

Paradigm Shift in Dutch Mental Health Care: An Explorative Study on the Transition to Mental Health Centers

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Abstract

Background: The pressure on Dutch mental health care (MHC) brought about a transition to mental health centers (MCs) situated in neighborhoods, aligned with centers of expertise, aiming to improve accessibility of MHC for citizens. The development and implementation of MCs were evaluated, using insights from action research and guided by the value-based health care model Quadruple Aim. **Methods:** The MCs were developed and evaluated, using iterative learning cycles and guided by four domains of Quadruple Aim i.e. population health, experiences of citizens/clients and professionals, and impact on costs. **Results:** Citizens who have had an exploratory meeting in a MC are generally positive and 29% do not need MHC. If care is needed, they need fewer intake interviews. At the end of treatment in a MC, 91% of the clients are satisfied with shared decision making. The average level of recovery has an effect size of 0.56. The total waiting time to start treatment has not yet decreased. Although for professionals, the transition requires a lot of pioneering, it also gives them professional space, energy and job satisfaction. **Conclusion:** Monitoring and learning from Action Research cycles guided by quadruple aim supports the transition process. The transition to MCs, contributes positively to delivering appropriate care. Further research is needed to get insight into long term and regional effects.

Keywords

Action Research, Quadruple Aim Model, Mental Health Care, Value Based Health Care, Vertical Collaboration, Shared Decision Making

1. Introduction

Within the next decennia, the demand for care in Western countries will increase due to population growth, ageing, higher prosperity, technology, a changing society, and epidemiological phenomena (KPMG, 2020a). In the Netherlands the mental health care sector is under pressure because of increasing mental health problems and no alignment between supply and demand (Boumans et al., 2023). This sector is struggling with long waiting lists and expanding healthcare costs in addition to the existing capacity problems. Recent research (Ten Have et al., 2023) showed that 3.5 million Dutch people had a mental illness in 2023 (Zorginstituut Nederland, 2023). Between 2009 and 2021, the mental health budget grew by 11 percent, while in the same period the number of people who developed mental disorders rose by 53 percent (Boumans et al., 2023). In the Netherlands, about 84,000 people with mental health problems are currently waiting for treatment, and half of them do not receive care for longer than the set standard (Zorginstituut Nederland, 2023). Next to major consequences for the individual, participation in society also declines (Prudon, 2023). Research by Prudon (2023) showed that every month of waiting for mental health care reduces the probability of work by 2 percentage points. This large increase in the demand for mental health care is even more acute because of reduced inflow capacity in training programs of mental health professionals in addition to a large outflow from the experienced group of professionals, which leads to an extensive labor market shortage. In addition, investments in the development and connection of healthcare professionals are important to promote job satisfaction and to retain and enthuse expert staff for the sector (Lips-Wiersma & Morris, 2011; Van den Broek, 2024).

In response to these pressures of the excessive demand for mental health care and shortage of expert staff, the Dutch mental health care sector feels the urgency for a change of course and intends to realize future-proof care that should be of high-quality, accessible, and effective (Boumans et al., 2023). Meanwhile, necessary paradigm shifts which lead to a transition in the health care system are underway (Nederlandse Zorgautoriteit, 2020; Van der Voort, 2023): from market forces to cooperation with stakeholders in networks (Varkevisser, 2019); and from disorder oriented to more transdiagnostic and recovery-oriented care (Huber et al., 2016; Leamy et al., 2011; Slade, 2010; Van der Heijden et al., 2020). In the last decades, evidence-based medicine (EBM) has contributed to the development of disorder-oriented standards and mental health treatment organized in diagnosis-oriented care lines. The advantages are an increase in evidence-based knowledge and skills regarding diagnosis-oriented treatments. The disadvantage is that mental health care has become mainly symptom oriented and segregated leading to separate waiting lists per kind of treatment.

In response to the pressure of the above-mentioned problems, structural changes that are closely linked to the realization of appropriate care are needed (Nederlandse Zorgautoriteit, 2020). Therefore, in 2020 mental health care institute GGz Breburg and health insurer CZ started in the southern part of the Netherlands

an innovative form of cooperation, i.e., a vertical collaboration, which focuses on realizing a future-proof transition (Van den Broek et al., 2022b). To make mental health care accessible and high of quality, an important development initiated from this collaboration is the transition to mental health centers situated in neighborhoods, complemented by expertise centers for specialist and complex treatment. A value-based health care strategy (Porter, 2009) using the Quadruple Aim could be helpful in guiding and evaluating the implementation of this innovation from the perspectives of involved stakeholders (Wallang et al., 2018; Zhang et al., 2022). In this strategy, access to health care and adding value for clients is important and should have a positive influence on reducing costs. Subsequently, the Quadruple Aim model assumes the importance of four goals: improving population health; enhancing patient experience, improving the well-being of the healthcare team, and reducing costs (Berwick et al., 2008; Bodenheimer & Sinsky, 2014; Sikka et al., 2015).

In this paper, we aim to give an overview of the development, implementation and evaluation of the transition into mental health centers in the context of vertical collaboration. For this purpose, we use insights from the iterative learning cycles from Action Research guided by the Quadruple Aim Model (Dedding et al., 2021; Van den Steene et al., 2019).

2. Methods

2.1. Intervention/Innovation

In the next two paragraphs we describe the vertical collaboration, followed by the description of mental health and expertise centers as a joint innovation with the exploratory meeting as an important first step in the transition.

2.2. Vertical Collaboration as a Context for Transition

To stimulate and facilitate the necessary transition in mental health care, health care provider GGz Breburg and health insurer CZ started a vertical partnership, also known as a sustainable coalition. This kind of vertical cooperation, involving two organizations each belonging to a different phase in the supply chain, is relatively new in Dutch health care settings (Porter & Kellogg, 2008). Usually, the reason for vertical collaboration is to achieve improved value creation and cost savings for both parties (Nooteboom, 2002). In this case, both healthcare providers and health insurers strive for the best quality of care for clients from everyone's perspective in such a cost-conscious way that as many clients as possible can benefit.

Within the vertical collaboration GGz Breburg and CZ realized mental health centers including exploratory meetings complemented by expertise centers for specialist and complex treatment. This means that citizens are first registered by the general practitioner at a Mental Health Center (MC) in order to be eligible for an Exploratory Meeting (EM). After the EM, the citizen can continue with his question in the social domain; as a client in a MC or in the case of a specialist and

complex question, the client can be registered with the Expertise Center (EC).

In line with insights gained from research on sustainable coalitions (Van den Broek et al., 2022a, Van den Broek et al., 2023) employees of both organizations engage in frequent (monthly) dialogue sessions about the retrieved findings from the action research learning cycles. This contributes to trust in the collaboration process and it is an impetus for the transition and stimulates the participating organizations to take ownership in the process of the transition (Van den Broek et al., 2022a, Van den Broek et al., 2023).

2.3. Mental Health Centers

With the MC, supported by a sustainable coalition with CZ, GGz Breburg is shaping neighborhood-oriented network organizations focused on the journey of citizens and clients with mental health problems (Van den Broek et al., 2022b). Based on the principles of appropriate care, self-management and personal direction, and the premise of “the right care in the right place”, we thus respond to the described bottlenecks in the mental health care sector (KPMG, 2020b; Zuil, 2011).

2.4. Exploratory Meeting

The exploratory meeting (EM) in the MC is an important element in the assignment of the right care in the right place and is organized entirely at the front, outside the mental health care setting. With the citizen and in line with his/her needs together with relatives, the story of the citizen and his request for help is examined. In addition, appropriate follow-up steps are discussed, focusing on the strengths of the citizen and his network. When the EM is closed it is clear whether and which care from network partners is most appropriate and if a referral to a mental health intake is necessary. This advice is summarized and sent to the citizen and General Practitioner (GP) as well. Based on this advice, further appropriate follow-up steps can be taken by the citizen and his/her network, the GP, a provider in the social domain, or a mental health care organization.

The short lines of communication and intensive cooperation in the network ensure that citizens' demands are answered more quickly and give insights that mental health treatment is not always necessary. This is an important step in the shared decision-making process (Metz et al., 2023) about appropriate care matching the needs of citizens and clients.

2.5. Action Research and Outcomes

A participatory action research was conducted. This approach helped to learn and improve during the development and implementation of the transition, guided by the four domains of the Quadruple Aim Model. The research team, consisting of all stakeholders, went through a cycle of steps to understand a problem and related questions, design the research process, collect results, and then make improvements in the transition and follow-up research methods as well. These iterative cycles were repeated until the set goals on the four areas of the Quadruple Aim were

achieved. This process contributed to active involvement in the transition, reflection and improvement based on continuous feedback. The quadruple aim model, as shown in **Figure 1**, was used as a framework for learning and improving in iterative cycles from the transition to mental health centers as an important innovation to achieve the necessary paradigm shift. This paper describes an overview of the results from two years (2022 and 2023) of action research using quadruple aim with the domains Population Health, Experiences Citizens & Professionals and Costs as a guideline. In the text below and in **Figure 1** these domains are further explained.

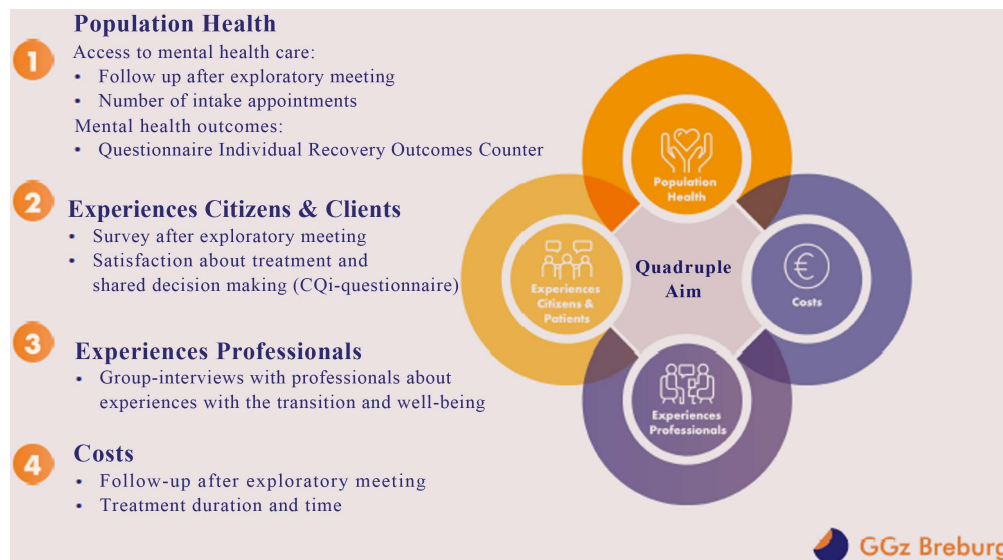


Figure 1. The quadruple aim model.

1. Population health consists of the aspects “Access to mental health care” and “Mental health outcomes”. Access to care was operationalized in the follow up after an EM aiming to attain appropriate help i.e. where are citizens referred to after the EM and if mental health care is necessary the number of intake-appointments before starting with the appropriate treatment. Mental health outcomes were described using the recovery outcome questionnaire I.ROC (Individual Recovery Outcomes Counter) (Beckers et al., 2022; Roze et al., 2020; Sportel et al., 2023), which clients fill out during treatment every three months. The results of this questionnaire showed the level of recovery in different areas of life.

2. Experiences of citizens and clients with the first innovative EM were investigated by a survey, which includes four questions about the work relation, goals and topics of the meeting, the approach and working method, and the overall experience with the first meeting. These questions are scored on a VAS (0 - 10) scale. In addition, there was one open question about experiences with the first meeting, which can be answered in text. All citizens received the survey within two weeks after the EM. Participation was voluntary and based on informed consent.

Feedback from clients about the level of satisfaction and shared decision

making was delivered by a questionnaire (Akwa GGZ, 2020) among clients who received treatment in one of the mental health centers.

3. Experiences of providers: The experiences and well-being of professionals during this transition was investigated by group-interviews with professionals working in the mental health and expertise centers and thematic analysis of the transcripts of these interviews.

4. The impact on costs was described by the follow-up after an EM, and in future also using indicators about treatment duration and time.

2.6. Ethics Approval and Consent to Participate

The Ethical Review Board (ERB) of Tilburg University (reference number: TSB_RP302) and the scientific committee of GGZ Breburg (reference number: 2021-34) approved this study. Participating citizens, clients and professionals were informed about the content and procedures of this study and gave written informed consent. During the study, they could withdraw their consent without specification of reasons and without consequences.

3. Results

Going through learning and improving cycles together with stakeholders using the quadruple aim model as a guideline, helps us to adjust during the transition aiming to realize the necessary paradigm shifts. The overall results of two years (2022 and 2023) of the transition to the mental health centers are described below.

3.1. Population Health

“Access to mental health care” and “Mental health outcomes”

In 2022 and 2023, 3434 EM's have been taken place. An average of 29% of the citizens do not need mental health care after an EM. 38% go on to basic mental health care, 15% to specialized mental health care in a MC, 13% goes to specialized mental health care in an expertise center of GGz Breburg and 5% get help from another mental health care provider. We also learned that, if mental health care is needed, citizens with an EM need fewer intake interviews on average and receive treatment faster after an EM. However, the total waiting time for registration to start treatment has not yet decreased. When looking at mental health outcomes, clients who receive treatment in a MC score an average positive large difference score with an effect size of 0.56 on the recovery total scale of the I.ROC at the end of treatment in a MC.

3.2. Experiences of Citizens and Clients

In 2022 and 2023, 3434 EMs have taken place. 38% (N = 1307) of the citizens who received an EM, gave informed consent and completed the survey about the EM afterwards. So far, citizens who have had an EM are generally positive, with the following scores: work relation 8.3; goals 8.4; working method 7.2 and overall experience 8.1. The majority of the respondents mentioned positive textual feedback

about the EM i.e.: “I felt heard and understood, I felt at ease, time was taken for my story, the right questions were asked, I felt safe and trustworthy, it felt equal and I was taken into account as a person”. We also learned that a relatively small group gave negative and more varied textual feedback about the EM, for example: “The EM was too short to explain the whole problem, the problem was not discussed in depth enough or the EM felt redundant with the conversation with the GP, medical assistant or the intake that I had after the EM and the waiting time till the appropriate care takes long”. At the end of treatment in a MC, clients were generally positive about the treatment they received with an average score of an 8.1 on the CQi index. Notably, 91% of the clients in the MCs were satisfied with the extent to which the treatment has come together due to shared decision making.

3.3. Experiences of Providers

During the interviews the employees gave us insight in the situation that the development of MCs requires a lot of pioneering, especially when it comes to the needed changes in internal and external collaboration. It takes investments to further improve the internal cooperation between MC and EC, and the external cooperation with providers in the social domain and other mental health care organizations. Keeping an overview of internal and external supply options is a key area for improvement according to the staff. Further investments in maintaining and developing cooperation with GPs is also important. This has been indicated by both employees of the MCs and GP's. However, during the interviews, employees also indicated that the new way of working, client centered and recovery oriented, gives them professional space, energy and job satisfaction.

3.4. Impact on Costs

As described at point 1 “Population health”, after an EM an average of 29% do not need relatively expensive mental health care. So, a relatively large group can continue with the agreed advice from the EM, on its own (and with the help of their network) or with appropriate (cheaper) help outside the mental health care for example by GPs and their practice support, community centers, social work, recovery academy or job coaching. No other cost-related findings such as intensity and duration of treatments can yet be reported over this relatively short period of time. This needs to be further monitored in the upcoming period, aiming to learn about the impact on costs.

4. Discussion

In this paper, we aim to analyze and evaluate to give an overview of the development, implementation and evaluation of the transition into mental health centers (MCs) as a transition in the context of a vertical collaboration. For this purpose, we use insights from the iterative learning cycles from Action Research (Dedding et al., 2021; Van den Steene et al., 2019) guided by the four domains of the

Quadruple Aim Model i.e.: population health; experiences of citizens and clients, experiences of providers and the impact on costs (Bodenheimer & Sinsky, 2014; Sikka et al., 2015).

Generally, collaborating with stakeholders in the context of a vertical collaboration (De Koning et al., 2024) and the continuous learning cycles and collaboration in Action Research (Dedding et al., 2021) contributed positively to the transition, because openness, ownership and an active attitude from the participants increases sharpness, inspiration and energy at crucial moments (Van den Broek et al., 2022a). This helps to make the necessary shift in attitude, behavior and vision from professionals and clients as well (Rijksoverheid, 2022). Due to the transition, many changes take place in the context of the work environment and processes, where the professional has no direct control over. Also, other competencies are addressed, such as flexibility and learning ability.

In the text below, the format of the quadruple aim model is used to reflect on the results of the transition.

4.1. Population Health

A groundbreaking finding is the fact that more than a quarter (29%) of the citizens didn't need mental health care after an EM. This observation has a potential positive impact on waiting lists overtime. It means that a significant proportion of the citizens, who otherwise would have to wait for treatment, can get on with life themselves or with appropriate other help, contributing to population health. This is consistent with the desire for accessible, appropriate and high-quality health care (Porter, 2009; Rijksoverheid, 2022).

Additionally, it was found that after an EM, citizens who need mental health treatment need fewer intake interviews and receive treatment faster. This may be related to the fact that during an EM the focus is demand-oriented and possible solutions are jointly sought. This approach leads to tailored indications for the appropriate type of treatment. Unfortunately, the overall waiting time for registration to start treatment has not yet decreased. The impact of the transition on the waiting list may need more time to develop positively and will be monitored over a longer period of time. The transition requires redesign of treatment processes, reassignment of staff to the MCs and ECs and a different way of working. Currently, the effects of these changes are difficult to assess in advance. In order to estimate this, the simulation method could be useful (Van den Broek & Smits, 2010). This method provides insight into the expected effects of the transition and could support management in the redesign of this care process, including the consequences for the re-allocation of staff inside and outside the mental health organization. This simulation method therefore could complement current measurements conducted by action research and guided by the quadruple aim framework.

With respect to mental health outcomes, a positive score on the recovery scale (I.ROC) was found at the end of treatment in the MC, which means "Improved Health", one of the goals of the Quadruple Aim model.

4.2. Experiences of Citizens and Clients

In two years more than 3434 EMs have taken place, with a positive assessment from citizens demonstrated by an overall mean score of an 8.1. Participants wrote that they felt “heard and at ease” and “treated equally and were approached as a unique person”. We can conclude that this corresponds with value driven care which is created in consultation with the client (shared decision making) (Rijksoverheid, 2022; Metz et al., 2023; Porter et al., 2009). This means that around the EM, both mental health professionals and clients have undergone a paradigm shift in attitude.

Citizens recommend that adequate communication about the purpose of the EM contributes to clear expectations of and understanding about the EM and also helps to accept possible waiting lists after an EM.

The fact that 91% of the clients who received treatment in the MC were satisfied with the extent of shared decision making during treatment, confirms the importance of one of the four principles of appropriate care. This is related to the paradigm shift towards increasing the degree of self-management of clients. The positive opinion about the treatment received in the MC (8.1 on the CQi index) confirms the quality of treatment.

4.3. Experiences of Providers

As mentioned in group interviews with professionals, the pressure on the staff increases during the transition. Furthermore, this is not only an internal reorganization, but a major transition in the regional social network. The regional stakeholders are also important for this. Both referrers, providers in the social domain, and citizens have to get used to this new way of working. Despite the increasing workload, employees of the MCs also experienced the new way of working positive for their professional space, energy and job satisfaction. Workflow optimization and work-life balance are items that still require a lot of attention and should be questioned in the longer term (Van den Broek & Smits, 2010).

4.4. Impact on Costs

It is hopeful that more than a quarter of the citizens who participated in an EM do not need relatively expensive mental health treatment. Furthermore, if they do need mental health treatment, a significant proportion are well served by (cheaper) mono-disciplinary treatment and they are sooner indicated for appropriate treatment. These signals are positive to reduce costs in the future. However, to conclude this, we need to follow this transition for a longer period of time. Simultaneously with investing in accessibility in the front end, it is important to manage expectations during treatment about goals, frequency of consultations and treatment duration (Metz et al., 2023). In our vision, managing expectations is part of the shared decision making process (SDM). This approach contributes to the realization of appropriate care, which consists of four basic principles: Care

is value-driven, created together with the client (SDM), is based on the right care in the right place, and is about health instead of illness (Rijksoverheid, 2022).

4.5. Strengths and Limitations

To our knowledge, this was the first paper that analyzed and evaluated gave an overview of the development, implementation and evaluation of client-centered mental health centers in the context of a vertical collaboration, using Action Research guided by the Quadruple Aim Model. Practice research on value-based health care in the mental health system is relatively new (Vegter et al., 2024). A strength of this study was the mixed methods design. Qualitative research methods, such as interviews, focus groups and an open survey question, were combined with quantitative methods, i.e. questionnaires measuring experiences, quality and recovery, and numerical information from the electronic patient record. Additionally, Action Research provided iterative learning cycles in collaboration with all stakeholders to continuously learn and improve on the quadruple aim domains, which created involvement and engagement of stakeholders.

There were however, also limitations to be mentioned. In this manuscript we gave an overview of the transition to MCs and described the most important results using the quadruple aim model. A detailed description of the methods and results per domain are necessary and in progress (Hoekstra et al., *in press*). Furthermore, this research mainly shows short term results about the transition. Trends in waiting lists, recovery of clients and costs, need to be monitored over a longer period of time. Furthermore, this is a major transition in the regional network. Keeping an overview of internal and external impact is essential. Future research should investigate the development of external logistics, cooperations and trends in the regional consumption of welfare and care. Therefore, it is important to broaden this research to a regional monitoring design, initiated and conducted by involved stakeholders in the social and health care domains, together with other health insurers besides CZ.

Finally, this study is going about the transition to MCs in one region, i.e. the middle and western parts of the Dutch province of Noord-Brabant. In future steps it will be important to investigate comparable transitions in other regions, aiming to learn from other areas in the Netherlands and abroad (GGZ Netwerken, n.d.).

5. Conclusion and Highlights

5.1. Conclusion

When a major transition is initiated in the mental health system, it helps to monitor and learn from it in a mixed methods Action Research design guided by the value-based framework of the quadruple aim model. Going through the iterative cycles together with stakeholders facilitated by the vertical collaboration, encouraged the changes in culture and behavior needed for this transition. The first results showed that the transition to MCs contributes positively to delivering

appropriate care. Follow-up research together with regional stakeholders focusing on long-term effects such as waiting lists, recovery and the regional consumption of care and welfare, is needed.

5.2. Highlights

- The pressure in mental healthcare triggered a vertical collaboration.
- Iterative cycles of action research help to learn and improve during a major transition.
- The quadruple aim model is appropriate as a framework for this research.
- Transition to mental health centers contributes to appropriate care and satisfaction for clients.
- Transition in mental healthcare realizes professional space and job satisfaction.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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