The position of self-governance and recovery centres in implementing the IZA mission to realise a national network of low-threshold support centres

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Abstract

In 2022, the Integraal Zorg Akkoord (IZA) was published. A mission of the IZA is to realise a regional and national network of low-threshold support centres for people with mental vulnerability by 2027. Self-governance and recovery centres are an example of low-threshold support centres. The goal of this research is to answer the following research requestion: '*What position do self-governance and recovery centres have in implementing the IZA mission, to set up a national network of low-threshold support centres, in the relation between the mental health sector and the social domain of the Municipality of Enschede?'*

Insight is provided into the interpretation of the problems and the development of the change plan of this IZA mission. Exploratory research, including literature review and interviews, has been conducted. 20 semi-structured interviews were conducted with different actors concerned by the IZA mission. The interviews are transcribed and coded and combined with literature published during the research.

The six most relevant actors are described with roles and responsibilities. Menzis oversees the transformation funds and assesses the transformation plans. These transformation funds are not applicable to low-threshold support centres. Twentse Koers has a coordinating role and is responsible for the Regioplan and is responsible for the SPUK IZA and SPUK transformation funds. SPUK, specifieke uitkering, entails the financial means to fund municipalities concerning the establishment of the IZA mission. SPUK IZA is allocated to Twentse Koers, this is budgeted for the coordination of Twentse Koers. SPUK transformation funds is a construct established to transfer IZA transformation funds to Twentse Koers. This is the resource from which low-threshold support centres can be funded. The Municipality of Enschede plays an operational role on local level and has a role to participate in developing the network of low-threshold support centres. Low-threshold support centres play a role in the preliminary field and contribute with knowledge and expertise from the client perspective. The general practitioners are a link between the social domain and ggz. Mediant has started with the IZA mission in collaboration with Ixta Noa.

The main barriers experienced are confusion between the IZA mission of low-threshold support centres with the IZA mission of Mentale gezondheidscentra. This causes ambiguity for the roles and finances of this IZA mission. This confusion is also found in the regional plan and corresponding budget. Self-interest plays a part in the IZA mission, due to self-interest initiatives that would fit in the network of low-threshold support centres are not seen as eligible for the funding. Self-governance and recovery centres are an example of low-threshold support centres, these are not interchangeable terms, meaning other initiatives can also be low-threshold support centres.

In conclusion, the position of self-governance and recovery centres can be found in the preliminary field. These low-threshold support centres are found between the lifeworld of the residents and the social domain. The role of self-governance and recovery centres by realising the IZA mission is contributing with knowledge and expertise from the client perspective.

Recommendations for the Municipality of Enschede are to become a more active participant at Twentse Koers, to participate in the development of a network of low-threshold support centres and to connect residents and general practitioners with the social domain.

1. Introduction

In the introduction, the rationale is discussed, which leads to the research questions. The subsequent section of the introduction will discuss the scientific and practical relevance. Thereafter, relevant context is discussed.

1.1. Rationale

In September 2022, the Integraal Zorgakkoord (IZA) has been published. The IZA originated from the 'zorgverzekeringswet' [1,2]. This agreement has a calendar of work activities which consists of 12 key elements in order to entail accessibility, increase collaboration between domains and maintain quality in healthcare. Section F represents 'Samenwerking sociaal domein, huisartsenzorg en ggz', this entails the collaboration of the social domain, general practitioner, and the mental health care sector (ggz). Section F represents three IZA missions. These missions are 'Domeinoverstijgende samenwerking voor mensen met psychische klachten', 'Landelijk en regionaal netwerk laagdrempelige steunpunten' and 'Mentale gezondheidscentra (now called 'Mentale gezondheidsnetwerken' but in this study still called according to the former name)'. This study focuses on the mission of 'Landelijk en regionaal netwerk laagdrempelige steunpunten', in this thesis referred to as the IZA mission of establishing a national and regional network of low-threshold support centres. A period of five years is provided to establish a regional network that will subsequently form the nationwide network [2]. This network should consist of easily accessible support facilities, to which all citizens have access, especially individuals with a serious mental illness. Self-governance and recovery centres serve as an example of low-threshold support centres. Self-governance and recovery facilities are operated by experts by experience and volunteers [2].

The roadmap 'Gezond leven' of the Vereniging van Nederlandse Gemeenten (VNG) provides guidance for the 'national and regional network of low-threshold support centres' [3]. The network will be developed by the regions. According to the roadmap, municipalities have a role of organizer which means municipalities establish or develop a network or organisational form. Agreements on how to fulfil this element will be made by the end of 2023. In 2025 latest, inhabitants with severe psychiatric disorders should know how to find or are referred to the low-threshold centres in the region. The VNG supports the regions with establishing the network. The ggz, general practitioners and the social domain are responsible for setting up the low-threshold support centres [3]. In region Twente the Twentse Koers plays a role in fulfilling this IZA mission.

For executing the IZA mission, transformation funds are allocated. The IZA mission mentions that the IZA investment resources are allocated at the municipal level for the establishment of low-threshold facilities [2]. In the region Twente, these resources, SPUK funds, are assigned to the Twentse Koers. Additionally, there are transformation resources that transcend domains to facilitate the implementation of the IZA mission. These transformation funds are €2.8 billion. These funds are allocated for expenditure between the years 2023 and 2027 for all missions outlined in the IZA and can be utilised starting from January 1st, 2023 [2]. The main health insurer of the region oversees dividing the transformation funds. These funds need to be used by 2027, because otherwise the remaining funds will be withdrawn [2]. The funds can be used to promote the necessary change. The budget is not divided beforehand per region or theme and the transformation plans are followed for dividing the funds [2]. The funds are monitored at the national level. In January 2022 the NZa, VWS and Zorginstituut worked on monitoring to keep the process equitable. Monitoring is conducted through retrospective review [2]. The mental health sector receives €160 million [2].

For a transformation to be eligible for transformation resources, specific requirements must be met [2]. These requirements state a transformation plan must be included. The health insurer assesses the transformation plan and reviews efforts and results, in order to decide on funding [2]. There are two phases to achieve a transparent procedure [2]. In 2023, possibly extending into 2024, the transformation funds are allocated in accordance with the updated pricing agreements between health insurers and providers participating in the transformation plan. From 2024 or 2025 onwards, the funds are allocated based on separate performance. This means that monitoring is more accessible, and it should ensure competitive neutrality and transparency [2].

The IZA suggests changes which requires collaboration among various actors. Due to the recent publication of the IZA and the involvement of various parties, the positions of these parties have not yet been identified. Positions indicate the place of the organisation relative to others in the network. This research concerns the Municipality of Enschede. The goal of the research is to enhance understanding of the positions of different actors, primarily self-governance and recovery centres, in relation to other actors in the Municipality of Enschede. The aim is to provide insight into the actors and collaborations between parties, and their roles and positions. Position considers the actors, collaborations, responsibilities, and roles in relation to others in the network, this is further explained in the theoretical framework. Additionally, the research will provide insight into the finances of the IZA mission, as well as the perspectives of different actors. This research was done in cooperation with the Municipality of Enschede and Ixta Noa. Ixta Noa is a self-governance and recovery centre in the Municipality of Enschede, thus serving as an example of a low-threshold support centre. This leads to the following research question:

'What position do self-governance and recovery centres have in implementing the IZA mission, to set up a national network of low-threshold support centres, in the relation between the mental health sector and the social domain of the Municipality of Enschede?'

Four sub research questions are formulated to answer the research question. These sub research questions are based on the operationalisation of the terms position and IZA mission.

1. What actors and collaborations are involved or valuable in the Municipality of Enschede concerning the IZA mission?
2. What roles and responsibilities belong to different actors in Enschede with executing the IZA mission?
3. What is the financial structure of the IZA and how does it influence the realisation of the IZA mission?
4. How do different actors view the IZA mission and ancillary positions?

1.2. Scientific relevance

This research offers a new perspective on the position of various actors in the healthcare landscape. It addresses the imperative transition from specialized mental healthcare to the broader social domain, yet the implications of this shift within the healthcare context remain poorly understood. Therefore, this study contributes to the understanding of healthcare policy and practice within the IZA by examining the shifts and challenges associated with the transition from the ggz to the social domain. Furthermore, this study contributes to our understanding of the emerging role played by self-governance and recovery centres within this domain.

While collaborations between the ggz and the social domain are not uncommon, this research sheds new light on the process through which individuals with mental vulnerabilities and illnesses transition from ggz treatment to the initial aid provided within the social domain. Additionally, this study explores organisation theory relevant to these dynamics. By exploring organisational theories in the context of this transition, this research contributes to the theoretical development of understanding change in healthcare and the role of various actors in the process.

1.3. Practical relevance

This research holds practical significance as it contributes to the establishment of the IZA mission of the network of low-threshold support centres. It provides valuable insights into the challenges associated with the IZA mission and the transition from the ggz to the social domain. Individuals with mental vulnerability or illness are central to the IZA mission, which aims to reduce pressure on the ggz by offering solutions within the social domain.

The IZA mission states that there should be a national covered network of low-threshold support centres within 5 years, requiring collaboration and clear specification of collaborations, roles, and responsibilities among various actors. The findings of this research are essential in developing and implementing the IZA mission, offering a comprehensive understanding of the actors involved in the current healthcare context. This includes insights into the IZA and finances of the IZA. Furthermore, this research uncovers the perspectives, barriers and incentives experienced by different stakeholders. Notably, this research enhances understanding to the position of self-governance and recovery centres, facilitating the exploration of innovative approaches in the transition from the ggz to the social domain and in establishing a network of low-threshold support centres.

Through this research, the Municipality of Enschede and Ixta Noa, among other actors, are more informed about this IZA mission. Ixta Noa and the Municipality of Enschede are better informed, which can lead to more active participation in the IZA mission. This leads to more active participation in establishing the low-threshold support centres.

1.4. Context

The following section provides context on the social domain, ggz, transformation from the ggz to the social domain and low-threshold support centres.

1.4.1. Social domain in the Municipality of Enschede

Since 2015 the social domain consists of three laws. These laws are the 'participatiewet', 'Jeugdwet' and 'Wet maatschappelijke ondersteuning' [4]. The Municipality of Enschede decided for an integrated approach. Central terms in the Municipality of Enschede are own strength, self-advocacy, and consideration of the involvement of people. Self-reliance and self-advocacy are promoted. Consideration of involvement of people balances legitimacy and self-governance of residents. The Municipality of Enschede operates from the perspective and environment of the residents [4].

1.4.2. Ggz

Ggz is care provided for psychological health problems or vulnerabilities [5]. The ggz includes a variety of care services, these are basic ggz, specialised ggz and highly specialised ggz [5,6]. Basic ggz serves as first-line healthcare, offering care for mild to moderate psychological problems [5]. It is designed to be easily accessible. Specialised ggz organisations can provide guidance to first line ggz workers [6]. When basic ggz proves inadequate and more specialised treatment is needed, individuals may be referred to second-line ggz, this is specialised ggz. Specialised ggz is typically provided by mental healthcare institutions [5,6]. In Enschede, Mediant is the primary ggz provider [7][8]. Additionally, general practitioners, GPs, can address mild mental health complaints. GPs collaborate with a practitioner assistant ggz (POH-GGZ). The GP is accountable for aid from the POH-GGZ [5]. GPs can refer patients to basic or specialised ggz.

According to various sources, the ggz confronts significant challenges that require change [9,10]. Reports highlight pressure on the ggz [9,11]. In the Netherlands, 48% of adults aged between 18 and 75 experience a mental health condition at least once in their lifetime [12,13]. In 2022, 1.2 million adults received healthcare from ggz providers [14].

Staff shortages pose a significant challenge for the ggz sector [11]. According to CBS, job vacancies are increasing [15]. In 2022, there were 67 job vacancies per 1000 positions. While 9,270 new employees entered the sector in the third quarter of 2022, 10,980 people left. This leads to a decrease of 1,710 workers in the third quarter of 2022. The sectors workforce consists of 103,000 employees in the same period [15].

All residents of the Netherlands are entitled to prompt, adequate and timely care. However, waiting lists currently exist [11]. 'Treeknorms', or waiting time standards, have been established. These standards define the maximum acceptable waiting times [16]. Treeknorms specify a maximum waiting period of 4 weeks for application processing and 10 weeks for treatment initiation, totalling 14 weeks. These standards apply to both basic ggz and specialised ggz [16]. Waiting time can be measured by the actual number of people awaiting care, encompassing both application and treatment times [16]. In May 2022, 80,000 individuals were waiting for ggz, with 41,000 exceeding Treeknorms [11,16]. Among individuals waiting for treatment 30% exceeded the Treeknorms, compared to 64% awaiting application processing [16]. In region Twente, nearly 2,000 people were waiting for ggz application, with just over half receiving care within Treeknorms. Approximately 20% of individuals waiting for treatment experienced delays beyond Treeknorms [16].

Another challenge within the ggz is the discrepancy between the care provided and the care needed. The Trimbos-Instituut has identified a gap between healthcare needs and provided care [17]. According to this study, there is a 38% mismatch in mental healthcare needs and the care being provided [17]. Of the participants surveyed by the Trimbos-instituut, 11% expressed a desire for care but are not receiving care. Additionally, 21% are receiving care from healthcare workers different than desired. Moreover, 6% of these participants are receiving care despite not wanting it [17].

1.4.3. Transformation ggz to social domain

There is a broad agreement that change in the mental health sector is needed in the preliminary field of the ggz [11]. Various studies are conducted on the movement from the ggz to the social domain. In this section different perspectives and studies are discussed.

Smit and Van Os suggest that tackling rising mental vulnerabilities, strongly linked to the socio-economic status, requires a collaborative public mental healthcare approach involving the ggz and the social domain [10]. Van Dorp et al. emphasise the urgency of initiating a public dialogue and taking joint action in the ggz and the social domain. The objective of this urgent initiative involves fostering collaboration with an integrated approach aimed at promoting an inclusive society that embraces individuals with mental vulnerabilities [9]. Interaction with the client's network and lifeworld is crucial in this transition [9].

In addition, according to research by Boumans, Kroon and Van der Hoek, there is a widely shared realization that psychological problems cannot be addressed only in an individual and medicalizing framework [11]. Submerging thoughts suggest that promoting mental health and exploring alternative approaches, beyond the official ggz, is necessary. Solutions outside the ggz should be considered, there may be other suitable solutions which can increase the chances of a successful recovery [11].

The transformation from the ggz to the social domain is characterised by several factors, including positive health, the social model, the integral method (which means including the social determinants), cross domain collaboration, utilise context (network) of the client and prevention (mental health promotion)[11].

Boumans, Kroon and, Van der Hoek have performed interviews, and from these interviews six 'building blocks' were established [11]. The building blocks of the transformation from the ggz to the social domain include:

1. Promotion of mental health during the entire lifetime
2. Low-threshold support for early problems, without labels
3. Integral viewing and collaboration in first-line care
4. Integral viewing and collaboration when people enter the ggz system
5. Not only being helped but helping yourself and others (self-governance)
6. Integrated care and support for people with a severe mental illness [11]

It is emphasised that these building blocks are needed to support the movement from the ggz to the social domain. Social infrastructure needs to be enhanced where one's network is an important part of the building blocks. Collaboration between the fields should be approached with realism. In addition, it is stated that finances allow and facilitate working according to the building blocks [11].

Furthermore, Van Os describes that in general there are two ways of seeing mental health. These are the bio-medical view and the public health view [18]. The biomedical view focusses on illness and

diagnostic labels, genetic liability, pharmacological interventions, and biological determinants. In the biomedical view, mental illness is seen as a brain disease. The public health view considers the natural perspectives such as social determinants, graded pathways between illness and health, self-determination and empowerment, resilience positive mental health and prevention [18]. Currently, mental health is predominantly approached from the medical perspective, with potential enhancement for cross domain collaboration.

Additionally, Philippe Delespaul advocates for care that creates more value by shifting from the WHO definition of health to the positive health definition [19]. Delespaul advocates for a system from vulnerability to resilience with recovery. He states that prevention, in the form of determining mentally vulnerable individuals beforehand, does not work. This puts emphasis on abnormality, which could even enhance mental vulnerability [19]. Delespaul states that targeted prevention is different than prevention focused on accessible facilities where resilience can be strengthened and is available for all. The focus is on resilience instead of vulnerability. According to Delespaul, the focus in the IZA is a shift from illness to health. Positive health is used and Delespaul summarizes this in three domains. Delespaul considers that good care occurs in all three domains.

- Symptomatic domain (physical functions and mental well-being)
- Societal domain (daily functioning and participation)
- Personal domain (quality of life and meaning) [19].

Damiaan Denys states that the ggz should work from the explicit view of human beings. In addition, it is stated that a selection needs to be made. It is not necessary for all mental suffering to be treated within the ggz [20]. Some of the aid could already be provided in the social domain.

Several researchers argue that the future of mental healthcare depends on the transformation from the ggz to the social domain. In the social domain, the resident's lifeworld and network is considered. Lifeworld is the world of citizens with their diversity of views and values [21]. According to the theory of Habermas (1984), the lifeworld needs systems to give structure and meaning. Economics, language, and law are these types of systems [22].

Moreover, there are several initiatives that stand for change in the mental health sector. 'De nieuwe ggz' indicates that current mental healthcare is mainly focused on symptom reduction according to evidence-based guidelines. This offers insufficient aid related to the lifeworld of clients or residents [23]. 'De nieuwe ggz' has developed GEM (Ecosysteem Mentale Gezondheid, Ecosystem mental health) and is an example of an initiative for change in the ggz [24]. Since 2020, GEM is concerned with providing, organising, and financing the vision of 'De nieuwe ggz'. GEM indicated that care does not improve by optimising the match between health demand and mental healthcare services but by formulating an answer to a client's question in collaboration with different parties. The answer needs to be drawn from a wider range of possible interventions and solutions than the healthcare services in the ggz. This implies making more use of other interventions that can be meaningful and relevant. GEM includes expertise by experience, welfare facilities and providers from the social domain [24]. GEM states that the mental healthcare needs to be redesigned concerning supply, organisation, and financing of care [24].

Different elements from these studies align into the general movement. The care provided should be preliminary, prior to consuming care in the ggz for more severe problems. Client's lifeworld are taken into consideration, and it is preferable to provide aid within a clients context. In addition, the social

model is addressed. In the social model, mental vulnerability or problems are seen as a societal problem where social factor should be considered. Thus, health and illness are understood in accordance with the concept of positive health. The preventive factor of the new movement signifies that care does not have to be provided by formal healthcare workers. Not all distress or mental problems need to immediately be solved in the ggz as symptom control, there is much value in prevention. Preventive measures involve a network that offers residents low-threshold assistance before issues escalate to the point of requiring ggz. In addition, attention is devoted to developing new practices of integral, cross-domain health and support focused on solving challenges [25,26].

1.4.4. Low-threshold support centres

Low-threshold support centres are physical places where every resident, especially people with severe psychiatric disorder can access. These places are run by volunteers, experts by experience, supported by social workers and in connection with mental health professionals [2]. 10 criteria are established to determine whether a facility is a low-threshold support centre. These criteria can be found in Appendix A. Self-governance and recovery centres are an example of low-threshold support centres.

Self-governance and recovery centres, operate differently from the ggz, reflecting a distinction between formal and informal care [27,28]. Formal care is provided by professionals. These professionals have studied to be able to provide care and get paid to provide care. In the Netherlands formal caregivers need to comply with certain obligations. A formal caregiver must be registered with accessible codes in the professional register, for some professions this is a legal obligation, for others this is voluntary [28]. These codes are utilised to determine the formal care rate [27]. For the registration of these codes, the professionals are required to maintain their profession [28].

Informal care is provided by family or friend caretakers, experts by experience, or volunteers. This care is unpaid, or compensation is provided [27,28]. The perspective of the lifeworld is the main principle and is seen as benefit of informal caregivers [28]. The expertise of experts of experience can be valuable because these experts know what it is like to live with certain psychological vulnerabilities or situations [29]. Volunteers are often part of the direct social environment of the participant or client [28]. In addition, volunteers encounter less requirements or demands of an organisation. However, informal caregivers must also have knowledge of the system world to be able to navigate participants or clients [28]. Therefore, experts by experience have also undergone education or training.

Experts by experience serve as informal client counsellors, in which three levels can be distinguished [28]:

1. People with experiences.
2. People with experience knowledge. These people have experience combined with sharing experiences and a knowledge developed based on analysis, self-perception, and other sources.
3. Experts by experience. People who developed skills through a training or education for utilisation of their expertise from experience.

Formal and informal care givers or client supporters can collaborate in different means for the purpose of the client. An example is transferring case work of patients between supporters and healthcare workers [28,29].

Ixta Noa is a self-governance and recovery centre, thus an example of a low-threshold support centre. The organisation supports people to use their own strengths and capabilities, supervised by experts by experience. A social support structure is offered as well as a social practice environment [30,31]. Ixta Noa has multiple locations in the Netherlands. Every location has a 'Praktijkhuis', which is a walk-in facility which every inhabitant can utilise[31]. Four locations of Ixta Noa offer 'Respijt' facilities [30]. In Respijt facilities people can stay for a maximum of two weeks to find rest and have a safe space to work on their goals and self-governance. A diagnosis is not required for admission to the Respijt facility [31]. Ixta Noa has a Praktijkhuis and Respijt facility in the Municipality of Enschede. Ixta Noa is developing new opportunities to guide people towards recovery. Examples of opportunities are initiatives as Ixta Sterk, Werk & Studie and other trainings [31].

The Nederlandse Vereniging voor Zelfregie en Herstel (NVZH), established in 2021, is an association for organisations that work with self-governance, recovery, and experts by experience [31]. Ixta Noa is part of the NVZH. The association is established together with 12 peer organisations[32]. Organisations or initiatives wishing to join the NVZH must demonstrate characteristics of self-governance and recovery centres [32].

The NVZH believes mental health is more than fitting and timely mental healthcare in contrast to ggz [33]. The organisation wants to normalize mental healthcare. Therefore, the NVZH established 9 values of mental health, consisting of: network, meaningful roles and activities, seeing yourself as more than sick or vulnerable, eating 3 times a day, catch your breath, timely and appropriate care, a little content at night on the couch, feeling home in your house and a safety net. These are factors, according to NVZH, that have an influence on mental health [33]. NVZH believes that if there is a focus on these 9 values, there is less of a need for the ggz [33].

Moreover, the NVZH not only emphasises the importance of self-governance and recovery initiatives, but also advocates for the transition from medicalisation to normalisation, from curation to prevention, from care to self-governance, from individual to collective and from cure to recovery [32]. Additionally, the NVZH states that collaboration with various organisations is required in realising the network of low-threshold support centres. These organisations are MIND, VNG, Sociaal Werk Nederland, De Nederlandse GGZ and the Ministerie van Volksgezondheid, Welzijn en Sport (VWS) [33]. Additionally, the NVZH is part of the 'Werkgroep laagdrempelige steunpunten; IZA-thematafel Samenwerking sociaal domein, huisartsen en ggz' [34].

2. Theoretical framework

The theoretical framework discusses concepts that are relevant to the research question and the theories examined in this study. An understanding on organisation theory is provided, followed by the operationalisation of the concepts position and IZA. The theoretical framework guides the methods and interview scheme of the research.

2.1. Organisation theory

The IZA proposes a change in the healthcare landscape. The IZA mission concerns an assignment to establish the network of low-threshold support centres within 5 years, thus reflecting a top-down approach [35]. Changes in a healthcare context can lead to specific structural responses. Organisation theory is used to provide guidance in this research. Organisation theory can be applied within an organisation but is used between organisations in this context. The organisation theory can be adapted to accommodate the change among different organisations due to collaboration, as well with changes within organisations. The model for managing organisational change provided in Figure 1, as well as 'the major steps in a change programme' provided in Figure 2 is utilised.

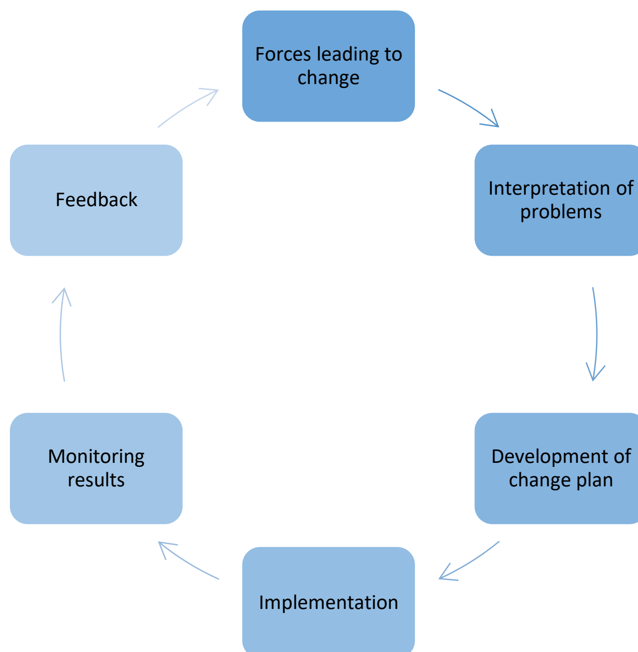

Figure 1: Major steps in a change programme

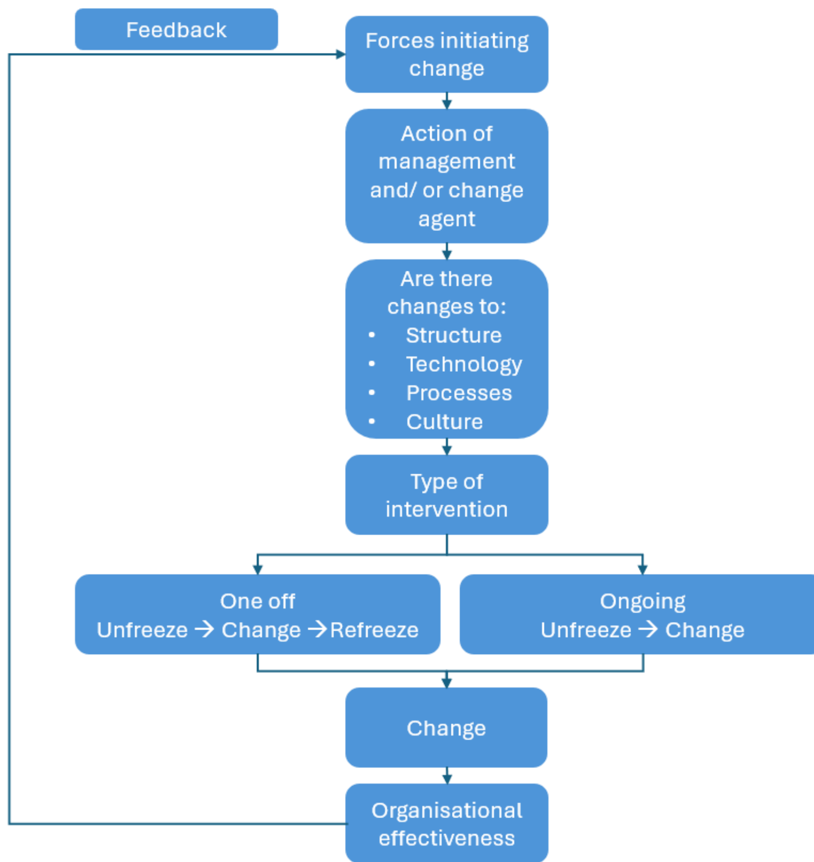

Figure 2: Model managing organisational change

The IZA mission entails planned change and results in a combination of revolutionary and evolutionary change. Exploring a new equilibrium is necessary. The mental healthcare environment needs to adapt to the change. However, different parts within organisations need change, which is a characteristic of evolutionary change. While the transformation utilises existing initiatives, the network of low-threshold support centres should be expanded for comprehensive coverage [35,36].

The IZA mission entails an iterative process where the plan is (mainly) constructed during the mission. As planned change is involved, a model can be utilised for managing organisation change as well as the outlining of the major steps in the change programme. Both models address 'forces initiating change'. In this case, the direct force initiating change is the IZA mission, which mandates the participation of concerned stakeholders. The indirect forces initiating change are the challenges experienced in the ggz, such as waiting lists and staff shortages.

Furthermore, the action of management or the change agent differs per Themalijn and IZA mission. The IZA is published by different parties including De Nederlandse ggz, VNG, Zorgverzerkeraars Nederland and the VWS. The specific change agents are unidentified for the specific IZA mission of realising a network of low-threshold support centres. However, various parties are involved in the IZA mission.

Currently, the IZA is still in the initial stages of both models. The change is initiated, but there is lack of clarity regarding the interpretation of problems and change plan. To fulfil the IZA mission and meet its requirements, all steps outlined in the models are necessary. Moreover, Figure 1 suggests that the

change plan is influenced by the interpretation of problems. The interpretation of problems is crucial for the development and implementation of a successful change plan. Figure 2 states possible changes to structure, technology, processes, and culture.

In this research the following steps of the models are explored:

- Interpretation of problems
- Action of management and/-or change agent
- Development of change plan
- Presence of changes to structure, technology, processes, culture

These steps provide context for the current mental healthcare context, including actors, roles, and responsibilities. The perspectives of the actors can be assessed concerning IZA. This should provide an indication for action of management or change agent and provide insight concerning the development of a change plan. Structure, technology, processes and culture need to be considered for the change plan. Technology indicates the IZA mission. Structure considers actors, collaborations, roles, and responsibilities. Processes consist of organisation and financial processes. Culture is important for the implementation of the change plan.

The desired results are well-known. The results of this IZA mission, and thus planned organisational change, should be a national covered network of low-threshold support centres by 2027. In conclusion, this research provides insight into managing the change. The research focuses on the interpretation of the problems to provide information on the development of the change plan.

2.2. Operationalisation

The research question examines the position of self-governance and recovery centres in relation to the IZA mission. The concepts 'position' and 'IZA' are operationalized, shown in Table 1. Position refers to the location of an organisation or type of organisation, relative to others in the network. Position considers the actors, collaborations, responsibilities, and roles in relation to others in the network. The concept IZA is operationalised in terms of the actors' perspectives and finances. These variables are further operationalised into indicators. These indicators are important in determining the answer on the research question.

Table 1: Operationalisation concepts

Concept	Variables	Indicator
Position	Actors	Actors concerned by IZA mission
	Collaborations	Collaborations between actors concerned by IZA mission
		What is the placement between different actors in the healthcare context
	Responsibilities	The responsibilities belonging to the actors related to the IZA mission
	Roles	Roles allocated to actor concerning the IZA mission
		Tasks or functions of the organisation concerning the IZA mission
IZA	Finances	Finance flows concerning the IZA mission
	Actor's view	Barriers experienced in realizing the IZA mission
		Misconceptions in realizing the IZA mission
		Incentives experienced in realizing the IZA mission

2.3. Conclusion theoretical framework

The theoretical framework entails organisation theory. This research offers an interpretation of the context and problems experienced to form a base for the start of the development plan, providing insight into the IZA mission and the position of self-governance and recovery centres. The models from Figure 1 and Figure 2, together with the operationalisation, can be integrated into the conceptual model. This study focuses on the interpretation of problems and the development of the change plan, highlighted in blue in Figure 3. Variables of the concepts are utilised to enhance understanding and, consequently, to interpret problems and develop the change plan. The variables of position include actors, collaborations, responsibilities, and roles. The variables of the IZA mission encompass finances and actor’s perspective.

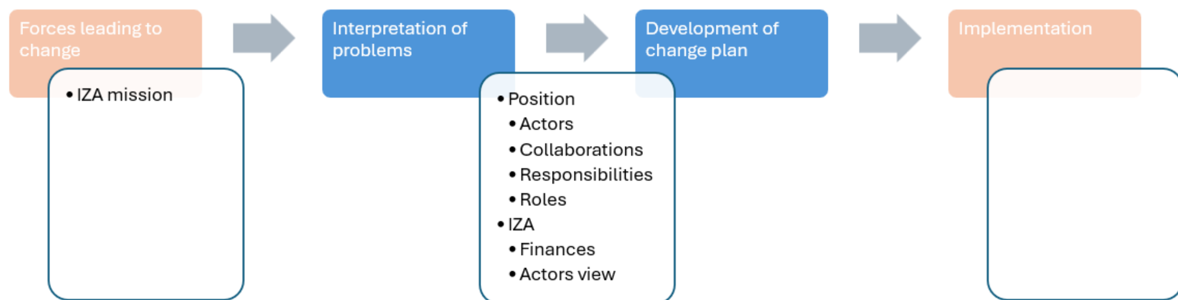

Figure 3: Conceptual model

3. Methodology

In the methodology section, the research design, data collection, research population, conduct of research, data analysis, ethical considerations, and validity and reliability are discussed.

3.1. Research design

To answer the research question, explorative research is conducted, because a new aspect is studied. To investigate the position of self-governance and recovery centres in implementing the IZA mission qualitative data needs to be researched. Desk research is done to create the theoretical framework. The snowball method was used to find sufficient literature to create the theoretical framework. The current context and available documents and studies are used to create a semi-structured interview scheme. The aim is to gain new understandings as the data is analysed in a qualitative manner. Interviews are conducted to gather the data. The interviews provide information on the view of organisations about self-governance and recovery centres and what their position is in implementing the IZA mission, relating to the national covered network of low threshold support centres. In addition, the interviews provide insight into the interpretation of problems and development of a change plan for organisations involved in the IZA mission.

Additionally, literature research is conducted for documents on the topic published during the research and when new or changing information is provided. Due to the constant changes of the IZA mission, new documents are assessed to fully emphasise the IZA mission. The analysis of the literature ensures facts and new developments were studied.

3.2. Data collection

Data is collected by interviewing twenty respondents from different organisations. The interviews are semi-structured, the topics are the leading principles. The interview scheme can be found in 'Appendix B: Interview scheme'. The length of the interviews was between 45 and 75 minutes, depending on the respondent. The colloquial language is Dutch.

Respondents are management level, additionally experts by experience were interviewed. Because of the differences of respondents, and the differences between organisations the interviews were different, but similar in nature. The different interviews with different respondents provide a holistic view on the current context, the actors, collaborations, roles, positions, and finances of the IZA mission, and in addition its barriers and incentives of the IZA mission.

It was indicated in the interviews that the IZA mission focused on is the IZA mission of a national covered network of low-threshold support centres, not to be confused with the IZA mission of mental healthcare centres. In addition, when there was uncertainty of self-governance and recovery centres, the researcher made sure to explain what these organisations are and stand for.

The literature assessed in this research was published in 2023 or 2024. Relevant literature was identified through comprehensive searches on newly published articles concerning the IZA mission. The selection of the literature was assessed by the researcher and predefined by inclusion criteria. These criteria are official documents concerning the IZA mission, relevant to the IZA mission of low-threshold support centres.

3.3. Research population

The research population must meet the following inclusion criteria. The research population exist of people that work in organisations that are involved or are affected by the IZA mission. The research population is familiar with the IZA mission and familiar with self-governance and recovery centres. The research population works in region Twente and are aged 18 and above.

Respondents are recruited through the supervisors of this research from both the Municipality of Enschede and Ixta Noa. The respondents are part of the network of the Municipality and Ixta Noa and have an influence or are impacted by IZA. The need to interview the VNG and Twentse Koers became apparent after multiple interviews and were contacted subsequently.

Nineteen interviews are conducted, which cover twenty respondents because the interview with organisation Menzis involved two respondents. An overview of the respondents is provided in Table 2.

Table 2: Respondents

Respondent	Datum	Organisation	Function	Online/ Offline
R1	11-12-2023	Mediant	Project manager	Online
R2	12-12-2023	-	Expert by experience	Offline
R3	13-12-2023	Intact	Family expert by experience	Online
R4	13-12-2023	Wijkteams	Programme manager	Offline
R5	18-12-2023	Dimence	Expert by experience policy officer	Online
R6	19-12-2023	NVZH	Board member	Online
R7	19-12-2023	Intact	Expert by experience	Online
R8	8-01-2023	Mediant	Transformation manager	Online
R9, R10	9-01-2023	Menzis	Zorginkoper, regional manager	Offline
R11	10-01-2023	Mens door Mens	Expert by experience and	Offline
R12	10-01-2023	Intact	Expert by experience and	Online
R13	11-01-2023	Thoon	POH-GGZ	Online
R14	11-01-2023	-	Kaderhuisarts ggz	Online
R15	11-01-2023	Ixta Noa	Expert by experience	Online
R16	24-01-2023	Twentse Koers	Topic manager mental healthcare	Offline

R17	26-01-2023	Gemeente Enschede	Policy advisor public health	Offline
R18	26-01-2023	Ixta Noa	Expert by experience and project coordinator	Offline
R19	29-01-2023	VNG	Policy advisor	Online
R20	31-02-2023	Gemeente Enschede	Accounthouder Twentse Koers	Online

3.4. Conduct of research

Prior to the interview, the participant was informed on the execution and analysis of the interview and are familiar with the aim and activities of the research. Respondents are informed of anonymisation. The name of the organisation is not anonymised, but the name of the respondent is not reported in the research. The participant is aware on their right to withdraw at any given moment during the interview.

An audio recording is made of the interview. The participants will give oral consent on the recorder. The audio recording is stored in a folder that only the researcher can access. The recordings and transcripts are destroyed when the research is completed with a maximum date on 30-06-2024. The participants must invest time for the interview. The interview lasted 45 minutes with a maximum of 75 minutes to reduce the burden of time investment. The interviews are held on location with 7 respondents and online with 12 respondents. The interviews were conducted starting on 11th of December 2023 and finished on 31st of January 2024.

3.5. Data analysis

The qualitative analysis is an iterative process. After conducting the interviews, the interviews are transcribed. The software 'Amberscript' is used. The interviews are coded with the software 'Atlas.ti'. Coding is done deductively and inductively. Inductive coding entailed open coding, then axial coding and then selective coding. Codes that are related or associated together are given an umbrella label. One code can belong to multiple umbrella labels. 'Atlas.ti' is used to place the codes in code groups. The codes and code groups are analysed. Two main code groups, 6 code groups and 55 codes were used. The main code groups are: 'IZA' and 'Position'. Within these main code groups differentiation was made between 6 code groups: 'Finances' and 'Actors view' for main code group 'IZA'. Code group 'Position' is differentiated by 'Actors', 'Collaborations', 'Roles' and 'Responsibilities'. Using these categories correlations were made that are in connection with the theoretical framework. The relations between codes and code groups are provided in a code tree shown in Appendix C.

3.6. Ethical considerations

The ethical committee of HSS of University of Twente approved the ethical considerations of this study before conducting this research, request number 230605. The respondents consented to participation of this research with verbal consent which is provided on the audio recording of the interview. The respondents have been informed about the conduct of the interview and the analysis. Assurance is given that respondents can withdraw from the interview at any time and that the individual interviewed remains anonymous, but the organisation is named. In addition, the transcripts were sent to the respective respondent. The respondent was given the opportunity to comment on their transcript.

3.7. Validity and reliability

A semi-structured interview has certain downsides. The validity can decrease because responses can be hard to compare. A researcher bias can possibly appear when a researcher is too subjective. The subjectiveness influences the outcomes of the semi-structured interview. To decrease the impact of certain biases, the interviews are structured according to interview topics. The researcher follows the topics and is as objective as possible. To maintain reliability the interviews are held as consistent and accurate as possible. The interview process of all interviews was similar. Moreover, to avoid selection bias, additional respondents were interviewed after these seemed of importance for the study and the IZA according to previous respondents. More respondents were interviewed than initially planned.

4. Results

In the results section, the findings of the research are examined per sub question. The findings reflect analysis and interpretation of collected data, collected through interviews and literature research. The sub questions provide a framework for answering the research question; hence conclusions of the sub questions are provided. This entails:

1. What actors and collaborations are involved in or valuable for Municipality of Enschede concerning the IZA mission?
2. What roles and responsibilities belong to different actors in Enschede with executing the IZA mission?
3. What is the financial structure of the IZA and how does it influence the realisation of the IZA mission?
4. How do different actors view the IZA mission and ancillary positions?

The results are supported by quotes of the respondents. The interviews were performed in Dutch; hence the quotes are translated to English. However, in Appendix D, the translation of the quotes can be found.

4.1. What actors and collaborations are involved in or valuable for Municipality of Enschede concerning the IZA mission?

In this section of the results, the actors and collaborations are discussed. For a successful transformation, leading to a network of low-threshold support centres, involved actors are crucial to consider. Six actors have an important role in realising the IZA mission of establishing a network of low-threshold support centres. However, multiple actors are influenced by this IZA mission. The most significant actors for the IZA mission in the Municipality of Enschede are Twentse Koers, the Municipality of Enschede, Menzis, low-threshold support centres, GPs and Mediant.

The Municipality of Enschede is an important stakeholder and this actor is organizer for the key element of a 'regional and national network of low-threshold support centres' [3]. The role of organizer entails establishing or developing a network or organisational form. The Municipality of Enschede is responsible for ensuring implementation of the IZA mission and accommodating at regional or local level [3].

In the region Twente, Twentse Koers has the coordinating role. Twentse Koers is an organisation where the 14 municipalities, including the Municipality of Enschede, province Overijssel, Menzis and GGD Twente participate. The municipalities have an equal vote. Twentse Koers has the responsibility of the Regioplan and is responsible for the SPUK funding of the IZA.

Menzis is the main health insurance organisation in the region of Twente. The IZA describes that the main health insurer per region is responsible for the transformation funds. VGZ is the active participating health insurer. In collaboration these stakeholders are responsible for the assessment of the transformation plans [37].

Low-threshold support centres are crucial in the IZA mission. These are low-threshold facilities accessible to all residents. Self-governance and recovery centres, such as Ixta Noa, are an example of low-threshold support centres.

The IZA assignment of low-threshold support centres is focused on these centres in the preliminary field. The ggz is not necessarily involved with realising the IZA mission. However, the transformation from the ggz to the social domain has an influence on the ggz actors. In addition, due to confusion between IZA missions, Mediant has started with the IZA mission in collaboration with Ixta Noa. Mediant is the main ggz organisation of 8 municipalities in region Twente. Mediant offers help, advice, and guidance for people with psychological and psychiatric problems [38]. Mediant offers crisis accommodation in ggz, but also offers activities in the social domain such as the walk-in facilities. Dimence is the main ggz organisation of 6 municipalities in region Twente.

The GP is often the initial place where people with psychological problems come [39]. The GP is crucial for recognition, diagnosis, treatment, and guidance of people with these problems. The POH-GGZ supports the GP and offers clarification on the question, diagnostics, short-term treatment, or support (can be longer term) and guidance with these people coming to the GP. These individuals can have psychological problems/ complaints or a psychological disorder which can be mild or stable. The general idea is that the individuals can self-govern. The POH-GGZ can be a social worker, (basic) psychologist, or a social psychiatric nurse [39].

Other stakeholders that are concerned with the IZA mission are the VNG, NVZH, Wijkteams, and other self-governance and recovery centres in region Twente such as, Intact, Bureau Herstel and Mens door Mens.

Wijkteams (community teams) provide help for residents of Enschede to be able to function better or more independently in the daily life of these residents [40]. Wijkteams have the role of first-line organisations where residents can get in contact through the wijkwijzer without any referral and there are no costs for the residents. A wijkwijzer helps navigating the healthcare landscape [41].

Furthermore, the VNG is the association for the Dutch municipalities [3]. For the IZA mission of a 'regional and national network of low-threshold support centres' the VNG has the role supporting the regions with setting up the network. The roadmap of VNG implies other stakeholders, involved in this IZA mission such as the ggz, GPs and the social domain, are jointly responsible for establishing the network [3].

The NVZH is an association for self-governance and recovery centres, hence the involvement on this IZA mission. Intact is a recovery and self-help suborganisation of Tactus. Tactus is the main provider of healthcare for addiction and offers help and advice to different groups [42]. Bureau Herstel, part of Mediant, is a self-governance and recovery centre, mainly used when an individual already had treatment at Mediant. Hence, it currently functions more as follow-up and aftercare. MensdoorMens is an independent self-governance and recovery centre located in Almelo.

Additionally, the 'Werkgroep laagdrempelige steunpunten; IZA -thematafel Samenwerking sociaal domein, huisartsen en ggz' is working on the IZA mission of establishing low-threshold support centres. This Werkgroep has published documents to guide in establishing the IZA mission. The Werkgroep consist of 7 organisations. These organisations are VNG, Sociaal Werk Nederland, Mind, VWS, Nederlandse ggz, NVZH and Valente. Mind is currently not part of the Werkgroep because Mind wants to compete in the European tender. The Patiëntenfederatie replaces Mind temporarily. The VNG is in the lead of the Werkgroep.

In conclusion, the actors and collaborations of the mental healthcare landscape can be concluded in Figure 4. In the circle of this figure the relation between the ggz, GP, social domain and lifeworld is portraited. The main actors involved in the IZA mission are the low-threshold support centres that fulfil the role of the low-threshold support centres. These centres can be found between the social domain and lifeworld. Self-governance and recovery centres are an example of low-threshold support centres. The GPs and POH-GGZs have a linking factor in this collaboration between the ggz and the social domain. In the circle the healthcare landscape is provided. Additionally, actors involved in the IZA mission are shown. The Municipality of Enschede, Twentse Koers and Menzis are not part of the healthcare landscape but are crucial in the organisation of the IZA.

Twentse Koers is a relevant actor, because of the responsibility of funding this particular IZA mission. The municipalities and Twentse Koers have a collaboration in realising the network of low-threshold support centres. In this collaboration, Twentse Koers has the coordinating role at the regional level, while the municipalities are responsible to its substance on local level. Menzis is not specifically connected to this IZA mission, but the organisation assesses the transformation plans. Mediant has started with this IZA assignment in collaboration with Ixta Noa because hours are allocated to Mediant to work on the IZA mission, and it also benefits Mediant.

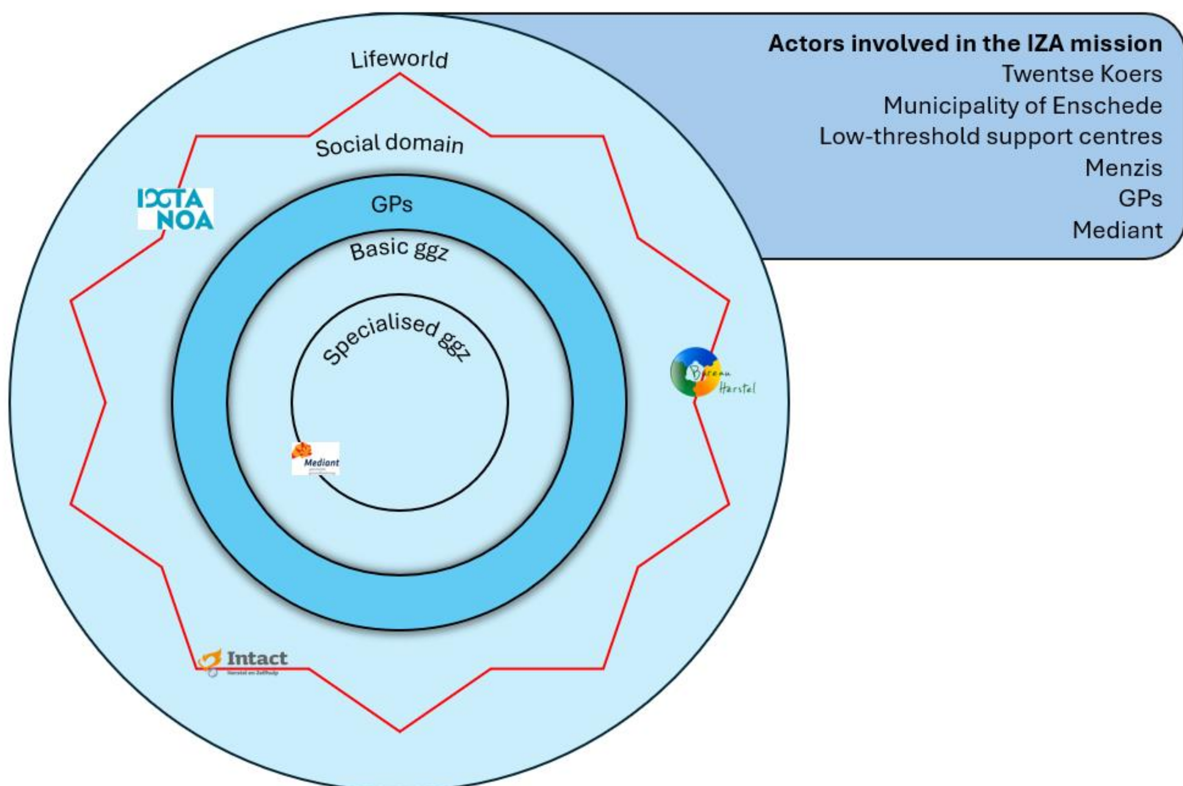

Figure 4: Mental healthcare landscape with actors relevant to the IZA mission

4.2. What roles and responsibilities belong to different actors in Enschede with executing the IZA mission?

In this chapter, an answer is provided to the following sub question: What roles and responsibilities belong to different actors in Enschede with executing the IZA mission. There are different roles, collaborative efforts, and responsibilities among the different actors in relation to the IZA assignment in Enschede. The six most important roles for this IZA mission are detailed. The actors, Menzis, Twentse Koers and the Municipality of Enschede, Mediant, Low-threshold support centres, GPs and POH-GGZ are discussed. Additionally, the Werkgroep is discussed. Finally, a general conclusion on roles and responsibilities is provided.

4.2.1. Menzis

Menzis is the main healthcare insurance organisation in Enschede and is responsible for the IZA transformation funds. Menzis is the coordinating insurer, while VGZ is the active participating insurance organisation concerning the IZA in region Twente. Menzis and VGZ collaborate to assess the transformation plans and determine eligibility for funding. Respondent 10 states that Menzis encourages actors to make plans.

The plans are submitted to the 'snelle toets', which is assessed by Menzis. The 'snelle toets' states if the initiative is likely to be applicable to the IZA mission and possibly can make a claim on IZA funding. Then, the involved actors can submit the transformation plan, Menzis reassesses the plan in further detail. If the plan has an effect for the Zorgverzekeringswet and meets requirements of the transformation funds, Menzis can allocate these to the healthcare party. Organisations must first invest in plans before funding becomes a possibility.

Menzis is part of the Twentse Koers and is involved, among others, to align and tune the regional plans. Menzis will monitor the regional plans.

4.2.2. Twentse Koers and the Municipality of Enschede

In region Twente, Twentse Koers plays the coordinating role instead of centrum municipalities. This implies that Twentse Koers holds the SPUK funding, consisting of SPUK IZA and SPUK transformation funds. Respondent 16 suggests that this role involves taking a holistic view of the matter and connecting different organisations, laying the foundation for the IZA mission.

One of Twentse Koers' assignments is the 'Ontwikkellijn Mentale gezondheid', which encompasses various IZA missions. The Twentse Koers is responsible for the Regiobeeld, followed by the Regioplan and corresponding general budget. Twentse Koers, along with Menzis, is responsible for the Regioplan which is developed by consultation agency Roset. A role of the municipalities is to implement plans from the Regioplan at local level. The municipalities decide what plans are realised.

Twentse Koers has the coordinating role in the social domain, the municipalities have the operational role at local level. Multiple respondents state the municipality has a big role concerning the low-threshold support centres, mainly with establishing the low-threshold support centres. Respondent 18 suggests that municipalities have a certain directive role.

Both respondent 11 and 19 appoint ownership of the municipalities and that municipalities must feel responsible for this IZA mission. With this responsibility comes a facilitating function. However, respondent 19 states that municipalities and Twentse Koers has ownership, although simultaneously

suggesting that these organisations do not. Certain ownership is with experts by experience of the low-threshold support centres.

R19: *The municipality has to facilitate and has ownership, but then again, it does not, because the owners are actually the experts by experience who lead and fill it in completely.*

The VNG signed the IZA mission and plays a role in advising municipalities, emphasizing the importance of municipal responsibility in the IZA mission. The respondent from VNG is not particularly stating Twentse Koers because this respondent states on national level. The Twente region is unique in having an entity like Twentse Koers.

Given that the VNG serves as the umbrella organisation for municipalities, respondent 19 emphasises the importance of VNG involvement. However, respondent 19 also states the role of VNG previously is not adequately fulfilled but it has now improved.

4.2.3. Mediant

Mediant is the primary ggz provider in 8 municipalities of the Twente region, including the Municipality of Enschede. In the remaining 6 municipalities, Dimence is the primary ggz provider. Therefore, Mediant leads certain IZA missions and certain IZA missions in collaboration with Dimence. Both Mediant and Dimence are seen as the hospital for ggz where specialistic ggz is provided.

Respondent 2 questions what should be expected from specialised ggz. According to various respondents, currently the ggz receives responsibility over patients that do not necessary require ggz. It is emphasised that the ggz should not draw all the patients towards itself and not allowing these patients to be supported in the social domain. Respondent 4 stressed that not all 'ggz' problems require an answer from the ggz.

Mediant is in the lead for the IZA mission for Mentale gezondheidscentra, this is a different IZA mission and must not be confused with the IZA of low-threshold support centres. As for the IZA mission concerning low-threshold support centres, the leading organisation and roles are unclear. Mediant is provided with hours for transformation managers. Hence, Mediant initiated its involvement in the IZA mission for low-threshold support centres.

Respondent 8 states that Mediant is an actor but not the actor, referring to self-governance and recovery organisation Ixta Noa. Thus, Mediant's involvement in the IZA mission of low-threshold support centres is in collaboration with Ixta Noa. Mediant indicates interest in taking a role in the IZA assignment of low-threshold support centres, partly due to mediant's a network of walk-in facilities. The role that mediant fulfils is the role of providing ggz expertise. Additionally, respondent 8 describes Mediant as 'supplier' of the target group for whom the low-threshold support centres would have value.

4.2.4. Low-threshold support centres

Self-governance and recovery centres play a role in the preliminary field. These centres are an example of low-threshold support centres where residents with a mental health vulnerability or complaint have access low threshold. In this preliminary field self-governance and recovery centres promote the values of mental health. According to respondent 18, low-threshold support centres should be integrated into the lifeworld. Respondent 16 indicates that self-governance and recovery centres are becoming more prominent.

Furthermore, low-threshold support centres play a role in the IZA mission. This role is providing expertise and knowledge to the content of the IZA mission. These centres and experts by experience consistently advocate the client perspective. Informing different actors and professionals is important for the success of establishing the network of low-threshold support centres. Respondents 8 and 16 mention the significant role that Ixta Noa, for example, should fulfil. This significant role entails a leading role in terms of content and knowledge. Respondent 8 appointed that when the task or role is too big for an organisation as Ixta Noa, then collaborations with other care organisations should be found. Agreeing on responsibilities and tasks is crucial. Respondent 18 from Ixta Noa mentions that Ixta Noa aims to contribute knowledge and experience in the social domain.

R18: *We just possess a lot of knowledge about what it's like to use care and use the social domain. I think it's also up to us to help in that too, therefore we also put in work and energy and time. Because we have that knowledge, but we also think it's important that things will be different.*

Ixta Noa is a member of the NVZH, among others. The NVZH mentions that it has both an inward and outward role. The outward role is representing the self-governance and recovery industry. To position this industry and increase its visibility, among other methods, is realised through the Werkgroep. The inward role is connecting self-governance and recovery centres. This provides opportunities for information exchange and collaboration, preventing organisations from reinventing the wheel. This leads to self-governance and recovery organisations leaving the pioneering stage. The NVZH is an actor that did not sign the IZA but has indicated its desire to play an equal and active role in the Werkgroep.

The Municipality of Enschede has 3 self-governance and recovery organisations. Ixta Noa, Bureau Herstel and Intact. At Intact, it is referred to as recovery and self-help. These 3 organisations occupy different places in the mental healthcare field. Respondent 18, from Ixta Noa, states that Ixta Noa, Bureau Herstel and Intact are different sort of places that are all needed. The organisations are (partly) focused on different target groups.

R18: *You need different TYPE of places, aimed at different audiences.*

Ixta Noa operates in a demand-oriented manner rather than supply-orientation. This implies that participators won't be sent away if the participator does not fall in the offer of support. No indication is needed for Ixta Noa. Ixta Noa differentiates participators in different stages, not in diagnosis. The first stage are participants who never had help before but are struggling. The second stage is familiar with diagnostics and might have had treatment before. This group deploys Ixta Noa in conjunction with other form of support. The third stage uses Ixta Noa as aftercare or reintegration place. This group participates on fixed days. Within the three stages all diagnostics and problems in all areas occur.

Intact is under the wings of Tactus. Tactus is addiction care, therefore Intact is more addiction focused. No referral is required for the use of Intact, and Intact does not have a physical location. Respondent 7 states that due to Tactus' lack of a psychical location, people often encounter Intact via Tactus. Therefore, Intact is less stage 1 oriented as mentioned by Ixta Noa, this shows that the position of Intact in the field is different than the position of Ixta Noa.

Bureau Herstel is positioned relatively in the end in the healthcare process and requires a referral. Respondent 2 stresses a main barrier for Bureau Herstel where a participator must be registered with Mediant to follow courses, otherwise the participator needs to pay. Bureau Herstel is mostly focused

on clients from Mediant and mainly funded through the Zorgverzekeringswet. According to respondent 18, the target group of Mediant is primarily the EPA group, which includes individuals with somewhat lower intellectual capacity compared to Ixta Noa.

4.2.5. GPs and POH-GGZ

General Practitioners have a role in referring patients to other organisations and actors within the ggz and social domain. Several respondents indicated that GPs do not sufficiently take up the role of referring to the social domain and mainly low-threshold support centres.

In addition, the POH-GGZ is responsible for informing residents and clients about the low-threshold support centres. The interviews reveal that the POH-GGZ often lacks the necessary knowledge to effectively fulfil this role. The POH-GGZ states to keep people in the GP office.

The GPs serve as the primary pathway to the ggz, but GPs refer far too often to the ggz, forgetting the social domain. Both GPs and POH-GGZs play a vital role in referring to and informing clients and residents, highlighting the key importance of this responsibility.

R4: *we now see that GPs are poor referrers, thinking far too often of ggz and using that far too heavily*.

4.2.6. Werkgroep

The 'Werkgroep laagdrempelige steunpunten; IZA -thematafel Samenwerking sociaal domein, huisartsen en ggz' is involved with the IZA mission of low-threshold support centres. According to respondent 6, the role of the Werkgroep is to ensure that all regions are equipped with knowledge, and the Werkgroep bears the responsibility for possessing all necessary knowledge. Initially, the members of the Werkgroep held different opinions on their roles, but now the members agree. Respondent 6 emphasises the importance of members of the Werkgoep feeling a sense of responsibility.

The Werkgroep is responsible for the process plan and published the handvattendocument for low-threshold support centres [43]. Among others, low-threshold support centres are defined in 10 criteria, these criteria can be found in Appendix A. Additionally, the Werkgroep will provide a support programme, meant to support for the design but also finances of the IZA e.g. The support programme will be subcontracted to an external party.

4.2.7. Concluding roles and responsibilities

In conclusion, the Municipality of Enschede assigns different roles and responsibilities to various actors. Six main actors are involved in this IZA mission in the Municipality of Enschede with corresponding roles and responsibilities. Menzis assesses the 'snelle toets' and subsequently reevaluates the plan. Additionally, Menzis is responsible for monitoring Regioplans and Menzis is part of the Twentse Koers.

The Twentse Koers has a coordinating role for region Twente and the organisation possesses the SPUK IZA and, in the future, the SPUK transformation funds. Twentse Koers is responsible for the Regiobeeld and Regioplan. The Municipality of Enschede is responsible for interpreting content at local level. In this regard, the Municipality of Enschede has a role in developing the network of low-threshold support centres. It is important for the municipality of Enschede to take share in Twentse Koers.

Mediant expresses interest in participating in this IZA mission sue to Mediants walk-in facilities. Mediant initiated working on the IZA assignment in collaboration with Ixta Noa. Mediant has no

assigned role or responsibility in this mission. Overall, the roles for this IZA mission were not clearly defined. This is due to ambiguity of different IZA missions.

Low-threshold support centres play a role in the preliminary field and contribute expertise and knowledge to the IZA mission. These centres play a role in representing the client perspective. GPs and POH-GGZ have a responsibility to bridge the gap between the ggz and the social domain. The GP is often the initial point of contact for residents, hence GPs have the responsibility to refer to the social domain, as well as the ggz.

4.3. What is the financial structure of the IZA and how does it influence the realisation of the IZA mission?

In this section of the results an answer is formulated on the sub question: What is the financial structure of the IZA and how does it influence the realisation of the IZA mission. The results discuss how the finances of the IZA are organized nationally, followed by information specific to region Twente. Ultimately, an overview of the finances is provided in Figure 5.

The results are based on the interviews in combination with information from a document published by the VNG and the general IZA document [2,44]. The VNG document contains information about the SPUK fundings and was only published on the 16th of January 2024 [44]. The Regioplan and regional budget of Twentse Koers were examined for region specific information [45,46]. In the interviews, different actors shared different information regarding the finances of the IZA mission.

Transformation funds are entrusted by the healthcare insurers. The IZA transformation funds are €2,8 billion a divided per sector or allocated for transformation plans [2]. Menzis holds the IZA transformation funds in region Twente. Menzis conducts the 'snelle toets' on transformation plans to determine if the plan meets the requirements. To be entitled to IZA transformation funds, the transformation plan must have an impact on the Zorgverzekeringswet, which entails that the transformation plan must be conducted in collaboration with or by a 'Zorgverzekeringswet' actor. Non 'Zorgverzekeringswet' actors can obtain the funding through the 'Zorgverzekeringswet' actor, which serves as cashier. Respondent 10 from Menzis states that the low-threshold support centres are intended to the SPUK funding.

R10*: in general, of course, health insured parties are actually always involved and which you can of course just make them cashier. But it must affect the Zorgverzekeringswet.*

Nationally, municipalities are entitled to funding concerning the Integraal Zorg Akkoord. However, in region Twente the entity Twentse Koers is granted the SPUK funding. A differentiation can be made between SPUK IZA funds and SPUK transformation funds. The SPUK IZA funds entails a maximum amount of 150 million per year structurally (depending on the new coalition). VWS is provider of the SPUK IZA. The SPUK IZA is intended for the municipal commitment to the work agenda of the IZA as included in the Regioplan. The low-threshold support centres are a subject on the work agenda. How these funds are allocated is included in the Regioplan and corresponding general budget.

In the Regioplan Mentale gezondheidscentra and low-threshold support centres are confused. Low-threshold support centres is only briefly noted [47]. This confusion has continued in the general budget of the Twentse Koers. In the overview of Themalijn Mentale gezondheid is it called Mentale gezondheid- en herstelcentra and not either Mentale gezondheidscentra or low-threshold support centres. The terms of the two IZA mission are combined which results in confusion in the general

budget. Hence, the IZA mission of low-threshold support centres is not adequately budgeted. The budgeted costs of Mentale gezondheid- en herstelcentra are €203,208.89 [46]. In this document it is stated that for the Mentale gezondheid- en herstelcentra IZA transformation funding, located at health insurers, can be claimed. However, only the Mentale gezondheidscentra are adequate for the IZA transformation funds, the low-threshold support centres cannot claim IZA transformation funds [46]. The low-threshold support centres are not part of the Zorgverzekeringswet, despite the influence of the transition on health insured care.

R10: *So, then the SPUK are much more appropriate means to set that up. Yes, ultimately, of course, it also has to land in the regular budget of the municipality itself.*

The SPUK IZA are elaborated in 'attachment 1 projectplannen' of the general budget of Twentse Koers [45]. The €203,208.89 consists of personnel expenses and the material costs. The personnel costs are €163,208.89 and the material costs are €40,000 [45]. This would mean that all funds budgeted for the low-threshold support centres are spent on Twentse Koers.

In the document of VNG a new funding stream is introduced [44]. These are the SPUK transformation funds. The recipient of the SPUK transformation funds are municipalities and possibly other partners in the social domain. These are partners that have submitted a transformation plan. As mentioned before, in region Twente, the SPUK transformation funds are granted to the Twentse Koers. VWS is provider of these incidental funds. During the last interview with respondent 19 from VNG, SPUK transformation funds were mentioned for the first time.

The SPUK transformation funding is a construct to get funding from the health insurer to the municipalities. Currently much is unclear around SPUK transformation funds. The amount of SPUK transformation funds and how these funds are supposed to go from the IZA transformation funds to the SPUK transformation funds is currently unknown[44]. This implies there are not yet SPUK transformation funds received at the Twentse Koers. The low-threshold support centres should be funded from the SPUK transformation funds. The SPUK IZA is directly deposited to the municipalities while with SPUK transformation funds is deposited to the health insurers and thereafter should be transferred to municipalities. Respondent 19 states that in creating the IZA, it is done from a healthcare perspective, forgetting that municipalities cannot receive funds from the health insurers.

R19: *IZA was set up from a care perspective, and I think it was less well thought out beforehand that health insurers cannot simply transfer those funds to municipalities. As a municipality, we do not provide care under the Zorgverzekeringswet. That was not thought through properly at the drawing board when they started the IZA. And besides, there are so many SPUKs that are complicated. That makes it unnecessarily complicated for municipalities and thus we lose speed and motivation.*

Further funding in the future is potentially possible through SPUK DOS. There might be an opening for a part of the target group of the funding of the WLZ for mental healthcare. Possibly there are openings in the gemeentefonds. However, the shortages for municipalities that are likely to happen in 2026, should be considered. Possibly, there are few subsidies' jars, which are not yet relevant for low-threshold support centres [44].

In conclusion, the IZA transformation funds are allocated to Menzis, but the IZA transformation funds are not applicable for the low-threshold support centres. The SPUK IZA is allocated to Twentse Koers. The SPUK IZA is spent on the coordination of Twentse Koers. Currently, the funding for low-threshold

support centres is not budgeted. The SPUK transformation funds are introduced, this is a construct to transfer funding from the health insurers to the municipalities. In case of region Twente to the Twentse Koers. Currently, the amount of SPUK transformation funds is unclear and it is unclear when and how it will be transferred. This entails that there is no funding budgeted for the interpretation of the network of low-threshold support centres.

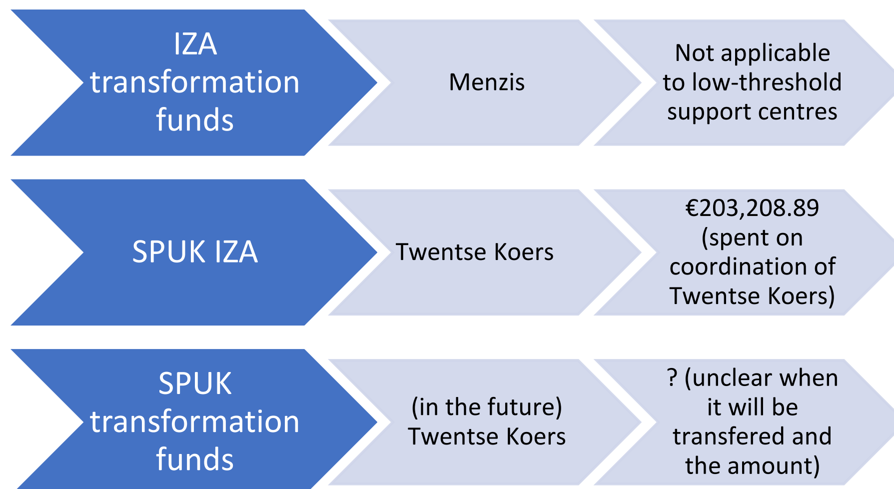

Figure 5: Finances of the IZA mission

4.4. How do different actors view the IZA mission and ancillary positions?

In this subpart an answer is found on the question: How do different actors view the IZA mission and ancillary positions? Barriers, misconceptions, and incentives experienced by the respondents are addressed.

4.4.1. Barriers

There are different barriers perceived in undertaking the IZA mission, which there seem to be different reasons for. Barriers experienced within the IZA mission are expressed in financial barriers, barriers in the relation between cost and benefit and a barrier due to self-interest.

4.4.1.1. Finances

The organisation of finances for the IZA mission is perceived as a barrier. Firstly, issues relating to SPUK funding are experienced as barrier. Additionally, municipal budget cuts create uncertainty about ensuring the network of low-threshold support centres. Finally, financing experts by experience is considered a barrier.

The SPUK transformation funds have not yet reached the municipalities. Currently, information about the amount of these funds and when the funds will be transferred in this construct is unclear. There is frustration due to the lack of clarity on the SPUK transformation funds. Furthermore, the SPUK IZA allocated to the Twentse Koers is only spent on the Twentse Koers. Currently, there are no transformation resources available to fund the low-threshold support centres. Currently, the only means of financing an IZA mission is through the transformation funds of Menzis. However, these funds cannot be claimed by the low-threshold support centres.

Moreover, municipalities are facing budget cuts in 2026, raising questions about ensuring the IZA in the future. Despite the budget cuts, low-threshold support centres will have to be financially secured in the future, presumably by the municipalities. This is perceived as a barrier and creates ambiguity.

Moreover, a barrier is experienced by financing the experts by experience. Organisations cannot always secure funding for experts by experience, even if the organisation would like to deploy the experts by experience. Only experts by experience with education level 5 can be funded through the health insurer with the Zorgprestatiemodel. Experts by experience with other education levels need to be funded by the social domain and sometimes miss out on funding.

4.4.1.2. Relation cost and benefit

Involvement of different organisations to establish the IZA mission can result in barriers. The main barrier due to different organisations relates to costs and benefits. The Municipality states that the benefits are for the health insurer, but the costs are for the municipality. However, Menzis states the transformation is made towards the social domain, for which the municipalities are responsible. There is uncertainty about responsibilities for funding. In different collaborations, not always correct, expectations are noted on responsibilities of other organisations. This may be partly caused by ambiguity and lack of awareness about the IZA funding. Diplomacy is required in the collaboration of different organisations with different positions.

4.4.1.3. Self-interest

Self-interest of different organisations or actors is a barrier. This is particularly evident in the self-governance and recovery branch. Self-governance and recovery centres are motivated to expand their industry and increase the employment opportunities for experts by experience. The NVZH states their activities of lobbying a few times. Partly due to lobbying within the Werkgroep, the 10 requirements of low-threshold support centres only allow self-governance and recovery centres to qualify, which excludes other initiatives from being a low-threshold support centre, even when this is not officially correct. While criteria are necessary to establish clear guidelines for low-threshold support centres, these criteria are heavily influenced by the NVZH. Originally intended for low-threshold support centres, these 10 criteria are now primarily associated with self-governance and recovery centres. As a result, self-governance and recovery centres are perceived as the primary representatives of low-threshold support centres, rather than just examples. Self-governance and recovery centres represent one type of low-threshold support centre, alongside other suitable initiatives. This self-interest has a vital influence in realising the network of low-threshold support centres.

R6: *Have we been working very strongly for the past two years and with good success. The fact that we are in the IZA, that is also a result of lobbying and preliminary work before we formally became an association.*

4.4.2. Misconceptions

The IZA causes certain misconceptions, which are associated with ambiguity and unknowing of different parties. Ambiguity is unclarity arising from the IZA mission, unknowing implies respondents that are not well informed. Respondent 6, from the workgroup and NVZH, states that the misconceptions are a consequence of sloppiness due to time pressure.

4.4.2.1. Ambiguity

The main source of ambiguity arises from the conjunction between the IZA mission of ‘Mentale gezondheidscentra’ and the low-threshold support centres. As mentioned before, section F of the IZA represents three IZA missions: ‘Domeinoverstijgende samenwerking voor mensen met psychische klachten’, ‘Landelijk en regionaal netwerk laagdrempelige steunpunten’ and ‘Mentale gezondheidscentra’. However, two IZA missions are confused. The confusion is evident in the Regioplan, the general budget and carries through within organisations.

In the Regioplan the ‘Themalijn Mentale gezondheid’ covers the ‘Project – Mentale gezondheids- en herstelcentra’. The term ‘Mentale gezondheids- en herstelcentra’, as stated in the Regioplan, confuses the following: ‘Mentale gezondheidscentra’ is an IZA mission, as previously mentioned. The term ‘Mentale gezondheidscentra’ is intertwined with the term ‘zelfregie- en herstelcentra’ (self-governance and recovery centres), which are an example of low-threshold support centres and belong to the IZA mission of low-threshold support centres. In essence, the IZA mission of ‘Mentale gezondheidscentra’ is associated with the conjoint term, where the IZA mission of low-threshold support centres seem forgotten. The IZA mission of ‘Mentale gezondheidscentra’ differs significantly from that of low-threshold support centres.

R8: *it is very often confused. Well, I know that respondent X also regularly lumps it together and sees that as the same thing, but it is not the same, is absolutely not the same.*

This confusion extends to the ‘Algemene begroting Twentse Koers 2024’ for the IZA missions [46]. Within the budget, as part of the ‘Themalijn Mentale gezondheid’ the term ‘Mentale gezondheids- en herstelcentra’ is used. However, this term does not accurately reflect the IZA missions and is incorrect. The budget overview specifies that €203,208.89 is allocated for the incorrect term of 'Mentale gezondheids- en herstelcentra’. This sum is SPUK IZA funding, invested in Twentse Koers. Both in this budget and in 'Bijlage 1: project plannen' it is noted that the 'Mentale gezondheids- en herstelcentra’ will be funded through the IZA transformation funds provided by the health insurers [45]. However, the ‘Mentale gezondheidscentra’ involve insured healthcare which is not applicable to the low-threshold support centres. The budget appears to allocate funds specifically for the ‘Mentale gezondheidscentra’ within this terminology. This mainly covers personnel costs related to Twentse Koers, as the terminology is now budgeted as if the content is budgeted from the transformation funds. This does not apply to the low-threshold support centres, as it is not care provided in the Zorgverzekeringswet.

The confusion between the IZA mission of Mentale gezondheidscentra and low-threshold support centres continues to be a key source of confusion. Respondent 4 believes that the ‘Mentale gezondheidscentra’ represents the sole IZA mission, thus completely overlooking the IZA mission of low-threshold support centres. Respondents have identified ambiguity related to the IZA mission on 52 occasions.

Furthermore, this confusion with terminology extends to financial uncertainty and unclear roles and responsibilities. Respondents’ express uncertainty regarding financial coherence, with various incorrect statements about finances being noted. There is lack of clarity on how transformations should be funded, and which organisations are eligible for the funding.

Moreover, there is uncertainty about the roles and responsibilities associated with the IZA mission. The roles of the IZA mission of ‘Mentale gezondheidscentra’ are clearly stated while the roles of the

IZA mission of low-threshold support centres remain uncertain. This results in unclear roles and responsibilities of the stakeholders. Respondent 8, 12 and 19 all note that the IZA mission is unclear for most organisations. This leads to different interpretations and makes it more challenging to align with each other and with the IZA mission.

R8: *This is not very clear in the IZA mission of these recovery centres if I am very honest. With the low-threshold support centres, it doesn't say in the IZA which party is in the lead. Indeed, there has been quite a search for it. With questions like, okay, but how should that be funded at all? Does it or does it not fall within IZA resources, or should we be? That the IZA funds that have gone to the municipality or are those IZA funds that come through also gone through the health insurer?*

4.4.2.2. Unknowing

Unknowing indicates a lack of knowledge among the involved actors and occurs in various areas. Unknowing of the IZA mission is evident from the questions asked, and from incorrect statements. Actors exhibit unknowing about the IZA mission and ancillary positions. Respondent 14 reports that 80% till 90% of GPs are not familiar with the IZA mission. Additionally, there is a lack of knowledge regarding the roles and finances of the IZA mission. This lack of awareness can be attributed to the previously mentioned ambiguity.

Meanwhile, there is a lack of knowledge about different entities in the field. Unknowing about the social domain, self-governance and recovery centres, and experts by experience is most prominently mentioned. Other professionals, as well as residents, lack awareness of the social domain or low-threshold support centres.

It is evident that many GPs lack knowledge about low-threshold support centres. There is uncertainty regarding the scope of the social domain and the position of self-governance and recovery centres. The POH-GGZ indicates that GPs and POH-GGZs operate within their own bubble. The GP states that 99% of the GPs do not refer to low-threshold support centres and many GPs are not aware of the IZA. Respondent 14, a GP, had not scaled self-governance and recovery centres in the social domain. Respondents 4, 5, and 18 emphasise that GPs and POH-GGZ have limited knowledge of the social domain, particularly low-threshold support centres. The GP mentions primarily considering the ggz when referring a patient, rarely considering the social domain.

The POH-GGZ is concerned about the social domains capacity to manage the transformation. The POH-GGZ lacks an overview of these services available in the social domain. Respondents perceive the social domain unclear due to its variability across municipalities and frequent changes. The need for a comprehensive overview or map of the social domain is highlighted. Besides GPs and POH-GGZs, the wijkcoaches are not well-informed either.

4.4.3. Incentives

In addition to barriers, respondents perceive stimulating or facilitating factors. Despite barriers being mentioned more frequently than incentives, respondents maintain positive views. A distinction can be made between existing incentives and factors that could support the IZA mission in the future.

Currently, respondents hold a positive outlook on the existence of the IZA. Several respondents expressed trust in the transformation. Respondent 18 notes that in the Twente region, there is alignment in thinking about the transformation, which is beneficial. Ixta Noa and MensdoorMens find

it beneficial to be part of the NVZH, which is viewed as an incentive. The NVZH shares all new information with its partners.

However, few factors are perceived as helpful for the future. The ability of organisations to communicate effectively, using a shared language, is viewed as an incentive. Enhancing connections between organisations facilitates easier networking, knowledge sharing is a significant facilitating factor, and providing information can reduce ignorance. It is important to inform GPs and POH-GGZ, as this group has an impact on the influx of low-threshold support centres. Education of GPs, POH-GGZs and wijkcoaches is considered important. According to respondent 17, initiatives like 'Welzijn op Recept', or 'SamSam' offer opportunities to strengthen the connection between GPs and the social domain. These are projects aim for connection between GPs and municipalities, to lead residents to appropriate aid.

R14: *The most important thing that we need to focus on, is that GPs and POH-GGZ, get more knowledge on the possibility of low-threshold support centres.*

Moreover, respondent 7 emphasises the need to enhance collaboration with experts by experience, emphasizing the importance of recognising their knowledge and contributions. Respondent 2 emphasises the importance of taking each other seriously and recognising the value of experts by experience. Respondent 7 suggests that involving experts by experience, especially in the social domain, could create opportunities for practitioners. Respondent 3 also stresses the significance of engaging experts by experience.

4.4.4. Concluding actors' view

In conclusion, barriers, misconceptions, and incentives are explained to provide insight into the perspectives of actors on the IZA mission and its ancillary positions. Barriers are emphasised regarding finances, the relationship between costs and benefits, and self-interest. Lack of clarity on SPUK transformation funds is a primary financial barrier for the IZA mission. Furthermore, budget cuts that municipalities are facing in 2026 represent a barrier. Moreover, disagreement over the allocation of costs relative to benefits creates a barrier. This barrier leads to disagreements between organisations. Another significant barrier is self-interest, particularly among the NVZH and self-governance and recovery centres.

Furthermore, misconceptions arise from ambiguity and unknowing. Ambiguity stems from unclarity related to the IZA mission, unknowing is caused by respondents that lack knowledge. The primary source of misconception is the confusion of terms in the Regioplan. This causes ambiguity in the roles and responsibilities, and finances of the IZA mission of low-threshold support centres. Additionally, there is a notable lack of knowledge regarding the IZA mission and various actors in the field.

Positive incentives include trust in the IZA mission and alignment of various actors on content in the Twente region. Factors facilitating future progress of the IZA include connecting organisations, share knowledge, and informing various stakeholders.

5. Conclusion and discussion

In the conclusion and discussion, the main findings are discussed. In addition, the theoretical and practical implications, as well as the methodological considerations and limitations are discussed. Moreover, recommendations are provided for the Municipality of Enschede.

5.1. Main findings

This research attempts to find an answer to the question: *'What position do self-governance and recovery centres have in implementing the IZA mission, to set up a national network of low-threshold support centres, in the relation between the mental health sector and the social domain of the Municipality of Enschede?'*

Self-governance and recovery centres are an example of low-threshold support centres. These self-governance and recovery centres should be part of the national covering network of low-threshold support centres for people with mental vulnerability. These low-threshold support centres can be found at the interface of the lifeworld and the social domain. In the IZA mission self-governance and recovery centres play a role of informing other organisations in the healthcare landscape concerned with the transformation. These organisations contribute with knowledge and expertise from the client perspective. The self-governance and recovery centres should work together with the municipalities and Twentse Koers, Menzis must be involved as assessor. It is essential that actors such as the Municipality of Enschede and Twentse Koers takes their part in executing this mission.

Furthermore, this research elaborates on four main findings. The first main finding is the confusion between the IZA mission of Mentale gezondheidscentra and low-threshold support centres. This confusion is found in the regional plan but continues in unclarity in roles and finances.

Due to the confusion between these missions the roles are unclear. The roles for the low-threshold support centres are not apparent from the IZA mission or the regional plan. Hence, the different actors take or take no role according to its own discretion. Mediant is involved in the IZA mission of Mentale gezondheidscentra, partly due to the confusion, Mediant is now involved in the low-threshold support centres. In addition, it is unclear what role the Municipality has in the IZA mission of low-threshold support centres. Especially because Mentale gezondheidscentra is financed through the IZA transformation funds relevant to insured health care and the low-threshold support centres are financed through the SPUK relevant for the social domain.

Barriers are experienced in the financial structure. These barriers consist of two obstacles. First, due to confusion of the IZA mission, the low-threshold support centres are not budgeted accordingly. The SPUK IZA is meant for coordination of Twentse Koers. It is stated in the Regioplan that the substance can be financed through transformation funds at the health insurer. However, this is only the case for the Mentale gezondheidscentra. The low-threshold support centres need to be financed through the SPUK funding. The amount of the SPUK transformation fund is unclear, as well as when this is transferred from the transformation funds of the health insurer.

The fourth main finding is the self-interest of self-governance and recovery centres. The self-governance and recovery centres are important as low-threshold support centres and fulfil an important role. However, these centres are an example of low-threshold support centres and not the only option for low-threshold support centres. It would be unfortunate that, due to lobbying, other initiatives, that would fit in the network of low-threshold support centres, are not eligible for the

funding. The lobbying is found in the Werkgroep and results in the 10 criteria for low-threshold support centres what is now changed to 10 criteria for self-governance and recovery centres. These are the exact same criteria. These criteria are only focused on self-governance and recovery centres disregarding other fitting alternatives.

5.2. Theoretical implications

This research offers a new perspective on the position of various actors in the healthcare landscape. It addresses the transition from specialized mental healthcare to the broader social domain, yet the implications of the transformation within the healthcare context are unclear.

Often, there is difficulty in collaborating between different policy fields. This research is an example and shows difficulty which can be experienced during a change where multiple sectors are involved. In this research the ggz and the social domain. The theoretical framework of this implies that for change, especially when multiple sectors are involved, a good plan is of importance. If there is no plan, the transformation may encounter several problems. This research confirms the theory that the IZA mission of low-threshold support centres does not have a proper change plan yet, therefore multiple problems are encountered.

Insight is provided of the interpretation of the problems encountered with the IZA mission and the development of the change plan. A new perspective is offered concerning the position of various actors in the healthcare landscape in the Municipality of Enschede. Understanding of the IZA mission of establishing low-threshold support centres is provided. This is important for continuing with the implementation of the IZA and to develop an accurate change plan. Additionally, new understanding is provided on the transformation in which individuals with mental vulnerabilities and illnesses transition from perceiving ggz-treatment to aid provided in the preliminary field. Moreover, this study contributes to our understanding of the increasing role played by self-governance and recovery centres as low-threshold support centres within this domain.

Furthermore, organisation theory relevant to the dynamics in the Municipality of Enschede are explored. By exploring organisational theories in the context of this transition, this research contributes to the theoretical development of understanding IZA mission and problems with the transformation and the role of various actors in the process. However, future research is recommended. In municipalities and governmental assignments there is not a method of operation for a change method in a healthcare context where many different organisations are involved. There is not yet a theory on a top-down change in a healthcare system which can provide a change plan and establish a network as to realise a network of low-threshold support centres. This research confirms the theory that interpretation of the problems and development of the change plan are necessary to provide results of the transformation.

A supportive framework concerning the finances is crucial to realise the IZA mission, especially regarding the SPUK transformation funds. Clear and sustainable funding is needed for realising the network of low-threshold support centres, confirming the theory of this research. In addition, there is a need to have a better understanding of the dynamics of the healthcare system as it undergoes this transformation. Future research should evaluate which change management strategies are most effective in implementing the IZA mission.

5.3. Practical implications

This research shows the importance of this IZA mission to various actors and important barriers were found. The main barrier is the confusion between two different IZA missions, which causes ambiguity in the finances and the roles. This research gives insight in the finances for the IZA mission of low-threshold support centres, in addition more clarity is provided for the roles of different actors in the Municipality of Enschede.

Realising the confusion between the IZA mission in the Regioplan and general budget can have impact in executing the transformation. Furthermore, this research provides knowledge for the actors on the IZA mission and ancillary positions. The Municipality of Enschede is currently considerate of the role it needs to fulfil. Additionally, this research provides information on the low-threshold support centres. Self-governance and recovery centres are not the only low-threshold support centre option to consider. Other initiatives can be changed to partake in the network of low-threshold support centres. The advice to engage more with general practitioners to utilise the social domain and low-threshold support centres can have influence on the influx at these low-threshold support centres, this has an impact on the transformation from the ggz to the social domain.

Further research is called for. The IZA changes continuously and therefore it is important to keep track of the changes and the implications of the changes. Moreover, there is uncertainty on the SPUK transformation funds. It is unclear how a construct can be developed to transfer funding from the health insurer to municipalities or actors in the social domain. Menzis assesses the transformation plans (including plans concerning the social domain) and decides whether it is applicable for IZA funding, even though Menzis does not possess the SPUK funding for the social domain.

The Municipality of Enschede is an important actor for realising the network of low-threshold support centres. Further research on the social domain map concerning low-threshold facilities is encouraged, to explore possibilities to create low-threshold support centres by adding experts by experience e.g.

5.4. Methodological considerations and limitations

In this research, methodological considerations and limitations are assessed. Certain respondents confused the IZA mission of low-threshold support centres with the IZA mission of 'Mentale gezondheidscentra', which can cause ambiguity in the research results. Additionally, the IZA mission is a process that changes during the mission, which can cause confusion in the answers of respondents. Both ambiguities can pose a threat to validity.

Furthermore, it is important to consider the complexity of the healthcare system in conjunction with the complexity of the IZA mission. Careful consideration is given to the interactions between different actors and the nuances in the interviews. This research is performed specifically on the healthcare context in the Municipality of Enschede with current conditions. The Municipality of Enschede has different stakeholders and entities than other areas in the Netherlands. Twentse Koers is only a stakeholder in the region of Twente, while in other regions, the centrum municipality holds a position similar to that of Twentse Koers. In addition, the landscape of low-threshold support centres differs per city or town. Furthermore, certain documents, like the Regioplan, is applicable just for the region of Twente. Therefore, while the results of the research cannot be generalised, certain aspects of it can be applied to other regions. The aspects that can be generalised are for example the national financial flow, including the transformation funds and SPUK funding, as well as the documents provided by the Werkgroep or VNG.

5.5. Recommendations

Based on this research, recommendations for the Municipality of Enschede and general recommendations are provided. Three main recommendations can be addressed for the Municipality of Enschede. The first recommendation is to become a more active participant in the collaboration with Twentse Koers. Twentse Koers plays a coordinating role and oversees the SPUK funding. The Municipality of Enschede should provide content on local level. Currently, it is not sufficiently assigned at municipal level.

In addition, the municipality should be involved in realising the network of low-threshold support centres. Mediant and Ixta Noa started with this IZA assignment. The low-threshold support centres are part of the social domain. Besides, the municipalities need to ensure finances of the low-threshold support centres after the IZA. Hence, the importance of involvement of the municipalities.

Informing GPs on this IZA mission and the low-threshold support centres is important to utilise the low-threshold support centres. The Municipality of Enschede can encourage these initiatives which aim to connect GPs and municipalities, examples of these initiatives include projects as 'Samsam' and 'Welzijn op recept'.

Furthermore, general recommendations can be provided. These general recommendations are mainly regional or national. The main general recommendation for the region Twente lies in the Regioplan. Due to the confusion between the terms of the IZA mission of Mentale gezondheidscentra and the IZA of low-threshold support centres, the realisation of the low-threshold support centres is not budgeted, and roles are unclear. The recommendation is to revise the Regioplan, in which the current project of 'Mentale gezondheids- en herstelcentra' is separated into two missions: IZA Mentale gezondheidscentra/ netwerken and the IZA mission of low-threshold support centres. This separation provides more clarity and gives less chance of overlooking the IZA mission of low-threshold support centres.

On national level, a recommendation on the funding can be provided. It is recommended that the funding of the IZA, including the SPUK transformation funding, becomes clearer. The construct of the SPUK transformation funds should become clear, in which the amount and when the funds can be transferred are known. The rules of the funding in general should become clearer, so all parties know their position and possibilities.

The last recommendation is to become aware that self-governance and recovery centres are an example of low-threshold support centres. The 10 criteria of low-threshold support centres are guidelines and is not an obligated framework. The recommendation is to not overlook other initiatives that could fit in and add value to the network of low-threshold support centres.

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7. Appendix

Appendix A: Criteria low-threshold support centres

1. It is easily accessible to everyone and in particular to people with (severe/long-term) mental health (the EPA target group) and/or social-emotional vulnerability and their loved ones.
2. The support centre is focused on learning, recovery, and development; this goes beyond just a listening ear and coffee.
3. Both visitors/participants and staff have something to get and something to bring. There is co-creation and joint ownership.
4. Support is shaped by people's needs.
5. We see each other as human beings, not as clients or social workers.
6. There is reciprocity and equality, based on mutual understanding, recognition, and acknowledgement.
7. We work from 'what suits you', without step-by-step plans or protocols; there is a range of methodical self-help that continues to develop from co-creation and peer support.
8. In the support centre, collective experiential knowledge comes together.
9. Experience experts and/or experience workers are in the lead in the initiative.
10. There is cooperation with formal and informal (chain) partners, such as:
    a. social domain (municipality)
    b. welfare organisations
    c. general practitioners
    d. care providers

    So that coordination can easily take place and people can be linked when necessary to the right people or bodies for them.

Appendix B: Interview schema

Technology:

1. Wat weet u van de IZA opdracht? Kunt u daar iets over vertellen?
2. Bent u betrokken bij de organisatie van de IZA opdracht? Binnen uw organisatie/ ook buiten uw organisatie?
3. Wordt er iets gedaan met de IZA opdracht binnen uw organisatie in relatie laagdrempelige steunpunten. Zo ja, hoe wordt dat opgepakt?
4. Zijn jullie daarbij ook met andere partijen betrokken?
5. Hebben jullie daarover contact met andere partijen?
6. Heeft de IZA opdracht nu al invloed op het netwerk? Wat vind je van de invloed die het IZA heeft?

Verantwoordelijkheden:

7. Heeft uw organisatie een bepaalde functie of verantwoordelijkheid bij het uitvoeren van de IZA opdracht? In relatie tot de laagdrempelige steunpunten?
8. Denkt u dat uw organisatie een bepaalde taak zou moeten hebben bij het uitvoeren van de IZA opdracht in relatie tot de laagdrempelige steunpunten?
9. Is er een verplaatsing in de verantwoordelijkheden bij het uitvoeren van de zorg?
10. Wie vind u dat verantwoordelijk zou moeten zijn voor de plek van laagdrempelige steunpunten in de regio?
11. Heeft uw organisatie verantwoordelijkheden in de inhoudelijke zorg in relatie tot de laagdrempelige steunpunten?

Rollen:

12. Wat voor zorg biedt uw organisatie aan? Waar staat uw organisatie in de zorgcontext? Wat is jullie rol in de mentale zorg sector? (Hoeveelste lijns, door wie wordt er aanspraak gemaakt op de zorg, is dat voorliggend of niet, indicatie niet indicatie)
13. Werken jullie op inhoudelijk zorggebied samen met andere partijen?
14. Hebben jullie een functie in het netwerk van de zorgcontext in de regio?
15. Is er een rol die jullie oppaken bij de uitvoering van de IZA opdracht? (dit kunnen verschillende rollen zijn: kartrekker, leidende rol, organisatorische rol, volgende rol (wie volg je dan))
16. Heeft uw organisatie invloed op de uitvoering van de IZA opdracht in relatie tot zelfregie en herstel? Is dit directe of indirecte invloed? Is dit met name in eigen organisatie of overstijgend aan eigen organisatie?

Processen:

Financiele processen:

17. Heb je inzicht in de IZA transformatiegelden?
18. Hoe sta je tegenover hoe de IZA gelden nu zijn vormgegeven met het transformatiegeld?
19. Zijn er factoren waar u organisatie afhankelijk van is?

Organisatieprocessen:

20. Bent u bekend met zelfregie en herstel centra?
21. Wat voor beeld heeft u van zelfregie en herstel initiatieven?

22. Is er een samenwerking tussen uw organisatie en zelfregie en herstel initiatieven? Hoe is de samenwerking tussen de organisaties met zelfregie en herstel waar je mee samenwerkt?
23. Hoe vindt u dat zo'n samenwerking gaat of zou moeten gaan zorginhoudelijk?
24. Hoe zou u een laagdrempelig dekkend netwerk inrichten? Heeft u daar een idee over?
25. Zijn er daarbij belemmeringen of helpende factoren?
26. Waar ziet u zelfregie en herstelcentra in het zorgplaatje van de regio?
27. Ziet u belang om zorg voorliggender te maken?
28. De beweging waar de mentale gezondheidszorg nu in zit is een beweging van de ggz naar het sociaal domein. Hoe staat u hier tegenover?

Culture:

29. Wat voor beeld heeft u van formele en informele clientondersteuning? Bent u hier bekend mee?
30. Heeft u inzicht in de samenwerking tussen formele en informele clientondersteuning?
31. Zijn er dingen waarvan u denkt dat belangrijk is om mee te nemen over deze samenwerking? Zijn er belemmeringen of juist dingen die het samenwerken bevorderen?
32. Wat is de visie betreft gezondheid? (Wanneer ze niet bekend zijn zal ik het principe van positieve gezondheid en medisch model toelichten)
33. Bent u bekend met de begrippen systeem- en leefwereld en medisch model?
34. Hoe wordt er nu omgegaan met verschil in visie?
35. Heeft u een idee hoe kan worden omgegaan met verschil in benadering over gezondheid (positieve gezondheid of WHO definitie, systeemwereld en leefwereld, en medisch en niet medisch model)?

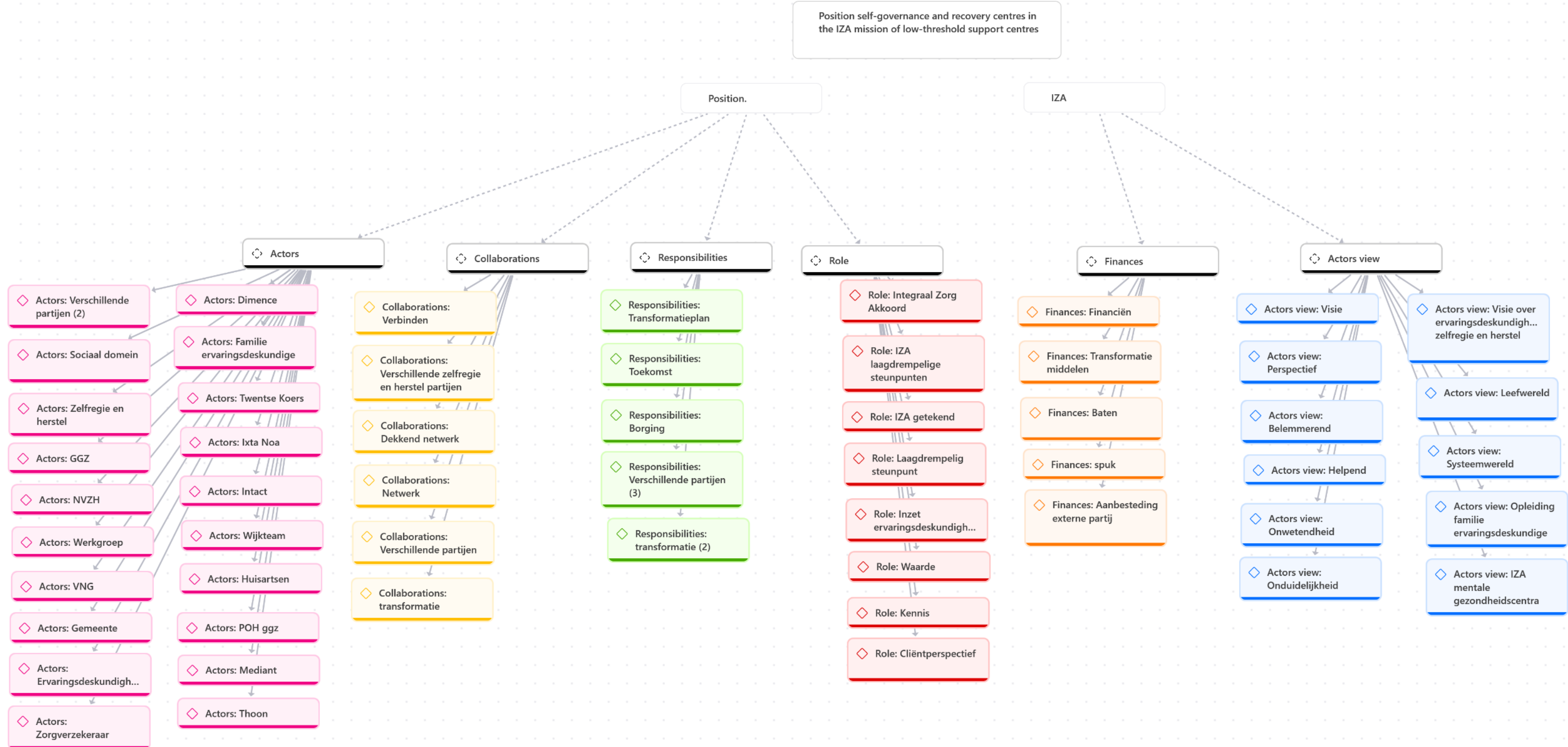
Voor intact en bureau herstel

36. Zien jullie intact/ bureau herstel als laagdrempelig steunpunt?
37. Op wat voor plek in het zorgproces wordt gebruik gemaakt van Intact/ bureau herstel?
38. Hoe is het verschillend van andere zelfregie en herstel centra zoals bijvoorbeeld Ixta Noa?
39. Hebben jullie een andere doelgroep dan bijvoorbeeld Ixta Noa?
40. Met welke visie werken jullie? Volgen jullie daarbij Tactus/ Mediant? Zo niet zijn daar verschillen?
41. Zien jullie mogelijkheden om de initiatieven meer naar voren te brengen? Dus meer voorliggend?
42. Hoe zien jullie een dekkend netwerk voor je? Hoe kunnen de laagdrempelige steunpunten de regio dekken?

Voor Menzis

43. Hoe zijn jullie betrokken bij uitvoering IZA?
44. Houden jullie toezicht op hoe dat gebeurd? Hoe hebben jullie contact met Mediant?
45. Hebben jullie ideeën hoe het voorliggend een dekkend netwerk kan worden?
46. Waar komen die partijen dan vandaan?

Appendix C: Coding tree



Appendix D: Translation of quotes

R19	The municipality has to facilitate and has ownership, but then again, it does not, because the owners are actually the experts by experience who lead and fill it in completely.
	De gemeente moet moet faciliteren en is eigenaar, maar ook weer niet, want de eigenaren zijn eigenlijk de ervaringsdeskundigen die het helemaal leiden en invullen.
R18	We just possess a lot of knowledge about what it's like to use care and use the social domain. I think it's also up to us to help in that too, therefore we also put in work and energy and time. Because we have that knowledge, but we also think it's important that things will be different.
	Wij hebben gewoon heel veel kennis over hoe Het is om gebruik te maken van zorg en gebruik te maken van het sociaal domein. Ik vind het ook wel aan ons om daarin ook te helpen, daarom ook werk en energie en tijd te steken, want We hebben en die kennis in huis, maar we vinden het ook belangrijk dat het anders gaat.
R18	You need different TYPE of places, aimed at different audiences.
	Je hebt verschillende TYPE plekken nodig, op andere doelgroepen gericht.
R4	We now see that GPs are poor referrers, thinking far too often of ggz and using that far too heavily.
	we zien nu dat huisartsen slechte verwijzers zijn, die veel te vaak denken aan ggz en dat veel te zwaar inzetten.
R10	In general, of course, health insured parties are actually always involved and which you can of course just make them cashier. But it must affect the Zorgverzekeringswet.
	Over het algemeen zijn natuurlijk eigenlijk altijd wel zorgverzekeringswet partijen bij betrokken en die kun je natuurlijk gewoon casshier maken. Maar het moet invloed hebben op de zorgverzekeringswet.
R10	So, then the SPUK are much more appropriate means to set that up. Yes, ultimately, of course, it also has to land in the regular budget of the municipality itself.
	Dus dan is zijn de SPUK veel meer aangewezen middelen om dat om dat op te zetten. Ja, uiteindelijk moet het natuurlijk ook landen In de reguliere begroting van de gemeente zelf.
R19	IZA was set up from a care perspective, and I think it was less well thought out beforehand that health insurers cannot simply transfer those funds to municipalities. As a municipality, we do not provide care under the Zorgverzekeringswet. That was not thought through properly at the drawing board when they started the IZA. And besides, there are so many SPUKs that are complicated. That makes it unnecessarily complicated for municipalities and thus we lose speed and motivation.
	IZA is opgezet vanuit zorgperspectief en ik denk dat er van tevoren minder goed over is nagedacht dat zorgverzekeraars die middelen niet zomaar naar gemeenten over kunnen hevelen. Als gemeente leveren we geen zorg uit de zorgverzekeringswet. Daar is aan de tekentafel niet goed overna gedacht toen ze met het IZA starten. En er zijn daarnaast zoveel spuks die ingewikkeld zijn opgezet. Dat maakt het voor gemeenten onnodig ingewikkeld en daarmee verliezen we snelheid en motivatie.
R6	Have we been working very strongly for the past two years and with good success. The fact that we are in the IZA, that is also a result of lobbying and preliminary work before we formally became an association.
	Zijn we de afgelopen twee jaar heel sterk bezig geweest en ook met goed succes, hè? Het feit dat we in het IZA staan, Dat is eigenlijk ook al een resultaat van lobby en voorwerk voordat we formeel een vereniging werden.
R8	Respondent 8 states: it is very often confused. Well, I know that respondent X also regularly lumps it together and sees that as the same thing, but it is not the same, is absolutely not the same.

	het wordt heel vaak verward. Het is ook. Nou ja ik ik. Ik weet dat respondent X het regelmatig ook bij mekaar schaart en dat als hetzelfde ziet, Maar het is niet hetzelfde, is absoluut niet hetzelfde.
R8	This is not very clear in the IZA mission of these recovery centres if I am very honest. With the low-threshold support centres, it doesn't say in the IZA which party is in the lead. Indeed, there has been quite a search for it. With questions like, okay, but how should that be funded at all? Does it or does it not fall within IZA resources, or should we be? That the IZA funds that have gone to the municipality or are those IZA funds that come through also gone through the health insurer?
	Dat is bij die herstelcentra niet heel duidelijk. Als ik heel eerlijk ben. Als je het hebt ook die herstel centra, staat niet in het IZA welke partij In de lead is? Sterker nog, er is een behoorlijke zoektocht geweest naar oké, maar hoe zou dat dan überhaupt gefinancierd moeten worden? Valt het wel of niet binnen IZA middelen of moeten we dat zijn? Dat de IZA middelen die naar de gemeente toe zijn gegaan of zijn dat IZA middelen die via dus ook verzekering komen?
14	The most important thing that we need to focus on, is that GPs and POH-GGZ, get more knowledge on the possibility of low-threshold support centres.
	Dat daar nu het belangrijkste is dat we daarop gaan richten, dat veel meer bekend wordt bij de huisartsen en de praktijkondersteuners dat deze mogelijkheid er is