18-year-olds) and their families in the prevention and care that is supplied because of health, behavioural, developmental, or educational problems;
- Gain insight in what kind of help families and children in care are asking in connection with the child's health, behavioural, developmental and educational problems (across sectors, especially general welfare work, Child & Family, School Guidance Centres, mental health care and other health facilities, special youth care, Flemish Office for Persons with a Handicap, family doctors and paediatricians) and in their case history;

- Check whether and to what degree evolutions in health, behavioural, developmental and educational problems and client perception of care (accessibility, participation, satisfaction) are connected with:
  - client and client system features
  - nature of the kind of help that is asked for
  - case history.
- Verify the outcome of early/timely care given to children and families at risk;
- Produce and offer instruments and procedures for 1) early screening of health, behavioural, developmental and educational problems and 2) the analysis of risk and protective factors.

#### **4. Method**

An accelerated longitudinal or cross-sequential design shall be used in which three cohorts (0-, 3-, 6-years-olds) are being followed for a period of four years (see Table 1). This design, in which the ages overlap at the ages of 3 and 6, has the advantage that, under certain conditions, at the end of the follow-up, statements can be made over a broader age range than the age range at the start (Achenbach, 1995). At the end of this study it will be possible to make statement on the ages 0-9 year. In case of continuation of the Support Centre the study shall be continued with cohorts of 9-, 12- and 15-year-olds, so that statement can be made over a period of 10 year on the ages 0-18 year<sup>4</sup>.

The sample is taken in two phases, starting from a 'conditional random sampling' plan. In the first phase regions across Flanders will be selected across all programs and project lines (see above). We will then select the corresponding regions of Child and Family (each with an average of some 1000 births per year). The families of children of 0 year are selected by taking the total number of children that are born in a region in a certain period till the required number of 6 000 babies is reached, and analogously the total number of children (or a proportion) is taken from the same region who in that period reach the age of 3 or 6 year till the required number of 3 000 children of each or of both age groups is reached.

---

<sup>4</sup> In case of continuation of the Support center the cohorts 1 till 3 too will be followed up.

*Table 1 Survey of the cohort study*

<p><u>Period 2007-2011</u></p> <p>Cohort 1 (n = 6.000): 0-year-olds (measuring at the age of 0, 1, 2 and 3 year)</p> <p>Cohort 2 (n = 3.000): 3-year-olds (measuring at the age of 3, 4, 5 and 6 year)</p> <p>Cohort 3 (n = 3.000): 6-year-olds (measuring at the age of 6, 7, 8 and 9 year)</p> <p><u>Period 2012-2016</u></p> <p>Cohort 4 (n = 3.000): 9-year-olds (measuring at the age of 9, 10, 11 and 12 year)</p> <p>Cohort 5 (n = 3.000): 12-year-olds (measuring at the age of 12, 13, 14 and 15 year)</p> <p>Cohort 6 (n = 3.000): 15-year-olds (measuring at the age of 15, 16, 17 and 18 year)</p>
--

As most children (approx. 95% of all newborn have at least once been in contact with Child & Family) between 0 and 3 year have a file with Child & Family and as of a large proportion of these children and their families (82,7% have at least 3 consultations in the first year of their life, 76,1% have at least 1 consultation in the second year of their life, and 54,0% have at least 1 consultation in the third year of their life; Child and Family, Annual report 2005) a lot of data are collected in a systematic way, we want to involve this organization as a partner from the start in our research project and to graft our measuring on the existing registrations (cf. IKAROS) with regard to health, development, behaviour and living situation of children in Flanders. From the age of 2,5 to 3 year most children go to school and have an School Guidance Centre-file. From that age on we will graft the data collection on the existing School Guidance Centre-registrations. In order to increase this study's relevance for policy and to realize the objectives we have set and proceeding from the present expertise in the diverse research groups concerned, we want to complete the information on health, development and living situation, collected by Child & Family and School Guidance Centre, with specific measuring.

We plan to measure the following variables:

- weight, feeding and movement behaviour and their determinants at different ages,
- temperament and behaviour regulation,
- cognitive and motor development,
- socio-communicative skills and language development (inclusive specific screening of autism spectrum disorders),
- educational stress and early signs of educational problem situations (with special attention to risks of child abuse),
- family situation and evolution,
- needs, real consumption of help and case histories.

Proceeding from the consortium's present expertise, a few target groups of children will be followed more extensively, especially children with low weight at birth, (young) children with a developmental disorder (among them children with autism spectrum problems) or a disability and (young) children who present serious externalizing problems (aggression, rule violating behaviour). The studies on these target groups are partly in keeping with current research in the research groups concerned and therefore additional means from other financing channels can be

used. This goes among other things for the study of premature children and children with an autism spectrum disorder.

The database that will be obtained in this way may be used in other projects by the Support Centre (e.g. as a control group) and will be open to other researchers than those of the Support Centre. It will be the responsibility of the data-manager attached to the Support Centre.

## **5. Phasing**

- year 1: preparation and start up of the longitudinal research project (among others contacts with Child & Family, School Guidance Centre); selection of the regions; selection of the specific parameters and instruments, implementation in the existing registrations;
- year 2-5: start and follow-up of the cohorts, data collection and interim analyses
- year 5: final report, dissemination, finishing doctoral dissertation, preparation research of following cohorts (depending on continuation of the Support Centre)

## **6. Expected output and valorisation**

- Data on the prevalence and the case history of health, behavioural, developmental and educational problems in 0-9-year-olds in Flanders in relation to the socio-economic features of their native region and in a longitudinal perspective
- Longitudinal data on the care families need and consume and on their determinants (child, family, social milieu) and on the (possible) discrepancy between care needed and care consumed;
- Longitudinal data on child, family and context factors that either buffer the presence of early risks or enhance them;
- Longitudinal data on the transitions of families and children (e.g. at the age of 2,5 year and of 6 year, and depending on the continuation of the Support Centre also at the age of 12 year) and its impact on health, behaviour, development and education;
- Data on the case histories of families that have been admitted to prevention and care because of health, behavioural developmental, or educational problems (in voluntary supply and in the different sectors concerned);
- Longitudinal data on the help families at risk are asking , its effect on family and child and the effect of (early) interventions;
- A differentiated understanding of the help parents are asking of professional care workers in connection with their child's health, behavioural, developmental and educational problems;
- An analysis in a longitudinal perspective of the connection between: 1) evolutions in health, behavioural, developmental and educational problems and client perception of

- care (accessibility, participation) and 2) client and system features, nature of care asked for and case history;
- A screening battery that may be used by the authorities and the different sectors concerned to map risks in families with young children; as an example we mention the POS-scale (Hellinckx e.a., 2001), that is being used by regional health visitors of Child & Family to screen the risks of educational problem situations that may end in physical abuse or neglect, and that soon will be adapted to be used in other age groups and sectors (among others School Guidance Centre, committees special youth welfare);
  - An annual report evaluating the project's state of affairs (inclusive the results of the different measuring moments);
  - A symposium at the end of the first phase of the Support Centre (and a new symposium in case of continuation of the Support Centre);
  - The research groups commit themselves to continue their mutual cooperation on behalf of the research project's objectives and for this purpose will look for external financing by (inter-)national instances (among other things the European Community). By doing so the index numbers and data that have been obtained on monitoring can be placed in an international perspective.

## 7. Bibliography

- Achenbach, T.M. (1995). Developmental issues in assessment, taxonomy, and diagnosis of child and adolescent psychopathology. In D. Cicchetti & D.J. Cohen (Eds.), *Developmental psychopathology. Volume 1. Theory and Methods* (pp. 57-80). New York: John Wiley & Sons, Inc.
- Amsterdam Born Children and their Development (ABCD). Zie: <http://www.abcd-study.nl>. [Afgehaald 31 juli 2006].
- Baartman, H.E.M. (1996). *Opvoeden kan zeer doen. Over oorzaken van kindermishandeling, hulpverlening en preventie*. Utrecht: SWP.
- Bird, H. (1996). Epidemiology of childhood disorders in cross-cultural context. *Journal of Child Psychology and Psychiatry*, 3, 35-49.
- Crijnen, A. A. M., Achenbach, T. M., & Verhulst, F. C. (1997). Comparisons of problems reported by parents of children in 12 cultures: Total Problems, Externalizing, and Internalizing. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 1269-1277.
- Crijnen, A. A. M., Achenbach, T. M., & Verhulst, F. C. (1999). Comparisons of problems reported by parents of children in twelve cultures: The CBCL/4-18 syndrome constructs. *American Journal of Psychiatry*, 156, 569-574.
- Hellinckx, W., De Munter, A., & Grietens, H. (Red.) (1991). *Gedrags- en emotionele problemen bij kinderen. Deel 1. Een epidemiologisch onderzoek bij 6-tot-12-jarigen in Vlaanderen*. Leuven: Garant.
- Hellinckx, W., De Munter, A., & Grietens, H. (Red.) (1993). *Gedrags- en emotionele problemen bij kinderen. Deel 2. Prevalentie van probleemgedrag bij kleuters. Diverse aspecten van probleemgedrag bij lagere-schoolkinderen. Synthese van het prevalentie-onderzoek in Vlaanderen*. Leuven: Garant.
- Hellinckx, W., Grietens, H., Geeraert, L., Moors, G., & Van Assche, V. (2001). *Risico op kindermishandeling? Een preventieve aanpak*. Leuven/Amersfoort: Acco.
- Kind & Gezin (2006). *Het kind in Vlaanderen 2005*. Brussel: Auteur.
- Meltzer H, Gatward R, Goodman R, & Ford T. (2000). *Mental health of children and adolescents in Great Britain*. London: Stationery Office.
- Sawyer, M.G., Arney, F.M., Baghurst, P.A., Clark, J.J., Graetz, R.J., Kosky, R.J., et al. (2001). The mental health of young people in Australia: Key findings from the Child and Adolescent Component of the National Survey of Mental Health and Well-being. *Australian and New Zealand Journal of Psychiatry*, 35, 806-814.
- Studiedienst van de Vlaamse Regering (2006). *VRIND 2006: Vlaamse regionale indicatoren*. Brussel: Auteur.

- Van den Bergh, B. (2004). Stoornis in zelfregulatie bij kinderen en adolescenten: Mede een gevolg van foetale programmering? In L. Goossens, D. Hutsebaut, & K. Verschueren (Red.), *Ontwikkeling en levensloop* (pp. 55-79). Leuven: Universitaire Pers.
- Verhulst (1995). The epidemiology of child and adolescent psychopathology. In F.C. Verhulst & H.M. Koot (Eds.), *The epidemiology of child and adolescent psychopathology* (pp. 1-21). Oxford: Oxford Medical Publications.
- Verhulst (1995). The epidemiology of child and adolescent psychopathology. In F.C. Verhulst & H.M. Koot (Eds.), *The epidemiology of child and adolescent psychopathology* (pp. 1-21). Oxford: Oxford Medical Publications.
- Vervotte, I. (2006). *Globaal Plan Jeugdzorg. De kwetsbaarheid voorbij...Opnieuw verbinding maken*. Brussel: Ministerie van Welzijn, Volksgezondheid en Gezin.
- Zwaanswijk, M., Verhaak, P.F.M., Bensing, J.M., van der Ende, J., & Verhulst, F.C. (2003). Help-seeking for emotional and behavioural problems in children and adolescents. *European Child and Adolescent Psychiatry*, 12, 153-161.

## 8. Personnel

Because of the study's interdisciplinary character we ask for 3 grant recipients from different disciplines (especially medical, psychological, educational).

**Project line 1.2 Adults**

**1. Coordination and research groups involved**

Coordinator: Prof.dr Jan Demaeseneer (UGent, Department of Family Medicine and Primary Care)

Catholic University of Leuven:

Prof.dr. Chantal Van Audenhove (LUCAS & Academic Centre for General Practice)

Dr. Koen Hermans (Centre for Sociologic Research)

Prof.dr. Bea Maes (Centre for family and orthopedagogics)

Prof.dr. Frank Buntinx (Academic Centre for General Practice)

Prof.dr. Emmanuel Lesaffre (Biostatistics Centre)

UGent:

Dr. Sara Willems (Department of Family Medicine and Primary Care)

Prof.dr. Ann Buysse (Department of experimental, clinical and health psychology)

Catholic Superior College of the Kempen:

B er enice Storms (Local Social Policy and local Economic Policy)

**2. Introduction**

The specific historical development of the Flemish welfare and health field led to a large variety of services, organizations and arrangements for adults. Most are private not-for-profit services which operate under the control of and are financed by the Flemish authorities. In addition, a broad set of organized interested parties are involved in this mixed economy of services and organizations. Each sector has its own regulations, paradigms, values, methods, registration systems and administrative organization. Also the registration numbers are sector-specific and organization-specific and show only the input-side in terms of inflow and performance. Little is known about service trajectories (inside one organization and across different services and sectors) and about direct effects of interventions. The current Flemish government aspires to diminish the compartmentalization and parochialism and to search for more coordination between the different sectors and organizations. This should lead to a higher effectiveness and efficiency, integration and strength of policy. To this end, it is necessary to map assistance trajectories within organizations, but also across organizations and sectors.

### 3. Aims

In Flemish welfare and health care, there currently are a large number of registrations that follow-up the functioning of different sectors. The data in these registrations contain a lot of information on the input of resources. The Flemish Regional Indicators yearly summarize these input registrations (among others for elderly care, care for people with disabilities, youth care and general welfare work). Moreover, there are good survey data on morbidity (among others, the National Health Survey). However, we dispose over far less data where the users of services, their use of care across services (parallel use of care) and the determinants of that use are concerned. Since 2001, the Flemish government subsidizes the Intego network that registers diseases, illnesses and disorders in selected general practices ([www.intego.be](http://www.intego.be)). Certain parts of care use (laboratories, medication, referring) are mapped by this network. This evidence is, however, very relevant for policy makers, because it clarifies, firstly, the appeal for welfare services and social care from a longitudinal point of view. Secondly, it allows detecting gaps and overlaps at the supply side. Thirdly, direct effects of specific welfare and care programs and interventions can be traced. Finally, by following service trajectories current effective forms of cooperation and the need for coordination between different services can be detected. Thus, service trajectories open the black box between input and outcomes.

This project consists of two phases. During the first year a gap analysis will be performed. This implies that all existing research databases, administrative data and registration systems concerning welfare, health and the family in general and service users in particular will be mapped. This will result in a clear overview of the existing evidence, potential overlaps and gaps. Special attention will be paid to the socio-economic and ethnic profile of service users. In the second phase, which covers the next four years, the service trajectories of four specific adult populations will be followed. Based on three factors, namely the current needs and expectations at the demand side, the Minister's policy priorities and researchers' expertise four adult populations are selected: (1) persons at risk of poverty, (2) persons with mental problems, (3) persons with relational problems, (4) people with disabilities. For these four groups common and problem-related indicators will be developed and measured. This strategy facilitates to search for connections between the target groups and the related problems.

To sum up, this projects aims at:

1. A gap analysis of existing research databases, administrative data and registration systems.
2. Data on the inflow into primary social services and health care
3. Data on the service trajectories of four adult populations (persons at risk of poverty, persons with mental problems, persons with relational problems, persons with disabilities) across services, organizations and sectors in a longitudinal perspective.
4. Data on the users' knowledge of social and health care services.
5. Data on the effects of service trajectories measured by a multi-dimensional conceptualization and measure of the quality of life.

6. Data on the users' experiences with and their satisfaction with the quality of social and health care services (special attention to the relational aspects of social services)
7. The tracing of personal and environmental factors which increase the quality of life of the four target groups.
8. The improvements for the refinement and amelioration of the quality of registration systems and practices

#### **4. Four adult target groups**

This project focuses on four target groups: (1) persons at risk of poverty, (2) persons with mental problems, (3) persons with relational problems, (4) persons with disabilities.

##### *4.1 Persons at risk of poverty*

The last EU-SILC survey of 2004 showed that 11.3 % of the Flemish population is at risk for poverty. This means that they live in a family in which the disposable income per member doesn't exceed 9,324 euro a year or 777 euro a month<sup>5</sup>. According to the family situation, this amount is adapted with the use of equivalence scales. Moreover, this figure is higher than the current Belgian poverty baseline as is used in the social assistance system. Little is known about if and how this target group uses social services and health care facilities. For instance, it is unclear when this group flows in and out of the Public Centres for Social Welfare (PCSW) at the local level and the financial and non-financial assistance they provide. Nor do we know whether they are satisfied with the assistance they receive or whether they make use of parallel service trajectories.

This target group will not only be selected in PCSW's, but also in independent Centres for General Welfare, because 17 % of the clients of these Centres at the intake state that they dispose of an income that is lower than the general social assistance benefit. Special attention will be paid to their mental and relational problems and to which extent they search for professional help for these kinds of problems. This evidence is essential for the implementation of the 'Social Home' at the local level, which aims to re-organize the social services on the local level and to ameliorate the fit between the demand and the supply side of social and health care services<sup>6</sup>.

##### *4.2 Persons with mental problems*

The Belgian Health Interview Survey of 2004 shows that almost 20 % of the Flemish population wrestles with mental problems. More specifically, 10 % feels suicidal, 8 % has somatic problems, 7 % has depressed moods and 5 % has anxiety disorders. These are alarming results. As a

---

<sup>5</sup> For more information: <http://epp.eurostat.ec.europa.eu> .

<sup>6</sup> Social Home is the conceptualisation of the Public Centres of Social Welfare on the local level.

consequence, the SWVG considers this target group to be a top priority. The project aims to follow-up the service trajectory of persons after a first official registration of mental problems (in Centres of General Welfare or Centres of General Welfare organized by the national health care services). In that way, evidence can be collected about the risk factors for depression after a first official registration and about policy interventions and personal and environmental factors which can prevent this.

#### *4.3 Persons with relational problems*

A general picture of persons with relational problems in figures is not available. A first indicator is the total amount of divorces. Over the last four decades, the number of divorces quadrupled (0.66/1000 inhabitants in 1970 and 2.69/1000 in 2004). That makes 16,171 divorces in 2004 with about 19,405 Flemish children (on average 1.2 children per divorce) and 32,342 divorcing partners involved. The process of divorce causes a stressful disruption of life circumstances that profoundly changes many aspects of the quality of life of divorcing partners and their children. Divorcing partners commonly report elevated levels of depression, anxiety, substance abuse, and poor health-related habits (Amato, 2000; Aseltine & Kessler, 1993; Booth & Amato, 1991; Gotlib & McCabe, 1990; Lorenz, Simons, & Chao, 1996; Simons & Johnson, 1996). Similarly, most children exhibit a variety of signs of disturbance in the months after the divorce, including anxiety, sadness, anger, aggression, non-compliance, sleep disturbances, and disrupted concentration at school (Buisse & Ackaert, 2006). This does not imply that these symptoms and problems should only be ascribed to the divorce as such. We should especially look at the coping strategies of the partners. As a consequence, optimal ‘care’ or ‘service’ provided by the judicial and mental health professionals assisting divorcing partners and their children can make the difference between an awful and a ‘good’ divorce. That is, the divorce process is not only a function of the characteristics of the divorcing partners, their children and the family relationships but also of the competences and qualifications of the professionals involved in the divorce trajectory. One of the new methods concerning divorce is mediation. Over 50 international studies (only one pilot study in Flanders) are supportive and in favour of mediation, pointing to better conflict resolution, cooperation, settlement rates, cost effectiveness and client satisfaction (Emery, 1995; McEwen et al., 1994; Walton, Oliver & Griffin, 1999). However, in Flanders less is known about divorce trajectories and about satisfying methods and interventions in terms of quality of life. In addition, divorcing partners are a prominent research population because of the higher incidence of mental problems. However, we don’t want to limit the target group of relational problems to divorcing partners. In 2005, about 6000 persons made an appeal to a CAW (Centre for General Welfare) because of relational problems. The first phase, namely the gap analysis, will study these figures in detail. Special attention will be paid to the socio-economic and ethnic characteristics of the people who appeal to a CAW for this reason. Based on this analysis, this target group will be specified and their service trajectories will be followed.

#### *4.4 Persons with disabilities*

According to international frames of reference such as ‘the International Classification of Impairments, Disabilities and Handicap’ (ICIDH, 2000) handicap is defined as a long-term and important problem of participation which is the result of the combination between functional impairments, activity limitations and personal and external factors. This target is very heterogeneous: visual, auditive, intellectual impairments, chronic diseases, multiple impairments, behavioural disorders, emotional disorders etc. In recent research we have found that there are still several bottlenecks in the care system for persons with a disability (Maes, Bruyninckx & Goffart, 2003). Focus groups and interviews with persons with intellectual disabilities and their parents, showed, firstly, that the support system and the regulations connected with it (with regard to structure, admission criteria, modalities) are unclear, not transparent and ambiguous to them. They lack information and help in their search for the assistance arrangements they desire. Their participation in the process of determining support that is most adequately geared to their needs, is too limited. Many of them have negative experiences with support workers who lacked respect and appreciation for their views or preferences. In their opinion, service systems are not flexible enough in adapting support to their specific needs. Services rather than clients still control the way in which support is provided.

In the official call for this proposal, persons with disabilities are not mentioned as a prioritized target group. Nevertheless, we choose to include them in the study. However, additional financial support will be searched for, for the data collection and data analysis. By using the same indicators and regions, this process can be standardized. In addition, a considerable overlap between the four target groups is to be expected. For instance, several international studies show that people with disabilities run an increased risk for mental and relational problems ranging from 20% up to 75 % depending on the applied diagnostic criteria and methodology (Došen & Day, 2001; O’Brien, 2000). In addition, concerning this target group, the researchers want to cooperate closely with the Flemish Agency for persons with a handicap because of their expertise and their current research projects.

### **5. Sample strategy**

For each target group, a specific sample consisting of 800 individuals will be drawn. These individuals will be interviewed three times in three years. For each target group, a separate sample strategy will be developed. Although it seems self-evident that overlaps between the four groups will be detected, the first selection criterion is one of four distinguished problems. During the analysis, members of the other target groups can be added if the other problem categories are detected.

### *5.1 Persons at risk of poverty*

The selection is based on the EU poverty line, which is higher than the national Belgian poverty line. As a consequence, the sample does not only consist of social assistance beneficiaries but also of persons with very low social security benefits (unemployment, sickness and disability). The individuals will be selected in two primary social services, the Public Centres for Social Welfare, which are responsible for the execution of the general minimum income scheme and the Centres for General Welfare. The latter are chosen because in 2004 17 % of their clients had an income lower than the general minimum income scheme at the moment of registration<sup>7</sup>.

### *5.2 Persons with mental problems*

The selection criterion for this target group is a first official registration of mental problems in two primary social welfare services, namely the Centres for General Welfare and the Centres for General Welfare organized by the national health insurance funds. In 2004 about 5900 persons made an appeal to the CGW's because of mental problems. Less is known about the inflow into the CGW's of the national health insurance funds, but it seems self-evident that these primary social services also are confronted with persons with mental problems.

### *5.3 Persons with relational problems*

This target group consists of two categories: (1) divorcing partners and (2) persons with relational problems. To track down the divorcing partners, four organizations will be contacted: (1) Flemish Bar Association, (2) courts and tribunals, via the First President of the Court of Appeal; (3) Centres for General Welfare; and (4) the Royal Federation of Belgian Notaries. The second category will be selected out of the users of the CGW's, as is the case for other target groups. In 2004, the CGW's supported 6000 persons because of relational problems. The selection will be founded on a more detailed analysis of these registration figures.

### *5.4 Persons with disabilities*

This target group will be traced in two ways. Firstly, the Flemish Agency of persons with a handicap reaches a large part of the Flemish people with disabilities because of their large supply of financial, material, living and educational aids and support. However, it's unclear to what extent they cover all persons with disabilities in Flanders. As a consequence, we try to detect those who do not make an appeal on the agency's services by consulting the local authorities (because of their financial aid to this target group), the national health care services, the Public Centres for Social Welfare and the Centres for General Welfare and the Crossroads Bank for Social security (for indicators of an increased child benefits, extended minority). Both strategies are necessary, because the monitoring of these two groups can clarify the possibly dissimilar

---

<sup>7</sup> For more info: [www.steunpunt.be](http://www.steunpunt.be).

profiles and why, when and how they do or do not make an appeal to the Flemish Agency for persons with a handicap.

### *5.5 The quality of the data collection*

Evidently, this kind of longitudinal research into these target groups is no sinecure. More concretely, non response bias and attrition may not be ignored. As a consequence, the researchers have to invest sufficient time and means into monitoring the quality of the data collection and into searching for enough support for the project. Four steps will be taken. First, the social services will be involved. Program 2 describes the concrete methods (concept mapping and advisory boards consisting of users and services). Second, because of their face-to-face interactions with users, practitioners can be the direct link between the researchers and the users. Third, the poverty organisations and the experiential experts in poverty will be contacted to act as mediators with the persons in poverty. Fourth, the interviewers have to be sufficiently familiar with the four target groups. As a consequence, intensive and purposeful selection and training methods are necessary. The support of the social services also renders it possible to test the effects of current and new interventions (see program 2). In that way, the project is a win-win situation for the social services and the researchers. On the one hand, attrition can be avoided and the quality of the data will be safeguarded. On the other hand, the social services in the selected regions will be put in contact with innovative and successful interventions in order to enhance the quality and effectiveness of their functioning.

## **6. Indicators**

For these four groups, a common list of indicators completed with problem-related indicators will be followed up. The common indicators are:

1. Quality of life:
  - a. well-being
  - b. health situation
  - c. interpersonal and relational situation
  - d. social network and social capital (friends, neighbourhood and associations)
  - e. financial situation (and the burden of debt)
  - f. labour participation and leisure activities
  - g. self care: smoking, food and exercise
  - h. housing
2. Knowledge of social services and health care
3. Appeals to social services and health care
4. Quality of relational aspects of social services
5. Experienced profit of and satisfaction with the services
6. Socio-economic and ethnic characteristics

The quality of life will be measured by the General Health Questionnaire' and the 'Quality of Life Questionnaire' (Schalock & Keith, 1993). Next to the health situation, the financial, relational, housing, labour market situation, the social capital, the social network and the extent of self care will be analyzed. This broad conception of quality of life allows studying the effects of policy interventions on various aspects of life and the correlation of poverty, (mental) health and relational problems. The knowledge about the social and health services indicator concerns the question whether the person has enough information about the supply-side to find the right service for his problem. The next question is which services are contacted and for what reasons. The relationship between the client and the professional is an essential part of human services. That is, the quality of this relationship determines to a large extent the intervention's success. The relational aspects are measured by the following indicators: disposing of sufficient and comprehensible information, giving the client sufficient time, creating participation in the service trajectory, showing empathy, opening up the dossier, starting from a holistic perspective. The concept 'experienced profit' is developed by the Dutch Verwey-Joncker institute and has a broader conception than only measuring the user's satisfaction (Melief, 2003). More concretely, the users decide about the experienced profits, the learning effects in terms of new knowledge and new information, the solution of problems and the potential acceptance of a hard to change situation. This form of experiential evidence is an essential part of a broader conception of evidence-based policy (see program 2) in which also the users' voice is acknowledged and valorised. Finally, we will explore to what extent this database can be connected anonymously with databases about the cost and the use of health care services (to search for links between the use of welfare services and health care).

## **7. Regions as starting point**

For each target group, 800 individuals will be followed up. They will be selected in the same regions as the other research projects.

## **8. Expected output and valorisation:**

- A gap analysis of existing research databases, administrative data and registration systems resulting in a clear overview of the existing evidence, potential overlaps and gaps
- The monitoring of the policy concerning four target policy priorities: poverty and social exclusion, relational problems, mental problems and handicap.
- Data on the inflow into primary social services and health care.
- Data on the service trajectories of four target groups (persons at risk of poverty, persons with psychological problems, persons with relational problems, persons with a handicap)
- Data on the users' knowledge about human services.
- Data on the experienced profits, the satisfaction and the effects of service trajectories, measured by means of a broad conception of quality of life.

- Data on parallel service trajectories across organisations and sectors.
- Longitudinal data on the care these target groups need and consume, on their determinants and on the (possible) discrepancy between care needed and care consumed;
- A longitudinal analysis of the correlation between poverty, mental problems and relational problems.
- Data on the forms of cooperation between services and organisations on the local level
- An overview of gaps and overlaps of the current supply of social welfare and health care services
- The improvement and tuning of referral and registration practices
- An overview of necessary forms of coordination between different organizations and sectors.

## 9. Literature

- Amato, P.R. (2000). The consequences of divorce for adults and children. *Journal of Marriage and the Family*, 62, 4, 1269 – 1287.
- Aseltine, R.H., Kessler, R.C. (1993). Marital disruption and depression in a community sample. *Journal of Health and Social behaviour*, 34, 3, 237-251.
- Booth, A., & Amato, P.R. (1991). Divorce and psychological stress. *Journal of Health and Social behaviour*, 32, 4, 396-407.
- Buysse, A., & Ackaert, K. (2006). Kinderen en Scheiding. *Tijdschrift voor Jeugd- en Kinder-rechten*, first edition.
- Došen, A., & Day, K. (2001). Epidemiology, etiology, and presentation of mental illness and behavior disorders in persons with mental retardation. In A. Došen, & K. Day (Eds.), *Treating mental illness and behavior disorders in children and adults with mental retardation* (pp. 3-24). Washington: American Psychiatric Press.
- Emery, R.E. (1995). Divorcing mediation – negotiating agreements and renegotiating relationships. *Family Relations*, 377 – 383.
- Gotlib, I., & McCabe, S.B. (1990). Marriage and psychopathology. In F.D. Fincham & T.N. Bradbury (Eds.), *The psychology of marriage* (pp.226-257). New York: Guilford Press.
- ICIDH-2 (2000). International Classification of Functioning and Disability. Geneva: World Health Organization.
- Lorenz, F.O., Simons, R.L., & Chao, W. (1996). Family structure and mother depression. In R.L. Simons (Eds.), *Understanding differences between divorced and intact families* (pp.65-77). Thousand Oaks, CA: Sage.
- Maes, B., Bruyninckx, W., Goffart, K; (2003). *Trajectbegeleiding voor personen met een handicap*. Leuven: Acco.
- Melief, W. (2003). Evidence based practice in sociale interventies. *Sociale Interventie*, 12 (4), 30-35.
- McEwen, C.A., Rogers, N.H., & Maiman, R.J. (1995). Bring in the lawyers – challenging the dominant approaches to ensuring fairness in divorce mediation. *Minnesota Law Review*, 79, 6, 1317-1411.
- O'Brien, G. (2000). Learning disability. In C. Gillberg & G. O'Brien (Eds.), *Developmental disability and behaviour* (pp. 12-26). Cambridge: University Press.
- Schallock, R.L., Keith, K.D. (1993). *Quality of Life Questionnaire*. Ohio: IDS Publishing Corporation.
- Simons, R.L., & Johnson, C. (1996). Mother's parenting. In R.L. Simons (Eds.), *Understanding differences between divorced and intact families* (pp.81-93). Thousand Oaks, CA: Sage.
- Walton, L, Oliver, C., Griffin, C. (1999). Divorce mediation: The impact of mediation on the psychological well-being of children and parents. *Journal of Community and Applied Social Psychology*, 9, 1, 35-46.

**Project line 1.3: Elderly people**

**1. Coordination and research groups involved**

Coordinator: Prof.dr. Anja Declercq (LUCAS)

Free Brussels University:  
Prof.dr. Dominique Verté (Department of Agogic Sciences)

Ghent University:  
Prof.dr. Jan De Maeseneer (Department of Family Medicine and Primary Care)

Catholic University of Leuven:  
Prof.dr. Jan De Lepeleire (Academic Centre for General Practice)

Catholic Superior College of the Kempen  
Dr. Guido Cuyvers (Research and knowledge centre for the third age)

**2. Introduction**

The number of elderly people is growing steadily in the Western world. Flanders is no exception in this evolution. By 2050 28.2% of the Flemish population will be over 65 (17.8% in 2005) (Pelfrene, 2005), while only 19.5 will be under 20 (22.1% in 2005). The majority of elderly people are active and in good health, maybe even providing care themselves for grandchildren or for their very old parents. A number of elderly people however do experience problems such as ill health, feelings of loneliness or feelings of unsafely. They are in need of help and/or care.

These demographic evolutions obviously have an impact on society as a whole. Two interrelated processes are widely acknowledged. One is the growing prevalence of long-term disability in the population, related to the greater longevity and the proportional increase of the ageing population. The second is the strain placed on the informal support systems: transitions such as the trend towards smaller families, greater freedom for women, separate and more independent living situations for older people, and workplaces that are separate from home, put the traditional mechanisms of providing unpaid care under pressure. A decline of informal care – at present the dominant form of care throughout the world – would undeniably have consequences for the care received as well as financial implications. According to the World Health Organization (WHO), the search for effective LTC policies is therefore one of the most pressing challenges facing modern society (Brodsky et al., 2003). These trends enhance the need for well coordinated and cost-effective long-term care (LTC).

### **3. Aim**

For purposes of policy making, a clear view is needed of the situation of elderly people in Flanders in general and of elderly people with specific needs in particular.

We aim at:

- (1) Providing an overview of the current situation of elderly people in Flanders.
- (2) Studying and comparing different target groups with specific problems, such as people with feelings of un wellbeing or people with cognitive problems.
- (3) Studying care and help trajectories across sectors. In Flanders, as elsewhere, the demand for an effective long-term care policy is growing. The economic costs of more institutional care are believed to be too high and not affordable. Long stays in hospitals are believed to have possible negative consequences (e.g. hospital bacteria). People seem to prefer staying at home and using home care as long as possible before going to a residential care service (Vanden Boer & Vanderleyden, 2004: 195; Van Meerbeeck, 2003: 69). Moreover, the care scenery is very fragmented, with regard to flows of funds, cultures and legislation. In order to provide a qualitative person-centred care, that is affordable and accessible, partitions between care sectors (for different target groups), between formal and informal care, between acute and chronic care, between institutional and community-based care, between in-patient and outpatient care... need to fade away. A balanced care model combines elements of both residential and community care. It seeks to provide an integrated system of interrelated services that are community-based and close to home, including services that offer home treatment, modern hospitals for acute admissions and long-term residential facilities in the community.

### **4. Methods**

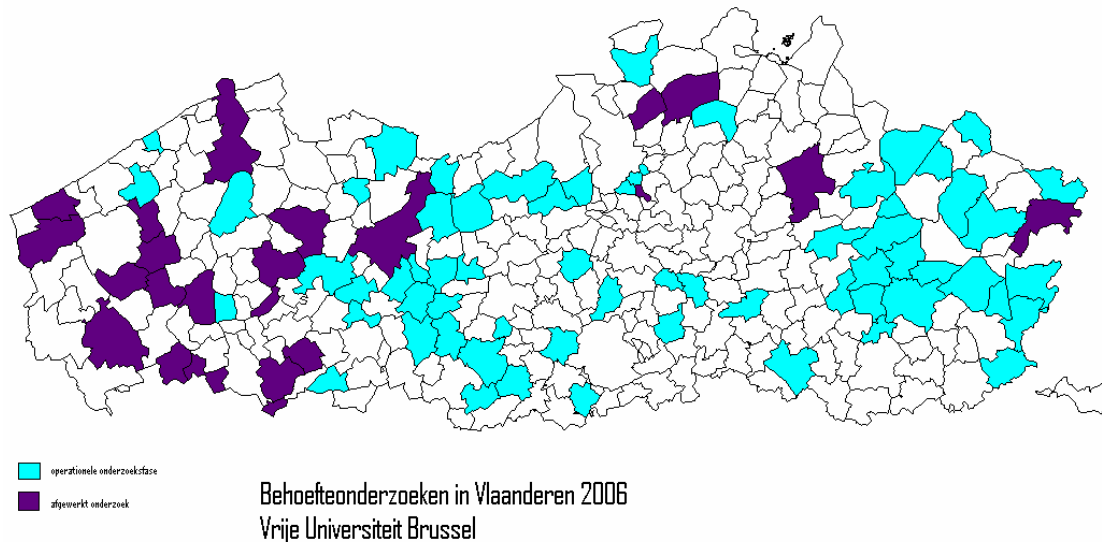
#### *4.1 Gap analysis*

During the first working year, a gap analysis will be preformed. A gap analysis aims first at identifying existing data sources, academic (e.g. LOVO research on the living situation of elderly people, Belgian data of the Survey on Health, Ageing and Retirement (SHARE) et cetera) as well as administrative. In this way, we can provide a global overview of all data available. Secondly, the gap analysis allows us to identify inconsistencies between different sources of data. If two data sources provide different numbers on the same issue, we will investigate and elucidate the inconsistency. Third, the gap analysis will make clear what data necessary for policy support, are not (yet) available.

The results of the gap analysis will support and guide actions taken in the following years. We for instance already know that the organisation of care by leans of sectors, limits a specific social welfare focus.

#### 4.2 Cross-sectional research

We already dispose of an extensive database on 50,000 elderly people living in Flanders. The data was gathered by Dominique Verté and his team. The database is still growing. It provides data that can be used in many different ways.



For this research, a standardized questionnaire was developed. It contains questions on socio-economic indicators, living conditions, involvement in the neighbourhood, loneliness, unsafely, mobility, health, problems of falling, available care and use of care services, provision of information, giving meaning to life, self-image, problems one is confronted with, cultural participation, social life, voluntary work, political involvement and influence, use of media, activities and pensions.

Health is measured in different ways. The Dutch short version of the Medical Outcome Scale (MOS-sf) (Kempen, 2005) is used. The degree in which and the task for which respondents need help are measured. Formal, informal and commercial help received is mapped, as are prevalence figures on falling.

Well-being is measured by three variables: negative affects (General Health Questionnaire, Affect Balance Scale), loneliness (scale developed by de Jong-Gierveld & Kamphuis) and feelings of unsafely (8 item scale developed by Elchardus & Smits).

Individual characteristics measured include sex, age and civil state. Socio-economic status is determined by education, income, living conditions, characteristics of the neighbourhood and involvement in the neighbourhood. Also, the quality and the quantity of the primary network are

measured. Alternatives for housing are determined by asking for the inclination of the elderly person to move to a care facility.

In every municipality, a proportionally stratified sample of at least 400 respondents is drawn (with adequate replacement addresses for non-response). Stratification is based on sex and age class (60-69, 70-79, 80+).

To optimize the response rate, elderly citizens of the municipality are recruited and trained to distribute the questionnaire and to provide help with filling it out when needed.

These data already exist or are being collected in the nearby future. They can be analysed in this project. If necessary, additional data can be gathered. The questionnaire is also been translated in – among others – Turkish and Italian in order to gather data on elderly immigrants or asylum seekers.

Moreover, at the moment pilot studies are being performed with the same questionnaire and methodology in Italy and the Netherlands. Other countries may follow, allowing us to compare Flemish data with data from other European countries.

#### *4.3 Longitudinal research*

As stated before in the introduction to this proposal, the group of elderly people is growing steadily in Flemish society. While many of them have no problems to speak of, a considerable number of elderly people experience feelings of unwell being. The National Health Survey for example shows that subjective feelings of ill health drastically increase with age (<http://www.iph.fgov.be/epidemiologie/epinl/crospnl/hisnl/his04nl/his21nl.pdf>). Problems of loneliness, feelings of unsafely and depression are often mentioned. Cross-sectional statistics on these problems are available (National Health Survey, Flemish LOVO-survey and others), but we have no insight in the way people deal (or not) with these problems, in the help they seek and in the trajectories they follow.

We therefore aim at following a sample of 1200 elderly people, from the moment they seek help from home care services. These services provide non-medical help at home, such as household tasks. They reach a very large number of people of different ages and different levels of need and health problems. With the collaboration of these services, we can detect symptoms of unwellbeing at a very early stage allowing us to follow-up, evaluate and intervene in different ways.

First, we want to screen for possible risks of depression. We can then study under what conditions and in which circumstances unwellbeing develops into clinical depression and how this can be prevented or captured at an early stage. The results of Dominique Verté's cross-sectional study provide us with general statistics and a norm group per region where unwellbeing and subjective health are concerned.

Second, we want to screen for cognitive problems. Elderly people suffering from dementia are a growing group of people in need of extensive and often complicated care. Little is known about the trajectories these people cover from the moment they start suffering from cognitive problems to the end of their life. We know that about 75 % of people suffering from dementia are living at home, but we have no knowledge about the care they use and whether this care indeed covers their needs. We also have limited insight in the circumstances in which residential care is chosen, and whether that indeed is the best option – personally as well as for policy purposes – at that time. The aim of this part of the longitudinal research is to study the accessibility, performance, efficiency and effectiveness of the care system for elderly people suffering from dementia.

In this part of the study, we will collaborate with Dr. Jan De Lepeleire of the ACHG of the K.U. Leuven, who carried out the Qualidem-research (<http://www.ulg.ac.be/psysante/qualidem/p22.htm>).

The regions in which the samples will be taken, will be determined as stated previously. They will correspond with the regions in which children and families and adults will be followed.

Depending on the results of the gap analysis, other target groups of course may be selected and followed.

## **5. Expected output and valorisation**

- a gap-analysis: the mapping of all relevant existing research databases, administrative data and registrations to gain better insight in the information already present, in overlap, in redundancy, and in hiatuses.
- the monitoring of the current policy for elderly people
- indicators on social participation of elderly people
- indicators on unwell being in elderly people
- indicators on care trajectories of elderly people with depression
- indicators on elderly people with cognitive problems
- indicators on care trajectories of elderly people with dementia
- indicators on the effects of assistance strategies
- indicators of the help experienced and the satisfaction of the users of services
- tracking down overlap and hiatuses in the current assistance and service model
- analyzing existing registration practices and systems
- developing trajectories for improvement of attuning of registration practises and systems, across sectors and organizations
- seeking for new forms of collaboration in order to better attune reference systems
- proposing amelioration plans to refine the usability and quality of registration data for policy planning

## 6. Bibliography

- Bradburn, N. (1969). *The Structure of Psychological Well-Being*. Chicago: Aldine.
- Brodsky, J., Habib, J. & Hirschfeld, M.J. (ed.) (2003). *Key policy issues in long-term care*. Geneva: World Health Organization.
- de Jong Gierveld, J. , van Tilburg, T. (1999), Cesuurbepaling van de eenzaamheidsschaal. *Tijdschrift Gerontologie en Geriatrie*, 30, pp. 158-163.
- Elchardus, M., Smits, W. (2003). Bedreigd, kwetsbaar en hulpeloos. Onveiligheidsgevoelens in Vlaanderen, 1998-2002. In: Vlaanderen Gepeild!, Vlaamse Gemeenschap, Brussel, 99-136.
- Kempen GIJM, Brillman EI, Heyink JW, Ormel J. (1995). *Het meten van de algemene gezondheidstoestand met de MOS Short-form General Health Survey (SF-20). Een handleiding (Measuring general health with the MOS (SF-20). A manual)*. Noordelijk Centrum voor Gezondheidsvraagstukken. Rijksuniversiteit Groningen, Groningen.
- Koeter, M., Ormel, J. (1991). *General Health Questionair*. Lisse: Swets and Zeitlinger.
- Pelfrene, E. (2005). Ontgroening en vergrijzing in Vlaanderen 1999-2050. Verkenningen op basis van de NIS-bevolkingsvooruitzichten. Stativaria. Brussel: Ministerie van de Vlaamse Gemeenschap.

## **Program 2: Evaluation and development**

### **Background summary**

In program 1, we showed how indicators will be collected from different target groups (children, adults and elderly people). This set of data will contain a multitude of data that are general (SES, ethnicity, living conditions, ...) as well as specific for certain themes that guided the selection of the target groups. Also, we provide a detailed overview of the supply of welfare and health services in different selected regions.

In program 2, the CWPF wants to answer a number of questions from the government regarding effectiveness and efficiency. This program starts with a status question. The indicators and index numbers that were collected in program 1, will be the base for an evaluation of program 2. By repeatedly questioning the panels and cohorts from program 1, the impact of innovations on the wellbeing of different specifically selected groups can be judged.

Program 2 also contains two other research lines: A. Spearheads and points of departure and B. Intervention and evaluation. For A, we will enquire in the same regions as in program 1 what the priorities of different groups of parties concerned are (users of health care and assistance, professionals and managers, members of the local community and policy makers), concerning the quality of health and welfare services. This enquiry will lead to the definition of a limited number of spearheads for the implementation of innovations. The implementation of innovations can thus differ between regions, but interregional exchange of experiences is also organized.

During the first phase of B, the researchers will offer the authorized Minister with a state of affairs in the field of scientific techniques and instruments to ameliorate the quality of health and welfare services. Based on this, the government can make better choices. In the second phase of B, the researchers will implement a number of evidence based practices in Flanders and they will evaluate their effects. Based on the current scientific knowledge, the priorities in the field and in policy, and the available know-how in the research group, the researchers can already present two programs for implementation that will start in the second working year. It concerns a project on healthy nutrition and exercise and a project on psycho-education.

In this program, the researchers not only study the effectiveness of the interventions and the innovations, they also study cost effectiveness. A specific objective of programme 2 is the establishment of a "health and welfare economic research cell" conducting economic evaluations of the delivery of services in the health and welfare sectors. This cell will bring together welfare and health economists aiming at enhancing the potential for economic expertise in these sectors and making this expertise available for policy makers as well for ad hoc as for long term projects. In the past, economic evaluations were only popular in the health sector, the new cell of expertise will introduce efficiency and effectiveness studies of care trajectories in the welfare sector.

Program 2 on the one hand contains a policy oriented analysis and follow-up of specific groups that were composed in program 1 based on collected indicators. Specific panels of people with relational problems, mental problems, at risk of poverty or with disabilities, cohorts of children and their families and groups of elderly people will be followed in the monitoring part of program 1. An evaluation of the functioning of the health and welfare services will be performed based on process and outcome measures and the impact of innovations in techniques and policies on satisfaction, quality of care and assistance and quality of life will be studied. Apart from this, program 2 also consists of specific interventions:

- A. Determination of spearheads and points of departure by means of concept-mapping
- B. Specific intervention studies on healthy nutrition and exercise, psycho-education, ... with pre- and post-studies with a control group.

### **1. Coordinator and research groups involved**

Coordinator: Prof.dr. Lea Maes

Daily management:

Prof.dr. Ilse De Bourdeaudhuij, Department of Movement and Sport Sciences

Prof.dr. Chantal Van Audenhove, LUCAS

Experts:

Catholic University of Leuven:

Prof.dr. Omer Van den Bergh, Centre for stress, health and wellbeing

Prof.dr. Dirk Hermans, Centre for learning psychology and experimental psychopathology

Prof.dr. Steven Simoens, Research group for pharmaceutical care and pharmacy-economics

Prof.dr. Bea Maes, Centre for family and orthopedagogics

Prof.dr. Filip Boen, Centre for Movement and Sport psychology and coaching

Prof.dr. Johan Lefevre, Section Physical Activity and Health

Prof.dr. Anja Declercq, LUCAS

Ghent University:

Prof. dr. Stefaan De Henauw, Department of Social Health

Prof. dr. Koen Schoors, Department of general economics

Prof. dr. Piet Taelman, Department of law

## **Project line A: The point of departure and the spearheads by means of concept-mapping**

### **1. Background**

In each region specific priorities in the field of effectiveness and quality improvement in care arise. Even if we can theoretically determine which criteria good care should fulfil, it is still advisable to determine a joint framework of priorities per region for interventions that can improve quality. To gain insight in the supply and the possibilities for improvement in this supply, is central in the first working year of program 2.

In every pilot region (same as in program 1), we will take action to ameliorate health and welfare services for target groups, based on collaboration with the services and organizations involved. The indicators collected in program 1, based on the registration data on the target groups and on the supply per region, will be the basis for a joint analysis per region on necessary additions or ameliorations of the supply. We resolutely aim at creating common frames of reference that go across target groups and sectors.

The following questions will be answered:

- Which elements are necessary in the supply of health and welfare services?
- What should be prioritized to realize or optimize this in your region?

### **2. Method: concept mapping**

To determine the spearheads, we will use a technique called concept mapping (Trochim, 1989, 1994). Concept mapping is a technique that can be used by groups to develop a conceptual framework, among others as a guiding principle for planning actions. A visual representation shows which ideas live in a group concerning a certain problem, how these ideas are connected and what ideas are most relevant, important or suitable. In that way, one can clarify the problem one wishes to tackle and bring the solutions into focus.

Concept-mapping has a number of advantages (De Rick, Loosveldt, Van Audenhove & Lammertyn, 2003; van Weeghel, Van Audenhove et al., 2005). First, the technique allows dealing with a complex aggregate of problems, while each problem continues to keep its own value without losing oneself in details. With the technique one relatively fast disposes of a comprehensible conceptual framework. A second advantage is the strong emphasis on collaboration and the group process. The contents as well as the interpretation and the use of the presentation of ideas (concept map) are determined by the participants. The conceptual framework consequently is in their own language and vocabulary and highlights the elements that are important to them. One interesting side-effect to this, is that the process enhances the coherence of the group of participants and enlarges their commitment and motivation to tackle the

problem. Finally, the end result of the process of concept mapping is easily comprehensible and thus can well be communicated to third parties.

In all pilot regions, the process of concept mapping will be organized. To this end, different groups of people involved will be invited: professionals and managers from all sectors concerned, users of these sectors and their families, members of the local communities and policy makers. We strive for participation of a group that is as broad as possible in order to bring together a large variety of possible angles and viewpoints;

In practice, concept mapping takes three meetings of about two to three hours, that can be organized on the same day.

### **3. Output**

The results offer qualitative and quantitative information on the nature and the relative importance of different concepts and values per region and per group involved. This should lead to a generalized framework, with among others a uniform list of concepts.

The results of the concept mapping can be used immediately for concrete planning of intervention and effect studies. Across the regions, a limited number of spearheads will be formulated. Interventions can be attuned to those, taking account of other information, such as the indicators collected in program 1, or certain policy decisions that have an impact on the priorities. The researchers base their choices for concrete interventions that will be tested for their effects, on this information (see below).

Indeed, one can suppose that not all possible improvements in quality are equally relevant for each region at a certain point in time. By working with spearheads, every region can determine and tackle its own priorities. Through a good exchange between regions, they also learn from each others experience

### **4. Timing**

The concept mapping is best organized at the end of the first working year (last trimester), once the regions are clearly defined and all organizations and services involved are informed on the goals of the CWPF. At the beginning of the second working year (first trimester), the presentation of the concept map can take place, coupled with the choice of spearheads. Once this has happened, the intervention studies can start.

## 5. References

- De Rick, K., Loosveldt, G., Van Audenhove, Ch. & Lammertyn, F. (2003). *De vermaatschappelijking van de geestelijke gezondheidszorg*. Leuven: LUCAS.
- Trochim, W. (1989). An introduction to concept mapping for planning and evaluation. *Evaluation and program planning*, 12, 1-16
- Trochim, W. (1994). Using concept mapping to develop a contextual framework of staf's views of a supported employment program for persons with severe mental illness. *Journal of Consulting and Clinical psychology*, 62, 766-775.
- van Weeghel, J., Van Audenhove, Ch., Colucci, M., Garanis-Papadatos, T., Liégeois, A., McCulloch, A., Muijen, M., Norcio, B., Ploumbidis, D. & Beauduin, D. (2005). The components of good community care for people with severe mental illness. Views of stakeholders in five European countries. *Psychiatric Rehabilitation Journal*, 28 (3), 274-281. <http://www.bu.edu/prj/winter2005/vanweeghel-et-al.html>

**Project line B: Intervention and Evaluation**

**1. Background**

By developing interventions, and by implementing and evaluating them, the CWPF wants to gain better insight in the effectiveness and efficiency of the work and organizational methods in the welfare and health sectors the Flemish government is responsible for. This part of the program fits in with international evolutions towards a more scientific foundation of practice and of policy decisions. ‘Evidence based practice’ is not limited to ‘efficacy’ (as studied in randomized control trials) in this proposal. We approach this from a broader perspective of working methodically, goal-oriented implementation of changes and innovations, and quality improvement with cost effectiveness as an important angle.

**2. Cost effectiveness**

Economic evaluation techniques and health technology assessment allow to assess the impact of diverse forms of supply of services and assistance within health and welfare and to compare those forms. In that way, they answer the question for decision-making in health and welfare and the spending of financial resources based on an objective, scientific rationality. Economic evaluation techniques take account of the effectiveness (is a supply form effective?) and the cost (what means are necessary for this supply form?) in order to study whether a supply form is cost effective (is the effect reached with a minimal cost?). Health technology assessment offers a broader and more multidisciplinary framework than economic evaluation by not only taking account of the cost-effectiveness, but by also taking consideration of social, ethical and legal aspects.

Welfare and health economics aims at supporting policy decisions by making information on the efficiency of different supply forms available. It allows to chose between alternatives by weighing the additional effectiveness of a supply form against the additional cost. This approach guarantees that only efficient supply forms will be financed and that the limited means will be used in the best way from the standpoint of welfare and public health.

Cost effectiveness studies are situated in program 2, but not limited to this part of the proposal. In program 1, cost and the deployment of resources will be an important indicator. Also, program 3 will follow along the same line when studying implementation in policy and organization. In this way, the government will be supported in the examination of costs and benefits through welfare and health economics data.

### **3. The need for a health and welfare economics specialization**

Even though welfare and health economics to a growing degree is used as a policy instrument in countries such as Australia and the United Kingdom, the contribution of welfare and health economics to decision-making in Flanders is rather limited. Among other things, this has to do with a lack of welfare and health economics expertise in Flanders. A specific objective of programme 2 is the establishment of a “health and welfare economic research cell” conducting economic evaluations of the delivery of services in the health and welfare sectors. This cell will bring together welfare and health economists aiming at enhancing the potential for economic expertise in these sectors and making this expertise available for policy makers as well for ad hoc as for long term projects. In the past, economic evaluations were only popular in the health sector, the new cell of expertise will introduce efficiency and effectiveness studies of care trajectories in the welfare sector.

### **4. A realistic view on effectiveness**

Fundamental scientific research on effectiveness will be the starting point for goal-oriented and well-thought-out implementation of necessary and desirable innovations. The studies of this Centre will thoroughly work out what works for which target group in what context. This ‘realistic evaluation’ (Pawson & Tilley, 1997) leaves space for contextual determinants and their impact on the way in which an intervention works instead of focussing unilaterally on the results of interventions for target groups with specific characteristics. This also allows for results to be judged on different levels. Indicators of personal welfare and wellbeing of users (such as the capacity to grow, optimism and hope, resilience, et cetera) will be used in the research, as well as indicators of quality of life (such as satisfaction with living environment, availability of recreational and leisure activities) and indicators of social capital (such as feeling safe, possibilities to participate, impact on local decision-making, social inclusion).

<p>In this program, we start from the idea that there are no nostrums. Even though the ‘evidence’ from scientific research can be overwhelming, one always has to check and recheck what works, how it works and for whom and in what specific contexts. We want to keep this basic attitude for the evaluation and development research in Flanders.</p>
---

### **5. Method**

The spearheads that were developed in part A of this program, will in the second working year guide concrete action projects in which interventions of good care and assistance will be implemented. We start from ‘evidence based practice’ as much as possible, that based on the demand of the sectors involved and the fields of action and in close consultation with the Minister and the administration, can lead to a better quality of care and services.

The technique of action-research, in which a careful evaluation of process and product is performed, will be used. In that way, the impact of innovations can be mapped in a 'realistic' way. By realizing these action projects within the regions that were determined for program 1, it becomes possible to study the impact of innovations on diverse outcome indicators such as quality of life, wellbeing, social inclusion, et cetera.

## **6. Interventions in the direction of 'good' care and assistance**

Next to the issue of (cost-) effectiveness of help and assistance, the program specializes in innovative trends that are relevant and current for Flanders, in view of the social evolutions sketched before and the policy priorities of the Minister. Based on the literature, the researchers already think about the following – mutually related – themes for interventions.

1. Client-oriented working (in other words: starting from the demand of the user and not merely supply-oriented, see the implementation of the mutual agreement model for intake, treatment choice and referring).

Care and assistance in Flanders is often strongly supply-oriented. The client receives the help that is present behind the counter or behind the front door of the centre he or she (mostly) coincidentally presents himself or herself to. A client-oriented approach implicates a thorough analysis of the demand and care and assistance need of the client. By organizing the processes of intake and therapy choice in a more professional and methodical way, one can accomplish that organizations start working from a vision on stepped care, in which the supply is optimally attuned to the demand and the real need of care and assistance. In that way, assistance seekers receive the type of care or assistance that is least interfering, leaving more interfering and sophisticated forms of care and assistance available to those who do need them.

2. Working in an emancipator way (e.g. guard the fact that one firstly appeals to the personal strength of the individual and his or her network to tackle problems instead of automatically offering professional help and 'taking over'). This can happen by, among other things, offering psycho-education on a larger scale and more systematically before offering professional help. When choosing between professional treatment forms, one can use decision aids to stimulate and optimize the participation of the user in the process of choice (O'Connor & Stacey, 2005).

An exaggerated medicalization or professionalization of normal human life course problems is a risk of super specialized and very accessible care that we know in Flanders. It should be recommended to firmly support that people can do a lot for themselves and that this can be very valuable. To work in an emancipator way presupposes approaches that stimulate the empowerment of the user. These approaches are especially important when we talk about so called neglected groups of users such as people at risk of poverty, migrants, and people with severe and enduring mental illnesses or with drug addiction.

3. To make social assistance easily accessible, by giving access to target groups that are hard to reach, (e.g. harm reduction strategies for homeless persons with mental illness or drug addiction) to a whole range of organizations with differing visions.  
For the most difficult to reach populations, the threshold to the most accessible assistance and service forms can still be too high. They need an approach that often also puts high and different demands on professionals.
4. To work in a way that is outreaching (to keep hold of alarming avoiders of care, see also suicide prevention techniques as presented in the European Alliance Against Depression (EAAD), or the discussion on ‘social necessity’ in youth care)  
Many forms of assistance do not offer the grip some target groups need. For this, innovations are advisable and needed that should get introduced in practice, but also innovations in education and training of groups of professionals are necessary. Indeed, it is not self-evident to keep functioning as a ‘good professional’ for years when confronted with very ‘hopeless’ and dead-end help seekers and care situations. There are specific techniques for this, but in particular also specific personal attitudes and forms of teamwork are a necessity. There is already a lot of know-how on this in practice, but there is a need for more systematic methodical support in many places.
5. To offer stepped care (this implies that one first offers the least interfering option that is still effective, before moving over to more interfering treatment and care forms)  
To this end, one needs a good overview of the full supply of care and assistance for all referents and target groups. Such an overview is now lacking in many cases, as is a consensus on who should be offered what kind of assistance or care at what time and with what criteria. Recent research in the domains of care for people with depression (De Coster et al., 2005; Van Meerbeeck et al., 2005; Van Audenhove, Everaert, Scheerder & De Coster, 2006) show that stepped care indeed is an acceptable framework in baseline care and in mental health care in Flanders. A translation into the welfare, youth and elderly care is a possibility.
6. To work in a preventive way (integration of prevention in treatment or strongly developed after-care for target groups at risk of re-occurrence)  
In care and assistance, the curative and the preventive are often strictly separated. In this way, many opportunities are missed to prevent disease, unwell being and dissatisfaction and re-occurrence.
7. To work coordinated (multidisciplinary team working, networking and cooperation: professional, informal,...)  
Many multidisciplinary ‘teams’ work as a group of individual professionals that see the same clients and that do only meet each other to exchange information. Collaboration between professionals who in different care sectors work with the same clients departing from a different vision and organisational framework is, to put it mildly, not easy. The informal carer

as a partner in care in society for persons with enduring or permanent limitations is a true wish of many, but a very difficult issue in practice.

On all of these points, the program wishes to offer support by implementing and evaluating goal-oriented actions.

8. To work in an inclusive way (to promote participation in society and to counter exclusion)  
Social exclusion, discrimination and stigmatization are phenomena that are more prominent in some regions for some groups of people. In this program, there should also be actions that counter these negative processes in a goal-oriented way. In particular, we think of discrimination and stigmatization of people with mental illnesses in society, but also in care and assistance.

***Concrete multi-annual research proposals for part B***

The international scientific literature already provides us with an insight of the ingredients that have a positive effect in a large number of care and assistance forms. In Flanders, there already is a lot of know-how available in the field of implementation of techniques that contain these working ingredients. In the first phase of the program we will thus develop a critical overview of the international literature and the know-how and experience that is available in Flanders. Possible gaps will be detected in this way. Moreover, we can offer the government a full catalogue of what the alternatives are in Flanders when the implementation of evidence based practice is concerned.

Based on this knowledge, and in consultation with the government and with the regions in which we work, priorities will be set for the sub-projects to be developed. At this point in time, we already make a proposition for two implementation projects that would start in the second working year: a project on healthy nutrition and exercise and a project on psycho-education (see below). This choice is inspired by the combination of scientific knowledge, policy priorities and the know-how of the research groups involved.

To embed further decisions in a vision on policy, a policy platform will be established, in which representatives of the administration, the cabinet of the Minister and the umbrella organizations will participate. The goal is to spread important scientific information in view of implementation and evolutions in Flanders and to stimulate a benchmarking attitude. The working method used will be to organize seminars.

This approach departs from a vision on the 'learning organization'.

**References**

- De Coster, I., Declercq, A. & Van Audenhove, Ch. (2005). *Naar een stepped-care programma in de behandeling van depressie door huisartsen en psychiaters*. Leuven: LUCAS.
- O'Connor, A.M. & Stacey, D. (2005) Should patient decision aids (PtDAs) be introduced in health care system? Copenhagen, WHO regional office for Europe. Health Evidence Network (HEN). [www.euro.who.int/document/E87991.pdf](http://www.euro.who.int/document/E87991.pdf)
- Pawson, R. and N. Tilley, (1997). *Realistic evaluation*. London: Sage.
- Van Audenhove, Everaert, Scheerder, De Coster (2006). *Getrapte zorg voor personen met depressie in de CGG. Deel 1: Analyse en evaluatie*. Niet gepubliceerd onderzoeksrapport i.o.v. de Vlaamse minister van WVG.
- Van Meerbeeck, A., Beck, M. & Van Audenhove, Ch. (2005). *Samenwerking tussen ambulante en residentiële zorg. Actieproject in de MFE 'Het klaverblad'*. Leuven: LUCAS
- Wallerstein, N. (2005) What is the evidence on effectiveness of empowerment on health? Copenhagen, WHO regional office for Europe, Health evidence network (HEN). [WWW.euro.who.int/document/88086.pdf](http://WWW.euro.who.int/document/88086.pdf)

**Community trial with focus on nutrition and physical activity for young families**

**1. Coordinator and research groups involved**

Coordinator: Prof.dr. Lea Maes (Ghent university, department of social health)

Ghent university:

Prof.dr. Ilse De Bourdheaudhuij (Department of movement and sport sciences)

Prof.dr. Stefaan De Henauw (Department of Social health)

Catholic University of Leuven:

Prof.dr. Johan Lefevre (Section Physical Activities and Health)

Prof.dr. Filip Boen (Centre for Movement, sport psychology and coaching)

**2. Background**

*2.1 Context*

Several recent international reports (e.g. from the World Health Organisation, WHO, 2003, 2004) show evidence for the key role that nutrition and physical activity play in explaining morbidity and mortality in Western countries. Eating habits and an inactive lifestyle are responsible for: 30 to 40% of cancer deaths, at least one third of the premature deaths because of heart diseases; overweight and obesity – also related to diabetes; osteoporosis and other diseases. In several countries policy is focussing on overweight and obesity based on a high level report of WHO. World wide overweight and obesity reach epidemic proportions. Figures from the Belgian health interview survey (2004) and of Policy Research Centre for Sport, Physical Activity and Health, show that almost half of the adult population in Flanders is overweight. The message from these reports and data are clear: nutritional messages and more physical activity have to be combined to curb the trend and prevent disease and enhance health and well being.

The Flemish health targets, for the first time formulated in 1997, include already the target to reduce the fat intake and enhance the fibre intake of the Flemish population. The revision and adaptation of the health targets for the coming years foresees the inclusion of the enhancement of physical activity.

More and more research results show that interventions in early childhood are needed to tackle overweight and obesity (Summerbell et al, 2005, Ells et al, 2005). The development of health and unhealthy habits starts at a very young age, within the families. At this early age habits can be positively influenced or changed. For interventions, a focus on families seems to be promising. However, families can be seen as independent entities. What happens in the families is influenced

by the larger environment: friends, neighbours, the community, local policy, media,...(Booth et al, 2001). Community interventions are needed, integrated initiatives for the family and the total community (Cohen et al, 2000). Socio-ecological models provide a theoretical basis for the development of community interventions (Stokols, 1992). Socio-ecological models of health behaviour are characterised by multiple levels of influence and are already widely accepted and successfully applied in tobacco control.

Within the community approach of this project, the development, implementation and evaluation of the interventions are focussing on families with young children. The aim is to develop evidence based interventions for implementation in Flanders. Collaboration between health and welfare services has to be fostered and enhanced. Also a clear link with the Flemish Health Promotion Institute, the local health promotion teams, and other organisations having contact with and impact on young families and their children will be established. This project will also have the capacity to evaluate the available health promotion infrastructure and capacity in Flanders and will detect bottlenecks for the implementation of health promotion projects.

## *2.2 Relationship with the global program*

This project is part of Program 2: professionalization, innovation and evaluation.

Enhancing the health promotion skills and competence of professionals in the health and welfare sector is a permanent task. Evidence based and theory based health promotion need to be stimulated and optimized. Research and researchers can play an important role in the realisation of more effective health promotion interventions in all relevant sectors. In the international literature several evidence based programs are described. This project will evaluate if and how these programs can be implemented in Flanders and if they lead to positive outcomes in the Flemish context.

This program is not only dealing with providing training for professionals but also with systematic implementation and evaluation of new strategies through action- and evaluation research.

The community approach is the central element, the project will first analyse the local needs and existing initiatives; provide the local services, organisations and decision makers with a catalogue of evidence based intervention possibilities and will give the necessary support the implementation of the interventions with the final aim to enhance health eating and more physical activity and to reduce overweight and obesity in young children.

## **3. Objectives**

### *General objective:*

Efficacy, efficiency and organisational study of prevention activities aiming at enhancing nutrition and physical activity of children, young people and their families and the development of collaborative models to enhance the offer of prevention initiatives in Flanders.

*Specific objectives:*

- the development of a multi-component intervention program (focussing on behavioural determinants in the community, the school, the family and the individual) aiming at enhancing nutrition and physical activity of pre school children (3-5 years old) and young school children (6 to 9 years old) and their families
- evaluation of the different aspects of the multi-component intervention program (effect on behaviour, feasibility, efficiency, ...), as well at the level of the receivers of the interventions (children and their parents) as the actors delivering the interventions (schools, local authorities, local health promotion networks, medical doctors, paramedics, ...)
- development of implementation models for community oriented multi component intervention programs in Flanders

#### **4. Methods**

The project will take place within the regions selected for the projects of the “Policy Research Centre Welfare, Health and Family”. At least 6 of the regions (or parts of regions) will be selected for this study.

A community trial design will be used involving at least 6 communities; at random at least 3 communities will be selected for the intervention condition and 3 communities for the control condition. In each community a sample of at least 250 children (and their parents) will be drawn (sample size based on: expected effect size of 0.25,  $\alpha=0.05$ ,  $\beta=0.80$ , clustering of the data). Base line data will be gathered in all communities, followed by the multi component intervention for 36 months in the 3 intervention communities, followed by post test in all communities after the interventions.

The intervention program combines initiatives at the level of the community, the school, the local organisations, the neighbourhood, the care givers, ... An essential element is the enhancement of the communication between all involved actors, the focus in on the families in the communities.

The intervention program focuses on the promotion of healthy eating and physical activity (within the context of the primary prevention of overweight and obesity and related chronic diseases).

The intervention program will make use of existing materials in Flanders and new materials will be developed where needed based on the international literature and the experience of the promoters of the project. Focus groups will be organised to ensure the match with and the adaptation to the needs of the actors and the receivers of the interventions.

Training will be provided for the actors to ensure a uniform message towards the target groups. The training will focus on knowledge transfer, attitude change, motivation techniques and skills for behavioural change.

a process evaluation as well as an effect evaluation will be conducted. Effect variables are: BMI, nutrition, physical activity, determinants of nutrition and physical activity and environmental factors. In the process evaluation attention will be given at problems and success factors for the implementation of the intervention in other communities in Flanders.

## **5. Output, milestones and indicators.**

### **Time line**

Jan 2007: development of a catalogue of interventions, partnership building, community analysis; further development of the community trial design

Sept 2007: pre-testing: 3-4-5 years old (pre school children) and their parents  
Pre-testing: 6-7-8 years old (primary school children) and their parents

2008-2009-2010: intervention period, and yearly process and effect evaluation

Sept 2010: post-testing: 6-8 years old  
Post-testing: 9-11 years old

### **Milestones:**

1. multi-component intervention for the enhancement of healthy eating habits and physical activity
2. Questionnaires and measurements for baseline and follow up
3. training of actors for implementation of the interventions
4. yearly effect and process evaluation
5. models for training and implementation adapted to the situation in Flanders

### **Indicators:**

- eating habits and physical activity of pre school and primary school children and their parents by social class
- differences in the change in eating habits and physical activity between intervention and control communities
- critical success factors at the level of the community, local decision makers, families and health and welfare professionals for the implementations of the interventions

## 6. Valorisation

- diffusion of evidence based interventions for children and their parents for the enhancement of healthy eating and physical activity in the community making use of the existing infrastructure and capacity in Flanders through training, information, ...
- scenario's for the successful implementation of interventions
- follow-up of the intervention and control cohort from childhood to adolescence and adulthood (in later phases of the Policy Research Centre).

## References

- Booth, S.L., Sallis, J.F., Ritenbaugh, C. et al. (2001). Environmental and societal factors affect food choice and physical activity: rationale, influences and leverage points. *Nutr Rev*; 59,S21-39; discussion: S57-65.
- Cohen, D.A., Scriber, R.A., Farley, T.A. (2000). A structural model of health behaviour: a pragmatic approach to explain and influence health behaviours at the populaton level. *Prev Med*, 30, 146-54.
- Ells, L.J., Campbell, K., Lidstone, J., Kelly, S., Lang, R., Summerbell, C. (2005). Prevention of childhood obesity. *Best Pract Res Clin Endocrinol Metab*, 19, 441-54. Review.
- Stokols, D. (1992). Establishing and maintaining environments. Towards a social ecology of health promotion. *Am Psychol*, 47, 6-22.
- Summerbell, C.D., Waters, E., Edmunds, L.D., Kelly, S., Brown, T. Campbell K.J. (2005). Interventions for preventing obesity in children. *Cochrane Database Syst Rev*, 3, CD001871. Review.
- WHO (2003). The first action plan for food and nuturion policy WHO European region.
- WHO (2004). Global strategy on Diet, Physical activity and Health. WHO. Geneva

**A psycho-educative teaching program on stress to prevent anxiety and depression**

**1. Coordinator and research groups involved**

Coordinator: Prof.dr. Chantal Van Audenhove (Catholic University of Leuven, LUCAS).

Catholic University of Leuven:

Prof.dr. Omer Van den Bergh (Research group for stress, health and wellbeing)

Prof.dr. Dirk Hermans (Centre for learning psychology)

**2. Background**

**Aim : Evaluation of the effects of a psycho educational program on stress and its preventive effects on anxiety and depressive disorders**

‘Stepped care’ (Haaga, 2000) intends to match the type and intensity of a treatment to the personal needs of a patient. In current mental health care, patients are often to early advised to start an intense individual therapy. Recent evidence documents the importance and effects of low threshold group educational approaches of short durations. Psycho education combines a educational model with the aims of psychotherapy. Doctor/therapist and patient roles are replaced by teacher/student roles. First, this major change in role definition emphasizes the individual responsibility of the participant, as the aim is not only to teach skills helping the student to overcome current problems, but also to cope with future adversities (Brown, 1980). Second, students are not expected to have a specific diagnosis or problem as the intention to learn new skills suffices for participation.

As a first step within a “stepped care” approach, psycho education can (1) have an important preventive role through detecting and solving problems at an early stage before they escalate to more serious levels; (2) offer a solution to the widespread waiting list problem in ambulatory mental health services; (3) be an effective and sufficient treatment for some patient groups; (4) serve as first layer and platform for more extensive treatments.

‘Treating anxiety and stress: A group psycho-educational approach using brief CBT.’ (Jim White, 2000) has recently been adapted for

the Flemish public (‘Word uw eigen gids bij stress en spanning’) in collaboration between psychologists of ISW-Limits (spin-off of the University) and Dirk Hermans and Omer van den Bergh, both professors at the Catholic University of Leuven (K.U.Leuven).

The content of the course contains 12 steps. Step 1 (1st session) is a general introduction to stress facts and processes and provides a frame for the subsequent sessions. Step 2 and 3 are contained in home work assigned in the first session. Students have to reflect and apply the course materials

to their own life situation and make a personalized work program. The home work intends to help students to decide which techniques are relevant for themselves.

The following 9 steps are the content of the subsequent sessions. Step 4, 5 and 6 (session 2, 3 and 4, respectively) provide more detailed information about the role of the body in stress, the role of thoughts and actions and how to change them. For step 7 to 10 all the acquired knowledge and techniques are applied to specific problems, such as anxiety, panic, sleep problems, depressive mood, acute stress problems and burnout. Step 11 and 12 provide an overview as a guide to manage stress problems in the future. Home work during the last 9 steps implies further training of the learned skills and keeping a personal diary of the training experiences and progress.

Research of Jim White documented the effectiveness of the method, lasting up to 8 years after the intervention (White, 2000). Preliminary data showed also for the Flemish adaptation a substantial decline from pre- to post test scores on several measures of stress, anxiety and depression related variables that continued to decline up to 4 months after the program.

### **3. Aim**

The aim of the present research plan is to carry out a systematic evaluation of the effects of a psycho-educative program that has already been developed. Different groups will be compared with three matched control groups: (1) no course; (2) self help course; (3) alternative treatments (homeopathy, yoga, relaxation, acupuncture).

Measures are divided into three sets :

#### **Set 1:**

- stress, anxiety and depression questionnaires
- worry behaviour
- problem solving skills (means-ends test)

#### **Set 2**

- consultations (both classic treatment settings, like GP's, mental health ambulatories, alternative consultations like homeopathy, acupuncture, etc.)
- longitudinal follow up of participants to assess the relative probabilities of mood (anxiety, depression) and somatisation disorders

#### **Set 3**

- Health economic assessment of the cost/benefit balance

### **4. Output, milestones, indicators and timeline**

#### **Year 1 :**

- Implementation of the program in a wide variety of settings
- Validation of measures
- Intermediate publications

**Year 2, 3 and 4:**

- Data collection
- Publications about the different effects of the program

**5. Valorisation**

- further shaping of the program taking into account the results of the study
- wide distribution of the program through first and second line caregivers and mental health professionals
- skills training of caregivers to offer this program through their organisations to the large public.

### **Program 3: Legal and institutional framework**

#### **Background summary**

The third program 'Legal and institutional framework' adopts an integrative approach towards the organization of social care and public health. Both institutional, managerial and legal aspects of social care and public health will be addressed in this program.

A first legal approach serves a double purpose. On the one hand it allows for legal benchmarking of research findings formulated within the other two programs. Consequently, a legal test could be implied in translating results for policy purposes in those programs. For instance, the integration of social and health care services and the delineation of the concepts of social and health care, necessarily implies a legal analysis of constitutional issues of competence. Also with regard to services provision in the region of Brussels, a constitutional background has to be taken into consideration.

On the other hand, the organization of care services increasingly invokes problems of a legal nature, as for instance in relation to confidentiality and the processing of personal data, the legal position of persons lacking legal capacity, patient mobility and liability. Legal solutions are more frequently solicited and analyses are made to check whether existing legal concepts and instruments should be redirected and/or adjusted to meet specificities of a social and health care environment. As a result, the third program explicitly aims to build a sound legal framework in order to enable a faster response to certain knowledge gaps.

A second institutional approach ensures a novel view of the existing structures of policy implementation in the field of social care, public health and family. Through a supply chain management perspective and bottom-up approach, the third program aims to enhance the efficiency and effectiveness of policy implementation.

**Project line 1: Legal framework**

This research line will be coordinated by Johan Put (K.U. Leuven, Institute for social law and youth criminality).

The research line contains three projects. In the first project, a comparative law project will be performed on all legal basic data in the fields of welfare and health. Apart from the possibility to intervene punctually when a legal test is necessary during the research activities of the other programs, two projects with structural legal research are introduced: (1) a legal analysis of the scope and the contents of a right to social care and services; and (2) an analysis of government tools for implementing and enforcing social care legislation

**Project 1: Comparative law project of basic legal data: legal texts, jurisdiction and legal doctrine**

## **1. Context**

At least within a Flemish context, legal research into aspects of social care has grown into an autonomous field of research. A functional approach has been adopted, meaning that diverse legal disciplines are consulted and that legal concepts and methods are used in a problem-oriented way, if necessary adjusted in the light of specific features of social care. Consequently, emphasis is placed on the development of a problem-oriented legal framework in which existing legal concepts are adopted and sometimes adjusted.

## **2. Focus and research aims**

1. The organization of social care is legally characterized by a policy triangle constituted out of the relationships between government, care home or institution and client. Each axis resembles a legal relation involving its own legal difficulties and research questions. Legal research within the third program will work towards a fine-tuning of this image. For instance the notion of government involves both legislator and administration, both influencing the organization of care in a different fashion. Also at the level of the care institutions further diversification is in order: individual caregivers, teams, management, board of directors, joint ventures and umbrella organizations. At a client/patient level, special attention should be given to the special position of 'client-systems', particularly the position of parents vis-à-vis their minor children.

Each legal relationship between the parties involved, evokes a different set of research questions. Some examples:

*Focus on the relation between government and client:*

- Analysis of effects of international, enforceable or non-enforceable fundamental rights (e.g. the right to privacy, housing, equal treatment).
- Translation of these fundamental rights into overarching client rights, with special attention to participation rights of clients.
- Research into modes of enforcement of these rights: judicial or extra-judicial routes. Attention to (collective) complaints procedures.

*Focus on the relation between government and institution or care home:*

- This relation is highly legally developed, however changes are occurring at a high pace. As a result, research will have to focus on internal and external effects on the organization of care and the differentiation of care types.

- In this respect, additional research into the integration of (general) health care services and social care services would be relevant.

*Focus on the relation between institution or care home and client:*

- Research into possibilities and limits of care agreements (parallel to the Dutch example of agreements of treatment in health care).
- In relation to legal protection, research into the advantages and disadvantages of developing a code of ethics and the introduction of rights in such and other rules.

2. The overarching approach of legal research will be client-oriented, meaning that legal relations will be analyzed in function of the improvement of the wellbeing of client and/or client-system. The main research question is to know which possibilities exist to legally enhance the quality of care for clients with attention to ethical considerations. This perspective, however, does not prevent that the relation between for instance the administration and a care home is included into research projects, as it can be relevant for the individual client as well.

3. Furthermore, the role the law could play in steering quality of care shall be reflected upon, with attention to the respective role of the legislator and administration. In this respect, government tools will be analyzed which are most effective in improving quality of care: protocols, management agreements, inspection et cetera. Of course, the constitutional margin of competence assigned to the Flemish Community should be considered, as well as the distribution of tasks between public and private parties in social care and the different ways in which they are regulated.

4. Also the spill-over effects of other legal concepts within social care shall be examined. Firstly, current legislation applicable in diverse care sectors will be analyzed, in order to find recurring features which could be included in a general social care framework act. However, there are also influences from administrative law (e.g. complaint procedures, ombudsman), civil and criminal law, social security law (legal position of the volunteer for instance) and health law (e.g. patient rights and care contracts). The fundamental question then arises to what extent specificities of social care require specific legal solutions, or rather to what extent general concepts of law could apply.

Furthermore, research activities will focus on the delineation of the concepts of social care, health and other related notions. Specific features have to be indicated so as to justify specific solutions or else the application of concepts drawn from civil, criminal, economic,... law.

This approach aims to formulate conclusions and policy suggestions with a view to the further development of a genuine social care law, the introduction of general principles and basic rules of social care law and its positioning in relation to other legal disciplines.

5. An inter-sector approach, however, is insufficient. In addition, the increasing influence of international developments with or without direct effect in the internal legal order should be considered.

It follows from this that attention will be given to relevant provisions of European law and case law of the Court of Justice. The main challenge will be to translate main lines of impact into a social care setting. More specifically, a certain level of impact could be expected from European rules on the free movement of services, establishment, services of general interest, migration and competition. Also European initiatives as for instance the open method of coordination in the field of long term care could be relevant. An international research approach is also adopted with regard to cross-border processes of learning and assimilation outside of European Union institutions. In this respect examples of parallel trends, experiences with alternative policy lines, experiments,... will be searched for.

### **3. Research method**

Legal analysis of legislation, case law and legal doctrine. Comparative research.  
Follow-up of international developments which could influence the organization of social care.

### **4. Output**

1. Legal benchmarking of policy options following research results of programs 1 and 2.
  2. Building a legal helpdesk within the consortium for all stakeholders.
  3. Reporting of results and active dissemination of knowledge on the basis of conferences and workshops (trans-sector approach). Organization of discussion rounds with policy stakeholders.
  4. Follow-up and reporting of international trends.
  5. Yearbook: reporting of legal findings and (international) developments.
- Preparatory work with regard to the development of a genuine social care legal framework.

**Project 2: Scope and Contents of a Right to Social Care and Services: a Legal Analysis**

**1. Background**

This project analyses the specific aspects of the right to social care and services. In particular, the degree in which and the way in which the client can put claims on the government for access to care and services of high quality.

**2. Research aims and topics**

The special nature of relationships in social care between clients, government and social care institutions are increasingly legally structured. Structuring relationships legally essentially aims to improve access to social care, legal certainty and quality of care. Legal solutions often apply legal concepts from a diverse set of legal disciplines (social security, civil and administrative law, et cetera). In addition, these legal disciplines can generate (unforeseen) indirect effects in the world of social care (for instance constitutional limits and possibilities of regional legislation, confidentiality issues in the field of social care, liability and guilty neglect, et cetera).

A rather new trend is the adoption of a (human) rights discourse with a view to strengthening the legal position of clients. Such a discourse is also increasingly adopted in the context of social work. In addition, social care organized and/or subsidized by governments is increasingly considered as an instrument for governments to comply with international obligations vis-à-vis the accomplishment of fundamental rights. In this perspective, the provision of social care becomes fundamentally linked to the realization of social inclusion. Fundamental social rights do not only aim to alleviate certain needs of the individual, but essentially aim to strengthen social cohesion and solidarity in society.

Fundamental human and/or social rights are increasingly taken into account in research into the formulation of claims for clients with regard to (e.g. access to, quality of) social care and social services. In addition, attempts are made to further develop those claims into legally enforceable rights. The central focus of this research project is on scope, contents and modalities of what will be coined a right to social care and services.

Following research questions will be addressed in this project:

- Which aspects of social care merit special legal protection (access to social services, continuity of care, proper housing, meeting quality standards of care, equal treatment, respect of privacy, et cetera)?

- How can legal protection be guaranteed in case of non-financial aid? How does it differ from financial aid situations?
- What fundamental human and/or social rights do already exist and to what extent are they relevant in accomplishing a specific set of rights to social care (e.g. the right to medical and legal aid, the right to social assistance, the right to social services and to social integration)?
- Which results do these rights have (a) in the internal legal order, (b) in the relationship between government and social care institution and (c) in the relationship between client and institution/caregiver?
- Which specific claims flow from those rights for a client and are they enforceable? What options exist for a client to enforce his rights?
- Is it only the individual client which is granted certain rights or can a more 'collective' approach towards legal protection be developed?

In order to make this legal framework more specific, abstract principles will be tested through a case-study of elderly care, broadly understood (e.g. residential and informal care, mental health, service-flats, commercial care formulas). In fact, social law schemes of most welfare states are increasingly confronted with new dimensions of care needs and long-term care dependency of elderly people. As a result, new legislation has been drafted at a high pace in order to create new formulas of social protection for the elderly. Elderly care has become one of the most legally developed social care sectors in comparative perspective. Furthermore, issues of legal protection of vulnerable elderly people are often of a pressing nature, e.g. in cases of legal incapacity or the factual incapacity of expressing one's wishes. Lastly, this sector has seen diverse experiments with a view to develop or strengthen client rights.

In order to present a thorough analysis of scope, contents and modalities of a right to social care and services, the research project will be divided into four parts focusing on each of the following questions and issues:

### *2.1 Modes of enforcing (fundamental) social rights*

A first approach starts from existing literature, including references to authoritative case law, regarding the enforceability of fundamental social rights.<sup>8</sup> Fundamental social rights are a generic

---

<sup>8</sup> Some examples of the abundant (international) literature: G. Maes, *De afdwingbaarheid van sociale grondrechten*, Antwerp, Intersentia, 2003, 523 p. ("The enforceability of fundamental social rights"); P. Hilpold, "Der Schutz sozialer Grundrechte in der Europäischen Union", *Zeitschrift für öffentliches Recht*, 2004, 59/4 (in German: "Protecting fundamental social rights in the European Union"); J. Iliopoulos-Strangas, *La protection des droits sociaux fondamentaux dans les états membres de l'union européenne*, Brussel, Bruylant, 2000 (in French: "Protecting fundamental social rights in the Member States of the European Union"); B. Van Buggenhout, "Caritas en sociale grondrechten", in Instituut voor Sociaal Recht (ed.), *Sociale bescherming op nieuwe paden, Liber Memorialis Béatrice Van Buggenhout*, Leuven, Universitaire Pers, 2003, 43-53 ("Caritas and fundamental social rights"); J. Van Langendonck, "Het recht

term of economic, social and cultural rights which a government is obliged to respect in order to grant each member of society a dignified existence and potential of personal development.

Enforcing social rights is a complex matter, particularly when non-financial aid is involved.<sup>9</sup> This is for instance the case with the right to education, to proper housing, to legal aid, the right to social care, medical treatment and employment. The difficulty of enforcing such rights does not only follow from the often vaguely formulated contents of these rights. An important explanation also involves the difficult trade-off that often has to be made with other rights or interests. The right to medical treatment for instance, should be balanced in relation to the freedom of association and assembly and the freedom of private health providers to engage freely in contracts.

The question rises to what extent such rights (could) contain subjective legal claims and in what ways these rights could be exercised by clients. Do they merely involve ‘programmatische’ policy guidelines? Do they impose on governments a duty to make efforts, or rather a duty to achieve results in implementing fundamental social rights? Do relevant provisions contain subjective rights which are directly enforceable in a court of justice? If not, what other options are there to exercise one’s right?<sup>10</sup> Is it possible for a court to order a government to reach a certain level of social service provision?

Reversely, the question should be addressed to what extent and under what circumstances social care institutions are under an obligation to admit clients when ordered to do so. In this respect, is there a distinction to be made between private and public social care provision? Is a court capable of ordering the compliance with access to social care rights in kind?

---

op sociale zekerheid als mensenrecht”, in Instituut voor Sociaal Recht (ed.), *Sociale bescherming op nieuwe paden, Liber Memorialis Béatrice Van Buggenhout*, Leuven, Universitaire Pers, 2003, 613-621 (“The right to social security as human right”); M. Kroes, *Werking en doorwerking van grondrechten*, Leiden, Stichting NCJM-boekerij, 1998 (“Application and effects of fundamental rights”); D. Pieters, “De sociale grondrechten in de lidstaten van de Europese Unie”, in F. Fleerackers (ed.), *Mens en recht. Essays tussen rechtstheorie en rechtspraktijk. Liber Amicorum Jan M. Broekman*, Leuven, Peeters, 1996, 243-255 (“Fundamental social rights in the Member States of the European Union”); W. Rauws, “Niet de ver-van-mijn-bed-show: sociale grondrechten en de praktijk” in W. Van Eeckhoutte en M. Rigaux (eds.) *Postuniversitaire cyclus Willy Delva 1995/1996. Sociaal recht: niets dan uitdagingen*, Gent, Mys & Breesch, 1996, 793-843 (“Not that uncommon: fundamental social rights and legal practice”); M. Daly and the Editorial Group for the Report on Access to Social Rights, *Access to Social Rights in Europe*, Strasbourg, Council of Europe Publishing, 2002, 116 p., [www.coe.int](http://www.coe.int).

<sup>9</sup> See for instance G. Maes, *o.c.*, 2003.

<sup>10</sup> The interpretative value of these provisions could be considered, as well as the judicial review of legislation by the Constitutional Court in the light of these fundamental rights, possible government liability for lack of sufficient legislation and the standstill-principle.

## 2.2. Modalities of a right to social care and social services

A second part of the project focuses on specific modalities of a right to social care. It will be questioned to what extent the beneficiary of a right to social care has a margin of choice in relation to the organizing (service providing) government. Does the right to social care include such a right to choose (a certain residence or specific type of social care provision); or rather is it limited to (publicly defined) ‘appropriate’ levels of care? In this respect it will be analyzed to what extent a certain degree of selectivity could be justified, how target groups are distinguished, how a government could prioritize in function of specific care needs. Special attention will be given to legal aspects of the highly problematic issue of waiting lists.

The analysis will also draw a parallel with related fundamental rights. A comparison of different categories of rights retained on the basis of the first part of the research will be made. Examples of relevant rights could be (in a Belgian context): the former subjective right to social services, the present right of social integration and the right to medical treatment.

A thorough analysis of a selection of fundamental rights implies that attention will be given to the origins of each right and the related preparatory works. In addition, the range of application of each right will be considered on the basis of an analysis of case law and legal doctrine.<sup>11</sup> The relevance of each right for the specificities of the care giving relationship in social care will be weighed. The way in which conflicting rights are balanced will be taken into consideration.

The research explicitly aims to search for international and foreign examples of related rights which could be useful as a model for (certain aspects of) the right to social care.

## 2.3. Client rights

A fully fledged analysis of the scope and contents of a right to social care and services cannot be limited however to a mere top-down approach of international fundamental rights. In social care circles a rights awareness has arisen and attempts have been made to develop client rights. In the context of Flanders, reference can be made to a draft Act of the Flemish Community concerning client rights. A conference and report have been dedicated to this draft.<sup>12</sup>

---

<sup>11</sup> For an analysis of the origins of the right to social services see for instance D. Pieters, *Sociale rechten. Een studie van de wetbepalingen over fundamentele sociale rechten in België en Duitsland*, Leuven, Acco, 1981, pp. 69-85 (“Social rights. An analysis of fundamental social rights legislation in Belgium and Germany”). See, in addition, C. Saelaert, “Twee jaar subjectief recht op maatschappelijke dienstverlening”, in W. Van Eeckhoutte en M. Rigaux (eds.) *Postuniversitaire cyclus Willy Delva 1995/1996. Sociaal recht: niets dan uitdagingen*, Gent, Mys & Breesch, 1996, pp. 749-791 (“Two years of subjective right to social services”).

<sup>12</sup> Draft Act of the Flemish Community submitted by Ria Van den Heuvel, Patricia Ceysens, Guy Swennen, Jan Roegiers and Sonja Becq concerning the legal protection and participation of social care clients, *Parl. St. VI. Parl. 2000-01, nr. 783/1*. Report: J. Put, V. Verdeyen and G. Loosveldt (eds.) *Gebruikersrechten in*

Additional research into such bottom-up approaches is appropriate, including attempts to reduce the level of abstraction of fundamental rights and to translate them into a social care setting.

Furthermore, similar legislative initiatives and their implementation in other welfare states have never been thoroughly researched. They will therefore be included in this research project.

#### *2.4. Additional dimensions of the right to social care and services*

Both the fundamental social rights and the client rights approach are often highly oriented towards the individual person in need of care. However, clients are often involved in situations in which they are only partially able or no longer able at all to express their wishes and to rely on enforceable rights. This is for instance the case when a care situation also involves constraints or when the person in need of care does not have full legal capacity. In this respect, the debate on the enforceability of fundamental rights has to be put into perspective. Often a third party will have to act on behalf of the client.

As a consequence, this project will look into possibilities to add other, collective dimensions to the legal protection of the client. It is important to note, for instance, that legal provisions in the relationship between client and social care institution may indirectly affect the relationship between client and institution as well. In fact, these provisions include quality requirements, good governance principles, ways of financing care, etc. Relevant research could be conducted into scope and contents of such provisions ‘on behalf of third parties’ in existing legislation. These provisions could add a collective dimension to the legal position of the client in a social care setting.

Lastly, the functioning of collective complaint procedures will be considered.

### **3. Research method**

Legal-comparative research.

1. Analysis of the multi-layered legal framework of social fundamental rights potentially applicable in a social care setting. Analysis of international developments on human rights: social and related fundamental rights in the respective framework of the Council of Europe, United Nations and the European Union. Attention to the possible indirect effects of fundamental rights, for instance the right to court, in a social care context.

---

*de welzijnszorg*, Bruges, die keure, 2003, 327 (“Client rights in social care”). In addition, see G. Loosveldt and B. Van Buggenhout (eds.) *Cliëntgerichte perspectieven in de welzijnszorg*, Leuven-Apeldoorn/Antwerp, Garant/Maklu, 2000, 222 p. (“Client-oriented perspectives in social care”).

2. Follow-up and analysis of cross-national assimilation processes: parallel trends, similar or diverging legislation in relation to the legal protection of persons in need of social care, relevant case law and doctrine with regard to the enforceability of social rights.

#### **4. Timing**

*General aim:*

Scientific research into scope and contents of a right to social care and social services with references to practical implications (enforceability, right of complaint, appeal procedures and client rights) with elderly care as a case-study.

*Time line:*

First phase (1 year):

Collecting (international) legal materials and preliminary analysis.

Second phase (2 years):

Data processing and thorough analysis of a selection of fundamental rights with a social care relevance.

Analysis on the basis of a case-study (elderly care).

Third phase (1 year):

Linking the results of the ‘top-down’ and ‘bottom-up’ approaches.

Developing overarching conclusions. Additional data-collecting and analysis, if proven necessary.

Fourth phase (1 year)

Finalizing PhD and presentation/dissemination of main conclusions.

#### **5. Output and valorisation**

1. Building a legal helpdesk within the consortium for policymakers and professionals in relation to all questions concerning the legal protection of clients/patients.
2. Reporting of results regarding each part of the project as well as overall results.
3. Active dissemination of knowledge through conferences and workshops. Organization of discussion rounds.
4. Follow-up of international trends.
5. Yearbook: reporting of (international) developments with regard to legal position and protection of clients.
6. Creating a social care-related legal framework in the field of legal protection.

**6. Staff**

One full-time researcher (5 years)

**Project 3: Analysis of Government Tools for Implementing/Enforcing Social Care Legislation**

**1. Research aims and topics**

The government has a particular responsibility in social care service provision, which is often considered to serve a general interest purpose. This responsibility is met by a rather extensive set of legal instruments used to improve quality of care and social services. This research project aims to analyze the diversity of instruments used and to assess the extent to which they serve the purposes of providing client-oriented social care services which meet high quality standards. An example of a legal instrument a government could use (or already is using) to meet those goals is the introduction of a social care contract; another example is to set legal criteria for recognition of care providers.

This research project will be based on parallel research activities currently conducted within the field of social security law which will end in December 2007. The research method and results of this social security project will be transposed into the field of social care and adjusted if necessary to meet the specificities of the organization of social care. Although social security and social care both aim to improve the public's social wellbeing, both serve general interest purposes and both involve the participation of private and public bodies, they also differ considerably. (Federal) social security schemes mainly involve financial benefits, whereas (regional) social care services generally refer to non-financial care and support activities in residences or at home.<sup>13</sup>

Instruments used to enhance the quality of service provision, might very well differ according to the government which is using them and according to the social care actor which the instrument aims to address.

Firstly, an important distinction exists between instruments used by the federal government (e.g. constitutional provisions), the regional government (e.g. subsidy norms) and the European institutions (e.g. the free movement of services).<sup>14</sup> Furthermore the involvement of the legislator versus that of the administration should be distinguished. In particular, the competencies of the

---

<sup>13</sup> W. BLOCKEN, K. DEWEERDT, I. VAN DER STRAETE and V. VERDEYEN, "Welzijnsrecht in het kielzog van de sociale zekerheid", in D. SIMOENS, D. PIETERS, J. PUT, P. SCHOUKENS and Y. STEVENS (eds.), *Sociale zekerheden in vraagvorm, liber amicorum prof.dr. Jef Van Langendonck*, Antwerpen, Intersentia, 2005, 41-65. ("Social welfare law following track of social security" in *Questioning Social Security. Liber Amicorum prof. dr. Jef Van Langendonck*)

<sup>14</sup> In this context a preparatory analysis was conducted at the Institute of Social Law: J. PUT, P. SCHOUKENS & I. VERDONCK, *Verkennde impactstudie van het ontwerp van dienstenrichtlijn voor de Vlaamse welzijnssector*, Research report commissioned by the Ministry of the Flemish Community, Department of Welfare, Public Health and Culture, January-February 2006, 37 p. (*Exploratory impact assessment of the draft services directive for the Flemish social care sector*)

different governments to steer (the quality of) social care provision in Flanders will be thoroughly analyzed. Attention will be paid to their interaction with the principle of the right to associate and to assemble and the freedom to provide services.

Secondly, the set of tools might differ according to the actor addressed by it. Government tools vis-à-vis social care institutions and nursing homes are numerous and highly visible. They can differ again according to the type of institution. Both public and private institutions are involved in implementing social care policy, but they differ considerably in relation to their legal constitution and the fact whether they are for profit. Some private institutions are given a special role in as far as they comply with a number of organizational and functional criteria. To that extent they are even legally qualified as administrative public bodies. As a result of this qualification, they have to act towards their clients as if they were a governmental body and will have to comply for instance with the general principles of good governance.<sup>15</sup> This research project will also address the impact of administrative law on the functioning of social care institutions.<sup>16</sup> To a lesser extent the government also addresses the person in need of social care directly, and therefore not via instruments addressing institutions, as for instance in the Act of the Flemish Community concerning the legal position of minors.

Following elements will be analyzed in depth:

- The legal constitution of social care institutions and nursing homes.
- The competencies of the different governments in relation to public versus private social care institutions in Flanders.
- An overview of tools will be presented and legally analyzed: the origin and aims will be listed for each instrument, as well as the legal possibilities to steer public versus private social care provision with them. Each instrument will be assessed in light of its usefulness in enhancing the quality of social care services. Lastly, attempts will be made to simplify, coordinate and integrate instruments when proven necessary.

Some examples of important government tools in social care are administrative norms in relation to subsidies and recognition, including rules on quality requirements. An important question

---

<sup>15</sup> The interpretation of several administrative law concepts has far-reaching consequences in a social care setting - as for instance the concept of administrative government. Recently, a parliamentary question was posed concerning the field of application of the Act of the Flemish Community on good governance. ( See V. VERDEYEN and J. PUT, “Openbaarheid van bestuur in de Vlaamse welzijnsvoorzieningen”, *T.S.R.* 2005, 515-571, “Good governance in Flemish social care institutions”). Following recent case law of the Belgian Supreme Court, the ombudsman was suddenly deprived of his competencies in relation to social housing corporations following a change in interpretation of the concept of administrative government (See V. VERDEYEN, “Administratieve overheden: een organieke nuancering van de functionele benadering”, *C.D.P.K.* 2006, in press, “Administrative governments: putting the functional approach back into an organizational perspective”).

<sup>16</sup> V. VERDEYEN and J. PUT, “Openbaarheid van bestuur in de Vlaamse welzijnsvoorzieningen”, *T.S.R.* 2005, 515-571, (“Good governance in Flemish social care institutions”).

concerning the instrument of recognition is to know what effects it has on third parties. To what extent can clients base their claims against an institution on breaches of quality requirements by that institution? Can they draw (indirect) legal protection from those administrative provisions concerning recognition of institutions? A similar set of questions rises in relation to social care contracts or ‘social care protocols’, and within the framework of public-private partnerships. The general rules of contract law might have an influence, as well as the principles of government liability in case of breaches of obligations and subsidy agreements.<sup>17</sup>

In addition, new instruments are being created in the context of client rights, as provided in the draft Act of the Flemish Community granting client rights, that has been submitted twice in the Flemish Parliament and the Act of the Flemish Community concerning the legal position of minors.<sup>18</sup> Lastly, different tools of inspection, general inspection, administrative inspection in relation to public bodies and specific modes of inspection will be included in this research project. An important question in this respect is whether inspection tools could not be better organized in a more integrated fashion, with adjustments for specific sectors if necessary.

In addition to a legal analysis of different government tools, suggestions will be formulated to improve individual instruments and to simplify and/or integrate them into a more balanced framework. In the end, a general picture of government tools in social care and its diverse sectors should enable policy makers to improve legal certainty and protection for social care institutions, governments and clients.

## 2. Research method

Existing government tools will be analyzed on the basis of current legislation addressing social care institutions and nursing homes and to a lesser extent addressing clients. On the basis of an analysis of these instruments within the context of each social care sector, this project will move on, adopting a more integrated and overarching approach for social care in general. Furthermore, relevant case law will be studied. Ultimately, positive and negative features of each instrument will be indicated and thoroughly discussed.

---

<sup>17</sup> Also in this respect, reference will be made to the results of the current social security research project, for instance in relation to the recognition of cooperating social security institutions and governance agreements between the federal State and public social security institutions.

<sup>18</sup> V. VERDEYEN, B. VAN BUGGENHOUT and G. LOOSVELDT, *Voorstel van decreet houdende de rechtsbescherming en inspraak van de gebruikers van welzijnsvoorzieningen, een juridisch onderzoek en een voorstel van standpuntbepaling van de Vlaamse regering*, Leuven, 2002, internal report, 100 p. (*Draft Act of the Flemish Community concerning the legal protection and participation of social care clients: a legal analysis and a proposal for the Flemish Government’s position*).

### **3. Output**

This research will result in a set of cards for each instrument used in a social care setting, indicating its main positive and negative features. On the basis of this analysis, suggestions will be made with a view to eliminate superfluous provisions and to integrate sets of subsidy and recognition norms in a more overarching framework. Ultimately, this research project aims to simplify and integrate government tools for the enhancement of quality of social care service delivery. In future, research results could be used as a basis for the development of an overarching and general Social Care Act.

### **4. Valorisation**

- Reporting of results, also in relation to the consortium's planned Yearbook.
- Formulating legal guidelines and suggestions to simplify and integrate current government tools.
- Organizing discussion rounds with government officials.
- Creating a legal helpdesk within the consortium to address legal issues of administrative law within social care.

### **5. Staff**

One part-time researcher for 2 years

**Project line 2: Institutional framework**

**1. Coordination and research groups involved**

Coordinator: Prof.dr. Johan Put (Institute for social law and youth criminality)

Catholic University of Leuven:

Prof.dr. Marleen Brans (Institute for the government)

Prof.dr. Koen Verhoest (Institute for the government)

Prof.dr. Johan Deklerck (Institute for social law and youth criminality)

Prof.dr. Jan Heyrman (Academic Centre for General Practice)

**2. Context**

The study of public administration is not only concerned with the way in which government organizations and parties involved are internally structured and how they relate to citizens and society at large. Moreover, it formulates proposals in order to enhance efficiency, effectiveness and legitimacy of government's actions. This mission statement indicates that public administration of management could be analyzed from several perspectives. Organization-theoretical and managerial approaches could be distinguished from policy-oriented approaches. The institutional analysis which is suggested in the framework of the consortium, however, is situated at the crossroads between both approaches and aims to critically assess the implementation of social care policy. Emphasis will be placed on fine-tuning of implementation through the introduction of the concepts of supply chain management and care trajectories in health care. There is a parallel between both concepts which deserves further study and exploration.

**3. Focus and research aims**

Within the Flemish government, the policy area of social care and public health is particularly confronted with problems of harmonization:

- Firstly, competencies are situated on diverse layers of government (on the level of the federal and regional governments, on the level of communities), which makes of social welfare policy a prime example of 'multi-level governance'.
- Secondly, this policy area is also situated within a heterogeneous administrative framework at the level of the Flemish Community. Several subdivisions of policy are highly divided along sector lines. Furthermore, within certain sector-based policies, important preparatory and implementing assignments are conducted by departments as well as agencies.

- Thirdly, actual policy implementation (care giving) is often conducted by a variety of third parties (private facilities or individuals).

In the organization of welfare care as well as in the organization of health care we see large problems of coordination, clear organization, and coherence because of the subdivision into diverse sectors. As these categorical sectors grow, they develop a strong vertical structure, a particular logic, an administration and procedures; This does enlarge professionalism, quality, transparency and it assures controllability. But in a care and welfare system aimed at integrated care around one individual person and his or her very particular environment, it creates obscurity, having to adapt again and to repeatedly start again in a new environment. This renders putting the person first and central and giving individualized care difficult.

Practice demonstrates that this complex organization implies indirect effects on implementation, particularly when a person or a family are subsequently confronted with several organizations which all belong to a specific sector and a specific administrative entity (trajectories of care).

- Often the client will be forced to follow intake-procedures all over again and to repeat his background due to the fact that each organization has a rather unique administrative structure (client registration, concept en scales, forms, ...).
- As a result of the complex organization and the lack of harmonization of the supply-side, it is not unlikely for the client to miss out on care and aid opportunities.
- Diverse sectors use different scales to assess people's needs or start of with a different set of care giving principles, criteria or methods, as a result of which clients cannot be helped or treated in a uniform fashion.
- Persons with more complex care needs are sometimes rejected because organizations are aiming at defined target groups.
- Due to the fact that each organization specializes in a particular type of care or treatment, and due to the fact that communication between organizations is often insufficient, it is difficult for governments to address and solve individual (and social) need situations in an integrated fashion.

Within this vertical and horizontal institutional complexity, it is difficult for the Flemish government to offer a harmonized and integrated package of care and to combine efficiency and client-oriented approaches. At the administrative level, one then has the tendency to react by installing coordinating structures and by reinforcing the coordination on top of the structures: consultative bodies, councils, multidisciplinary consultation and stipulation of task agreements. The problem is that this even expands structuring, making the complexity uncontrollable and increasing alienation: the client does not follow anymore on the hand and on the other hand the professionals more and more work in structures and consultative bodies and alienate from their clients or patients.

The CWPF sees this as an important issue and therefore wants to establish an institutional approach. This would make it possible to address the difficulties mentioned on the basis of a

client-oriented scan of the supply side of social care and public health. Specifically, the Centre wants to keep watch over two elements in its multi-annual approach. On the one hand, we wish to investigate the drawing of care trajectories and the registration of chains of assistance and care from the perspective of supply chain management and health care trajectories. On the other hand, the demand for clustering of care around units that are easily accessible and recognizable for the patient is strong. This is aimed at not putting the coordination at the level of the umbrella organization, but at the individual level close to the patient or client.

Such an analysis aims to contribute to a better harmonization:

- At the operational level, care for clients/patients could be improved by offering an adequate type of treatment at the right time in the context of smoothly organized care trajectories.
- At the organizational level, by fine-tuning the supply of diverse organizations in continuous dialogue.
- At the level of policy stakeholders, by restructuring the supply of sectors and administrations on a structural and procedural level.
- At the level of the entire policy domain, by promoting good practices among public officials in relation to supply chain management.

#### **4. Research method**

Exploratory analysis of specific care trajectories through diverse organizations.  
Survey of stakeholders.

#### **5. Output**

- Reporting of research results and dissemination of knowledge on the basis of conferences and workshops.
- Promoting principles of chain management in the policy area of welfare, public health and the family.
- Organization of chain negotiations between care homes and other organizations, administrations, sectors and civil servants.

## 5. Summary of the projects

Research index card	Health, development, behaviour and parenting in 0-18-year-old children: A longitudinal study on the prevalence and case history of problems and the care trajectories of families
Project number	1.1
Aims	<ul style="list-style-type: none"> <li>-collect data on the prevalence of health, developmental, behavioural and educational problems in children;</li> <li>-gain insight in the evolutions, the protective and the risk factors with regard to these problems;</li> <li>-assess the needs and help seeking behaviour of parents because of these problems and their determinants on micro, meso and macro level;</li> <li>-collect data on the entrance and trajectories of these children and families in the preventive and care system;</li> <li>-gain insight in the association between (1) evolutions in problems and client perception of care and (2) client and client system features, nature of the help that is asked for and case histories;</li> <li>-verify the outcomes of early intervention given to children and families at risk;</li> <li>-offer instruments and procedures for (1) early detection of health, behavioural, developmental and educational problems and (2) the analysis of risk and protective factors.</li> </ul>
Method	<ul style="list-style-type: none"> <li>-an accelerated longitudinal or cross-sequential design shall be used in which three cohorts (0-, 3-, 6-years-olds) are being followed for a period of four years</li> <li>-we will use the same general regions that have been selected over all programs</li> <li>-‘conditional random sampling’ based on the regions of Child and Family</li> <li>- cohort 0-year-olds (n = 6.000 with measures at the age of 0, 1, 2 and 3), cohort 3-year-olds (n = 3.000, with measures at the age of 3, 4, 5 and 6) and cohort 6-year-olds (n = 3.000, with measures at the age of 6, 7, 8 and 9)</li> <li>- in case of continuation (2012-2016) the study shall be continued with cohorts of 9-, 12- and 15-year-olds</li> <li>-data collection based on existing registrations (IKAROS; file of the School Guidance Centre), with additional data on <ul style="list-style-type: none"> <li>- weight, feeding and movement behaviour,</li> <li>- temperament and behaviour regulation,</li> <li>- cognitive and motor development,</li> <li>- socio-communicative skills and language development,</li> <li>- educational stress and early signs of educational problem situations,</li> <li>- family situation and evolution, needs, real consumption of help and</li> </ul> </li> </ul>

	case histories.
Background	Program 1 Project line a 4 years
Outcomes, indicators and timeline	<p><i>Outputs:</i></p> <ul style="list-style-type: none"> <li>-data on the prevalence and the evolutions of health, behavioural, developmental and educational problems in 0-9-year-olds in Flanders;</li> <li>-data on the families' care needs and consume and on their determinants (child, family, social context) and on the (possible) discrepancy between care needed and care consumed;</li> <li>-longitudinal data on child, family and context factors that either buffer the presence of early risks or enhance them;</li> <li>-longitudinal data on the transitions of families and children and its impact on health, behaviour, development and education;</li> <li>-a differentiated understanding of the help seeking behaviour, the entrance and the care trajectories and histories of families in the preventive and care system, because of health, behavioural developmental, or educational problems;</li> <li>-data on the connection between: 1) evolutions in health, behavioural, developmental and educational problems and client perception of care (accessibility, participation, satisfaction) and 2) client and system features, nature of care asked for and case history;</li> <li>-a screening battery that may be used by the authorities and the different sectors concerned to map risks in families with young children.</li> </ul> <p><i>Phasing:</i></p> <ul style="list-style-type: none"> <li>-year 1: preparation and start up of the longitudinal research project; selection of the regions; selection of the specific parameters and instruments, implementation in the existing registrations;</li> <li>-year 2-5: start and follow-up of the cohorts, data collection and interim analyses</li> <li>-year 5: final report, dissemination</li> </ul>
Valorising	<ul style="list-style-type: none"> <li>-annual report evaluating the project's state of affairs (inclusive the results of the different measuring moments);</li> <li>-a symposium at the end of the first phase of the Support Centre.</li> </ul>
Coordination	<p>Prof.dr. Hans Grietens, KUL, Centre for Disabilities, Special Needs Education and Child Care, coordinator</p> <p>Prof.dr. Karel Hoppenbrouwers, KUL, Centre for Youth Health Care</p> <p>Prof.dr. Herbert Roeyers, University of Ghent, Centre for Experimental Clinical and Health Psychology</p>
Resources FTE	Personnel: 3 FTE

Research index card	Program 1 Adults
Project number	1.2
Aims	<p>By developing panels of users this project aims to collect data about the needs of service users, their consumption of services (across organizations and sectors) and the determinants of these processes. These data permit to map service trajectories and their direct effects on the users' quality of life. This evidence opens the black box between input and outcome.</p> <p>This project consists of two phases. During the first year a gap analysis will be performed. This implies that all existing research databases, administrative data and registration systems concerning welfare, health and the family in general and service users specifically will be mapped. This will result in a clear overview of the existing evidence, potential overlaps and gaps. Special attention will be paid to the socio-economic and ethnic profile of service users. During the second phase, which covers the next four years, the service trajectories of four specific adult populations will be followed. Based on three factors, namely the current needs and expectations at the demand side, the Minister's policy priorities and researchers' expertise four adult populations are selected: (1) persons at risk of poverty, (2) persons with psychological problems, (3) persons with relational problems, (4) persons with a handicap. For these four groups common and problem-related indicators will be developed and measured. This strategy facilitates to search for connections between the target groups and the related problems.</p> <p>To sum up, this projects aims for:</p> <ol style="list-style-type: none"> <li>1. A gap analysis of existing research databases, administrative data and registration systems.</li> <li>2. Data on the inflow into primary social services and health care</li> <li>3. Data on the service trajectories of four adult populations across services, organizations and sectors and from a longitudinal perspective.</li> <li>4. Data on the users' knowledge of social and health care services.</li> <li>5. Data on the effects of service trajectories measured by a multi-dimensional conceptualization of the quality of life.</li> <li>6. Data on the users' experiences with and the satisfaction on the quality of social and health care services</li> <li>7. The tracing of personal and environmental factors which increase the quality of life of the four target groups.</li> </ol> <p>The improvements for the refinement and amelioration of the quality of registration systems and practices</p>

Multi-annual program

Method	<p>For each target group, a specific sample consisting of 800 individuals will be carried out. These individuals will be contacted three times in three years. These panels will be selected in a number of regions in Flanders and Brussels. For each target, a specific sample strategy will be followed.</p> <p>For these four groups, a common list of indicators will be followed up: quality of life (well-being, health situation, interpersonal and relational situation, social network and social capital, financial situation, labour participation and leisure activities, self care, housing), knowledge of social services and health care, appeals to social services and health care, quality of relational aspects of social services, experienced profit of and satisfaction with the services, Socio-economic and ethnic control variables.</p>
Background	Program 1
Outcomes, indicators and timeline	<ol style="list-style-type: none"> <li>1. A gap analysis of existing research databases, administrative data and registration systems resulting in a clear overview of the existing evidence, potential overlaps and gaps.</li> <li>2. Data on the inflow into primary social services and health care.</li> <li>3. Data on the service trajectories of four target groups</li> <li>4. Data on the users' knowledge about human services.</li> <li>5. Data on the care these target groups need and consume and on the (possible) discrepancy between their needs and their consumption</li> <li>6. Data on the experienced profits, the satisfaction and the effects of service trajectories, measured by means of a broad conception of quality of life.</li> <li>7. Data on parallel service trajectories across organisations and sectors.</li> <li>8. A longitudinal analysis of the correlation between poverty, psychological problems and relational problems.</li> <li>9. Data on the forms of cooperation between services and organisations on the local level</li> <li>10. An overview of gaps and overlaps of the current supply side of social welfare and health care services</li> <li>11. The improvement and tuning of referral and registration practices</li> <li>12. The identification of necessary forms of cooperation on the local and the Flemish level.</li> </ol>
Resources FTE	2,5 FTE

Research index card	Program 1: Elderly people
Project number	1.3
Aims	<p>For purposes of policy making, a clear view is needed of the situation of elderly people in Flanders in general and of elderly people with specific needs in particular.</p> <p>We aim at:</p> <p>(1) Providing an overview of the current situation of elderly people in Flanders.</p> <p>(2) Studying and comparing different target groups with specific problems, such as people with feelings of unwell being or people with cognitive problems.</p> <p>(3) Studying care and help trajectories across sectors. In Flanders, as elsewhere, the demand for an effective long-term care policy is growing.</p>
Method	<ul style="list-style-type: none"> <li>- gap analysis</li> <li>- cross-sectional research in over 50,000 elderly people in Flanders</li> <li>- longitudinal research with 1200 elderly people, with specific attention for <ul style="list-style-type: none"> <li>- unwell being and depression</li> <li>- cognitive problems and dementia</li> </ul> </li> </ul>
Background	Program 1 'indicators and monitoring'
Outcomes, indicators and timeline	<ul style="list-style-type: none"> <li>- a gap-analysis: the mapping of all relevant existing research databases, administrative data and registrations to gain better insight in the information already present, in overlap, in redundancy, and in hiatuses.</li> <li>- the monitoring of the current policy for elderly people</li> <li>- indicators on social participation of elderly people</li> <li>- indicators on unwell being in elderly people</li> <li>- indicators on care trajectories of elderly people with depression</li> <li>- indicators on elderly people with cognitive problems</li> <li>- indicators on care trajectories of elderly people with dementia</li> <li>- indicators on the effects of assistance strategies</li> <li>- indicators of the help experienced and the satisfaction of the users of services</li> <li>- tracking down overlap and hiatuses in the current assistance and service model</li> <li>- analyzing existing registration practices and systems</li> <li>- developing trajectories for improvement of attuning of registration practises and systems, across sectors and</li> </ul>

Multi-annual program

	<p>organizations</p> <ul style="list-style-type: none"> <li>- seeking for new forms of collaboration in order to better attune reference systems</li> </ul> <p>proposing amelioration plans to refine the usability and quality of registration data for policy planning</p>
Valorising	
Coordination	Prof.dr. Anja Declercq, LUCAS
Resources	1,5 FTE
FTE	

Research index card	Starting point and spearheads
Project number	2.1
Aims	<p>In each region specific priorities in the field of effectiveness and quality improvement in care arise. Even if we can theoretically determine which criteria good care should fulfil, it is still advisable to determine a joint framework of priorities per region for interventions that can improve quality. To gain insight in the supply and the possibilities for improvement in this supply, is central in the first working year</p> <p>The following questions will be answered:</p> <ul style="list-style-type: none"> <li>Which elements are necessary in the supply of health and welfare services?</li> <li>What should be prioritized to realize or optimize this in your region?</li> <li>What evidence based practices are relevant for the target groups and for the sectors?</li> <li>What know how is present in Flanders to apply these practices?</li> </ul>
Method	To determine the spearheads, we will use a technique called concept mapping (Trochim, 1989, 1994). In all pilot regions, the process of concept mapping will be organized. To this end, different groups of people involved will be invited: professionals and managers from all sectors concerned, users of these sectors and their families, members of the local communities and policy makers. We strive for participation of a group that is as broad as possible in order to bring together a large variety of possible angles and viewpoints.
Background	<p>Programme 2A en 2B</p> <p>Start date – end date</p> <p>Jan 2007- Dec 2008</p>
Outcomes, indicators and timeline	The results offer qualitative and quantitative information on the nature and the relative importance of different concepts and values per region and per group involved. This should lead to a generalized framework, with among others a uniform list of concepts.
Valorising	<p>The results of the concept mapping can be used immediately for concrete planning of intervention and effect studies. Across the regions, a limited number of spearheads will be formulated.</p> <p>A review of evidence based practices and a catalogue of applications that are already present in Flanders</p>
Coordination	<p>Prof.dr. Chantal Van Audenhove, LUCAS</p> <p>Prof.dr. Anja Declercq, LUCAS</p>
Resources	1 FTE 2 years
FTE	

Research index card	Community trial with focus on nutrition and physical activity for young families
Project number	2.2
Aims	<i>General objective:</i> Efficacy, efficiency and organisational study of prevention activities aiming at enhancing nutrition and physical activity of children, young people and their families and the development of collaborative models to enhance the offer of prevention initiatives in Flanders.
Method	The development of a multi-component intervention program (focussing on behavioural determinants in the community, the school, the family and the individual) aiming at enhancing nutrition and physical activity of pre school children (3-5 years old) and young school children (6 to 9 years old) and their families Evaluation of the different aspects of the multi-component intervention program (effect on behaviour, feasibility, efficiency, ...), as well at the level of the receivers of the interventions (children and their parents) as the actors delivering the interventions (schools, local authorities, local health promotion networks, medical doctors, para medics, ...) Development of implementation models for community oriented multi component intervention programs in Flanders
Background	This project is part of program 2: Evaluation and development. Enhancing the health promotion skills and competence of professionals in the health and welfare sector is a permanent task. Evidence based and theory based health promotion need to be stimulated and optimized. This project will evaluate if and how these programs can be implemented in Flanders and if they lead to positive outcomes in the Flemish context. This program is not only dealing with providing training for professionals but also with systematic implementation and evaluation of new strategies through action- and evaluation research. The community approach is the central element, the project will first analyse the local needs and existing initiatives; provide the local services, organisations and decision makers with a catalogue of evidence based intervention possibilities and will give the necessary support the implementation of the interventions with the final aim to enhance health eating and more physical activity and to reduce overweight and obesity in young children.
Outcomes, indicators and timeline	Milestones: <ul style="list-style-type: none"> <li>- multi-component intervention for the enhancement of healthy eating habits and physical activity</li> <li>- Questionnaires and measurements for baseline and follow up</li> </ul>

Multi-annual program

	<ul style="list-style-type: none"> <li>- training of actors for implementation of the interventions</li> <li>- yearly effect and process evaluation</li> <li>- models for training and implementation adapted to the situation in Flanders</li> <li>- Indicators:             <ul style="list-style-type: none"> <li>- eating habits and physical activity of pre school and primary school children and their parents by social class</li> <li>- differences in the change in eating habits and physical activity between intervention and control communities</li> <li>- critical success factors at the level of the community, local decision makers, families and health and welfare professionals for the implementations of the interventions</li> </ul> </li> </ul>
Valorising	<ul style="list-style-type: none"> <li>- diffusion of evidence based interventions for children and their parents for the enhancement of healthy eating and physical activity in the community making use of the existing infrastructure and capacity in Flanders through training, information, ...</li> <li>- scenario's for the successful implementation of interventions</li> <li>- follow-up of the intervention and control cohort from childhood to adolescence and adulthood (in later phases of the Policy Research Centre).</li> </ul>
Coordination	<p>Coordinator: Prof.dr. Lea Maes, Department of Social Health            Prof.dr. Ilse De Bourdheaudhuij, Department of Movement and Sport Sciences            Prof.dr. Stefaan De Henauw, Department of Social Health            Prof.dr. Johan Lefevre, Section physical Activity and Health            Prof.dr. Filip Boen, Centre for Movement and Sport psychology and coaching</p>
Resources FTE	1FTE

Research index card	Evaluation of the effects of a psycho educational program on stress and its preventive effects on anxiety and depressive disorders
Project number	2.3
Aims	<p>‘Stepped care’ (Haaga, 2000) intends to match the type and intensity of a treatment to the personal needs of a patient. In current mental health care, patients are often too early advised to start an intense individual therapy. Recent evidence documents the importance and effects of low threshold group educational approaches of short durations. Psycho education combines a educational model with the aims of psychotherapy. Doctor/therapist and patient roles are replaced by teacher/student roles. First, this major change in role definition emphasizes the individual responsibility of the participant, as the aim is not only to teach skills helping the student to overcome current problems, but also to cope with future adversities (Brown, 1980). Second, students are not expected to have a specific diagnosis or problem as the intention to learn new skills suffices for participation. As a first step within a “stepped care” approach, psycho education can (1) have an important preventive role through detecting and solving problems at an early stage before they escalate to more serious levels; (2) offer a solution to the widespread waiting list problem in ambulatory mental health services; (3) be an effective and sufficient treatment for some patient groups; (4) serve as first layer and platform for more extensive treatments.</p> <p>‘Treating anxiety and stress: A group psycho-educational approach using brief CBT.’ (Jim White, 2000) has recently been adapted for the Flemish public (‘Word uw eigen gids bij stress en spanning’) in collaboration between psychologists of ISW-Limits (spin-off of the University) and Dirk Hermans and Omer van den Bergh, both professors at the Catholic University of Leuven (K.U.Leuven).</p> <p>The content of the course contains 12 steps. Step 1 (1st session) is a general introduction to stress facts and processes and provides a frame for the subsequent sessions. Step 2 and 3 are contained in home work assigned in the first session. Students have to reflect and apply the course materials to their own life situation and make a personalized work program. The home work intends to help students to decide which techniques are relevant for themselves.</p> <p>The following 9 steps are the content of the subsequent sessions. Step 4, 5 and 6 (session 2, 3 and 4, respectively) provide more detailed</p>

	<p>information about the role of the body in stress, the role of thoughts and actions and how to change them. For step 7 to 10 all the acquired knowledge and techniques are applied to specific problems, such as anxiety, panic, sleep problems, depressive mood, acute stress problems and burnout. Step 11 and 12 provide an overview as a guide to manage stress problems in the future. Home work during the last 9 steps implies further training of the learned skills and keeping a personal diary of the training experiences and progress.</p> <p>Research of Jim White documented the effectiveness of the method, lasting up to 8 years after the intervention (White, 2000). Preliminary data showed also for the Flemish adaptation a substantial decline from pre- to post test scores on several measures of stress, anxiety and depression related variables, that continued to decline up to 4 months after the program.</p>
Method	<p>The course is already being taught through organisations like a Medical Insurance company (i.c. Christelijke Mutualiteiten) and some private firms and many participants have followed it. The aim of the present research plan is to carry out a systematic evaluation of its effects. Different groups will be compared with three matched control groups: (1) no course; (2) self help course; (3) alternative treatments (homeopathy, yoga, relaxation, acupuncture).</p> <p>Measures are divided into three sets :</p> <p><b>Set 1:</b></p> <ul style="list-style-type: none"> <li>- stress, anxiety and depression questionnaires</li> <li>- worry behaviour</li> <li>- problem solving skills (means-ends test)</li> </ul> <p><b>Set 2</b></p> <ul style="list-style-type: none"> <li>- consultations (both classic treatment settings, like GP's, mental health ambulatories, alternative consultations like homeopathy, acupuncture, etc.)</li> <li>- longitudinal follow up of participants to assess the relative probabilities of mood (anxiety, depression) and somatisation disorders</li> </ul> <p><b>Set 3</b></p> <ul style="list-style-type: none"> <li>- Health economic assessment of the cost/benefit balance</li> </ul>
Background	
Outcomes, indicators and timeline	<p><b>Year 1 :</b></p> <ul style="list-style-type: none"> <li>- Implementation of the program in a wide variety of settings</li> </ul>

Multi-annual program

	<ul style="list-style-type: none"> <li>- Validation of measures</li> <li>- Intermediate publications</li> </ul> <p><b>Year 2 , 3 and 4 :</b></p> <ul style="list-style-type: none"> <li>- Data collection</li> <li>- Publications about the different effects of the program</li> </ul>
Valorising	<ul style="list-style-type: none"> <li>- further shaping of the program taking into account the results of the study</li> <li>- wide distribution of the program through first and second line caregivers and mental health professionals</li> <li>- skills training of caregivers to offer this program through their organisations to the large public.</li> </ul>
Coordination	<p>Prof.dr. Omer Van den Bergh, Research Group for Stress, Health and Well-being, Dept Psychology, K.U.Leuven</p> <p>Prof.dr. Dirk Hermans, Centre for Learning Psychology and Experimental Psychopathology</p>
Resources FTE	0.5 FTE for 4 years

Research index card	Legal and/ or human rights protection of the social care client
Project number	3.1
Aims	<p>Fundamental human and/or social rights are increasingly taken into account in research into the formulation of claims for clients with regard to (access to, quality of, ...) social care and social services. In addition, attempts are made to further develop those claims into legally enforceable rights. The central focus of this research project is on scope, contents and modalities of what will be coined a right to social care and services. Research findings will be tested within the context of elderly care as a case-study.</p> <p>Following research questions will be addressed in this project:</p> <ul style="list-style-type: none"> <li>- Which aspects of social care merit special legal protection (access to social services, continuity of care, proper housing, meeting quality standards of care, equal treatment, respect of privacy, et cetera)?</li> <li>- How can legal protection be guaranteed in case of non-financial aid? How does it differ from financial aid situations?</li> <li>- What fundamental human and/or social rights do already exist and to what extent are they relevant in accomplishing a specific set of rights to social care (e.g. the right to medical and legal aid, the right to social assistance, the right to social services and to social integration)?</li> <li>- Which results do these rights have (a) in the internal legal order, (b) in the relationship between government and social care institution and (c) in the relationship between client and institution/caregiver?</li> <li>- Which specific claims flow from those rights for a client and are they enforceable? What options exist for a client to enforce his rights?</li> <li>- Is it only the individual client which is granted certain rights or can a more 'collective' approach towards legal protection be developed?</li> </ul> <p>The research project entails four parts combining top-down and bottom-up approaches. Firstly a thorough analysis of international literature will be conducted into the enforceability of (fundamental) social rights which could be relevant in a social care setting. In this respect it will be questioned, for instance, whether or not it is possible for a court to order a government to reach a certain level of social</p>

	<p>services and whether or not an obligation of admission can be imposed on residences. Secondly specific modalities of a right to social care and services will be analyzed. It will be considered for instance whether or not a client has a certain freedom of choice, or rather a mere right to (publicly defined) ‘appropriate’ care.</p> <p>Thirdly, through a bottom-up approach examples of client (consumer?) rights developed and/or implemented within a social care setting will be researched. In this respect, attention will be given to legislative initiatives in other welfare states. Lastly, the research project will consider possibilities to expand a mere individual approach to a right to social care with a more collective dimension.</p>
Method	Legal-comparative analysis.
Outcomes, indicators and timeline	<ol style="list-style-type: none"> <li>1. Building a legal helpdesk within the consortium for policymakers and professionals in relation to all questions concerning the legal protection of clients/patients.</li> <li>2. Reporting of results regarding each part of the project as well as overall results.</li> <li>3. Active dissemination of knowledge through conferences and workshops. Organization of discussion rounds.</li> <li>4. Follow-up of international trends.</li> <li>5. Yearbook: reporting of (international) developments with regard to legal position and protection of clients.</li> <li>6. Creating a social care-related legal framework in the field of legal protection.</li> </ol>
Timing	<p>First phase (1 year): Collecting (international) data and preliminary analysis.</p> <p>Second phase (2 years): Data processing and thorough analysis of a selection of fundamental rights with a social care relevance. Analysis on the basis of a case-study (elderly care).</p> <p>Third phase (1 year): Linking the results of the ‘top-down’ and ‘bottom-up’ approaches. Developing overarching conclusions. Additional data-collecting and analysis, if necessary.</p> <p>Fourth phase (1 year) Finalizing PhD and presentation/dissemination of main conclusions.</p>
Background	Program 3, legal framework

Multi-annual program

---

Coordination	Prof. dr. Johan Put Institute of Social Law, Research Unit Welfare Law, K.U.Leuven
Resources FTE	1 FTE

Research index card	Administrative law and tools for quality control in social care
Project number	3.2
Aims	<p>The government has a particular responsibility in social care service provision, which is often considered to serve a general interest purpose. This responsibility is met by a rather extensive set of legal instruments used to improve quality of care and social services. This research project aims to analyze the diversity of instruments used and to assess the extent to which they serve the purposes of providing client-oriented social care services which meet high quality standards. An example of a legal instrument a government could use (or already is using) to meet those goals is the introduction of a social care contract; another example is to set legal criteria for recognition of care providers.</p> <p>Firstly, an important distinction exists between instruments used by the federal government (e.g. constitutional provisions), the regional government (e.g. subsidy norms) and the European institutions (e.g. the free movement of services). In particular, the competencies of the different governments to steer (the quality of) social care provision in Flanders will be thoroughly analyzed. Attention will be paid to their interaction with the principle of the right to associate and to assemble and the freedom to provide services.</p> <p>Secondly, the set of tools might differ according to the actor addressed by it. Government tools vis-à-vis social care institutions and nursing homes are numerous and highly visible. They can differ again according to the type of institution. Both public and private institutions are involved in implementing social care policy, but they differ considerably in relation to their legal constitution and the fact whether are not they are for profit. Some private institutions are given a special role in as far as they comply with a number of organizational and functional criteria. To that extent they are even legally qualified as administrative public bodies. To a lesser extent the government also addresses the person in need of social care directly, and therefore not via instruments addressing institutions, as for instance in the Act of the Flemish Community concerning the legal position of minors.</p> <p>Following elements will be analyzed in depth:</p> <ul style="list-style-type: none"> <li>- The legal constitution of social care institutions and nursing homes.</li> <li>- The competencies of the different governments in relation to public versus private social care institutions in Flanders.</li> <li>- An overview of tools will be presented and legally analyzed (subsidies and recognition, quality requirements, social care protocols and contracts): the origin and aims will be listed for each instrument, as well as the legal possibilities to steer public versus private social care provision with them. Each instrument will be assessed in light of its usefulness in enhancing the quality of social care services. Lastly, attempts will be made to simplify, coordinate and integrate</li> </ul>

Multi-annual program

	<p>instruments.</p> <p>In addition to a legal analysis of different government tools, suggestions will be formulated to improve individual instruments and to simplify and/or integrate them into a more balanced framework. In the end, a general picture of government tools in social care and its diverse sectors should enable policy makers to improve legal certainty for social care institutions and governments and improve legal protection for clients.</p>
Method	<p>Existing government tools will be analyzed on the basis of current legislation addressing social care institutions and nursing homes and to a lesser extent addressing clients. For each instrument, a research card will be drafted. On the basis of an analysis of this set of instruments within the context of each social care sector, this project will move on, adopting a more integrated and overarching approach for social care in general. Furthermore, relevant case law will be studied.</p>
Outcomes, indicators and valorisation	<ol style="list-style-type: none"> <li>1. Reporting of results, also in relation to the consortium's planned Yearbook.</li> <li>2. Formulating legal guidelines and suggestions to simplify and integrate current government tools into a general and overarching framework.</li> <li>3. Organizing discussion rounds with government officials to disseminate preliminary findings and to test suggestions.</li> <li>4. Creating a legal helpdesk within the consortium to address legal issues of administrative law within social care.</li> </ol>
Background	<p>Program 3, legal framework</p>
Coordination	<p>Prof. dr. Johan Put Institute of Social Law – Research Unit Welfare Law K.U.Leuven</p>
Resources FTE	<p>1 part-time researcher for 2 years</p>

Research index card	<p>Proposal ‘Supply Chain Management’</p> <p>The welfare and health care supply from a customer (client) perspective</p> <p>A study of the needs and the possible types of working with chains in the field of welfare, health &amp; family</p>
Project number	3.3
Aims	<p>Formulation of the research issue</p> <p>The number of executive services and organizations in the sector of public health, welfare &amp; family is immense: services for accompanied living, centres for general well-being (Centra voor Algemeen Welzijn, CAW), centres for home care, hospitals, rest homes, Centres for child care and family support (Centra voor Kinderzorg en Gezinsondersteuning, CKG)... Each organization/service belongs to its own sector and has its own contexts, frames of reference, regulation on financing, assistance principles, -criteria and -methods, as well as an own administrative organization of that service (customer recording, initial interview process, concepts and scales, forms...). It is difficult for the Flemish government to offer a good trajectory of care within these vertical (inter-government) and horizontal (administration-exceeding) institutional complexity. Moreover, it is difficult for an ‘integral government’ to work as a customer-oriented and efficient government.<sup>19</sup> A government, who devotes lots of attention to ‘good governance’, cannot tolerate these problems.</p> <p>Several sectors already felt this need and formulated a number of sector-based and/or regional answers on the fragmentation, by means of the introduction of care trajectories, cooperation initiatives in first line health care, care directors and/or region managers. The project ‘Integrated Youth Aid’ made a further step by coordinating the aid supply on a cross-sector level and by designing aid trajectories. Despite the fact that all of these initiatives are a kind of ‘chain management<sup>20</sup>’, the exercise was still not made for all the sectors</p>

<sup>19</sup> Also the Flemish Health Council (2006) emphasises these problems in a recent note. The Council pleads for a better coordination between welfare and health.

<sup>20</sup> ‘Supply chain management’ is the organisation and the development of a (better) service by stimulating the organizations in the chain to have a better coordination of their activities and by filling in the missing links. As a consequence, the questions for aid will be answered in a better way.

	<p>involved. However, the complete policy sector<sup>21</sup> would profit of the principles and insights on supply chain management. In this way, not only the first line care, but also the second and third ‘lines’ could be involved in the chain coordination.</p> <p>Research Goals</p> <p>This research project wants to support - by exploring the welfare and health care sector from the perspective of supply chain management – the design of care trajectories and the management of chains of aid and care. Answering the following policy-relevant questions is thereby at stake:</p> <ul style="list-style-type: none"> <li>- To what extent are the principles of chain management already applied in the welfare and healthcare sector?</li> <li>- What links have been developed least in the chains?</li> <li>- Which chain connections (passage between links) have been structured the weakest?</li> <li>- Is the daily trajectory management supported by ‘chain agreements’ and by good chain informatisation?</li> <li>- Which contextual factors impede a better chain control?</li> <li>- How can the Flemish Government promote the thinking/working in terms of chain management within the policy domain of welfare, healthcare and family?</li> <li>- How should the chains be steered by the Government?</li> <li>- Which internal structures &amp; processes should be redesigned to foster a better steering of the chains?</li> <li>-...</li> </ul> <p>The project wants to answer these questions from the bottom-up<sup>22</sup> perspective by starting from the concrete trajectories on the executive</p>
--	---

<sup>21</sup> In the Netherlands, the supply chain management is used as a tool to monitor the societal support of vulnerable groups in society, health care, youth care,...

<sup>22</sup> This project does not have the ambition to redo the debate on core-tasks of public authorities in the Belgian federal state, nor does it want to make a top-down analysis of the mission and the division of competences between and within governmental levels and/or sectors.

<sup>23</sup> Directive questions are: What information is unnecessary? Which information can be distributed? Which information flows should be structurally institutionalized?

<sup>24</sup> The Dutch Inspection on Health Care (IGZ, 2003) concluded that the coordination between chronically ill people and the professionals that are involved is not guaranteed.

<sup>25</sup> Cfr. amongst others, Van Duivenbode, Van Twist, Veldhuizen & In't Veld (2000, Ketenmanagement in de publieke sector), Rosendal (2006, Keten zorg voor chronische ziekten: mode of must?) and Van der Aa & Konijn (2002, Ketens, ketenregisseurs en ketenontwikkeling).

	<p>level. By taking the client perspective as the main point, we want to reach an illustrated, practice-relevant and clarifying insight in the concrete functioning of the cooperation between executive services in the domain of welfare, public health and family. It is thereby the explicit intention to map the gaps and the overlaps in the service trajectories (both administrative, as caring) and to think of improvement trajectories where special attention will be devoted to the provision of information<sup>23</sup> within the care chains. In this way, Flanders follows a trend which is very present in the Dutch welfare- and care sector.<sup>24</sup></p> <p>On the fundamental field it is our ambition to refine the conceptual and theoretical framework concerning supply chain management<sup>25</sup>, among others by exploring the contextual variables that influence the success of chain supply management.</p>
Method	<p>The research project consists out of two parts:</p> <ol style="list-style-type: none"> <li>1. Via an explorative bottom-up analysis, clear insights should be obtained of the AS IS-situation, i.e. the need of supply chain management within the Flemish care sector. This AS-IS analysis will be conducted in two ways/at two levels<sup>26</sup>: <ul style="list-style-type: none"> <li>-First, the trajectory of a number of concrete care dossiers<sup>27</sup> will be followed up from the moment that the clients present themselves. Special attention will be devoted to the sequence of several chain links and to the transition and cooperation between these links, including the analysis of the information transfer between diverse partners of the chain. This analysis will be implemented on the executive operational level</li> <li>-Second, the service organizations from the chain will be questioned about their experiences and needs concerning supply chain management. A questionnaire will be elaborated for this survey-research. Inspiration for the questionnaire will be granted from the Dutch care sector. They have developed a 'quick scan' instrument<sup>28</sup> to map chain problems on an inter-organizational level.</li> </ul> </li> <li>2. Via a TO BE-analysis, the possibilities to achieve a better care</li> </ol>

<sup>26</sup>A lot can be learned by comparing the results of both research methods. For example, there can be investigated if the trajectories match with the agreements within the chain.

<sup>27</sup>We will make use of the care dossiers/trajectories who were gathered by other research projects.

<sup>28</sup>Cfr. BWKI (2005). De ketenspiegel. Achtergrondinformatie, werkwijze en gespreksthema's. 10 p.

	<p>chain and to reach better management should be mapped. For this, there will be thought about structural chain solutions<sup>29</sup> in dialogue with the chain partners. If necessary and possible, a directed international comparative research will be conducted. The TO BE-analysis should result in a list of improvement-proposals that should be realized in the first place, as well as in the field of care trajectories, as in the field of structural supply chain management.</p> <p>As we realize that it is impossible to implement these analyses for the whole policy domain at the same time, we opt to limit ourselves to one or two sub sectors or target groups in the first place. Consecutively, a second chain will be studied. This choice of priorities (qua sector, target group and/or problems) will be made together with the commissioner.</p>
Background	
Outcomes, indicators and timeline	<p>Phases</p> <p>This research project consists of an introductory theoretical-conceptual exploration of the concept ‘supply chain management’ in the public sector. Then a profound chain analysis will be conducted in two sub fields of the policy domain.</p> <p>Phase 1: Reading literature on supply chain management, introduction to the policy field + preparing the survey-research (Months 30-40)</p> <p>Phase 2: Chain analysis 1 (Months 41-50)</p> <ul style="list-style-type: none"> <li>-Explorative bottom-up analysis (Months 41-45)</li> <li>-TO BE-analysis (Months 46-50)</li> </ul> <p>Phase 3: Chain analysis 2 (Months 51-60)</p> <ul style="list-style-type: none"> <li>-Explorative bottom-up analysis (Months 51-55)</li> <li>-TO BE-analysis (Months 56-60)</li> </ul> <p>Milestones</p> <p>The first phase needs to result in a well elaborated conceptual framework and the necessary research instruments (questionnaires/instruments of self-analysis) to implement the chain analyses.</p> <p>The explorative AS IS-analysis should –based on concrete experiences and needs of clients and organizations- result in an illustrated list of gaps in the chain.</p> <p>The TO BE-analysis not only should result in a constructive choice of the steps that should be taken in order to improve the chain trajectories</p>

<sup>29</sup> As concrete examples of problematic care trajectories from daily practice will feed the problem analysis, the discussion between chain partners about the chain management should be facilitated..

	<p>and the supply chain management. It should also lead to some recommendations with regards to the steering and supporting of the thinking in terms of chains by the Government (administrations).</p> <p>Outputs  This research project will result in three types of output:  Policy relevant outputs on a descriptive level.  Each of the empirical phase researches within the project will result in a research report. Dependent on the goals of the particular phase, the report will enhance both the impediments and points of action.</p> <p>Policy relevant outputs on a prescriptive level.  By analogy with the Dutch instrument ‘Ketenspiegel’ the project wants to develop an instrument of self analysis that can be used ‘in the field’. This instrument should enable us to explore and discuss relevant chain topics and should be an impulse for a further framing of the supply chain cooperation and to stipulate the agenda to realize the cooperation.</p> <p>Scientific output  The scientific output will not only consist of conceptual and theoretical publications on supply chain management, but also in diverse articles in scientific journals in the field of social policy and public management.</p>
Valorising	<p>Development of a website on supply chain management with relevant background information.</p> <p>Disseminating the principles concerning supply chain management in the policy sector by publishing articles in sector-oriented journals and by participating in study days.</p>
Coordination	<p>Prof.dr. Marleen Brans, Public Management Institute  Prof.dr. Koen Verhoest, Public Management Institute</p>
Resources FTE	<p>1 part time researcher 3 years</p>

## 6. Suggestions for focused research and advice

The SVG brings together the expertise of several university departments and research groups from three universities and one college. The consortium has a great potential and there is a great readiness for additional focused research. Far from being exhaustive, below some suggestions are given for focused research based on the expertise of the experts involved. The suggestions are a “catalogue” of themes and research questions which can be further developed into research projects (by one or more of the experts in the consortium) on request of the sponsor of the Policy Research Centre.

In the Flemish version of the proposal more details are given on all the themes listed below.

### 6.1 Suggestions for focused research in the field child and adolescence welfare

#### **Integral Youth Care**

*Main focus:* Analysis of the composition and expertise of the new teams, analysis of the diagnostic procedures and the criteria used in the allocation of clients.

#### **Assistance in the implementation process of the Triple P-program**

*Main focus* evaluation of the pilot programs in the Antwerp region

#### **Feasibility study of the usefulness of multi system therapy (MST) in special youth care**

*Main focus:* feasibility study of MST for young people with behavioural problems

### 6.2. Suggestions for focused research concerning the elderly.

#### **Developments of methods fostering participation of the elderly.**

*Main focus:* reviewing existing empowerment strategies and evaluating the effect of the implementation of new strategies to empower elderly people.

*Timing:* preferably three years because of the measurement of relative long term effects

#### **Perceptions of mental illness by allochthon and autochthon elderly people.**

*Main focus:* evaluation of existing perceptions in both populations and evaluation of interventions focussing on changing the perceptions (e.g. using psycho-education).

*Timing:* preferably 3 years because of the measurement of relative long term effects

### **6.3. Suggestions for focused research in primary care.**

#### **Integrated, interdisciplinary work at the primary care level: casual cooperation team or working together under one roof?**

*Objective:*

In the actual discussions about the organisation of the primary health care and the home care, especially as far as integrated care including health and welfare are concerned, there is a regularly discussion about the optimisation of the organisational model: is it possible to improve the integrated approach and the interdisciplinary cooperation in a model "under one roof" (e.g. integrated community health centre), or is better to go for a casual cooperation model (e.g. casual cooperation home care teams, composed of different organisations and providers)?

Taking into account the fact that the decree on cooperation in the primary care has to be implemented through concrete measures, it is important to explore the advantages and disadvantages, but also the feasibility of the different approaches. The aim is to use a literature search and case studies in Flanders in order to try to answer the questions, utilising a SWOT-analysis of the 2 models.

*Timing:* 6 months.

#### **How big should cooperation models at a primary care level be?**

*Objective:*

In Flanders, the multidisciplinary cooperation in the home care developed since 1990 with different "sizes" in the different Flemish provinces. Advantages and disadvantages of bigger and smaller organisational models never have been researched in a systematic way. In order to implement the degree on cooperation in primary health care it is important to make adequate choices. Sources for this project are: literature research, exploration of models in other countries and the actual experiences in the field.

*Timing:* 6 months, leading to concrete suggestions.

#### **Development of an ethno-sensitive approach in health and welfare.**

*Objective:*

In a more and more multicultural society, an ethno-specific approach (focussed on the exploration of one specific culture) is no longer possible. The need for an ethno-sensitive strategy is obvious, but the underpinning and development of this approach is scarce. The aim of this research is to make a first exploration, utilising literature search and experiences abroad, looking for the most important aspects that contribute to an ethno-sensitive approach. Moreover, a first attempt to

develop ethno-sensitive education at different levels for health and welfare personnel will be made.

*Timing:* for the first exploratory phase: 12 months.

#### **6.4. Suggestions for ad hoc research concerning people with a handicap.**

##### **Community care.**

*Main focus:* effect study of the differential outcomes of different living and working arrangements for people with a handicap.

##### **Assistance by demand for people with a handicap.**

*Main focus:* efficiency and effectiveness study of several forms of assistance of people with a handicap.

#### **6.5 Suggestions for ad hoc research concerning Local Social Policy.**

##### **Analysis of the local policy plan for 2008.**

*Main focus:* focus of the analysis: which indicators are used in the plans? How are they used? what are the definitions of social policy? which priorities are chosen? What partners are involved? Approaches for the functioning of the Social Houses? Etc.

*Timing:* 6 months.

##### **The Social House and the accessibility of services at the local level.**

*Main focus:* search for local innovative initiatives to enhance the accessibility of local services, search for new initiatives abroad, suggestions for new initiatives in the future.

#### **6.6. Suggestions for ad hoc projects in the field of prevention.**

##### **Follow up of the longitudinal study of the development of eating habits and physical activity of young children (promoters: Prof. Dr. L. Maes and Prof Dr. I. De Bourdeaudhuij).**

Starting in October 2002 more than 1200 children and their parents take part in a longitudinal study of some health related behaviours and their determinants. The participants are yearly surveyed. The last survey dates from October 2005. At the start of the study the pupils were 10 years old and going to school in the 5<sup>th</sup> grade of the primary school. The cohort is a representative sample of the pupils of the 5<sup>th</sup> grade in East- and West Flanders. An internet questionnaire (or a postal questionnaire if preferred by pupils or parents) is used to obtain the data. The project was funded by a research grant of the Ghent University.

Aim of this proposal is to organise 2 additional surveys of this cohort, namely in November 2007 and in November 2009. In 2007 the pupils will have a mean age of 15years, in 2009 of 17 years. Though this extension, the tracking of eating habits, physical activity and their determinants between 10 and 17 years can be studied.

*Budget:* researcher for 6 months + working budget in 2007 and 2009.

### **Development and evaluation of an internet intervention for the prevention of depression in adolescence.**

Mental health problems are one of the main treats for health in the coming years. Minister Vervotte argued in her Policy Letter for 2005-2006 that prevention of mental health problems should have a high priority. In the literature a lot of arguments can be found for the development of large scale prevention projects. The internet offers the possibility of making self help interventions available for large groups of people not having contact yet with mental health services but in need for some help. Internet interventions have a proven effectiveness for the prevention of anxiety and panic as well in adult populations as in student populations. Recent the positive results of the randomised trial of an internet intervention for depression (Moodgym) were published. The Australian Moodgym internet intervention also proved to be cost-effective. Internet interventions seem to be particularly interesting to reach adolescents. Recently a research team of the Trimbos Institute started the development and evaluation of internet interventions for adolescents.

In Flanders a similar internet for young people could be developed and evaluated with a RCT.

*Budget.*

*Personnel:* 1 researcher for 3 years (partly financed on the Policy Research Centre and partly on the budget for the 6<sup>th</sup> health target in Flanders)

*Development of the intervention*

The production of an internet intervention is relatively expensive. A budget of 100 000 euros must be foreseen. After the development a budget for the support of the website is needed.

### **Feasibility study of the implementation of a social skills program in Flemish schools (primary and secondary).**

Two recent Cochrane reviews show evidence for the effect of school programs making use of the social skills or social influence methods on smoking and illicit drug use. For other health related behaviours the effects are less clear. In Flanders some organisations are offering programs of this type as The Life Skills program and others. Little is known about the implementation of these programs in Flanders.

A study of the Flemish Education Council made clear that there are several implementation problems for this type of programs and for the implementation of the concepts of the health promoting schools. The implementation of social skills programs necessitates a thorough training of a lot of teachers, there is the problem of the turn over of trained teachers, an important time

investment is needed for the preparation and coordination of the lessons, a relative large amount of teaching hours need to be invested, and others.

Aim of this proposal is to conduct a feasibility study for the general implementation of social skills program base on a literature study and focus groups with school principles and teachers and with key persons in the Flemish educational sector.

*Budget:* researcher for six months + working budget.

### **6.7. Suggestions for ad hoc research in the field of mental health.**

#### **Development and evaluation of information tools to guide decisions in the treatment of depression.**

*Main focus:* development of an information tool that can help the client and the care giver in decisions concerning the treatment of minor and medium depression in the non residential care sector.

*Timing:* 2 years.

#### **Socialisation of care (Community treatment?) for the mentally ill: implementation of effective home care for people with severe mental problems.**

*Main focus:* review of the main aspects of community care adding surplus value; conditions under which community care can be effective; evaluation of the surplus value of community care versus actual practice.

*Timing:* 2 years.

#### **Labour rehabilitation for people with severe and long term mental problems: implementation of evidence based practice in Flanders.**

*Main focus:* separate evaluation of the implementation problems of the principles of individual placement and support programs (IPS) in the Flemish context.

*Timing:* 2 years for the development and evaluation of methods of IPS and additional 2 years for the cost effectiveness study.

### **6.8 Suggestions for legal ad hoc research programs**

Short-term legal research could serve a double purpose within the consortium. On the one hand it could offer legal support to the other research programs in case legal difficulties are encountered there. On the other hand, it appears from frequent contacts with both social care professionals and public officials that legal issues often arise in social care settings (e.g. in relation to special youth protection, confidentiality, liability, good governance, division of competencies, impact of European law, etc.). The Institute of Social Law's staff has frequently been involved in short-term practice and policy-oriented research.

### **Principles of good governance and their relationship to other legislation**

*Aim:* The interpretation of certain concepts – e.g. administrative government, public bodies- has far-reaching consequences in social care. A first example is recent case law of the Supreme Court in which the ombudsman was considered incompetent to hear cases of social housing corporations following a shift in interpretation of the concept of administrative government. Secondly, a parliamentary question has recently been submitted with regard to the scope of application of the new Act of the Flemish Community on Good Governance following a broader interpretation of the concept of public body (see for instance V. Verdeyen & J. Put, “Openbaarheid van bestuur in de Vlaamse welzijnsvoorzieningen”, *T.S.R.* 2005, pp. 515-571, “Good Governance in Flemish social care institutions”). Additional research into this Act would be relevant, particularly with a view to its consequences in relation to making data publicly accessible. The same applies with regard to research into the coordination of all legislation applying to data files, the public versus confidential nature of data, communication policy and exchange of data.

*Timing:* depending on the nature and scope of a question, 1 to 3 months

### **Liability**

*Aim:* The Institute of Social Law is currently conducting research into aspects of liability and guilty neglect in relation to the social care institutions and caregivers involved in youth care. The problematic nature of liability issues, however, is not limited to this type of care situation but should be considered in social care in general. Not only should the liability of institutions and caregivers be taken into consideration, but also the (joint) liability of the client and government. The question arises whether a client could be held liable for the failure of a certain type of care when for instance he refuses to participate in a program or when he jeopardizes the aid offered to other clients in a care home. Also aspects of government liability could come into play. However, can a government body be held liable in cases of absence of sufficient and efficient inspection? Or rather: could a government be held liable for insufficient levels of social care provision?

*Timing:* 3 to 6 months

### **Relevance of contracts in social care**

*Aim:* Research into the legal value of contracts in the context of social care. What are the consequences for instance of a unilateral termination of a contract by a care home? Secondly, agreements in the context of public-private partnerships could be further analyzed. A third example of the potential use of contracts in social care is an analysis of aspects of contracts in relation to codes of ethics. Is the law of obligations involved in such codes and what are the consequences when they are considered contracts?

*Timing:* 3 months

### **Follow-up of social welfare legislation in ‘close-by’ legal orders**

*Aim:* Preparatory work with a view to the systematic monitoring of legislation in the Netherlands, the French speaking Community of Belgium and Brussels. Designing a monitoring-system and database. Inventory of websites, ‘search engines’, most important current legislation. Making contacts with relevant organizations abroad. Developing best practices in relation to reporting on international developments and making information available. In the longer term, this project could be broadened to include other legal orders considered relevant.

*Timing:* 6 months + additional costs of 1000 euro (travel costs)

### **Short term research into the impact of European law**

*Aim:* Addressing urgent issues in the context of European legislation, legal practice of the European Commission and the Court of Justice. Examples are: the impact of the free movement of services and freedom of establishment on the organization of social care, possible grounds of exemption for social services and services of general interest, relevant developments in the field of patient mobility and other international aspects of health care, the free movement of professionals and the recognition of professional qualifications, the impact of European competition law.

*Timing:* depending of the nature and scope of the question, 1 to 6 months

### **Relationship between social care and the judiciary**

*Aim:* Analysis of legal questions arising in the context of the relationship between social care institutions and the judiciary, e.g. social action schemes in relation to drug abuse, the treatment of sex offenders and involuntary hospitalization. Following issues could be taken into consideration: the obligation on caregivers to report crimes to the police, the protection of confidentiality and privacy.

*Timing:* 3 months

### **Involuntary care**

*Aim:* This project starts from the fact that care situations generally imply an intrusion into the private life of clients. Preferably, social care should therefore be based on the client’s request or assent. Nevertheless questions arise in relation to the concept of involuntary care, both prior to entry into a care home (involuntary admission) and during a stay in a care home (forced treatment, fixation, and isolation). Often this happens following a court order or when safety

considerations for the client himself, other clients and property are involved. The difficult trade-off between all considerations involved and the conditions and limits of involuntary care should be further legally analyzed.

*Timing:* 3 months

### **Analysis of the new youth protection act**

*Aim:* Analysis of the influence of this Act on Flemish legislation and potential preparatory work with a view to making amendments to this legislation, e.g. in relation to mediation, community services, educational projects, possible extension of measures until 23 years.

*Timing:* 6 months

### **Division of competencies in the field of social care**

*Aim:* Analysis of constitutional rules dividing competencies between the federal government, communities and regions in the broad field of social welfare. Analysis of case law of the Constitutional Court and Conseil d'Etat with regard to the interpretation of these rules. Analysis of case law applying in neighbouring fields such as education. In addition, attention will be given to the precise delineation of health, social assistance and social care. Research into institutional possibilities and limits following the application and interpretation of these rules.

*Timing:* 6 to 12 months

### **Constitutional issues of social care in the Brussels region**

*Aim:* Analysis of possibilities to enact social care legislation in the Brussels Region. Focus on particular institutional difficulties and possibilities to strengthen the interaction between Dutch speaking and French speaking service providers.

*Timing:* 6 months

### **Extension and adjustments of 'Juriwel' (legal on-line database on social care)**

*Aim 1:* Inventory of health care legislation with a view to its later integration into the Juriwel database.

*Aim 2:* Extension of Juriwel with references to literature and case law.

*Timing:* 6 months each

**Other suggestions**

Harmonization, codification and simplification of social welfare law; legal position of informal care and legal protection of the informal caregiver, government intervention within the context of problematic upbringing and the protection of private life; appeal procedures in social welfare law; restructuring the supply-side in social care.