NATURE-ASSISTED THERAPIES: FACILITATORS & BARRIERS FOR IMPLEMENTATION

A QUALITATIVE STUDY AMONGST STAKEHOLDERS IN THE DUTCH MENTAL HEALTHCARE SECTOR

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LIST OF ABBREVIATIONS

ACT Academic Consultancy Training, part of the master curriculum of Wageningen University

bGGZ *Basis geestelijke gezondheidszorg*, literally translated 'basic mental healthcare, referring to mental healthcare tailored to individuals suffering from mild psychological complaints

COVID-19 An infectious disease caused by the coronavirus SARS-CoV-2 that caused a pandemic from the end of 2019 onwards

EBP Evidence-based practice

EMDR Eye Movement Desensitisation and Reprocessing

GGZ *Geestelijke gezondheidszorg*, literally translated 'mental healthcare'

GZ-psycholoog *Gezondheidszorg psycholoog*, also known as certified healthcare psychologist

HALL Healthy Alliances

NAT Nature-assisted therapy, also known as 'outdoor psychology' (or in Dutch: *buitenpsychologie*)

NCDs Non-communicable diseases

POH-GGZ Supports a general practice with the care for individuals who suffer from mild psychological complaints

RCT Randomized controlled trial

sGGZ *Specialistische geestelijke gezondheidszorg*, literally translated 'specialised mental healthcare', referring to mental healthcare tailored to individuals suffering from more severe and complex psychological complaints

SSI Semi-structured interview

TMTs Top Management Teams

WHO World Health Organisation

Wlz *Wet langdurige zorg*

WMO *Wet Maatschappelijke Ondersteuning,* Dutch Long-term Healthcare Act

EXECUTIVE SUMMARY

The current study was set out to explore facilitating and hindering factors for the further implementation of nature-assisted therapy in the mental healthcare sector of the Netherlands. The inclusion of stakeholders in qualitative research has become a crucial aspect, considering the healthcare developments in the last decades (market forces, ample competition, budget cuts). The aim of the current research was to get a grasp on the (implicit) assumptions and opinions that stakeholders might hold up against nature-assisted therapies and investigate practical, organisational and therapeutical factors that could hinder or facilitate further implementation of nature-assisted therapies in the Netherlands. The current study was built on the work of Cooley et al. (2020), which was based on the experiences of outdoor practitioners and their clients and comparing them with the opinions of 'conventional' psychologists who work indoors. 13 semi-structured interviews and 1 email interview have been conducted with a wide diversity of stakeholders from the Dutch mental healthcare sector. The qualitative analysis of the interview transcripts led to the identification of several important themes that determine the future development of NAT within the Dutch mental healthcare sector. Recommendations for future implementation, like education, publication and collaboration with other (mental) healthcare organisation that have affiliation with nature could foster implementation. On the other hand, the current organisation and culture of the Dutch mental healthcare sector and practical and organisational difficulties that accompany setting up a NAT practice hinder its implementation. Furthermore, client and therapist characteristics and opinions of stakeholders or mental healthcare practitioners could either obstruct or facilitate its implementation. Both practitioner and client must be suitable for NAT and should be intrinsically motivated to practice it. Concerning the opinions and assumptions of stakeholders and mental health practitioners, it actually depends on whether they are actually familiar with NAT and what stakes they have. The major limitations of this study were an overrepresentation of mental healthcare workers and an underrepresentation of the inclusion of policy makers, institutions in the area of research and development and other non-governmental organisations like Nature for Health. In spite of its limitations, the study certainly adds to our understanding of the difficulties that new and innovative healthcare interventions must face in order to be 'accepted' by the entire sector, which also underlines the complexity and some problematic developments (competition, scarcity, hyper-segmented care). Considerably more work will need to be done to determine on how NAT should professionally organise themselves and how they can actually use the suggested recommendation for further implementation to become more visible and professionally acknowledged in general.

1. INTRODUCTION & PROBLEM STATEMENT

In recent years, the use of the natural environment as a setting for health interventions has gained considerable attention from researchers worldwide (Haubenhofer et al., 2010). In general, 'green care' is considered an umbrella term for traditional health interventions that are combined with either husbandry, agriculture, gardening, landscape conservation or animal keeping. One of those green care interventions is called nature-assisted therapy (NAT), that uses the natural environment as a backdrop for psychological treatment and counselling. It is regarded as a holistic approach, taking into account the physical, social and mental health and wellbeing of individuals (Shanahan et al., 2019).

There is ample academic literature and research available on nature's beneficial effects on both human physical and mental health (e.g. Cooley et al., 2020; Ohly et al., 2016; Annerstedt van den Bosch et al., 2016; Haubenhofer et al., 2010). Furthermore, qualitative and anecdotal evidence from a variety of mental health practitioners suggest that NAT is at least as or more effective in treating mental health problems compared to indoor therapy (Cooley et al., 2020). However, it seems there are many barriers and practicalities that hinder implementation in the mental healthcare sector. For instance, a mixed-methods study carried out by students from a diverse background, including myself, Sanne de Bruin, uncovered numerous barriers that are hindering practical implementation and public support for the full implementation of NAT in the Dutch mental healthcare sector (in Dutch: *GGZ*). In this particular study, several (outdoor) psychologists and experts in the field of human-nature relationships were interviewed about NAT (De Bruin et al., 2020). Most outdoor psychologists expressed that they experienced a lack of awareness, recognition, knowledge and stigma against NAT by a majority of the Dutch healthcare sector. They also pointed out that that some of their clients and colleagues were hesitant about the effectiveness of NAT and did not consider it as an valid option for psychotherapy (De Bruin et al., 2020).

Building on the results that were found during the interviews with outdoor psychologists in the study by De Bruin et al. (2020), the interviews with human-nature experts displayed similar results (De Bruin et al., 2020). Several of these interviewees indicated that fully implementing NAT in the Dutch mental healthcare system might not be feasible yet, since they assumed that most stakeholders, such as healthcare insurance companies, are not ready to entirely support NAT (De Bruin et al., 2020). Fortunately, these interviewees were able to come up with useful recommendations. For instance, they proposed that the national government can act as a key player to mobilise awareness and knowledge about NAT's potential in the Dutch *GGZ*. Furthermore, it was suggested by both the human nature experts as well as the psychologists that one of the main reasons for doubt was a lack of clear-cut scientific evidence of NAT (De Bruin et al., 2020). Even though it is acknowledged its state of science is still a work in progress, the reader should bear in mind the current thesis mainly concerns itself with investigating perceived barriers and facilitators for implementation within the entire Dutch mental

healthcare sector. In addition, one interviewee mentioned that more mental health stakeholders would be interested in NAT if research could demonstrate that NAT can be more cost-effective than conventional indoor therapy, resulting in less sessions per client (De Bruin et al., 2020).

So which stakeholders could play a significant role in the implementation of NAT? Collectively, the research by Cooley et al. (2020) and De Bruin et al. (2020) outline a critical role for stakeholders in the Dutch mental healthcare sector, such as educational institutes, the national government, public mental health institutes and healthcare insurance companies. Their public support and awareness might be a fundamental factor of success in this process. Involving stakeholders in societal transformations has the potential to increase its societal relevance and legitimacy and can identify the principal actors for change (Van Paassen, 2019)[1] The survival and success of NAT in the Netherlands cannot sustain without the coordinated involvement of organisations and institutes within or connected to the Dutch mental healthcare system and organisation. Langely et al. (2018) suggest that for co-creation of knowledge in healthcare, Knowledge Mobilisation (KMb), known as "the activation of available knowledge within a given context." (Langely et al., 2018, p. 1) is of vital importance. Furthermore, co-production of knowledge by multiple (academic) stakeholders ought to be practical for its end users, and barriers between the researchers and end users should be utilised and softened (Langely et al., 2018). Thus, in order to generate practical knowledge on the possibilities for successful implementation of the mental healthcare sector, NAT practitioners should collaborate with various stakeholders to establish societal legitimate research that resonates with the sector.

So far, only (outdoor) psychologists and practitioners and human-nature experts have been interviewed about their perspectives and experiences on the implementation of NAT in the Dutch *GGZ*. The current thesis was thus set out to examine the (implicit) perspectives and assumptions about NAT that a wider variety of Dutch stakeholders from the *GGZ* might have. Based on these outcomes, the aim of the current thesis is to gain insight in the stakeholder's views and perspectives of NAT and investigate which practical, organisational and therapeutical factors could hinder or facilitate further implementation of NAT into existing mental health services in the Netherlands. This will be done by building upon prior knowledge and future research recommendations gathered by Cooley et al. (2020) and the student report of De Bruin et al. (2020). Even though it should be acknowledged that more extensive research in the form of randomised control trials (RCT's) on the effectivity and efficiency of NAT is needed, the current thesis will cautiously and with advancing insight presume the validity of NAT's scientific foundation, however, that is outside the scope of the current thesis.

[1] Source derived from Brightspace WUR (not publicly available).

2. THEORETICAL FRAMEWORK

Within this chapter, a theoretical framework is constructed that determines the particular focus that I have with regard to the object under study , namely the interviews that I conducted. In other words, the three subchapters form the foundation of how I perceive the practical, therapeutical and organisational factors that could hinder or facilitate the implementation of NAT in the Dutch *GGZ*. Grant & Osanloo (2014) note that a theoretical framework can be regarded as a so-called 'blueprint' for your research or a "…lens with which you view the world…" (Grant & Osanloo, 2014, p. 20).

First, the comprehensive framework based on the experiences of both NAT practitioners and their clients will be discussed. Second, a brief overview of strategic stakeholder management will be presented. Third, the context of the current thesis, the organisation and structure of the Dutch mental healthcare sector, will be presented. Lastly, the three subchapters will be integrated into one conceptual model.

2.1 COMPREHENSIVE FRAMEWORK FOR NATURE-ASSISTED THERAPY

APPLICABILITY OF THE FRAMEWORK

In spite of stakeholder's reluctance against NAT, more and more psychologists take their clients outside (Cooley et al., 2020). This was confirmed by the study of De Bruin et al. (2020), in which the interviewed participants mentioned that they took their clients outside more often as a result of the COVID-19 restrictions in the Netherlands. Additionally, many mental healthcare practitioners pointed out that very little is known about the mechanisms underlying a successful implementation of NAT. Therefore, Cooley et al. (2020) established a framework for best practice in which they reviewed the experiences of mental health practitioners and their clients. This framework not only identifies relevant themes, such as enrichment of nature to therapy, but might also be of added value for relevant stakeholders questioning the scientific foundation for NAT, identified as one of the barriers for implementation by De Bruin et al. (2020). Therefore, I will discuss the relevant themes of this framework of best practice.

Cooley et al. (2020) reviewed 38 mixed-methods studies in order to expand their comprehension of the experiences of clients and practitioners that already practices NAT in the form of a best practice framework. The inclusion of multiple mental health professionals, instead of merely certified health psychologists (in Dutch: *GZ-psychologen*), allows each professional for their unique appraisal towards NAT, creating an integrative framework, (Cooley et al., 2020). The thematic analysis revealed first and second level themes, each of them that are illustrated in *figure 1* The themes relevant to my research questions and the interview content will be discussed below.

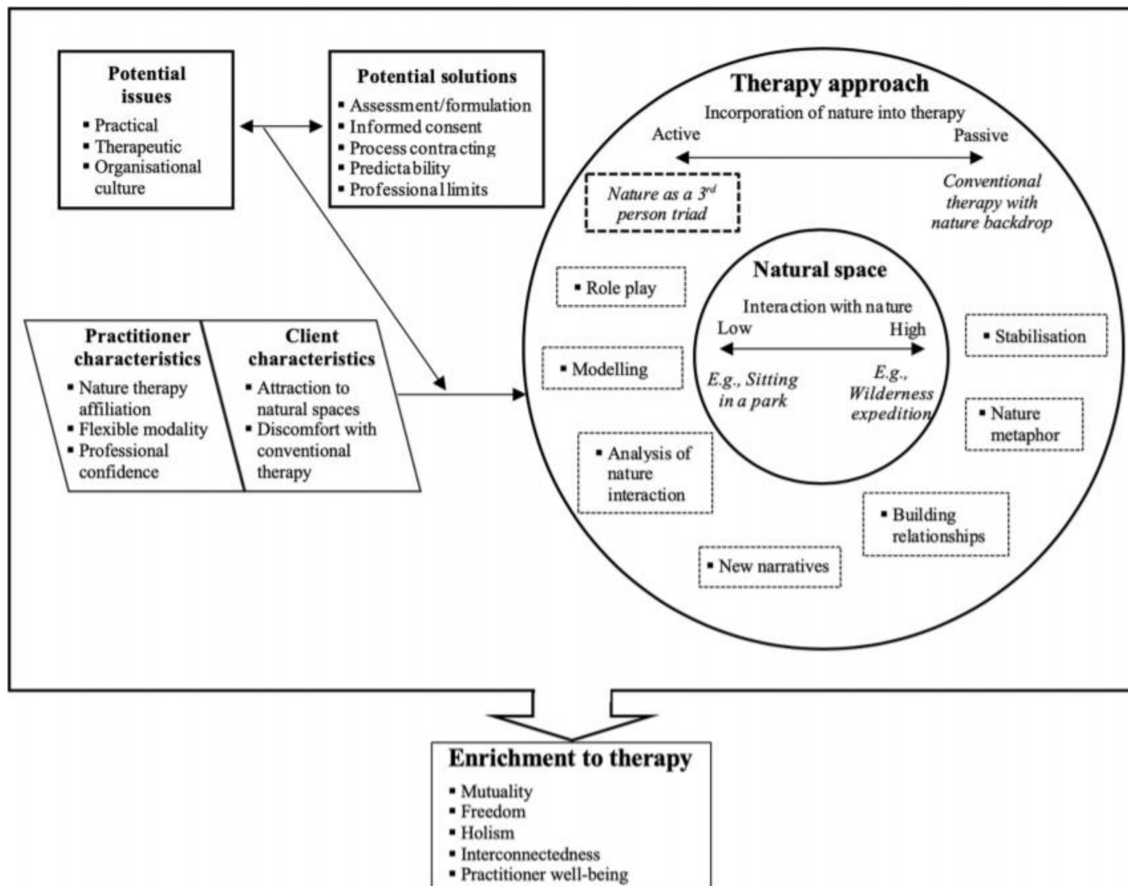

Figure 1; A comprehensive framework for nature-assisted therapy (Cooley et al., 2020)

RELEVANT THEMES

In *figure 1,* the first level themes are in **bold**, while the second level themes are written in standard lettering. Firstly, the authors classified the themes '**practitioner characteristics**' and '**client characteristics**'; both parties must be eager and confident to work with a rather unconventional therapy practice and feel a certain affiliation with nature. Additionally, the practitioner ought to have professional confidence to perform NAT. For those clients that expressed their level of discomfort with indoor settings for therapy, causing them to feel trapped, anxious, restless or uninspired, NAT might be a better opportunity (Cooley et al., 2020).

The third relevant first-level theme is '**therapy approach'**. Nature can provide a more passive background, closely resembling conventional therapy approaches, or its role could be active, in which the therapist acted as a mediator between clients and nature, allowing them to cultivate a direct relationship with nature. Once more, the approach allows itself for flexibility in this category. Furthermore, nature could be used for comfort during times of distress, labelled as 'stabilisation', and the unpredictable forces of nature could be used to relate to human struggles, named 'nature metaphors' and used to build relationships between families, clients and practitioners. On the more

active continuum, in ‘analysis of nature interactions’, the therapist could observe their client’s behaviour in nature, for instance, their walking pace could reveal a lot about their unconscious state of mind. A more experiential approach was to let clients engage with ‘role play’ activities, or learn directly from others who were “modelling” adequate behaviour whilst dealing with nature’s challenges. Finally, nature could foster the formation of ‘new narratives’ about certain life experiences.

A first-level theme of particular interest for the current thesis is ‘**potential issues**’, a theme that was also identified in my ACT report (de Bruin et al., 2020). I assume that these issues also might play a crucial role as to why most key stakeholders are quite reluctant towards further implementing NAT into the existing mental healthcare system. In *figure 1*, Cooley et al. (2020) distinguish between practical, therapeutic and organisational issues, which will be discussed below.

The first second-level theme, practical issues, includes the risks and uncertainties about the weather, terrain, and physical safety that clients and practitioners could encounter. Another practical issue was ‘access’, as some practitioners indicated that their therapy room was not surrounded by an abundancy of green areas. The second second-level issue, ‘therapeutic issues’, entailed a broad range of difficulties. For instance, the unpredictability of the natural space sometimes interfered with the cultivation of professional boundaries and structures, and emotional or physical reactivity of clients could be unpredictable. Lastly, another relevant therapeutical issue was a difficulty with adhering to ethical practice guidelines, which also implies that therapeutical encounters should maintain confidential. For instance, there is a potential chance that clients run into acquaintances.
The third second-level theme is ‘organisational issues’. As stated in the introduction, many NAT practitioners experience a perceived dominance of the biomedical model, in which counselling and therapy follows a rather ‘one-size-fits-all-approach’, is evidence-based and at its core build upon efficiency, calculability and predictability (Cooley et al., 2020), which makes it more strenuous for practitioners to experiment with NAT. Another organisational issue, which I also observed in my ACT report, is that most NAT practitioners, such as certified health psychologists, perceive “a lack of guidance and support from the wider profession” (Cooley et al., 2020, p. 8). This implies that NAT practitioners have to figure out a lot by themselves, lacking the adequate training programmes, supervision, ethical guidelines and best practice frameworks. Establishing those missing aspects with the whole health sector community could foster and strengthen the position and evidence-based quality of NAT in the Netherlands.

The fourth first-level theme of interest is , ‘**possible solutions**’, and it is what Cooley et al. (2020) frame as the answers to the issues mentioned in the previous paragraph. A first step for alleviating these issues is the ‘assessment and formulation’ of client’s physical and mental goodness-of-fit for NAT. A next step was to create an ‘informed consent’, a working contract between client and

professional, where the client is informed about its risks that they may encounter and both parties create an agreement regarding certain barriers they might face while practicing outdoors. 'Process contracting' would guarantee mutual and regular adaption and back casting to the contract, to see whether walking or sitting was more appropriate in the current session of a client's therapeutical journey. Introducing 'predictability 'of the therapeutic setting such as set time frames, despite some aspects of the natural area that cannot be controlled, ensured containment for both parties. A final solution to possible issues that was identified in their review was 'being aware of professional limits'. If deemed necessary, practitioners shouldn't hesitate to seek external help, for instance when taking part in an outdoor activity.

The final relevant first-level theme that Cooley et al. (2020) identified was '**enrichment to therapy**'. Both clients and professionals mentioned a perceived 'mutuality', both in the physical space and in their relationship, relaxing the strict hierarchical structure between client and professional and thereby also empowering the client in their therapeutical process and process. NAT also fostered a sense of 'freedom' in the expression of clients' emotions, and some even reported to feel relieved from daily life stressors and their mental health complaints (Cooley et al., 2020). NAT was also said to facilitate a more 'holistic' perspective of life, in which clients were better in tune with their emotions, behaviour, body and physical surroundings. Additionally, an overview of the studies revealed that clients enjoy a feeling of interconnectivity with nature, being part of a larger and more meaningful ecological system and a disconnection from modern technology. Finally, a last enrichment observed by Cooley et al. (2020) was an increase in 'practitioners wellbeing', a finding that was also supported by our ACT report, where both traditional and outdoor psychologists reported practicing outside improved their lifestyle and personal wellbeing (De Bruin et al., 2020).

In conclusion, the framework by Cooley et al. (2020) provides an integrative overview of the experiences of both clients and professionals practicing NAT. Moreover, it deliberates reflection for its planning and facilitation in training programmes and existing health services. In the context of my thesis, it prompts ample input I could probe with my participants as to what hinders or facilitates implementation of NAT in the Dutch mental healthcare sector. Strategic stakeholder management

2.2 STRATEGIC STAKEHOLDER MANAGEMENT

Providing that my research is mainly concerned with interviewing stakeholders, it is essential that we not only define them, but also examine their relative position in the Dutch mental healthcare sector in relation towards my main research question. Stakeholders are defined as "those groups or individuals who are affected by the organization as well as those who can affect it among the number of an organization's stakeholders" (Ackermann & Eden, 2011, p. 179). Ackermann & Eden (2011) note that strategic stakeholder management occurs while adjusting between the different, often competing interests that actors might have regarding its strategic goals. This is also the case for the stakeholders

that have been interviewed. Each one of them has their own agenda and interest in relative to NAT's implementation issue. For instance, the healthcare insurance companies might be primarily concerned its financial consequences, while NAT practioners are already convinced of its effectiveness and merely want to gain more publicity and credibility with regards to the mental health sector. The main objective of Ackermann & Eden (2011) was to identify those stakeholders that "have a powerful effect on the feasibility of an organization achieving its strategic goals and thus helping assure its long-term viability." (Ackermann & Eden, 2011, p. 181). In order to distinguish between the different types of stakeholders, the authors developed the 'Power-interest grid' to enable them to map the position of each stakeholder according to the dimensions power and interest (see *figure 2*).

As a result, 4 categories of stakeholders can be distinguished. Members in the upper most categories have the most interest in the issue-at-stake, but have varying degrees of power. 'Subjects' have low power (i.e. influence), but nevertheless show high interest in the issue-at-stake. In the context of my thesis, individuals such as psychologists who already practice NAT (e.g. outdoor psychologists, or other types of NAT practitioners) or want to experiment with the technique could be considered 'subjects'. In the Netherlands, this group is relatively small, while most psychologists depend on a referral from a GP or other medical doctor in order to receive clients (zorgwijzer.nl, 2020), which puts them in a very dependent position. However, Ackermann & Eden (2011) note that Top Mangement Teams (TMTs) could determine which activities they could undertake in order to increase their power, such as forming alliances with similar stakeholders. 'Players', on the other hand, score relatively high on both dimensions and thus form a very interesting category for strategic management (Ackermann & Eden, 2011). In the context of the current research, 'Players' might be identified as healthcare insurance companies or subsidy suppliers from the national government (such as *Zorginstituut Nederland*, National Health Care Institute) and other financiers that might be interested in the practice of NAT and want to support its growth and development in our country. Currently, these parties haven't been identified yet. The third category, 'Context setters', are those individuals that can significantly contribute to the issue (i.e. high in power), but could feel reluctant to do so (i.e. low in interest). Some of the interviewed stakeholders might belong to this group, such as prominent mental healthcare institutes and organisations. According to Ackermann & Eden (2011), those disinterested stakeholders should be made aware of the importance of the issue so they could be transformed into players. The last category, the "crowd" can be considered merely non-stakeholders, since management targeted at raising both their power and interest would probably outweigh its benefits.

In conclusion, the aim of the power-interest grid is to determine on which stakeholders we should prioritise in order to meet the further implementation of NAT in the Dutch healthcare sector. Even though it is not the main objective of the current thesis, a consequence of interviewing various stakeholders in the sector about hindering and facilitating factors and their position is that we can

determine their 'stakeholder salience', that is, which stakeholders should have our main focus with regards to the strategic goal (Ackermann & Eden, 2011; Mitchell et al., 1997).

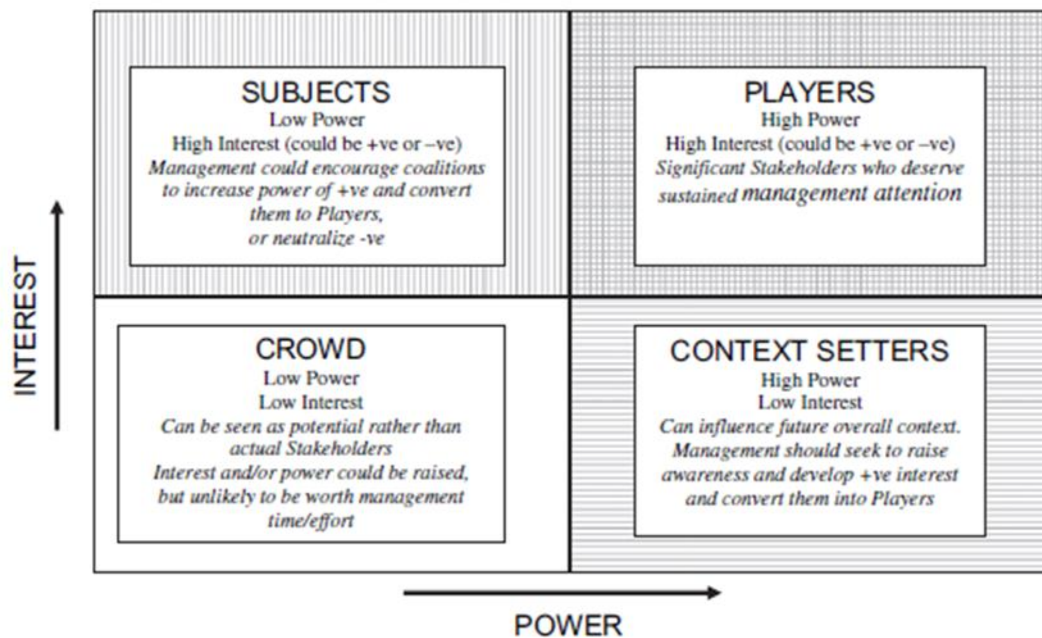

Figure 2; The power-interest grid for stakeholder management

2.3 DUTCH MENTAL HEALTHCARE SYSTEM & FUNDING

The Dutch mental healthcare sector (in Dutch: *Geestelijke Gezondheidszorg* or *GGZ*) is much of a system on its own and therefore justifies elaboration in a separate chapter. The current research predominantly positions itself within that system, provided that this research was set out to get a grasp on practical, therapeutical and organisational/structural factors that could hinder or facilitate implementation of NAT. Those factors are inherently tied to the organisation, structure and funding of this sector. Thus, to answer the main research question, it is of essential value to acquire a thorough understanding of its structure, a theme that will also be brought up during the interviews conducted for this study.

GENERAL STRUCTURE & REFERRAL

In recent years, the number of people that appeal to the Dutch mental healthcare has been increasing, up to 1,3 million people in 2017 (Algemene Rekenkamer, 2020). For the majority of those people, the starting point of referral is their local GP, who makes an indication of the severity and complexity of the psychological complaints. Depending on the GP's assessment, the individual will be provided with the most appropriate type of psychological care. When individuals experience 'mild' psychological complaints, they can be supported within the GP's primary care service. For instance, the doctor can prescribe certain medication, e-health modules and provide psychoeducation. Another option is that

those individuals can be counselled by the general practice-based nurse specialist (in Dutch: *Praktijkondersteuner Huisartsenzorg GGZ, POH-GGZ*) who can help them cognitively deal with those complaints (zorgwijzer.nl, 2020).

When complaints are considered of light to moderate severity, the person can be referred to the basic mental healthcare (in Dutch: *basis GGZ*) by a GP, occupational physician or other medical professional (e.g. geriatrician). The individual will usually be guided by a certified healthcare / neuro psychologist or a psychotherapist. In case of either very complex or severe complaints, or long history in which the individual didn't show initial improvement within the basic mental healthcare, the patient can be referred to specialised mental healthcare (in Dutch: *specialistische GGZ*), in which individuals can also be counselled by a psychiatrist on top of the mental health practitioners mentioned above (LVVP, n.d.).

REIMBURSEMENT MENTAL HEALTHCARE

The reimbursement system of the Dutch mental healthcare sector could be thought of as 'complex' the least. In general, psychological counselling is reimbursed from basic health insurance (in Dutch *basisverzekering*). The Dutch health insurance act (in Dutch: *Zorgverzekeringswet*) requires referral by a GP or medical specialist for any type of psychotherapy to be reimbursed by this insurance (LVVP, n.d.). Mental healthcare providers and institutions make annual agreements with contracted healthcare insurers about the maximum amount of care expenses that can be made, named "revenue ceiling" (in Dutch: *omzetplafond*). In case of exceedance of this particular ceiling, insurers might decide to cut the annual budget for a specific practitioner or institution (Nationale Rekenkamer, 2020), so mental healthcare providers try to avoid this at all costs.

kaasUnlike many other countries, in the Netherlands, 'psychologist' is not a protected professional title. For this reason, there are a lot of different types of registrations and qualifications for psychologists (NIP, n.d.). The exact definitions and differences between each type of registration or qualification lie outside the scope of relevance of the current thesis. However, the lack of protection of professional title and incoherence of all these different registrations and qualifications might be regarded as another hindering organisational factor relating to the structure and funding of the Dutch mental healthcare system. One of the most relevant protected professional titles for psychologists is *GZ-psycholoog*, or certified healthcare psychologist (NIP, n.d.), since they are usually contracted with the majority of healthcare insures (psyned.nl, 2021). As a consequence, the psychological counselling of individuals that are referred to certified healthcare psychologists will be reimbursed.

Counselling by psychologists without this protected professional title and without referral from a GP (LVVP, n.d..) won't automatically be covered by Dutch healthcare insurances and implies that individuals partly have to cover the cost of therapy themselves, depending on the company and type of

healthcare insurance they have (psyned.nl, 2021) Yet, not all certified health psychologists have contracts with all of the different health insurance companies. Furthermore, therapy will solely be covered provided that the individual is suffering from a condition that is mentioned in the DMS-V (Diagnostic and Statistical Manual of Mental Disorders) (Ministerie van Volksgezondheid, Welzijn en Sport 2021). The rather complex reimbursement system for psychological counselling can be considered a direct result of market forces in healthcare, which might be another hindering factor in the implementation of NAT.

A simplified overview of the Dutch mental healthcare system, its referral and funding is illustrated in *figure 3* below. The blue boxes, GP & POH-GGZ (in Dutch: *huisartsenzorg*), basic mental healthcare and specialised mental healthcare are funded by the Dutch Health Insurance Act. The yellow box represents mental healthcare for minors and is funded by the Youth Act (in Dutch: *Jeugdwet*) and is carried out by local municipalities. The two brown boxes depict mental healthcare that is funded by the Dutch Long-term Healthcare Act (in Dutch: *Wet langdurige zorg, Wlz*) and the Dutch Social Support Act (in Dutch: *Wet Maatschappelijke Ondersteuning, WMO*). The double arrows indicate referral and feedback between primary care and the basic and specialised mental healthcare. For instance, once an individual has finalised psychological counselling within specialised mental healthcare, their GP might check in with them frequently and might ask their former mental health practitioner for aftercare.

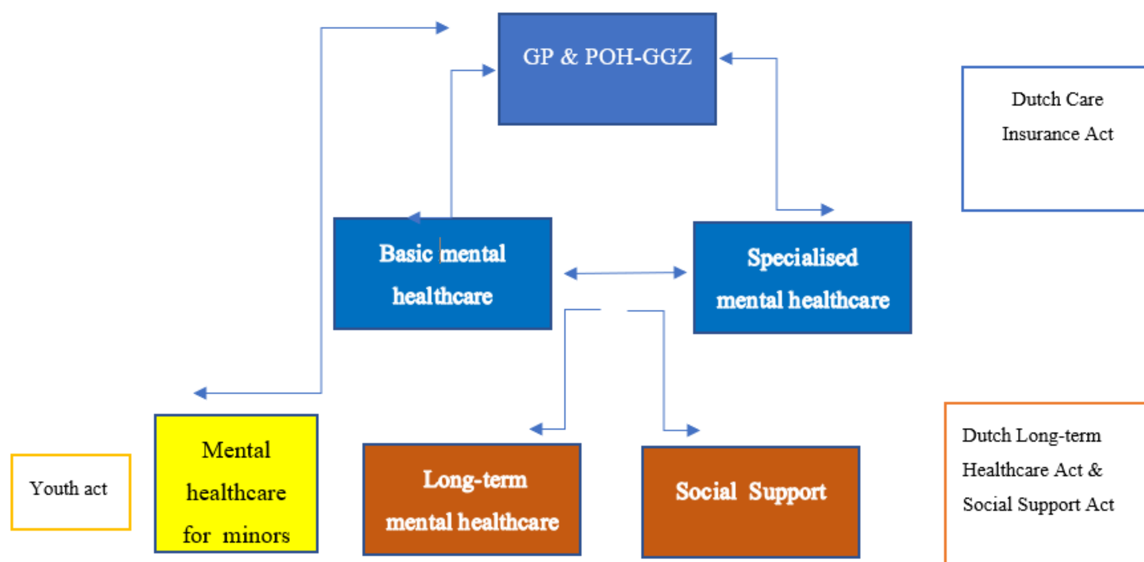

Figure 3; Structure, funding and referral in the Dutch mental healthcare sector (Algemene Rekenkamer, 2020; Zorgwijzer.nl, 2020)

ROLE OF NATIONAL HEALTH CARE INSTITUTE & INSURANCE COMPANIES

In addition to referral, professional title of practitioner, classification according to the DSM-V and agreements made with the specific healthcare practitioner, there is yet another complicating factor which determines whether a specific type of psychotherapy is reimbursed. This depends on the judgement of whether or not the specific therapy is deemed 'effective and evidence-based' and complies with the 'current state of science and practice'. These guidelines are drawn up by the National Health Care Institute in Dutch: *Zorginstituut Nederland*) and have to be executed by the individual healthcare insurance companies (National Health Care Institute, April 29th, 2021). Put another way, the Dutch Health Insurance Act (in Dutch: Zorgverzekeringswet) requires that the healthcare insurers are primarily responsible for the effectivity assessment of new interventions or treatments, while the National Health Care Institute functions more as advisory board with the fundamental requirements.

Other package criteria for healthcare innovations are cost-effectiveness, necessity and feasibility (National Health Care Institute, personal communication, April 29th, 2021). If insurance companies are unsure whether or not a psychological intervention adheres to these requirements, they might consult the National Health Care Institute. Furthermore, the individual insurance companies are supported by an advisory panel that is called "Procedure healthcare advise GGZ", which consists of "Dutch Healthcare Insurers (in Dutch: *Zorgverzekeraars Nederland*) and "Knowledge centre GGZ" (in Dutch: *Kenniscentrum GGZ*). Furthermore, the assessment on whether new healthcare should be taken up in the basic healthcare insurance is supported by other stakeholders, such as patient associations, healthcare insurance companies and marketing authorisation holders of medication (if applicable) (National Health Care Institute, personal communication, April 29th, 2021).

This procedure suggests that the National Dutch Health Care Institute and insurance companies have a dominant influence over the choice and interpretation of healthcare treatments or interventions that are either rejected or accepted as being reimbursed from the basic healthcare insurance. Their dominant position suggests that both the National Health Care Institute and healthcare insurance companies, including umbrella organisations like "Dutch Healthcare Insurers" can be regarded as parties with a lot of power and influence over the current issue-at-stake.

POTENTIAL REIMBURSEMENT FOR NAT

There are a few different options for NAT to be (partly) reimbursed by individual healthcare insurers. Provided that the practitioner is a certified health psychologist (*GZ-psycholoog*), that is counselling clients diagnosed according to the DSM-V, the trajectory will be fully covered with contracted insurance companies (zorgwijzer.nl, 2021). Potential reimbursement of NAT could be regarded as a facilitating factor, since its financial coverage by healthcare insurers gives individual practitioners the

possibility to experiment with this therapy application. Nevertheless, the reimbursement will be done on the precondition that the session will be no different from a regular indoor therapy session, which usually takes 45 minutes for the therapy session and 15 minutes for reporting in the client's dossier. For an outdoor session, it might be more difficult to adhere to this schedule.

When the practitioner is either not contracted with the client's health insurance company or working as a master psychologist (in Dutch: *basispsycholoog*), clients themselves have to submit their bill to their insurance. In that latter case, depending on the type of insurance, approximately 50 to 80% of total costs will be reimbursed (psyned.nl, 2021). If that is not the case, the insurance might cover therapy from individual additional insurance (in Dutch: *aanvullende verzekering*) (Ministerie van Volksgezondheid, Welzijn en Sport, 2021). However, in this scenario, there is an assumption that NAT can be assigned under the "conventional" therapy options, like cognitive behavioural therapy. Another scenario might be that is will be regarded as a new form/approach to psychotherapy. In the latter case, the National Health Care Institute (personal communication, April 29th, 2021) pointed out that is crucial to find support in academic professional associations that inspect whether enough scientific evidence on the application of this new therapy approach has yet been compiled and whether this new approach adheres to the requirements and guidelines set out by academic professional association.

Of course, the facilitating and hindering factors suggested in this chapter are not the only justifications for a lack of implementation of NAT in the Dutch mental healthcare sector. The current thesis is an attempt to uncover multiple factors that could hinder or facilitate NAT implementation. These are not only organisational (concerning the structure of the mental healthcare sector among others), but also practical and therapeutical factors, which will be achieved via semi-structured interviews with a variety of stakeholders from the Dutch mental healthcare sector.

2.4 INTEGRATION OF THEORIES

The final theoretical framework consist of; the comprehensive framework of NAT by Cooley et al. (2020), theory about strategic stakeholder management by Ackermann & Eden (2011) and Van Paassen (2019) and theoretical knowledge about the systematic organisation and funding of the Dutch mental healthcare sector (e.g. zorgwijzer.nl, 2021; Ministerie van Volksgezondheid, Welzijn en Sport, 2021; psyned.nl. 2021; Algemene Rekenkamer, 2020; LVVP, n.d). Collectively, they structure and guide my research. Nevertheless, the separate theories, concepts and models should also be integrated into a holistic framework. Both the strategic stakeholder management and the background information about the organisation, structure and funding of the Dutch mental healthcare sector can be related to the comprehensive framework of Cooley et al. (2020). In the study by Cooley at al. (2020) the participants of the meta-synthesis were all NAT practitioners and their clients. However, in the current thesis, the study participants that will be interviewed about the relevant themes identified in this

comprehensive framework are a variety of Dutch stakeholders from the mental healthcare sector. Therefore, it justifies to gather strategic stakeholder management knowledge, since it could facilitate determining how these stakeholders should be categorised and which stakeholders should be paid most attention towards in the future. Additionally, the background information about the Dutch mental healthcare sector allows for a rich and in-depth understanding of the input from my interviewees, who know the sector inside out. Since the purpose of the current thesis is to explore which factors that directly or closely relate to the Dutch mental healthcare sector can either hinder or facilitate the professional development of NAT, it is of fundamental value to investigate this setting of which my interviewed stakeholders are part of.

In sum, the relevant themes that are part of the comprehensive framework by Cooley et al. (2020) form the foundation of my theoretical framework, the theory about strategic stakeholder management by Ackermann & Eden (2011) and the organisation of the Dutch mental healthcare sector provide the necessary context about the type of study participants and the current research setting they belong to.

3. RESEARCH QUESTION

The introduction, theoretical framework and chapter concerning the Dutch mental healthcare lead to the following main research question:

Which practical, therapeutical and organisational/structural factors hinder or facilitate the implementation of nature-assisted therapies in the Dutch mental healthcare sector (GGZ)?

This research question will be answered by building upon the knowledge gained through qualitative research in the form of semi-structured interviews conducted with several stakeholders in the Dutch mental healthcare sector.

4. METHODOLOGY

In this chapter, the methodology applied to the research question will be discussed. First, I will elaborate on the methodological design. Second, data collection via means of interviewing will be examined. Third, the construction of the research instrument is discussed.

4.1 METHODOLOGICAL DESIGN

For the current thesis, a qualitative research design is chosen. According to Creswell (2014), a qualitative study design is "… an approach for exploring and understanding the meaning of individuals or groups ascribe to a social or human problem." (Creswell, 2014, p.2). Thus, I consider it a valid option for getting a grip on the (implicit) opinions and perspectives of a variety of different stakeholders in the Dutch mental healthcare sector (*GGZ*). A qualitative research design is especially useful provided that limited research has been done on the subject and it has never been studied with the particular participants under study (Creswell, 2014). Thus, using a qualitative study design might unravel unexpected but crucial themes that influence the opinion and attitude of a variety of stakeholders in the Dutch mental healthcare sector, which has not been done before.

4.2 DATA COLLECTION: INTERVIEWS

RECRUITMENT OF MENTAL HEALTHCARE STAKEHOLDERS

It was attempted to recruit a varied group of Dutch stakeholders from the mental healthcare sector through means of non-probability sampling. The types of non-probability sampling that I used were convenience (also known as accidental) and snowball sampling. I already knew some people in my network that worked within or with the Dutch *GGZ*. Eventually I started recruiting study participants online via LinkedIn, phone or email. Etikan, Musa & Alkassim (2016) state that convenience sampling is mainly adopted when members of the study population meet certain practicalities, such as availability within the data collection phase, willingness to participate to the study and easy accessibility to the researcher. The interviews were conducted between February and April 2021.

The goal was to recruit approximately 15 participants. Eventually, I recruited 14 participants, of which 13 completed an online semi-structured interview and 1 participant answered a selection of interview questions via email, due to a lack of time. Of the 30 participants that I approached, 14 of them were eager to participate, which lead to a response rate of approximately 47%. The main obstacles in the recruiting phase were the willingness to participate and the specificity of the study population. The sample population is quite limited, since participants were required to work within or with the Dutch *GGZ* and many were unfamiliar with NAT (or in Dutch: *buitenpsychologie/therapie*). Many stakeholders that I contacted did not reply at all, said they were not interested or communicated that

they did not know anything about NAT and were doubting if they were the ‘right participant’ for me. Many people also informed that they cannot find the time for an interview at the moment, explaining that they were very busy because of covid-19-related reasons. Indeed, this could be a valid argument, since a worldwide survey of the WHO found that COVID-19 has not only disrupted existing mental health services, but also puts increased demands on this sector (WHO, 2020).

As can be seen in *table 1* underneath, I was able to recruit a very diverse group of stakeholders, belonging to five different profession groups, each one having their own unique position in the healthcare sector.

Profession group	**Mental health practitioner**	**Policy in health insurances**	**Social work / Counselling**	**Primary care**	**Expert health & wellbeing**
Specific profession	Certified health psychologist (*GZ-psycholoog*), psychotherapist	Medical adviser *GGZ* at healthcare insurance company	Sociotherapist psychiatric institution	General Practitioner first aid	Expert human health & nature
	Certified health psychologist & running therapist	Policy advisor GGZ at healthcare insurance company	All-round mentor psychiatric institution	Manager multidisciplinary healthcare foundation in primary care	
	Manager and psychiatrist of psychology practice		Social worker (own practice)	Manager POH-GGZ	
	Manager and certified health psychologist at psychology practice			National Health Care Institute (*Zorginstituut Nederland*)	

Table 1 An overview of the professions of the interviewed stakeholders

DEVELOPMENT OF RESEARCH INSTRUMENT: IN-PERSON INTERVIEWS

Based on the problem statement, research question and the comprehensive framework by Cooley et al. (2020), crucial themes that formed the foundation for the semis-structured interview could be identified. Topics of the interview contained participant's familiarity and opinion on NAT, facilitating and hindering factors for the implementation of NAT and lastly, role and position and their overall opinion about the Dutch mental healthcare sector in general. *Table 2*below summarises the content and function of each part of the interview guide and the conceptual model or framework it is based on. The complete interview guide can be found in the appendix. Still, it is important to note that the specific topics, questions and order are not 'carved in stone' (Adams, 2015). Some interviewees might place more emphasis on certain topics than others, based on their education, professional background and personal preferences and dislikes. Both the interview guide and actual interviews were carried out in Dutch.

Interview part	**Content**	**Theoretical construct**
1. Introduction	Brief explanation of research procedure and purpose. Checking participant's interview consent Getting to know participant's profession and link with mental healthcare	-
2. Opinion NAT in Dutch mental healthcare	Assessing participant's familiarity with NAT Exploring participant's opinion and associations with NAT	Interest dimension of the power-interest grid (Ackermann & Eden, 2011)
3. Facilitating factors implementatio n	Future developments in Dutch mental healthcare sector Identification of salient stakeholders for implementation of NAT Existing possibilities for NAT in Dutch mental healthcare sector	Possible solutions in 'Best practice framework' by Cooley et al. (2020) Strategic stakeholder management and increasing power by forming alliances of stakeholders (Ackermann & Eden, 2011)

4. Hindering factors implementation	Participant's perspective on hindering factors (practical, organisational, therapeutical) concerning system and organisation of Dutch mental healthcare sector Influence of Dutch mental healthcare sector on implementation of NAT	Potential issues in 'Best practice framework by Cooley et al. (2020) Dutch mental healthcare system and funding (e.g. zorgwijzer.nl, 2020; Nationale Rekenkamer, 2020)
5. Role and position within Dutch mental healthcare sector	Determining participant's power by asking about their stakeholder relations Exploring general opinion on alliances in Dutch mental healthcare sector	Power dimension of power-interest grid (Ackermann & Eden, 2011) Dutch mental healthcare system and funding (e.g. zorgwijzer.nl, 2020; Nationale Rekenkamer, 2020)

Table 2 Specific parts, content and theoretical constructs of the interview guide

DEVELOPMENT OF RESEARCH INSTRUMENT: EMAIL INTERVIEW

As stated in section "Data collection: interviews" , the National Health Care Institute (in Dutch: *Zorginstituut Nederland*) chose to answer the interview questions via e-mail instead of phone or video call. Due to a lack of time and resources, it was chosen to deviate from the interview guide created for the current research, and instead send a limited amount of questions specifically tailored to the tasks, organisation and structure of the National Health Care Institute, that would have been difficukt to answer by other stakeholders. Hence, their answers could complement the input brought up by other participants and theoretical knowledge about the Dutch healthcare system in general (mentioned in a separate chapter). For a complete overview of these adapted interview questions, see the appendix.

INTERVIEW PREPARATION

Before participation to the interview, either written and/or verbal consent was agreed upon by the researcher and participant. I made sure that participants received the informed consent before the interview appointment, so they could inform themselves about the content of the study and their rights as a participant of qualitative research. Additionally, the informed consent emphasised that their identity would remain anonymous by numbering the participants in sequential order. Before starting the actual interview, I always checked if respondents agreed with the recording of the interviews. Of the 14 participants, 9 gave written and 5 gave verbal consent. Some participants had been unable to

read the informed consent beforehand. In the latter case, I provided a brief outline of the informed consent and asked for their verbal consent instantaneously.

Another crucial aspect is that I always stressed that my participants did not have to have a lot of knowledge about NAT beforehand. Some participants told me that they worried whether they were not informed enough about the subject. I covered this by providing a quick overview of NAT during the interview, so the confusion about the definition and terminology of NAT would be minimised. Nevertheless, its Dutch definition still raised some questions in participants. The exact outcomes and implication of this theme will be discussed further in the chapters Results and Discussion.

4.3 DATA ANALYSIS INTERVIEWS

Even though the research of the current thesis is of mere explorative nature, both top-down (deductive) and bottom-up (inductive) coding have been applied to the interviews, since main and subthemes discussed in the theoretical framework by Cooley et al. (2020) identified in best practice framework by Cooley et al. (2020) were the foundation of the top-down coding scheme. However, throughout the interviews with all different kind of stakeholders, new, additional and expected themes were also expected to arise, since a wide variety of stakeholders in the Dutch mental healthcare sector were interviewed and might all have their unique view on the interview topic and the sector they work in.

The data analysis was a more or less iterative and cyclic process. Firstly, all of the interviews have been transcribed by hand in Microsoft Word. The next step was to actually familiarise myself with the data by reading through the transcribed interviews. Then, open coding (known as first cycle coding) was applied to five out of 13 of the interviews. This was done by hand with a printout of the interviews. Because of the explorative approach of the current thesis, I choose descriptive coding. Miles, Huberman & Saldaña (2013) explain descriptive coding as one of the most fundamental approaches to coding units of qualitative data. All of the assigned codes were still individual labels without an overarching theme. After coding five interviews by hand, the coding process was continued in Quirkos, a software programme for qualitative data analysis. The second cycle coding, also called ‘pattern coding’ by Miles, Huberman & Saldaña (2013), allowed for some data reduction in the amount of first cycle coding themes into a few main themes. Initially, ten main themes were established. After the final revision of the main and subthemes and reflection on the research question, 5 main themes remained, each having between three to seven sub themes.

5. RESULTS

5.1 GENERAL CHARACTERISTICS INTERVIEWEES

According to the interviewed participants, consisting of various employees that work with or within the Dutch mental healthcare sector, there are a plethora of factors that could, depending on the specific setting and context, be either hindering or facilitating the further implementation of NAT in the Dutch mental healthcare sector.

In total, a group of 14 participants have been interviewed, of whom 5 where female, 8 were male and one representing an organisation, namely the National Health Care Institute. Under this section, the results of the 'in person' interviews will be presented. The results of the written e-mail interview with the National Health Care Institute have been integrated within the disquisition of the Dutch mental healthcare sector within the theoretical framework and have also partly determined the thematic codes that could be recognised in my overall data. Furthermore, based on the five profession groups established in the methods chapter, 4 of the interviewees could be categorised as mental health practitioners, 2 as policy makers working for insurance companies, 3 interviewees being a social worker, 3 working in primary healthcare and 1 expert in health and wellbeing (with the history of working for a local health insurance company). For the purpose of clarification, the anonymised interviewee identities have been added. An overview of the categorisation of interviewees according to the profession groups and corresponding interviewee numbers can be found in *table 3* below. In addition, the interviewees could be identified conforming to the four stakeholder groups as suggested by Ackermann & Eden (2011) in the theoretical framework, as illustrated by *table 4* below. The allotment to each stakeholder group have been based on the two dimensions in their power-interest grid. Furter interpretation and implications for the current research of these categorisations will be reviewed in the discussion chapter.

Profession group	**Mental health practitioner**	**Policy in health insurances**	**Social work / Counselling**	**Primary care**	**Expert health & wellbeing**
Count	4	3	3	3	1

Table 3; Categorisation of interviewees based on profession group

Stakeholder group	Subjects	Players	Crowd	Context setters
Count	6	2	0	6

Table 4; Categorisation according to the stakeholder groups of Ackermann & Eden (2011)

5.2 MAIN AND SUB-THEMES INTERVIEWS

In this section, the main and sub-themes that recurred from the 13 semi-structured interviews will be presented. In total, five main themes have been established; practical & organisational aspects, culture & characteristics of the Dutch healthcare sector, characteristics & beliefs of stakeholders and practitioners, client & therapy characteristics and recommendations for further implementation. Each main theme and its associated sub themes will be elaborated below.

PRACTICAL & ORGANISATIONAL ASPECTS

A theme often recurred was practical & organisational aspects. This theme had to do with all activities and factors that should be taken into account, provided that someone would actually start to practice NAT with their clients. Some were more on the practical side, such as the influence of the outdoor setting, while others had to do with the re-organisation of a counselling practice. Among this main-theme, I found the following subthemes:

1. **Implementation ideas:** a lot of participants, especially those who had experience with setting up their own primary care alliance or psychology practice, gave ample ideas on how NAT could organise themselves professionally by either presenting it as an totally new group of therapy or as a supplement to conventional therapy. For instance, one of the interviewees, a policymaker for a mayor health insurer stated that:
   "…NAT can further implement itself into the Dutch mental healthcare by either; seeing if NAT can be accommodated within the existing therapies that have been approved, or it should be introduced as a completely new therapy approach. However, the consequence of choosing the latter is that it needs be supported by ample new scientific and practical evidence of its efficacy."
2. **Definition of NAT:** Some participants doubted whether the Dutch definition for NAT, "buitenpsychologie", is actually an adequate translation, as its definition brought up confusion in several participants. Does it assume that it should only be practiced by psychologists? Does it cover both therapy and counselling? Those who questioned its exact definition and its professional limits also suggested different Dutch definitions for NAT. One of them was a social worker who coined a different Dutch name for NAT:
   "… to me, outdoor psychology suggests that it should only be practiced by psychologists, is it? That might be confusing, since you told me other mental health practitioners could also take their clients outside. A better name might by green (mental) care."
3. **Time:** A lot of participants expected that NAT will be more time-costly compared to indoor therapy, since both therapist and client need to travel and forth to the outdoor setting, and this will be subtracted from actual time that is needed for the therapy session, which is generally

45 minutes per client. This issue is also illustrated what one interviewee, a psychologist said: *"… you will always have to take into account some time for travelling in-between sessions, and I'm unsure if every employer wants to reimburse that loss of time."*

4. **Costs:** Consequently, as most interviewees agreed that NAT sessions need more time, participants thought it might be more expensive than conventional therapy. Several participants mentioned that mayor mental health institutions will always opt for the cheapest therapy option. However, if the costs for NAT would be equal to indoor therapy, it might create opportunities for more mental health practitioners to experiment with NAT.
5. **Location:** Whether an outdoor setting is suitable for NAT, typically depends on the location of the therapist's practice. Practicing NAT in the centre of Amsterdam can be considered less ideal than a practice that is located on the forest edge of Wageningen. Clients might become too distracted by the noise and people passing by in urban green areas, such as parks.
6. **Privacy:** Depending on the location and the crowdedness of that natural area, therapist and client might experience compromised privacy. While this might be reasonable for some types of clients and problems, others might experience severe disruption or distress and discussion of their complaints demands a quiet and discrete surrounding.
7. **Making notes:** Several participants questioned whether and how the therapist could take notes or explain something visually while practicing therapy outdoors. On the other hand, one of the participants, a human-nature expert brought up that one could record the session with a Dictaphone or voice recorder and that this would safe time instead of writing out lengthy reports.

CULTURE & CHARACTERISTICS OF THE DUTCH HEALTHCARE SECTOR

The second main theme identified was Culture and characteristics of the Dutch healthcare sector. Because the exploration of barriers and facilitators for the implementation of NAT mainly take place in the setting of the Dutch mental healthcare sector, many brought up characteristics of the Dutch mental healthcare system that can influence its implementation with either hindering or facilitating factors. Among this main theme, I found the following subthemes:

1. **Reluctance/Conservative approach:** Multiple participants pointed out that the Dutch mental healthcare sector in itself is quite conservative. One interviewee stated that if several therapy approaches (e.g. cognitive behavioural therapy and psychopharmaceuticals) have already been proven to be effective in alleviating psychological problems, they might not be very eager to experiment with another new therapy approach. As one of the interviewees, working in primary care, stated:
   "I think, within the mental healthcare sector, there has been a quite conservative approach towards treatment options. If, for example, you are a therapist and you have been given the

same type of therapy for more than ten years, then you have the efficacy and professional confidence that it is doing what it is supposed to do and you will not be very eager to experiment with new approaches, because that means you will have to admit that your prior approach maybe wasn't that good, that is difficult to do for most people."

2. **Scarcity of resources and capacity:** The majority of interviewees indicated their frustration towards the financial cuts on space and personnel. Some participants even went as far as claiming there is a tendency of general impoverishment of care. One of the participants, who had a background in the somatic healthcare, was quite confused by the lack of resources, capacity and the long waiting lists in general. As he noted:
   "I have never quite seen anything like that in somatic healthcare. The doctor will never tell you: sorry, we haven't made enough healthcare purchases for your urgent heart surgery, so we cannot treat you."
   He wondered if mental healthcare could possibly learn something from somatic healthcare.
3. **Prominent role of insurance companies:** Those who worked as mental health practitioners (usually psychologists) ventilated their frustration about the prominent role of healthcare insurance companies in treatment options. In general, the contracted insurance company determines the type and amount therapy sessions that are deemed effective for each type of psychological problem, thus putting the practitioners in a dependent position. A practice holder of his own psychological practice noted.
   "You know [Sanne] that has been such a difficult issue. The moment you think you understand the financing system completely, it radically changes by law. Sometimes, that resulted in treatment trajectories that had been reimbursed earlier, who now had been denied, leading to a conflict between us and our contracted insurance companies."
4. **Complexity of financing & structure:** Some participants indicated that the financing system of the Dutch mental healthcare system is relatively complex and is constantly subject to change. As a consequence, they experience a lack of flexibility in therapy approach and difficulty in tailoring to each individual client. One of the interviewees, who has been a psychiatrist for a reasonable time noticed a total change of the mental healthcare system and organisation as the years passed by:
   "What I've seen changing is that nowadays, you have many more providers than back in the old days. Not that many organisations, but I always knew where I could send my patients who needed more specialised care. However, this is the consequence of the market forces in modern healthcare, there has been a steep increase in the amount of competition of mental healthcare providers. Of course, healthcare insurers want the cheapest provider available, so many institutions that I knew have gone bankrupt. And in my opinion, the quality of the new mental healthcare providers isn't always that good"

CHARACTERISTICS & BELIEFS OF THE STAKEHOLDERS AND PRACTITIONERS

The third main theme is characteristics and beliefs of the stakeholders and practitioners. The wide variety of interviewed stakeholders resulted in different attitudes and beliefs towards the implementation of NAT in the Dutch mental healthcare sector. Those attitudes and beliefs partly define whether or not mental health practitioners might consider working with NAT or even consider it a valid therapy application (not all interviewees identified as mental health practitioners).

1. **Perceived added value of NAT:** The majority of interviewees could imagine the added value of NAT compared to conventional therapy. This sub-theme included benefits such as: physical and mental activation of the client, being outdoors and relief of stress in both client and therapist. This is illustrated by one of the interviewees, a social worker said, as she stated that undertaking an activity while talking seems to ease up the conversation in some type of clients, who might feel uncomfortable sitting still in an indoor setting.
2. **Unfamiliarity/Reluctance against NAT:** Unfamiliarity with NAT and its possibilities for both clients and therapists is assumed to result in a reluctance to experiment with it. Additionally, many interviewees pointed out that therapists are often quite conservative in their therapy approach. Why should they change it when it's already working? It became clear from an interview with a psychiatrist that this reluctance and unfamiliarity can also be caused by a lack of room for experimentation with more 'alternative' therapy options. Management teams often have difficulties keeping up with the tight annual budgets, so the way it's organised does not facilitate therapy innovations.
3. **Physical/Mental capacity:** Many participants thought that practicing outdoors would place additional mental and physical burden on therapists themselves. Therapists should be physically fit and ought to have ample mental capacity for improvising with NAT. Not all therapist might feel enough professional confidence to go outside with their clients. As interviewee 1, a social worker noted: "You can't expect a therapist walk for more than 8 hours per day.
4. **Intrinsic motivation to practice NAT:** Interviewees stressed that therapists' intrinsic motivation and affiliation with nature is one of the most important stepping stones for implementing NAT. The decision to start with NAT should be bottom-up (brought up by therapists and clients), not top-down (imposed by management teams of mental health institutions). Therapists and clients themselves have to decide whether they would like to practice outside.

CLIENT & THERAPY CHARACTERISTICS

The fourth main theme identified is client and therapy characteristics. Not every client might be willing to be counselled in the outdoor setting, and not all types of psychological problems lend themselves for the outdoor approach.

1. **Physical and mental (Contra)indications:** Not all types of clients and psychological problems lend themselves for outdoor therapy. There might be physical contraindications, such as having COPD or psychological contraindications, such as certain phobias or anxieties. On the other hand, interviewee 13 also revealed that this could also be an ideal setting to conquer their phobias by means of exposure therapy, for instance, when a client suffers from agoraphobia.
2. **Reluctance of clients:** Just like therapists, clients might also experience reluctance to go outdoors. This might be the result of unfamiliarity, but could also be caused by a lack of affiliation with nature or lethargic behaviour resulting from the psychological problem they struggle with.
3. **Type and trajectory of therapy:** Not all types of therapy are suitable for the outdoor setting. As some interviewees pointed out, trauma and EMDR are more difficult to carry out in nature. In the same vein, intakes are deemed to take place in an indoor setting, as the practitioner has to process a lot of client information in a brief window of time. However, it also depends on the therapy goal. According to an interviewed certified health psychologist, NAT should be complementary to conventional therapy. She mentioned that some clients have difficulties expressing themselves and kicking off the start of a new day. In that case, NAT could be part of a complementary intervention build up a healthy habit as part of the therapy process

RECOMMENDATIONS FOR FURTHER IMPLEMENTATION

The last main theme, primarily consists of **recommendations for further implementation**. A lot of participants, especially those who established a mental health practice themselves, had several ideas for progression. These consist of:

1. **Creating publicity:** A subtheme often mentioned is that practitioners should be made aware of the applications and possibilities of NAT in the mental healthcare sector. As one interviewee mentioned: “It all starts with awareness. Unknown usually means unloved”
2. **Research about NAT:** Nowadays, the paramount factor of credibility and validity of any type of therapy is evidence-based research. Not only should it touch upon its general effectivity, it should also be investigated for what type of clients and problems it works best.
3. **Practical applications with NAT:** Interviewees point out that a practitioner can take their clients outdoors for various reasons and with several different approaches. For instance, one

interviewee explained that some of her colleagues (social workers and mentors) already take the clients that they counsel outdoors. It can be used to calm them down, to distract them from disruptive thoughts and instead start to observe the surrounding of nature.

4. **Ideas for supporting or expanding NAT:** Many interviewees had ideas and suggestions for taking the implementation of NAT a step further. This not only included parties they could form an alliance or collaboration with, but also dealt with creating an interest group or association of NAT practitioners, so they can exchange best practices and protocols for outdoor therapy. For instance, interviewee 13, an advisor for a major insurance company, mentioned that is very important that there is a professional NAT association, in which NAT practitioners can unite and later decide to develop some sort of quality register and practical guidelines.

5.3 OVERARCHING THEME OF INTERVIEW RESULTS

In general, all of the discussed main and subthemes touched upon one general, overarching theme, namely characteristics that should be taken into consideration for implementation of NAT in the Dutch healthcare sector. *Figure 4* provides a brief overview of the main themes discussed in the results chapter:

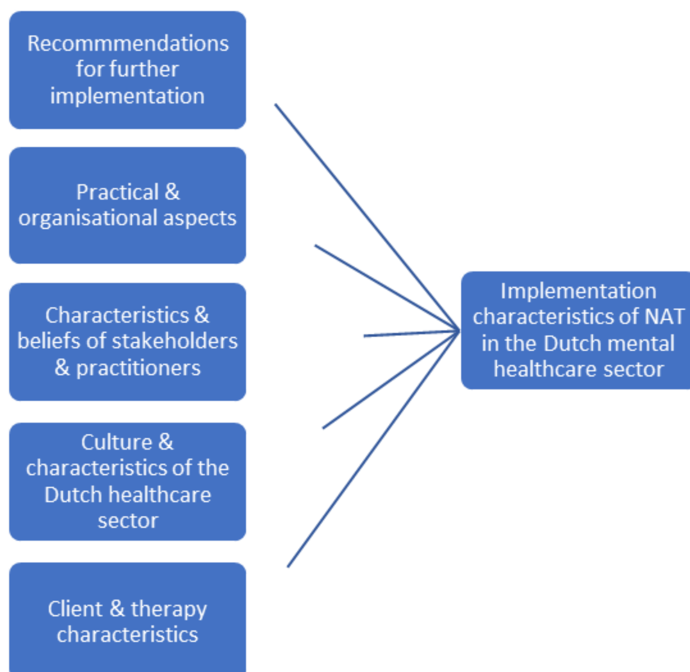

Figure 4; An overview of the main themes of the implementation of NAT in the Dutch healthcare sector

6. DISCUSSION

In this chapter, the results will be discussed more extensively and put into context. First, the main and sub themes will be interpreted and identified as facilitators and barriers, as established in the methods and results chapter. Second, the internal and external validity of the current research will be examined. Lastly, the research limitations and implications for further research will be discussed.

6.1 FACILITATING AND HINDERING FACTORS

The research question of whether a certain main or subtheme is either a facilitator or hindering factor, is context-sensitive and sometimes ambiguous, while for other main themes, this seems more straightforward and it could easily be categorised as either hindering or facilitating. Thus, this results in three different kind of factors; those that could be identified as both facilitators or hinderers and those that could undeniably identified as either facilitator or hinderer.

For instance, whether the main theme **client & therapy characteristics** is either a facilitator or barrier is dependent on the type of therapy and clients that needs psychological counselling. For instance, as argued earlier by some interviewees, an intake was considered less optimal for an outdoor setting. In this specific case, the type and trajectory of therapy would be considered a hindering factor. However, if the client doesn't feel comfortable between four concrete walls and finds it difficult about talk about his feelings in an indoor setting, then it might benefit the therapeutic process of this specific client to continue therapy in an outdoor settings. In this specific case, the main theme "client & therapy characteristics" is considered a facilitator, since it could benefit the therapeutic process of certain client groups.

In the same vein, the main theme **characteristics & beliefs of the stakeholders** could also be regarded as supporting or obstructing the further implementation of NAT in the Netherlands, depending on the actors involved. For example, when comparing the interview transcripts of study participants that have been identified as context setter or subject. In general, interviewees from the 'Subject' stakeholder (based on the power-interest grid by Ackermann & Eden, 2011, see *table 2*) group brought up considerations about the intrinsic motivation and affiliation with nature as an import precondition for NAT practice. On the other hand, interviewees that belonged to the 'Context setters' stakeholder group oftentimes placed heavier emphasis on its scientific credibility and wondered whether it actually differed so much from indoor therapy.

Far less ambiguous main themes were;

1. **Practical & organisational aspects**
2. **Recommendations for further implementation**
3. **Culture & characteristics of the Dutch healthcare sector**

In sum, **1. practical & organisational aspects**, contained ample pragmatic and coordinative difficulties that hamper further implementation into the Dutch mental healthcare sector, so it could be clearly identified as a barrier. Additionally, **2. culture & characteristics of the Dutch healthcare sector** touched upon particular aspects that describe the 'society' of the Dutch healthcare sector in relation to the establishment of new therapy options, and the sector in general doesn't seem ready yet for NAT, which also makes it a barrier. Lastly, **3. recommendations for further implementations** can clearly be distinguished as a facilitator, as this theme contained ample suggestions brought up by the interviewed stakeholders. Recommendations such as setting up a professional association for NAT practitioners might help in acquiring the professional and academic credibility and recognition, not only within the Dutch mental healthcare but also the public sector. Hence, this main theme is perceived as a facilitator. See figure *5* below for an overview for the facilitators and barriers in the current study. The red boxes indicate the barriers, the orange ones illustrate the ambiguous factors, those that could be either facilitator or barriers, contingent on the exact context. Lastly, the green box represents the facilitators

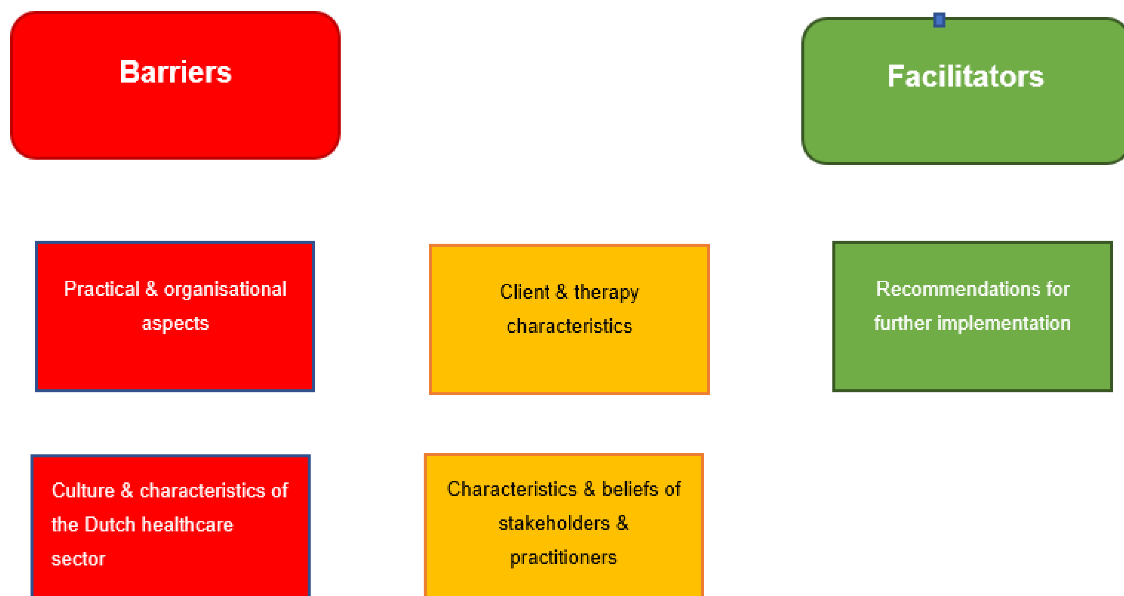

Figure 5 An overview of the identified barriers, facilitators & ambiguous factors

6.2 STAKEHOLDER CATEGORISATION

Furthermore, all of the interviewed participants were categorised according to the power-interest grid of Ackermann & Eden (2011). Provided that management team often lack time, Ackermann & Eden (2011) state that TMTs should limit their time and effort to an affordable amount of key stakeholders, consisting of at least the key stakeholders, the so-called 'Players', that are at the high end of both the

power and the interest dimension. In the current thesis, the 'Players' that have been identified consist of two mental health practitioners and the human-nature expert. Those interviewees showed a high interest for the implementation of NAT in the Dutch mental healthcare sector, while at the same time already having experimented with it in a certain way. The second most important stakeholders are the 'Context setters'. Those stakeholders have a lot of power, but are a bit less invested in the issue-at-stake, which makes them 'potential' stakeholders. This group contained a social worker, two policy advisors for health insurers and one context setter from primary care (National Health Care Institute). Ackermann & Eden state that TMTs should try to raise the interest by demonstrating the importance of their share in the issue. However, these authors don't specify how this should be done. Furthermore, 6 'Subjects' have been identified in the current data set. Those participants worked in primary care, as mental health practitioners or did social work. Those participants had a lot of interest, but little value on the power dimension. TMTs can attempt to raise their power by facilitating the establishment of certain coalitions of mindlike individuals. As already brought up by several interviewees, especially those who run a mental health practice themselves, starting up a professional association for NAT practitioners might be a powerful progression in order to further professionalise this field of practice.

6.2 INTERPRETATION OF RESEARCH RESULTS

The current thesis was set out to explore the facilitating and hindering factors for the implementation of NAT that resonated with the stakeholders of the Dutch mental healthcare sector. What is currently obstructing its implementation and could we ease up this process, what are its necessities? Each stakeholder had its own and unique perspective on the issue at stake. The interview data suggest that there are a plethora of factors that influence the inclusion and implementation of NAT in the Dutch mental healthcare system. The major outcomes of the current research can be reported as follows. At the current moment, one of the main obstacles of developing NAT to its full potential within the Dutch mental healthcare sector lays in the current organisation, structure and funding of the Dutch mental healthcare sector, which has a rather conservative approach and is predominantly dependent on the contracts with individual insurance companies for reimbursement of treatments. There is already a lot of scarcity of space and resources and as a result of market forces, there is ample competition of thousands mental healthcare providers with a plethora of therapy options. In order to be accepted as an established practice within the current Dutch mental healthcare sector, extensive research in the form of large-scale RCTs is an absolute necessity. Furthermore, there are some organisational and practical issues that obstruct further implementation. Most interviewees considered NAT to be a more time-costly intervention, and it is unclear so far which type of psychological issues and clients are suitable for NAT. Additionally, in order to be visible and to be professionally recognised in the future, NAT should consider how to present and organise themselves. Except from *de Buitenpsychologen*, that consist of a professional and educational association that consist of certified health psychologists that provide outdoor therapy, it is unclear to the study participants who practices NAT and what types of

therapy are actually considered NAT. Thus, it seems that it is still a relatively unknown form of therapy, even amongst the healthcare workers 'on the frontline' that have been interviewed.

Another fundamental theme that was the culture of the Dutch mental healthcare sector. It is organised in a rather conservative and segmented specialities and therefore barley allows for experimentation with alternative techniques and approaches that might benefit certain patient groups that don't respond well to conventional therapeutic interventions. Market forces seem to have an adverse outcome on the mental healthcare sector in general. This results in competition of diverse mental healthcare providers choosing to take up the 'easiest' clients, with the lowest risk of exceeding their annual revenue ceiling. Additionally, the financing system is rather complex and mental healthcare workers are dependent on multiple parties, such as the National Health Care Institute and their contracts with individual health insurers. The current system doesn't allow flexibility in approach nor for financial space to experiment with NAT, which is a difficult position, provided that a lot of mental healthcare workers are dependent on financiers like health insurers (zorgwijzer,nl, 2021). It can therefore be assumed that in the current Dutch mental healthcare system, the options for NAT are very limited. The interview outcomes thus support and complement the chapter about the Dutch mental healthcare sector.

On the other hand, several participants came up with thoughtful recommendations and ideas to overcome the barriers of the Dutch mental healthcare system. The stakeholders sometimes differed in their emphasis on the importance of different suggestion. For instance, what was suggested by almost all interviewees but stressed most by 'Context setters', was the urge for scientific credibility of its method. Some individual Dutch researchers, like Agnes van den Berg, have already done ample research on the applicability of NAT in mental healthcare (agnesvandenberg.nl, 2021). If NAT can be validated as a significant therapy application that is at least as or more effective as indoor therapy, it could spark the interest of both the National Health Care Institute and health insurers. But in order to set up a large-scale randomized controlled trial (RCT), NAT practitioners, psychology researchers and other stakeholders, such as ZonMw, a Dutch major subsidy provider for research in health sciences and care innovations, as brought up by an interviewee that worked as a policy advisor mental healthcare for a major health insurer. However, before these coalitions with salient stakeholders can be build, it should first be considered how NAT should organise itself and which practitioners should be included in a potential NAT professional association, another suggestion proposed by an interviewee that founded his own psychology practice in Amsterdam. Within this association, there should be a clear division between different profession groups, therapeutic guideline for each group and training possibilities. A next step, as pointed out the interviewee who started his own psychology practice, could be a quality register for green (mental) healthcare workers.

In fact, most individuals that had been approached for participation in the current study had never heard from *buitenpsychologie* the coined, but unofficial term for NAT. This term was chosen since a

few psychologists who started to practice outdoors united themselves as ‘de buitenpsychologen’ (debuitenspychologen.nl, n.d). In retrospect, the Dutch term is also inconsistent with the academic term ‘nature-assisted therapy, since this covers any therapist or mental health practitioner and not just psychologists. As stated in the results chapter, the Dutch term created lots of confusion about its professional definition, should NAT only be practiced by psychologists, or can it be applied by all kinds of social workers and professionals in the mental healthcare? Some alternative name have been coined by the participants, like *de groene GGZ* or *groene zorg*, literally translated ‘green (mental) healthcare’. Some participants went even as far as stating that practicing outdoors isn’t something what a psychologist ought to be doing. They thought it was more suitable for social or welfare workers, as they don’t treat clinical symptoms, but have a more guiding role in the daily lives of their clients. According to this participant, green care in general could be adopted as an intervention to prevent ample medical conditions, like obesity, especially among populations in high- and middle income countries with a low socio-economic status (SES) that have been investigated in a systematic review by Heisse, Romppel, Molnar et al. (2021). Yet, as mentioned by an interviewee that worked for a major health insurer, the Dutch Health Insurance Act doesn’t primarily reimburse interventions that are based on prevention of medical conditions. Of course, green (mental)healthcare can take on many forms and be applied to each specific client group, however, the exact subdivision of it is outside the scope of the current research.

SIMILARITIES & DIFFERENCES WITH THEORETICAL FRAMEWORK

Now that the main themes that have been derived from the interview outcomes have been categorised as either facilitating, ambiguous or hindering factors, the most fundamental study results will be related to framework outlined in the theoretical framework by Cooley et al. (2020). Not only similarities, but also a lot of differences were identified between the comprehensive framework of Cooley et al. (2020) and the visual overview of my research data in *figure 5*.

Concerning the differences, rather than placing central emphasis on the experiences of NAT practitioners and their clients, as carried out in the meta-synthesis by Cooley et al. (2020), I choose to focus on interviewing a wide diversity of Dutch stakeholders on their perspectives towards NAT. Eventually, even though the interview guide was mainly inspired by the relevant themes of Cooley et al. (2020), the qualitative data analysis revealed slightly different main and subthemes. The relevant themes of the Cooley et al. (2020) framework consisted of possible issues, potential solutions, practitioner & client characteristics and enrichment to therapy. On the other hand, I built my qualitative data around more general characteristics that could be considered either facilitator, barrier or ambiguous factor, depending on the specific context and the participant interviewed. This seemed more suitable to the current data set, as the purpose of the current study was mainly to collect the perspectives and assumptions of a wide variety of stakeholders, who had a quite heterogenous division

of opinion. Furthermore, it is important to note that that the comprehensive framework of Cooley et al. (2020) was built up by carrying out a meta-synthesis of 38 mixed methods, while the data of the current thesis consisted of 14 semi-structured interviews that I conducted myself.

Concerning the similarities, both Cooley al. (2020) and the current thesis have a rather loose definition of NAT that is not limited to one specific practitioner or training. Nevertheless, this might also be a possible weakness, since it made both the study participants and me question the exact professional boundaries of NAT: who should practice it, who is suitable for NAT and how should NAT be professionally organised? Another similarity is that both figure X that I made and the comprehensive framework by Cooley et al. (2020) focus on a diverse range of experiences and perspectives. It not only allows room for problems and issues, but also brings up solutions to these issues and explain what aspects enrich the therapy. In the same vein, my current thesis also focussed on challenges or obstacles and future opportunities for implementation.

6.3 RESEARCH VALIDITY

As discussed in the methods chapter, the interview guide is referred to as the research instrument. However, one should bear in mind that this study contains a rather small sample size (n =14) and it also included issues exclusively applicable to the Dutch mental healthcare sector, such as the numerous types of registrations for psychologists. The results of this study therefore need to be interpreted with caution and not all findings can simply be extrapolated to other nations. A major concern however, is the replicability of the current study, since I attempted to adapt the interview guide for each unique stakeholder. As stated earlier, the prepared interview questions were used as a guide, but not ‘set in stone’. In some cases, the interview guide was strictly followed, while in other cases, it was beneficial for the conversational flow to merely use it as a list with prerequisite themes that should be consulted.

The current study used non-probability sampling as means of recruiting the Dutch mental healthcare stakeholders. Similar studies, such as the Dutch mental healthcare stakeholder study by Bierbooms et al. (2016) used probability sampling by recruiting participants via 8 randomly assigned identified stakeholder groups. However, because the current research was merely explorative and small-scale, non-probability sampling was applied. Though, this resulted in an overrepresentation of mental healthcare workers ‘on the frontline’, such as primary care, psychologists and social workers. Consequently, of the 14 participants that have been recruited, 10 could be identified as such. This is due to the fact that I have a lot of acquaintances that work in the (mental)healthcare sector. On the other hand, this led to either a complete lack of or an underrepresentation of the following stakeholder groups; patient organisations (e.g. Stichting Burn-out), institutions in the area of research and development (such as ZonMw), non-governmental organisations like Nature for Health and mental health education and training institutes (e.g. de RINO Groep). As a result, this might influence how the

issues under study are perceived, as this might allow for a dominant position of the 'caregivers perspective' (resulting from an overrepresentation workers 'on the frontline'). Furthermore, as stated earlier in the methods, many potential respondents rejected study participation, which lead to a response rate of 47%. This response rate doesn't seem too bad, since Stieger & Göritz (2006) note that a meta-analysis for instant messaging for internet based interviews is 39,6%.

6.4 LIMITATIONS AND FURTHER RESEARCH

Even though ample recommendations have been proposed and a great diversity of stakeholders have been interviewed, the current study has a some major limitations in the study of its stakeholders. Future research could identify even more stakeholders in detail in the further implementation of NAT. Example of these stakeholders could be those there are mentioned in section 6.3, in particular institutions in the area of research & development, patient organisations and similar professional associations for other therapy forms that are considered 'alternative' or innovative. Additionally, it could also finetune prioritising stakeholder demands, by following the example set by Bierbooms et al. (2016). These authors define stakeholder salience by the three parameters power, legitimacy and urgency (Mitchell et al., 1997). In doing so, future research could identify improvements defining the definite stakeholders in the implementation of NAT, so they can be mobilised Bierbooms et al. (2016) also note the importance of effective stakeholder management, now that healthcare organisations have become dependent on a diverse number of stakeholder groups (e.g. financiers, referring GPs, patients, research & development centres) due to market forces, competition and increased cuts on budgets. Further research could therefore also focus on using the entire stakeholder management model of Preble (2005), which starts with stakeholder identification, followed by determining their expectations, then determines the performance gaps within each stakeholder group and finishes off by prioritising stakeholder demands.

Further work is required to establish the viability of a so-called professional association, and if that would be the case, what kind of green (mental)healthcare workers should be included in it. The finding that almost all participants didn't know what *buitenpsychologie* entails, is rather disappointing and an important signal that the current Dutch name is unsuitable, considering that most people assumed that NAT is solely meant to be practiced by psychologists. One could investigate the viability of a professional association for green mental healthcare by organising focus groups with several stakeholders from mental healthcare, such as the stakeholder groups identified by Bierbooms et al. (2016) and several mental health practitioners that might be willing to form alliances and join forces with other experts in the field. The Healthy Alliances framework by Koelen et al. (2012) could be used as a backdrop to identify factors that either hinder or facilitate the success of the alliance, that can be divided into; institutional factors, factors relating to the individual actors of the alliance and "… factors relating to the organisation of the alliance." (Koelen et al., 2012, p. 132). There is abundant

room for further progress in determining how NAT should organise itself in the competing world of scarcity in budgeting and Dutch market forces.

Another limitation of the current study is the applied method of study. The study could have been more useful if it was a mixed methods study, for instance combining the semi-structured interviews with a questionnaire. The use of semi-structured interviews (SSIs) does come with its own advantages and disadvantages. For instance, one of the pros of SSIs is that one can have in-dept conversation with participants and pick up a lot of non-verbal communication that might reveal useful information relating to the study under conduct (Kakilla, 2021). Furthermore, the flexible approach of SSIs allows for multiple themes and topics to be discussed, and a flowing conversation can inspire the researcher with new ideas to use in their research. Kakilla (2021) notes that a con in SSI is potential data loss due to a lack of interviewing participants face-to-face. Nevertheless, Kakilla (2021) fails to understand that due to the current circumstances of COVID-19 restrictions, it is very difficult to meet face-to-face just for an interview. Furthermore, Kakilla (2021) notes that limited understanding about a certain topic and poor or limited responses from the interviewees could sabotage the outcomes of the SSI. Additionally, a low response rate could lead to an underrepresentation of the research population under study (Kakilla, 2021; Denzin, 2017), which might be the case for the stakeholders in the current study that have not been identified as ‘frontline healthcare workers’. The current research could have been even more interesting if I had also conducted interviews with patient organisations, other financiers for research and development such as ZonMw, umbrella organisations like ‘Dutch Healthcare Insurers’ (*Zorgverzekeraars Nederland*) and alternative professional associations, like ‘ Dutch Association EMDR’(*Vereniging EMDR Nederland*).

Vereniging EMDR Nederland is one of the biggest psychotherapy associations in the Netherlands and has been founded in 1994, when EMDR started gaining ground in the Dutch mental healthcare sector. Future research in the area of mental healthcare innovation concerning NAT could identify similarities and differences between the earlier successful implementation of EMDR and the current (struggle with) implementation of NAT in the Dutch mental healthcare sector. Even though there were a lot of controversies about its exact underlying mechanism of action, it was one of the first interventions tailored to relieve clients from post-traumatic stress disorder (PTSD) to be empirically tested on its effectiveness (Landin-Romero et al., 2018). From the beginning of its initial development, Francine Shapiro, the founder of EMDR, kept on carrying out both case and controlled studies. She continuously improved the treatment approach EMDR with feedback from both clients and colleagues that she educated (emdr.com, n.d.). Nowadays, it has been proven an effective and evidence-based intervention for many different types of clients and problems. Until 2018, at least 26 RCTs have been carried out since the start in 1989. Its development and process of gaining ground in the Netherlands could share some parallels with the implementation of NAT and could give future direction on its necessities for successful implementation in the Dutch mental healthcare sector.

7. CONCLUSION

In summary, this study is known as one of the first attempts to explore the perspectives of relevant Dutch stakeholders on the implementation of NAT in the mental healthcare sector. The aim of the present study was to identify practical, therapeutical and organisational factors that could hinder or facilitate the implementation of NAT in the Dutch mental healthcare sector, which is done by means of qualitative research.

14 semi-structured interviews have been conducted with a wide variety of Dutch mental healthcare stakeholders, ranging from 'frontline workers' such as certified health psychologists to policy advisors for major health insurance companies. The qualitative study amongst these study participants has identified a plethora of factors and aspects of practical, therapeutical and organisational nature that either obstruct or facilitate implementation of NAT in the Dutch mental healthcare sector. The relevance and dependence of most individual mental healthcare practitioners (including those who practice NAT) on individual healthcare insurance companies, which was also stated in the theoretical framework, is clearly supported by the current research findings. All interviewees agreed that the successful implementation of NAT stands or falls with support and professional recognition of the insurance companies, who fund most mental healthcare interventions in the Netherlands. In order to earn be acknowledged as a legitimate therapy option, more and extensive research in the form of large-scale RCTs are needed, as these are deemed standards for evidence-based medicine. However, whether NAT should actually be organised as a total new approach to therapy or merely as a supplementary application for indoor therapy is still the question. The interviews indicate there is clearly support for NAT, especially from the 'frontline' workers, but in general, the exact terminology and professional field of NAT practitioners remain relatively unknown. Due to the limited amount of necessary research, its organisation and professional boundaries are still loosely defined. The present study has also confirmed that the current culture and organisation of the Dutch mental healthcare clearly obstruct implementation of NAT. In order to facilitate the further implementation of NAT in the Dutch healthcare sector, several types of green mental healthcare workers should join forces and form a coalition in the form of a professional association for green mental healthcare worker to authorise justify their position in the competing offer from numerous mental healthcare providers. In order to facilitate the further implementation of NAT in the Dutch healthcare sector, several types of green mental healthcare workers should join forces and form a coalition in the form of a professional association for green mental healthcare worker to authorise justify their position in the competing offer from numerous mental healthcare providers. Future investigations in this research area should consider further inspecting the role of different stakeholder positions, their expectations and power, legitimacy and urgency in relation to the implementation of NAT in the Dutch mental healthcare sector.

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APPENDIX

INTERVIEW GUIDE NATIONAL HEALTH CARE INSITUTE

APPLICABILITY OF INTERVIEW

For the purpose of being as succinctly and specific as possible, an adapted interview guide is created for the National Health Care Institute. The questions were specifically tailored to the organisation, system and specific tasks of the National Healthcare Institute, in order to get a more thorough understanding of the organisation and structure of the Dutch mental healthcare system and its role within this system. These could in turn be indicated as either hindering or facilitating factors in the implementation of NAT in the Dutch mental healthcare sector. Once again, because this interview concerns a Dutch participant, the original questions were stated in Dutch and have been translated to English.

The adapted questions were states as follows;

1. As indicated on your webpage, new healthcare innovations should comply with the current 'state of science and practice' and for this assessment, you adhere to the principles of evidence-based medicine. Could you explain to me what these principles entail and to what kind of research they will be applied? In other words, what kind of preconditions and types of research are fundamental when assessing new healthcare innovations?
2. I already read that for some types of healthcare the current state of science and practice is not available. In that case, other assessments of new healthcare innovations apply, such as 'responsible and appropriate care'. Provided that this principles applies, the service or care ought to be effective and the safety and the ease of use should be guaranteed. I was wondering, how is the effectiveness of new healthcare or service without scientific evidence assessed?
3. What alliances have been formed with the National Health Care Institute, which stakeholders (external interested parties) do you collaborate with and what are some of your common goals?
4. Which preconditions must be met, provided there is a sound scientific evidence for a new treatment, in order to be brought to the attention of external/multidisciplinary consultation moments with the National Health Care Institute? In other words, how should a group like outdoor psychologists organise itself in order to be taken as a
5. • What is the role of chief practitioners (i.e. doctors, psychotherapists, certified health psychologists, etc.) in determining the usefulness and effectiveness of new healthcare?

INTERVIEW HANDLEIDING BELANGHEBBENDEN GGZ NEDERLAND

INTRODUCTIE

Beste (naam), welkom bij dit interview, fijn dat u hiervoor tijd kon vrijmaken. Ik begreep dat u bij (vul positie van betreffende participant in) betrokken bent (binnen de GGZ). Allereerst zal ik mijzelf kort voorstellen. Mijn naam is Sanne de Bruin, ik ben tweedejaars masterstudent aan de Wageningen Universiteit en ik ben momenteel bezig met mijn masterscriptie. Hiervoor doe ik onderzoek naar de **organisatie en de rol van verschillende belanghebbenden binnen de GGZ** en vraag ik naar hun **perspectief** ten opzichte van de **buitenpsychologie**, een nog relatief onbekende vorm van therapie in Nederland.

- *Allereerst wil ik u vragen, heeft u de tijd gehad om het participatieformulier door te nemen en in te vullen?*

[Zo ja] Had u naar aanleiding hiervan nog vragen over de inhoud van dit formulier? [Zo ja, beantwoord vragen over inhoud van het participatieformulier, daarna door naar volgende onderdeel.] [Zo nee, door naar volgende onderdeel.]

[Zo nee] Ik begrijp dat u er misschien niet aan bent toegekomen om dit participatieformulier te lezen. Om u op te hoogte te brengen zal ik u een korte samenvatting van de inhoud geven: Het doel van dit interview is om meer te weten te komen over **uw rol en positie binnen de GGZ / connectie met de GGZ** en wat volgens u de implementatie van de **buitenpsychologie binnen de Nederlandse GGZ** zou kunnen helpen en hinderen. Deelname aan dit interview is geheel vrijwillig en uw anonimiteit zal gewaarborgd zijn (leg eventueel uit wat dit concreet inhoudt). Voor onderzoeksdoeleinden zal ons interview worden opgenomen en worden uitgeschreven, en het transcript zal na afronding van dit onderzoek veilig worden opgeslagen in de WUR-database. Het interview zal ongeveer een half uur tot drie kwartier duren en u heeft het recht om op elk moment uw deelname zonder opgaaf van reden te stoppen.

Oké, dan gaan we nu door naar het daadwerkelijke interview, vanaf hier zal ik de opname starten. Gaat u ermee akkoord dat het interview zal worden opgenomen?

-**[Zo ja, zet opname aan]**

[Zo nee, geen start van audio-opname, vraag participant of hij akkoord gaat met het meeschrijven van het interview]

Zo, dan gaan we nu beginnen met het daadwerkelijke interview. Voordat we het over de buitenpsychologie gaan hebben, ben ik allereerst heel benieuwd naar de volgende zaken:

- *Bij welk bedrijf of welke organisatie bent u werkzaam?*
- *Hoe zou u de functie bij uw huidige werkgever omschrijven?*
- *Hoe lang werkt u al voor dit bedrijf / deze organisatie?*
- *Wat is de connectie tussen het bedrijf/de organisatie waar u werkzaam bent de geestelijke gezondheidszorg (vanaf nu: GGZ) in Nederland?*

OPINIE BUITENPSYCHOLOGIE IN DE GGZ

Voordat ik u daadwerkelijk de eerste paar vragen over de buitenpsychologie ga stellen, zou ik u een korte uitleg willen geven over wat ik in dit interview versta onder de buitenpsychologie. Dit omdat veel mensen hier nog onbekend mee zijn en om verwarring over de terminologie binnen dit interview te voorkomen.

BUITENPSYCHOLOGIE

Buitenpsychologie/therapie, ook wel "*nature-assisted therapy (NAT)*" genoemd, is een overkoepelende term voor diverse therapievormen. Deze sessies zijn meestal onder begeleiding van een psychotherapeut of (GZ-) psycholoog, maar dit kan ook een coach of wandeltherapeut zijn. De natuurlijke omgeving vormt een geïntegreerd onderdeel van de gedragstherapie. De interactie met de natuurlijke omgeving komt in verschillende gradaties voor, van meer passief naar vrij actief. Zo kunnen cliënt en psycholoog hun sessies al wandelend door een park of natuurgebied houden. Ook kunnen elementen (zoals een storm of regenbui) uit de natuur metaforisch worden ingezet tijdens het gesprek, dit kan het voor de cliënt makkelijker maken om bepaalde onderwerpen te bespreken. Daarnaast kunnen andere onderdelen (zoals takken en stenen) worden ingezet om bepaald doelen te behalen, zoals het overbruggen van water en het maken van beschutting. Daarnaast zijn er wat fysiek intensievere vormen van buitenpsychologie, waarbij in groepslessen running therapie wordt gegeven of cliënten een bootcamp moeten afleggen. In dit interview gaan wij uit van de buitenpsychologie die wordt verstrekt door de psycholoog (niet noodzakelijkerwijs een GZ-psycholoog) en dus onderdeel is van de reguliere GGZ (geestelijke gezondheidszorg) in Nederland.

In Nederland is dit nog een vrij onbekende vorm van therapie, die meestal ook niet wordt vergoed, tenzij deze door een gecontracteerde GZ-psycholoog wordt gegeven.

- *Was u voor dit interview bekend met de buitenpsychologie?*

[Zo ja] Via welke weg bent u in aanraking gekomen met de buitenpsychologie?

- Waar?
- Door wie?
- Via welke organisatie/bedrijf?

[Zo nee, door naar volgende vraag]

- *Hoe ziet u zo'n sessie met een buitenpsycholoog voor zich? / Welke voorstelling heeft u bij een dergelijke vorm van therapie?*
- *Wat vindt u van de therapievorm buitenpsychologie?*
- *Wat voor associaties heeft u bij de buitenpsychologie?*
- *Met welke andere vormen van therapieën vindt u het vergelijkbaar (laat participant toelichten)?*
- *Wat is volgens u een toegevoegde waarde / voordelen die de buitenpsychologie volgens u kunnen bieden ten opzichte van conventionele therapie (d.w.z. psychotherapie die binnen wordt gegeven)?*

- *Welke aspecten zouden het voor u aantrekkelijk of juist onaantrekkelijk maken om voor de buitenpsychologie te kiezen?*

Oké, dit waren voor nu de algemene vragen over uw houding ten opzichte van de buitenpsychologie, dan gaan we nu verder naar het volgende onderdeel. Hierin vraag ik u naar factoren vanuit de organisatie en structuur van de GGZ die het op de kaart zetten van de buitenpsychologie kunnen bevorderen.

FACILITERENDE FACTOREN

Naast het peilen van uw houding ten opzichte van de buitenpsychologie ben ik ook geïnteresseerd in structurele en organisatorische factoren die het breder uitrollen van deze therapie binnen de GGZ makkelijker kunnen maken, zodat het toegankelijker wordt voor het brede publiek.

- *Als u kijkt naar de ontwikkelingen binnen de GGZ van de afgelopen tien jaar, kunt u zich dan voorstellen dat de buitenpsychologie hierin een gevestigde plek gaat innemen?*

[Zo ja] Kunt u dat toelichten?

[Zo nee] Leg uit

- *Welke aspecten en connecties binnen en met de GGZ (dus ook met partijen buiten de GGZ, zoals huisartsen) zouden het beter op de kaart brengen van de buitenpsychologie kunnen ondersteunen ?*
- *Welke belanghebbende partijen (ook wel "stakeholders") zouden daar volgens u bij moeten samenwerken?*
- *Hoe zou een succesvolle samenwerking eruit zien / verlopen? (vraag werkt waarschijnlijk niet bij iedere participant)*
- *Stel, u zou gevraagd worden om de buitenpsychologie hierbij te helpen. Met welke partijen zou u hierbij een samenwerking aangaan? Waarom deze partijen?*
- *Wat zou de buitenpsychologie (als groep of organisatie) zelf kunnen doen om over 10 á 15 jaar meer erkenning en naambekendheid te krijgen?*

MOGELIJKE BARRIERES

We hebben het tot nu toe gehad over uw algemene visie over de buitenpsychologie en factoren die de buitenpsychologie kunnen helpen om meer naamsbekendheid en erkenning te krijgen. De integratie en implementatie van de buitenpsychologie in Nederland verloopt nu nog wat stroef, het wordt nog niet veel ingezet binnen de reguliere GGZ. Daarom wil ik het nu met u hebben over de mogelijke barrières of weerstand waar de buitenpsychologie tegenaan kan lopen wanneer dit type therapie vaker zou worden toegepast in de reguliere GGZ.

- *Wat ziet u, vanuit uw vakgebied, als mogelijke belemmeringen die de buitenpsychologie ervan weerhouden om verder geïmplementeerd en erkend te worden in het systeem en de organisatie van de GGZ?*
- *Op welke manier speelt de wijze waarop de GGZ wordt georganiseerd daarbij een rol?*

- *Denkt u dat er ook praktische problemen zijn (voor zowel cliënten, hulpverleners en de GGZ zelf) die hierbij meespelen?*

[Zo ja] Aan welke praktische problemen denkt u dan zoal?

[Zo nee, door naar de volgende vraag]

- *In hoeverre denkt u dat therapie die buiten wordt gegeven van voldoende kwaliteit kan zijn?*

ROL EN POSITIE BINNEN GGZ

U heeft al heel veel kunnen delen over uw functie, uw visie en factoren waarvan u denkt dat deze de implementatie van de buitenpsychologie kunnen ondersteunen of hinderen. Ten slotte ben ik nog benieuwd naar partijen waar u vanuit uw functie reeds mee samenwerkt, eventuele gezamenlijke doelen die jullie hadden en hoe u de toekomst van de Nederlandse GGZ ziet. Maar ik zal deze vragen alleen stellen als die ook voor de aard van uw werk relevant zijn.

- Hoe is binnen uw bedrijf de cultuur van samenwerkingen met andere partijen / organisaties?
- *Met welke externe partners en bedrijven werkt u vanuit uw huidige functie zoal samen?*
- *Uit wat voor bedrijfstakken komen die externe partners?*
- *Wat zijn mogelijke gezamenlijke doelen van zo'n samenwerking?*
- *Kunnen deze doelen altijd bereikt worden?*

[Zo ja] Kunt u mij iets meer vertellen over hoe zo'n mogelijke samenwerking verloopt?

[Zo nee] Wat is meestal de reden dat dergelijke doelen niet bereikt kunnen worden in zo'n samenwerking?

- *Komen er bij die samenwerkingen wel eens moeilijkheden voor?*

[Zo ja] Waar liep u dan tegen aan tijdens zo'n samenwerking?

- Met welke personen was die samenwerking?
- Bij welke organisaties/bedrijven waren die personen betrokken?
- Waar ging het conflict over?
- Tussen welke partijen botste het in het conflict?
- Waarom/Welke belangen kwamen niet overeen?

[Zo nee, door naar de volgende vraag]

- *Hoe kijkt u momenteel aan tegen de samenwerkingsbanden binnen en met de GGZ (dus ook met andere sectoren zoals de algemene gezondheidszorg)?*
- *Wat zou er volgens u beter kunnen?*
- *Als het aan u lag, hoe zouden die samenwerkingsverbanden worden vormgegeven?*

Dit was voor nu het laatste onderdeel en de laatste vraag van ons interview. Heeft u voor u nog andere vragen of opmerkingen die gerelateerd zijn aan de inhoud van het interview? Dan is er nu de ruimte om het daarover te hebben.

[Zo ja] Laat respondent de vraag stellen, beantwoord de vraag zo volledig mogelijk

[Zo nee, door naar volgende vraag]

Wilt op de hoogte worden gehouden van de uitkomsten van dit onderzoek? Deze kan ik dan achteraf naar u mailen.

[Zo ja] Vraag of je hiervoor het emailadres mag bewaren

[Zo nee, door naar de volgende vraag]

Zo ik uw adresgegevens mogen om u een kleine attentie voor uw deelname op te sturen?

[Zo ja] Vraag om de adresgegevens

[Zo nee, door naar de volgende vraag]

Dan heb ik nog een belangrijke vraag aan u: Kent u nog andere mensen die misschien deel zouden willen nemen aan dit onderzoek? Dit kunnen diverse personen zijn die binnen of met de GGZ (samen)werken, zoals therapeuten, verzekeringsartsen, directie van zorgverzekeraars, psychiaters, adviseurs van zorginstituut Nederland en dergelijke.

[Zo ja] Heeft u voor mij de naam en contactgegevens van deze persoon?

[Zo nee] Geen probleem, alle kleine beetjes helpen, ik waardeer het al heel erg dat u mee kon doen!

Dan wil ik u heel erg bedanken de investering van uw tijd en moeite. Uw bijdrage helpt mij enorm om verder te komen met mijn master scriptie.

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