Scientific Research Publishing

Open Journal of Therapy and Rehabilitation, 2023, 11, 122-147
https://www.scirp.org/journal/ojtr
ISSN Online: 2332-1830
ISSN Print: 2332-1822

Tackling Addiction with Integrated Care

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How to cite this paper: Kamp, J. (2023) Tackling Addiction with Integrated Care. *Open Journal of Therapy and Rehabilitation*, **11**, 122-147.
https://doi.org/10.4236/ojtr.2023.113010

Received: July 22, 2023
Accepted: August 22, 2023
Published: August 25, 2023

Abstract

Addiction is recognised as one of the chronic illnesses, often leading to medical, psychological, economic, and social problems, making multi-dimensional care for these people within the existing system a challenge. This loads an already loaded primary and secondary care system. The Verslavingskoepel Kempen (VKK) is an initiative to answer this challenge as it aims to integrate the care provided by the zeroth to third-line care around addiction treatment. Zeroth refers to the care and support provided by the human context of the patients, such as family and peers. This extends the integrated care model that is suggested by the WHO. The aim of the dissertation is firstly, to identify the organizational aspects crucial for the success of the network. The Findings show that success is confirmed by participating local communities when highlighting the importance of the intramural connection between their community social services and professionals, hospitals, and experience holders. All interviewees recognize collateral and process leadership with resources emerging from different partners and without hierarchical management. The second aim considers whether success must be attributed to the instrumental organizational aspects of the collaboration or the values of the different caregivers. The Findings show that in this network the organizational aspects and the caregivers' values are complementary. The third aim is to develop conclusions on the transferability of the network model. This is confirmed; however, the governmental policy is not accompanied by a funding system within the institutionalized remuneration and reimbursement structure. It makes the initiative dependent on the motivation of partner organizations to participate financially, raises doubt about the sustainability of the initiative, and sets conditions for as well as limitations on transferability.

Keywords

Integrated Care, People with Addiction, Efficacy, Transferability

1. Introduction

1.1. Problem Domain

The scope of this case study is the Verslavingskoepel Kempen (VKK) a network of care providers for people suffering from addiction in the Kempen, which is situated in the Antwerp Province of Flanders in Belgium. The network integrates the different professional services that together provide care for people with addiction and the support of experience holders, the people that suffered from addiction themselves. Addiction is recognized as a medical, psychological, and social problem by organizations all over the world (Table 1).

The traditional fragmented diagnose-treatment model used in healthcare settings tends not to work for problems with a psycho-medical-social background and consequences [6]. The fragmented model offers specialized care contributions that can lead to duplication or a lack of coordination when trying to connect the specialized services. In the fragmented model, patients themselves must make appropriate decisions and find their way in the care landscape which can be complicated. WHO proposes to transform the fragmented model into an integrated care model providing seamless care which is expected to (...) "contribute

Table 1. How organizations address addiction, examples.

Organization	Statement
American Society of Addiction Medicine [1]	Addiction is a treatable, chronic medical disease involving complex interactions among brain-circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.
Substance Abuse and Mental Health Services Administration [2]	"Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime" "(.) research shows that consumers in Integrated Treatment programs were more successful than consumers in non-integrated programs"
Council of European Union [3]	"(--) recognise the need for cross-service partnerships between healthcare, social care providers and patient/carers groups"
Australian Government [4]	"Addressing these co-occurring problems is essential in order to reduce the harms associated with alcohol, tobacco and other drug use. Australian alcohol, tobacco and other drug treatment services should therefore work closely with general health, mental health, social welfare and other relevant services to provide a holistic approach to treatment"
Australian Network of Alcohol and other Drugs Agencies [5]	"people using alcohol and other drugs often have multiple and complex needs. There can be a high prevalence of co-occurring mental and physical health conditions as well as social and welfare needs"

to improved access to services, fewer unnecessary hospitalizations and readmissions, better adherence to treatment, increased patient satisfaction, health literacy and self-care, greater job satisfaction for health workers, and overall improved health outcomes." [6] The lack of fit between the current model and the multi-dimensional needs facing healthcare and society at large points at gabs. Trying to fill the gabs in the existing system can result in a further load on the system. Already, the Belgian healthcare system is becoming more and more loaded. Indicator is the number of doctors which in 2019 was 3.2/1000 population compared to the European average of 3.9/1000 population [7]. In 2019 44% of the doctors were over 55 and heading towards retirement in the coming five years. Although it is expected that the number of GPs will show an increase of 3% in the years till 2026 [7] this will not solve the load. The number of beds in hospitals has declined to 5.6 beds per 1000 population [7]. Although lower than the European average of 39%, the percentage of people with at least one chronic disease has increased from 20% in 2017 to 26% in 2019 [7] [8]. Addiction or Substance Use Disorder (SUD) is considered a chronic illness [9] [10] [11] and will continue to put pressure on the healthcare system. The EC biannual "State of Health Report" per country includes data on lifestyle aspects that influence health, including the use of alcohol and drugs [7] as well as a report on Trends and Developments in the use of drugs in Europe [12]. The first mentioned publication shows data on excessive drinking that is summarized in **Table 2**. **Table 3** provides data on the users of drugs, measured by the level of residues, Belgium is depicted as belonging to the top drug users.

For a considerable number of cases repeated treatment turns out to be necessary (**Table 4**).

Table 2. Use of alcohol. Source: (OECD, 2021), author created.

OECD		
Belgium: State of Health 2021		
Nearly 30% of adults reported regular heavy alcohol consumption		
6% of deaths can be attributed to alcohol		
Binge drinking is more common in Belgium that in most other EU countries		
At least 1/month in 2018	37% male	18% female

Table 3. Highest levels of residues of drugs in wastewater in Europe. Source: (EMCDDA, 2020), author created.

Residues in Wastewater 2011-2019		
mg/1000 population/day	Cocaine	Amph.
Antwerp/Brussels	>1000	>300
Amsterdam/Utrecht	>750	>300
Stockholm		>500

Table 4. Users of drugs in treatment, source: (EMCDDA, 2020), author created.

Users in treatment	Canabis	Cocaine	Amph.	Heroin
Mean age first use	17	23	21	24
Mean age first treatment	25	34	30	25
% of users in first entrance treatment	68%	48%	60%	19%
% previously treated	32%	52%	40%	82%

1.2. Diagnosis and Treatment of Addictive Behaviour

In the case of addictive behaviour multiple people with different expertise play a role in diagnosis, treatment, and rehabilitation which comes with different professional requirements and perspectives. While the patient and his direct friends or family may be aware of excessive use of substances, the diagnosis is usually done by a general practitioner (G.P.). In the case of an overdose of drugs or heavy drinking, the person is taken to the hospital emergency department (ED). Most hospitals do not have beds dedicated to the treatment of these people and tend to release them after the initial detox period of three to eight days. Of these, a maximum of five days is covered financially in the current compensation system, while in most cases follow-on care is needed to avoid relapse. Even when the decision to restrain from alcohol or drugs is taken, the detox period can be followed by physical and emotional symptoms such as liver or heart disease and feelings of anxiety, depression, and exhaustion [13]. The physical consequences are treated by secondary care, often in hospitals. For the follow-on care of the behavioural and emotional consequences, patients are often directed to an organization in the self-help landscape. Examples such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) offer a 12-step programme, and people who do not want a programmed rehab can join SOS groups. The main goal of these self-help initiatives is abstinence. Family members cannot join the same group as the patient but can benefit from an Al-anon programme. The complexity of the addiction problem with the multidimensional care that is needed and the number of users in an already loaded system requires the introduction of a more effective model.

1.3. The Aims and Objectives of This Study

The VKK network integrates the different services that together provide care for people with an addiction. The study aims to analyze the workings of complex network organization that lies behind the VKK and to identify the factors that determine its efficacy. The VKK has a distinguished place in primary care as well as in public health. More specifically the study aims to answer the following questions:

1) "*Which organizational aspects are crucial to enable the success of the VKK network*?"

2) "*Must success be attributed to the instrumental organizational aspects of*

the collaboration or to the different caregivers with their values, attitude, and behaviour?"

3) "*To what extent can the findings be transferable to other contemporary issues within the context of primary care and public health*?"

To investigate the aims, two connected objectives were set:

⇒ Investigate the perspectives of different stakeholders on organizational instrumental aspects and the values they hold towards the VKK.

⇒ Comparison of the VKK in its daily operations with two theoretical concepts.

2. Literature Review

2.1. Adequate Care for People with an Addiction

To decide what sort of care is adequate, integrated, or provider-led care, the problem must be defined. In the literature, two different points of view can be recognized. Firstly, the recognition that addiction is a chronic illness, and secondly, it can be seen as a moral problem with which societies must cope [10]. The first approach can be found with individual doctors who define addiction as a chronic illness that needs continuous care [11]. Also, the diagnostic system DSM-V, categorizes addictions as severe Substance Use Disorder (SUD). When hitting six or more out of eleven symptoms, the need for ongoing care is stressed [9], which is the case when diagnosed with addiction. Representatives of the alternative perspective tend to label addictions as a moral problem which results in stigmatizing the people suffering from it, inadequate treatment, and improper funding of care [10]. The positioning of care for people with addiction is even more complicated within the Belgian healthcare system. Characteristic of this system is the fragmentation of responsibilities and regulation based on three levels of power, the federal authority, federated regions (Walloon, Flanders, and Brussels communities) and the local authorities [14]. Decisions about primary healthcare and public health are taken by the Federal government and are fed by discussions in the Inter-Ministerial Conference by the nine ministers of health [15]. "The federated communities are responsible for health promotion, disease prevention…, prevention of substance abuse…" Local authorities are responsible for the care of the poor and their related social and medical problems [14]. Viewing addiction as a moral problem makes the fit in primary care questionable as mental health is defined as a subject for secondary care. To avoid lengthy discussions about the right positioning of addiction care which would potentially paralyze action, Rechel's [16] suggestion could be followed to integrate the two sectors which would fit the patients' care as well as societal needs. Such an integrated approach is supported by the findings in a review of cases that present interventions by primary care and public health collaboration [17]. The cases address community health problems and inequity in care highlighting examples of lifestyle counseling and chronic care rehabilitation [17]. In these studies, the word addiction is not used, but chronic care rehabilitation is. Additionally, the moral aspect is not made explicitly, however, it could potentially fit lifestyle

counseling. The studies show that collaboration between primary care and public health "can enhance follow-up and improve health outcomes, reduce duplication of services, and achieve economies of scale by centralizing services." [17] From another angle, the findings of Cameron, *et al.* [18] are also supporting an integrated approach. They found in their meta-study that the flexibility and integration of different roles are supportive in care services. For professionals, dedicated time spent outside their mainstream work and adopting a focus on the multidisciplinary team task facilitates taking up responsibility broader than their own work. In the same study, however, the authors draw on a potential negative effect of unclear boundaries between the roles [19]. Building on Murray, *et al.* [20], Aunger, *et al.* [21] suggest that cultural and professional differences may result in different attitudes and beliefs. They conclude that differences in attitude and beliefs can result in tension, give ground for conflicts, and decrease trust in each other and confidence in the collaboration. It is not clear from these studies whether the consequences of such differences due to a variety of professions and or cultures could be overcome by an agreed commitment to an overarching vision or by a basic respect for each other's beliefs.

2.2. From Fragmented to Integrated Care

The change from delivering a particular service to a client-centred approach is not unique to healthcare. The need to switch approaches was recognized in many branches of business leading to a focus on effectively connecting the supplier(s) and the customer and defining the supply chain from development to delivery. Prahalad & Ramaswamy [22] speak about a transition in the industry with a shift from a "firm-centric view" toward the "co-creation" of value for the customer. In other words, from selling what is produced to producing in cooperation what is asked for. Building on Sinha & Kohnke [23], the supply chain of healthcare can be defined on a macro level as upstream input from developers of care systems, middle services that include financing and handling of claims, and downstream output of service delivery to the community. They point at the interrelatedness and dependence upon each other as well as the potential differences in the interest of the different contributors [23]. Dobrzykowsky [24] adds that the approach particularly fits the decentralized Bismarck model in which funding is based on the contributions of the government and employers, with the last contributions taken care of by private insurance organizations. The Belgian healthcare system is based on the Bismarck model, with a note that almost every person will be granted basic hospital costs, even people in poverty who cannot contribute (FPS Social Security, BeSoc) [25]. In the middle part of the healthcare supply chain, regulations and policies as set by the government and insurance companies tend to influence decision-making on the value and the effectiveness of the delivery of services. Because the services are difficult to standardize and the outcome is unique as it is the result of an interplay between the different caregivers and the patients it is questionable where in the system value

is created, or how effectiveness is influenced most. The question of whether it was the general practitioner (GP), the hospital admission, the neurologist, the medication, or other contextual factors that made the difference, cannot be answered unequivocally. Meeting the requirement of cost-effectiveness as well as customer's demand is not only applicable for healthcare but also a recognized challenge of supply chain management in the industry [22]. Their statement that "products can be commoditized, but co-creation experiences cannot" is described as valid for healthcare in general [26] and seems valid for the multidimensional rehabilitation services in which the GP, neurologist, social worker, psychologist, experience expert, local authorities and family members are being involved.

2.3. Collaboration in a Network

Kodner & Spreeuwenberg [27] refer to Lawrence & Lorsch [28] when arguing that the specialization of actors in a complex system usually "interferes with efficiency and quality goals". They refer to Brown & McCool [29] saying that "integration allows for greater efficiency and effectiveness, less duplication and waste, more flexible service provision, and better coordination and continuity". In both references no causality is given in the descriptions and different interpretations are allowed when using the words such as "usually" and "allows for". Missing from the studies is the effect of a common vision, and the role of consensual or different goals. Building on the work of Galbraith [30] interference can be handled by cooperation or by collaboration that aims to realize agreed goals. When cooperation is institutionalized as in a network or a platform, Phillips, *et al.* [31], call it the collaboration and describe collaboration as "a cooperative relationship among institutional fields that relies on neither market nor hierarchical mechanisms of control". This implies that the legitimate authority of a network must have different pillars on which (social) rules and systemic power are based. Phillips, *et al.* [31] conclude that legitimacy is built on the "authority of the participants, their trustworthy reasoning, and the ownership of critical resources". They describe the purpose or goal as a condition to collaborate and arrive at synergy. Positioning collaboration in the context of integrated care, Valentijn [32] stresses the importance of integration-mindedness. He concluded in his research that where stakeholders are not likewise integration-minded, trust-based, and control-based collaboration processes are both needed to align them. Moreover, when stakeholders are like-minded, trust-based, and control-based collaboration increases effectiveness [32]. Philips, *et al.* [31] recognize that the dynamics in collaboration include cooperation as well as conflicts and are influenced by the allocation and distribution of power. Even when the specialism-related goals are aligned with overall goals, the allocation of power is supportive and the synergetic effect is present, the involvement of multidisciplinary contributions can still be expected to complicate collaboration. Firstly, the participants come from different disciplines with institutional interests, rules, standards, and terminology [26]. When different disciplines stick to their approach-

es, priorities, and solutions a sub-optimized effect or tension will be the result [33]. Secondly, participants individually have their value systems that influence their attitudes and priorities. Scholars who define personal values as beliefs have in common that values are considered cognitive constructs and chosen by the person [34] [35] [36]. This implies that the priorities of distinctive people can be expected to differ and can vary even intrapersonal, influenced by the circumstances. People have their personal value priorities connected to what they desire or want to be realized. It may not be clear in the early days of collaboration to what extent people's value priorities are likewise. Jones and George [37] use the concept of "conditional trust" as a start for collaboration that over time can develop into "unconditional trust" when it has been proven that individual values are not conflicting. They argue that in a collaboration it is easier to start with trust than with distrust.

Thirdly, the number of participants and the openness of the network influences its effectiveness [38]. Although a correlation between team size and team effectiveness is not proven, an influence of size on the effectiveness of processes can be expected [39]. Aunger, *et al.* [21] point out that with the increase in size, informality, and autonomy will decrease, slow down communication, and will require more initial trust. Hayat, *et al.* [38] found in their study that a network's productivity was built on "coherence, boundedness, shared goals, and high rates of interaction, which may be influenced by the network size.

2.4. Supportive Behaviour for Collaboration

Mulvale, *et al.* [40] use a "three-level action model" to picture interprofessional collaboration. They position individuals in care teams on the "micro-level", managers of institutions at the "meso-level", and policymakers at the "macro-level". In their meta-study, they found the most influence on collaboration on the micro-level and concluded that formal team-related aspects, as well as attitudes, are supportive of effective collaboration. On the individual level, it was the belief in the concept of collaboration that was supportive, and on meso-level, a formal information system was identified as contributing. It can be argued that belief in the concept of collaboration is closely related to Valentijn's [32] findings about the importance of integration-mindedness of stakeholders. Regardless of uncertainties about the alignment of individual value priorities at the start of a collaboration [34] [35] [36], the conditional trust concept [37] explains why collaboration can start. Building on Aunger [21], confidence refers to the belief that actors have in functional collaboration within a system while trust refers to interpersonal relationships. A decrease in trust in each other could influence confidence but does not necessarily lead to a halt in collaboration if the structure is strong and the outcome is still expected to be positive.

2.5. Values and Collaboration

Focusing on the micro level, Schwartz [36] points to three personal values supportive of collaboration that he found dominantly present in different studies

and many cultures, being "benevolence" (caring and dependability), "universalism" (e.g., tolerance, societal concern), and "self-direction related values". Benevolence refers to the maintenance of the group that one feels close to and is familiar with, while with universalism the view goes outside of the own group and points to the protection and respect of others. Schwartz draws on the work of scholars such as Campbell, Parsons, Schwartz & Bardi to explain that these values benefit the individual as an internalized guide. By doing so, the values also serve to maintain societies by avoiding the necessity to control people's behaviour. The values of self-direction elicit behaviour that is built on intrinsic motivation as a driving force to reach mastery and encompasses thoughts and actions to reach self-chosen goals. When studying intrinsic motivation as a driving force, other scholars refer to the Self Determination Theory (SDT) [41] [42]. The SDT states that the need for autonomy, competence, and relatedness form the basics of intrinsic motivation [41] [42] and that an autonomous orientation in volunteering work related positively to the willingness and amount of work which volunteers took up. A later study by Dysvik, *et al.* [43] points to the quality of the relationship between the three needs and concludes that although all three together are building intrinsic motivation, the "synergetic effect is not completely three-way based". Of the three basic values, only the "satisfaction of the need for competence" was found to be also positively related to extrinsic motivation while for "autonomy" and "relatedness" a positive relationship could not be found [43]. Illes & Vogell do not speak about intrinsic and extrinsic motivation but distinguish values from norms. Values are described as desired, and personal, and serve as "internalized guide" for a person [44] while norms are "restrictive, raising expectations", and serve to evaluate individual and group behaviour. Rohan [35] distinguishes personal value priorities and social value priorities as intrapsychic cognitive structures. He labels a specific group adhering to specific priorities as an "ideological value system" and does not mark the latest as norms as Illes & Vogell do. Although describing values in the context of collaboration in indifferent ways, values are seen to be of major importance.

2.6. Summary of Literature Review

Literature describes the care of addiction as either based on the view that addiction is a moral problem [10] or a chronic disease [9] [11]. This study is built on the view that addiction is a chronic disease and best organized in a system of integrated care with a focus on serving patients' as well as societal needs [17] [18]. Scholars give different descriptions of integrated care that correspond with their roles in the value chain (**Table 5**).

2.7. The Theoretical Framework for This Study

The theoretical framework for this case study leans on two earlier studies that allow for different focus points. The first model, created by Alexander, *et al.* [48] is based on cases in the context of collaborative community health partnership. The model includes five overarching instrumental themes (**Table 6**) identified as

Table 5. Descriptions of integrated care from different viewpoints, author created.

Reference	Description of Integrated Care	Perspective
[45]	"…the ability to encourage more holistic and personal approaches to multidimensional health needs."	Professional perspective
[27]	"…a step in the process of health systems and health care delivery becoming more complete and comprehensive."	Holistic process perspective
[46]	"…bringing together of inputs, delivery, management and organisation of services as a means [of] improving access, quality, user satisfaction and efficiency."	Governance perspective
[47]	"…a coherent set of products and services, delivered by collaborating local and regional health care agencies to multi-problem patients."	Client-centred organisational perspective

Table 6. Five themes for collaborative community health partnerships, Source: Alexander, *et al.* (2001), author created.

Theme	Includes e.g.
Systems thinking	- disease-based medical model and wellness-based social model, - structural drivers, - knowledge of the formal and informal healthcare system, - staying focused on the big picture.
Vision	- a vivid picture of the aspired future state, - based on care values and core purpose that create an own identity, - shared with partner organisations and the community at large.
Collateral leadership	- partnership staff, - resources emerging from the distinctive partner organisations, - advocates for a specific community segment.
Power sharing	- operating as a virtual organisation, - no legal status and no physical space, - funded by financial contributions of the partner organisations, - time and action provided by the partners.
Process leadership	- goals are realised without hierarchical management, - interpersonal skills - communication channels and fitting messages.

required for partnerships that are based on voluntary collaboration by representatives from different sectors. The partnering is typically a coalition between private and public stakeholders, with commitments to contribute varying resources to the network and deliver joint services that create value for society as well as themselves. This model is used as a first frame for coding the interviews that were held with seventeen partners, to shed light on the first question: "Which organizational aspects are crucial to enable the success of the VKK network?"

A second coding round of the interviews around a set of identified values is expected to feed the author's aim to investigate the question: "Must success be

attributed to the instrumental organizational aspects of the collaboration or to the different caregivers with their values, attitude, and behaviour?" This coding round is based on the theoretical model obtained by an international Delphi study by Zonneveld, *et al.* [49] **Table 7**. It addresses the "Values Underpinning Integrated People-Centred Health Services".

Table 7. Values underpinning integrated people-centred health services (Zonneveld, 2022, pp. 4-5).

Person-centred	Valuing people through establishing and maintaining personal contact and relationships, to ensure that services and communication are based on the unique situations of users and informal carers.
Co-ordinated	Connection and alignment between users, informal carers, professionals and organisations in the care chain, to reach a common focus matching the needs of the unique person.
Holistic	Putting users and informal carers in the centre of a service that is "whole person" focused in terms of their physical, social, socio-economical. biomedical psychological, spiritual and emotional needs.
Effective	Ensuring that care is designed in such a way that outcomes serve health outcomes, costs, user experience and professional experience.
Trustful	Enabling mutual trusting between users, informal carers, communities, professionals and organisations, in and across teams.
Empowering	Supporting people's ability and responsibility to build on their strengths, make their own decisions and manage their own health, depending on their needs and capacities.
Respectful	Treating people with respect and dignity, being aware of their experiences, feelings, perceptions, culture and social circumstances.
Led by whole-system-thinking	Taking interrelatedness and interconnectedness into account, realising changes in one part of the system can affect other parts.

3. Research Methodology

This research has the form of an "intrinsic case study" and follows a qualitative, inductive approach and interpretive format [50]. The methodology allows for a focus on the unique situation of the Verslavingskoepel Kempen (VKK). Neither experience nor literature points to other comparable initiatives in Belgium. Inductive refers to the exploratory process starting with observing the real world and identification of patterns, leading to tentative hypotheses, and finally arriving at conclusions. Focus of study is a specific group in the population, meaning the people that suffer from a chronic condition of addictive behaviour such as the excessive use of alcohol and/or drugs and their care providers. The study aims to understand the relationships between them, and the professionals involved in the distinctive care. The inductive approach is followed to identify functional characteristics of the chosen organizational model and to disclose the value patterns that different stakeholder groups in the network attribute to their collaboration. The chosen theoretical framework is expected to support conclu-

sions on the complexity of an integrated care system and makes a quantitative and statistical analysis not applicable [50].

3.1. Data Analytical Approach

The analytical approach of this research is qualitative. It includes objective as well as subjective aspects and applies Thematic Analysis under a Grounded Theory (GT) approach. Historic documents, the VKK website, and recorded and transcribed interviews provide the data. The qualitative approach includes a "content analysis" [51] of all obtained information. The GT approach implies the search for concepts behind perceptions of real-world events by looking for "codes" [52]. The codes were derived from two theoretical models and the Thematic Analysis encompasses the process of defining broad categories of codes that seem related. The first theoretical model [48] defines the instrumental requirements for collaboration by different actors in a community health setting while the focus of the second model is on the values the actors hold [49]. Key-point coding is used as it is expected to go faster than a micro-analysis of 17 interviews. Drawing on Illes & Vogell [44], research is called objective when it refers to figures and norms and is subjective in terms of opinions and values. In this case study, the objective data on instrumental aspects are gathered in documentary research by studying historic documents and the VKK website. Subjective information on the participants' perception of collaboration and their values are obtained from interviewees. The analysis of the findings is followed by the intention to develop a theoretical explanation, which implies that the study will be inductive [51]. Compared and where possible validated with findings in other studies and available concepts, it is the aim to arrive at substantive conclusions about generalizability to other multidimensional network constructs in healthcare.

3.2. Research Design and Data Collection Process

Given the nature of an intrinsic case study some choices had to be made on the research design, it makes up for the consequences of the analytical process (**Table 8**):

1) To describe the context, historical information is studied. However, the available information is limited and needs additional information from individual storylines from people involved in the founding and development of the network.

2) The research takes the individual storylines as sources of explicit as well as implicit indicators of the workings of the network.

3) The storylines come with different perspectives and subjective evaluations and introduces ambiguity. It can be expected that institutional, professional, and personal values are interlinked, resulting in similarities and differences.

4) The theoretical models do not include a focus on the successfulness of collaboration, a separate questionnaire was used to grab the view of governmental partner organizations.

Table 8. Data collection process.

Cycle 1	Objective	Result
1. July 2022	Gather historical data, information from the VKK website, minutes of meetings.	Historic information to create the context.
2. August 2022	Information on activities and events. First six interviews. The themes from theoretical model 1 [48] are defined for coding.	Timeline 2007-2022 Audio recordings of interviews. Questionnaire.
Cycle 2		
3. September-October 2022	Eleven successive interviews with participants. Reflection on the results creates the need to add a theoretical model 2 [49].	Recordings, transcripts, translations and coding in Excel.
Cycle 3		
4. October-November 2022	Final interviews. Questionnaire sent out to fourteen aldermen of local Community Councils.	Recording, transcripts, translations, and coding in Excel.

3.3. Robustness of the Data

The questions used for the initial interviews were not identically phrased in words as used in the theoretical framework. In this way directing the interviewees toward a particular answer was avoided and a free expression of perception, experience, and values was stimulated. The categories and values labeled in the two theoretical models served the coding process. In some interviews, the themes and values were expressed spontaneously (Example 1) while in other interviews these could be derived from the interviewee's narrative (Example 1 and Example 2).

Example 1: Values: **holistic**

R2: *Integration of care is a means to good overall care. The current means are not sufficient, and we need a* ***holistic approach*** *to care that is decoupled from politics.*

Example 2: Value: **respectful**

E4: People with addiction are self-centered liars, over time their spouses get deformed. Have them all in one group **supports understanding**. **The urge** to help **is strong** but the **person must ask for it**.

3.4. Target Samples

For this case study, the "elite interviewing" method is chosen to assure the involvement of knowledgeable people who can be expected to contribute information productively and effectively [53]. Interviewees are clustered in subgroups to facilitate differentiation in data for the analysis as it is expected that actors with different roles will have different expectations or interests and values [49]. The fourteen aldermen from local community councils were asked to answer two questions related to the way the VKK is valued in their community. **Figure 1** shows the numbers of involved people in the interviews and in the questionnaire.

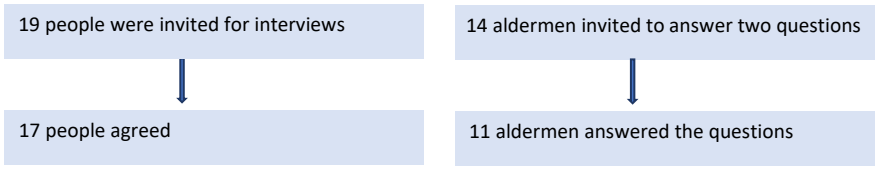

Figure 1. Involved in the case-study.

The interviewees were either involved in the VKK in the early days as founders or because of their current role or position in the network. They are grouped into four clusters: Professional partners (P1 - P5), Residential care partners (R1 - R4), Governing authority (GA1 - GA2), and Experience holders (E1 - E4) and Context/family of Experience holders (CE1 - CE2). The professionals (P) in this research all represent a professional care partner organization whereas the experience holders (E). Initially, experience holders acted on their own behalf, later and after the Charter was written they officially could represent the VKK network. The residential care partners (R) are represented by CEOs and Medical Executives of the facilities. The Governing Authority representatives (G1 - G2) are governors in the local community of Geel. The interviewees were easily approachable through the VKK's chairperson.

The aims of this case study start with the premise that the VKK network is a success. To verify this assumption, the Local Community partners must be asked if they perceive it as such. They have a major responsibility in organizing the conditions for Public Health. To include the perception from the fourteen Local Community partners, the responsible aldermen in each Community Council (A1 - A10) were sent a two questions' questionnaire:

1) "*Is partnership in the VKK for your community important? Why?*"

2) "*Do you experience the activities of the VKK as a success in your community? Why?*"

In total eleven of the fourteen aldermen responded to the questionnaire in writing.

3.5. Ethical Considerations

The gathering of data is predominantly based on individual interviews with the stakeholders of the VKK including hospital management, professional care providers as well as experience holders. Defining addiction as a chronic disease implies 'once a person with an addiction, always a person with addiction'. The information obtained from experience holders is expected to include personal experiences and opinions in addition to official views and political arguments from professionals and authorities. One-on-one exploratory interviewing is often an invitation to share in-depth or personal information [51]. The aim of this case study is not to evaluate individual stories, but to detect the success drivers of the VKK, being the integrated network structure and/or the attitude and values of the actors involved in the network. People within the VKK are, unlike the AA, open about their addiction and willing to share their experiences in interviews.

Opt-out is always possible, also during or after the interview.

4. Findings

This section gives an overview of the findings obtained through studying the VKK website, the bylaws, minutes of meetings, the questionnaire, and the interviews. Access to the documents gave historic information and insight into the organization structure, vision, and mission of the VKK. Information on the actual funding was obtained in the interviews and from the Budget 2023-2026. The Findings are organized along the lines of the two theoretical models and the Analysis is based on both the results of the questionnaire and the interviews, leading to answers to the three research questions.

4.1. The VKK's Organizational Structure, Vision, and Mission

The vision of the VKK is to be a network of collaborating partners that provide continuous help for people with an addiction. Activities are integrated into a process of care through the collaboration of hospitals and professional partner organizations, with experience holders and self-help groups while respecting each other's expertise and boundaries.

The collaboration is based on the mission to provide client-centred services within the total landscape of care and to create societal awareness and serves VKK's vision and mission as a guide for all partners in the network [54]. Dr. Viaene, the chairperson of the VKK Board, explains in an interview how four pillars carry the work. Firstly, the VKK is an open space that allows professionals, experience holders, local authorities, people with an addiction, and their families to meet each other. There is no threshold or exception for seeking and receiving help in professional background, sort and severity of the addiction, societal position, role, age, or gender. The second pillar entails that the VKK platform invites participants to learn from each other, based on mutual respect by contributing different expertise and experience. Thirdly, local authorities support the VKK to cover costs that are not part of the current reimbursement schemes and are meant to compensate for the involvement and coordination of experience holders. The fourth pillar has an ethical character, influences the other three, and refers to the work of the phenomenologist Levinas [55]. Ethics and responsible behaviour are not depending on the act of the self but are elicited by the encounter with "the other". An encounter implies the obligation to take the responsibility to apply justice, rightness, and respect for each other.

In 2014 a dialogue between professionals and experience holders resulted in an organizational structure called the "Kempisch Model" [56], which was further developed into the current model, **Figure 2**. It took fifteen years with meetings, dialogues, and struggles to arrive at the current VKK. Professionals phrase it: "*It was a struggle to find each other, our speed and dedication were different.*" And "*Our thinking was different; process approach of professionals and action orientation of experience holders required external support to let go.*"

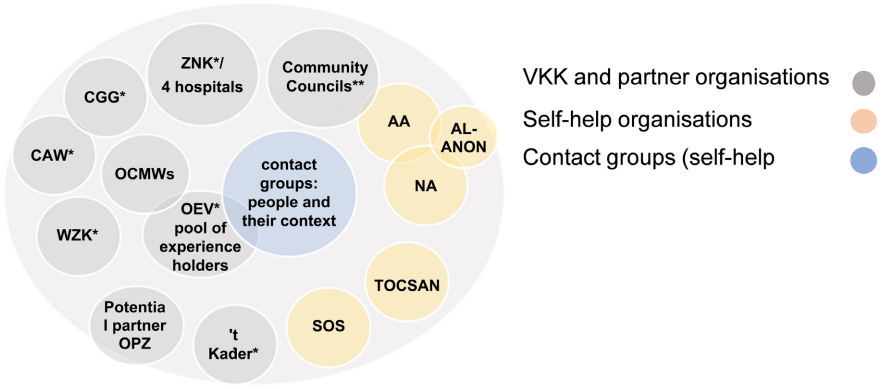

Figure 2. The VKK partner organisations, and self-help landscape (information from interviews, author-created).

4.2. Funding of the VKK

The Belgian Bismarck model, raises the expectations of federal, federate, regional, and local level funding. Although recognized on the federate level as coordination and service body, the VKK as a multi-level partnership is not subsidized within the current healthcare system (Figure 3).

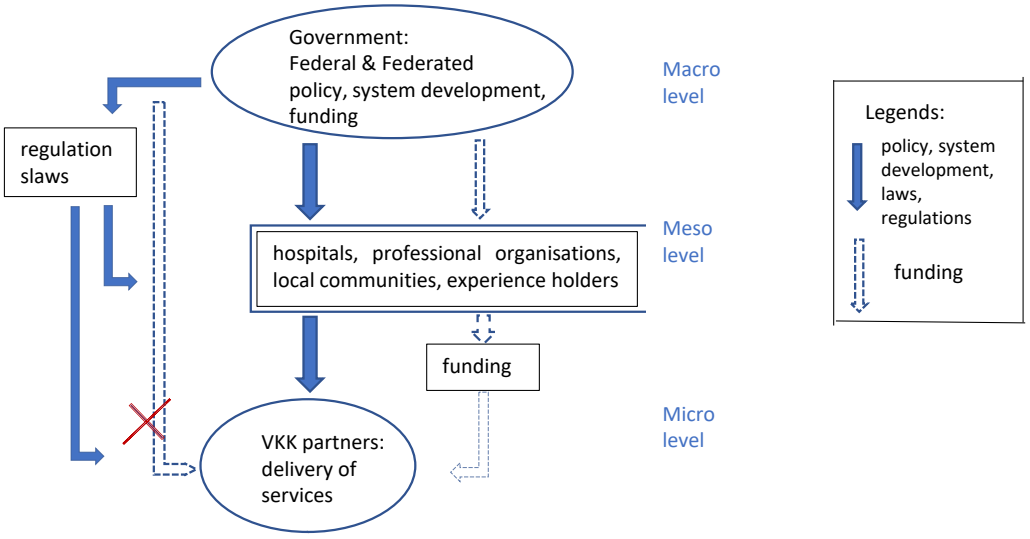

Figure 3. Policy and funding of the VKK partnership, author created (Dobrzykowsky, 2019) (Mulvale, *et al.*, 2016).

The disconnected Federal policy and Flemish operational execution from actual funding makes the working of integrated care less sustainable and dependent on the decisions of local political governance. A system or structure is often influenced by the way the operations are funded [27]. Martens, *et al.* conclude in their studies that Belgium has a "fragmented supply-oriented healthcare system", meaning that policy and system development, decision power, and funding are distributed among the different governmental levels. It raises the question of how integration is possible within a non-integrated political landscape and sug-

gests that the only way is to find a common interest and go for their commitment.

The region has thirty-eight beds and seven chairs which is insufficient to cover the need. All emergency departments in the region are confronted with a need for detoxication services after the misuse of substances. The costs for a bed occupied by a person with addiction are covered for the detox period of five days. As eight days are needed, three days are not financially covered. Moreover, once occupied, the beds cannot be used for other treatments that are financed. A projection study [57] draws on Van de Voorde, *et al.* [58] when concluding that by 2025 the number of beds will need a shift from cure to care support for the elderly and chronic diseases, so the gap will increase.

4.3. The Success of the VKK as Perceived by Local Communities

In total eleven replies to the questionnaire were returned by the aldermen of participating communities. Except for two, all respondents perceive the VKK as a success in their community. Two make the note that they just entered the partnership and expect it beneficial for the community but cannot build on realized success yet. The results show that most respondents agree on three elements they consider important:

1) The support is **easily accessible** for people with addiction and their family members.

2) The VKK network offers an **intramural care path** by connecting the community social services, professionals, hospitals, and experience holders.

3) Through the contact groups the VKK offers support and aftercare for **patients as well as their family.**

4.4. The Interview Findings

Two theoretical models were used for coding the interviews, however along different lines. Theoretical model 1 [48] depicts collaborative community health partnerships using five instrumental themes. The second theoretical model developed by Zonneveld, *et al.* [49] was used to inventarise the interviewees' priority values.

Reviewing the findings in **Table 9** from left to right several conclusions can be made on the appearance of the themes and elements in the interviews. Interviewees almost unanimously mention *Collateral* and "*Process Leadership*". The themes "*Systems thinking*", and "*Vision*" are particularly recognized by governmental representatives, professionals, and the management of residential facilities.

4.5. Findings on the Priority Values from the 2nd Theoretical Model

Drawing on the earlier findings from Zonneveld, *et al.* [49] the second theoretical model was used to inventarise the interviewees' priority values in the context of participation in the VKK network. The results are shown in **Table 10**.

Table 9. Results on the five themes (Alexander, 2001), obtained by interviews, author-created.

Groups of interviewees about the themes	Systems Thinking				Vision				Collatoral Leadership		Power Sharing			Process Leadership			
	Linking the disease based medical model and wellness based social model.	Knowledge of structural drivers.	Knowledge of the formal and informal healthcare system.	Staying focused on the big picture.	A vivid picture of the aspired future state.	Based on care values and core purpose that create an own identity.	Shared with partner organisations and the community at large.	Partnership staff.	Resources emerging from the distinctive partner organisations.	Advocates for a specific community segment.	Operating as a virtual organisation*	No legal status and no physical space**	Funded by financial contributions of the partner organisations***	Time and effort provided by the partners.	Goals are realised without hierarchical management.	Interpersonal skills.	Communication channels and fitting messages.
G1	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔	✔	✔	✔
G2	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔	✔	✔	✔
P1	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔	✔	✔	✔
P2	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔	✔	✔	✔
P3	O	✔	✔	✔	✔	✔	✔	O	✔				✔	✔	✔	✔	✔
P4	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔			✔	✔
P5	✔	✔	✔	✔	✔	✔	✔	✔	✔					✔	✔	✔	✔
R1	✔	✔	O	✔	✔	✔	O	✔	✔				✔	✔			
R2	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔		
R3	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	
R4	✔	O	✔	✔	✔	✔	✔		✔	✔				✔	✔	✔	✔
E1		✔	✔	✔	✔	✔	✔		✔					✔	✔	✔	✔
E2						✔	✔		✔					✔	✔	✔	✔
E3					✔				✔					✔	✔	✔	✔
E4			✔	✔		✔	✔		✔					✔	✔	✔	✔
CE1									✔	✔				✔		✔	✔
CE2									✔	✔				✔	✔	✔	✔

The different shades of grey are meant for easier reading and indicate the interviewees who mentioned the theme, both within the subgroups and over the groups. G = Governing Authority, P = Professional, R = Residential manager, E(C) = Experience holder (Context). An "O" is used in the table in those cases that interviewees did not point at this element, however, it would be unlikely that they are not aware.

The only value pointed at by all interviewees, no matter the subgroup they belong to, is ***Holistic*** which was described by Zonneveld, *et al.* [49] as "*Putting users and informal carers in the centre of a service that is 'whole person' focused in terms of their physical, social, socio-economical. biomedical psychological, spiritual, and emotional needs.*" This description seems closely connected with the themes, "person-centred" (Table 2, Table 3).

Table 10. Values indicated per partner group, author-created.

Indicated Value	Holistic	Person-centred	Co-produced	Respectful	Trustful	Shared responsibility & accountability	Led by whole-system-thinking	Coordinated	Empowering	Effective
Partner										
Policy & Authority										
G1	✔	✔	✔			✔	✔	✔	✔	✔
G2	✔	✔				✔	✔	✔	✔	✔
Professional										
P1	✔		✔		✔		✔	✔		✔
P2	✔	✔	✔		✔		✔	✔		✔
P3	✔	✔	✔	✔		✔		✔		✔
P4	✔	✔	✔				✔	✔	✔	✔
P5	✔	✔	✔	✔			✔	✔	✔	✔
Residential										
R1	✔	✔					✔			✔
R2	✔	✔				✔	✔	✔	✔	✔
R3	✔	✔			✔	✔	✔	✔	✔	✔
R4	✔	✔				✔	✔	✔		✔
Experience holder & Family										
E1	✔	✔	✔	✔	✔	✔	✔		✔	✔
E2	✔	✔	✔		✔			✔	✔	✔
E3	✔	✔		✔	✔	✔				
E4	✔	✔	✔	✔	✔			✔		
CE1	✔	✔			✔					
CE2	✔	✔								

Note: The different shades of grey are meant for easier reading and indicate the common values mentioned by all interviewees, or except one, within a subgroup.

5. Conclusions

The study by Zonneveld, *et al.* [49] reveals that different perspectives are connected to the roles of identified actors or stakeholders. This case study also indicates that distinguished perspectives come down to the main area of concern, the responsibility or contextual situation on which the stakeholders differentiate.

1) Question 1: "*Which organizational aspects are crucial to enable the success of the VKK*?"

This question required the verification of whether the VKK is considered a success. In total eleven participating municipalities that are considered responsible for public health in their communities confirm the success. The local alder-

men mention the easy accessibility of the contact groups, the intramural care path that connects with the community social services, and the aftercare and support that is provided to patients as well as their families.

Of the five themes of Alexander's theoretical model that are defined as being "required for partnerships based on voluntary collaboration", the themes "*System thinking*" and "*Vision*" are mainly recognized by governmental representatives, professionals, and the management of residential facilities. These groups highlight the values "*coordinate*d", "*effective*" and "*led by whole-system thinking*", while the outstanding value for experience holders is "*trustful*". Unanimously recognized by all interviewees are the operational themes "*Collateral Leadership and Process Leadership*" and the values "*holistic*" and "*person-centred*". It is clear to almost all interviewees that "resources emerge from the distinctive organizations" and that they are "advocating for a specific community segment".

The VKK as a legal structure gives all stakeholders including the volunteering experience holders a recognized profile and formal position. Gagné [59] concludes in his findings that an autonomous orientation in volunteering work relates positively to the willingness and amount of work volunteers take up. In this study, the experience holders recognize their work as important for the addicted people as well as for themselves.

Especially the general managers of residences and the VKK Advisory board point to an important inconsistency as the governmental policy and funding system are not led by thinking as a whole system. The Federal Statement says: "Integrated care projects for the management of chronic patients, such that stakeholders (including social care) are incentivized to set up innovative initiatives of care centred around patients across different care settings in their geographical area" [57]. In summary, the Federal Authorities are responsible for hospital budgets, the regulations of health activities, and care professionals. The Flemish government carries the responsibility for primary care, mental health, and rehabilitation [57], and local authorities have a responsibility for public health and care for the poor. Although the VKK vision is politically recognized, no funding is provided within the federal or federated healthcare system. It makes the VKK network completely dependent on the partners' contributions, time, and effort.

2) Question 2: "Must success be attributed to the instrumental organizational aspects of the collaboration or to the different caregivers with their values, attitude and behaviour?"

Drawing on the interview findings, the VKK network meets most aspects of the five instrumental themes as described by Alexander, *et al.* [48]. Additionally, mentioned by hospital management is the invitation of experience holders to patients' beds with the objective to unload the professional caregivers and to offer coordinated (after) care while decreasing the chance of a revolving door effect [56]. The "revolving door effect" was mentioned by hospital management to indicate patients that return to the Emergency Department soon after being discharged. Also instrumental for the partnering local communities is that the VKK

offers effective help for patients and their families. This provides a coordinated way to answer their public health responsibility within a transmural care path. Drawing on Zonneveld, *et al.* [49], values can include instrumental aspects as well as personal beliefs and values. A comparison of the results of Zonneveld's work [49] and this case study leads to the conclusion that all interviewees specifically value the "*person-centred*" and "*holistic approach*", while professionals as well as policy & decision makers also mention the values "*coordination*", "*effectiveness*", and "*led by whole systems-thinking*". The experience holders perceive their work as meaningful for others as well as for themselves. By helping others, they are reinforced to face their own addictive tendencies by "continuous confrontations with the problem and others" [56]. In the WHO Working Document, Ferrer [60] builds on different studies when saying that "(...) providers of peer support report less depression, heightened self-esteem, and self-efficacy, as well as improved quality of life". Givers experience it "particularly rewarding and facilitating their own recovery" [61], and it "(...) leads to greater self-efficacy, self-esteem and feeling more valued" [62]. This makes for the conclusion that the success of the VKK network relates to the fulfilment of the partners' needs and expectations through its organizational characteristics as well as to meeting the common values that serve as internal guides [36] and group norms [44].

3) Question 3: "*To what extent can the findings be transferable to other contemporary issues that fit within the context of primary care and public health*?"

In answering this third question some considerations must be made. While the need for addiction care is recognized [7] [12] and can be considered a strong driving force, the diversified governmental healthcare policy [14] and lacking governmental funding could turn out an insurmountable obstacle. In this VKK situation it however resulted in an effect that experience holders together with professionals and decision-makers managed to turn the unsupportive dynamic into a common challenge and success. Starting with the recognition of a deficiency of care for people with addiction in this region the answer was found by agreeing a common vision of different partners offering distinctive contributions. Together, the contributions of professionals in terms of expertise and effort, with the funding of hospitals and local communities, and finally the willingness of experience holders to contribute as volunteers, made the network effective but also vulnerable. Building on the observation that the partners are unanimous in recognizing the need for person-centred care and a holistic approach, the analysis points to important supportive mechanisms for transferability. First is the alignment of individuals in teams, management of institutions, and policymakers on the common belief in collaboration, which was also found by Valentijn [32]. Second, the "requirement for partnerships that are based on voluntary collaboration by representatives from different sectors" [48] is the contribution of resources, time, and effort, from the distinctive partners. Third is the legitimacy of the system. In October 2014, the self-help landscape with organizations such as AA accepted the Charter written by experience holders. The next step was the acceptance by the Flemish Cabinet of the Vision document in

October 2015, followed by the acknowledgement of the legal structure in November 2017. As such it is an example of legitimacy built on "the authority of the participants, their trustworthy reasoning, and the ownership of critical resources" [31].

The second consideration on transferability is supported by the work of Rechel [16] and Shahzad, *et al.* [17]. The integration of care could be seen as a solution for themes that position in primary care as well as public health. The current healthcare governance model in Belgium shows divided policies, fragmented operational management, and corresponding funding, on different governmental levels. This complicates the holistic approach of care on the local level and the provision of health care services in daily practice. Building on Martens *et al.* it is concluded that care for chronic diseases needs aligned governmental policies and funding to reinforce the voluntary commitment and contributions of individual professionals and organizations [63]. They stress the importance "that objectives and actions across different policy levels are aligned closely to improve policy coherence, accountability, coordination, and leadership in decision-making".

The third consideration is the absence of a comparison of cost and efficiency with the traditional fragmented way of providing care for people with addiction. Insufficient funding structures for the network potentially set limitations to the willingness of policy & decision makers to adopt an integrated model for other healthcare applications that pass the boundaries of primary care or public health. The WHO [45] describes most health systems as not fitted for today's "individual and community health needs of the populations" and suggests alternative ways to close the gap between primary care and public health. In the same report is mentioned that parties "are working together to expand the evidence base with a particular interest in return on investment". Decisions to change are difficult when short term out of pocket costs must be balanced to longer term coordination gains, a positive effect on public health or resulting in a decrease of chronic care. Building on a Policy Summary published by the WHO the results of economic analysis on integrated care are ambiguous [45] and are influenced by the definition of integrated care, and the sort of analysis used: cost-effectiveness such as the benefits of certain interventions, cost outcomes such as the use of particular services, or cost as expenditure such as fees [64].

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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