Attachment-Based Family Therapy Between Magritte and Poirot:
Dissemination Dreams, Challenges and Solutions in Belgium

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Abstract

Attachment-Based Family Therapy (ABFT) was introduced into Belgium in 2009. Since then, three home-based services (Child Welfare System) and one inpatient young adult psychiatric unit (Mental Health care System) implemented ABFT as a treatment model. Although financial and organizational barriers exist, preliminary data suggest that ABFT can be successfully implemented in Belgium, and yields promising results. ABFT appeals to counselors and therapists who receive training. Future dissemination will be facilitated by the establishment of a new ABFT training center in Flanders.

Keywords

Attachment-Based Family Therapy, depression, adolescents, child welfare, mental health care, dissemination, implementation
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Attachment-Based Family Therapy (ABFT; Diamond, Diamond, & Levy, 2014) was first introduced in Flanders\(^1\) in 2009 in collaboration with Ghent University during a three-day introductory workshop. Since then, there have been ongoing efforts to introduce ABFT in two different professional caregiving sectors: since 2009 in the Flemish Child Welfare System (CWS) and, since 2015 in the Flemish Mental Health care System (MHS). To date, requests for ABFT training have exponentially increased. Recently, the government funded the foundation of a new ABFT training center in order to facilitate further dissemination of ABFT in Belgium. In the current paper we will first give a brief overview of the Flemish caregiving landscape, with specific attention to the CWS and the MHS as context of the services that currently experiment with implementing ABFT. Next we describe how ABFT fits within the latter services’ scope, the current status of several ABFT projects, the implementation challenges we encountered and the solutions that aimed to overcome these challenges. Finally, we will reflect on how ABFT fits within the current organization of family therapy trainings in Flanders, and on future dissemination of ABFT through the establishment of a new ABFT training center in Flanders.

The Flemish caregiving system

The Flemish caregiving system for children and youth is not a unitary organization. It has historically and organically developed as a complex and hard to comprehend tangle of organizations that are organized as part of six different sectors, including the CWS and the MHS (Vanderfaeillie & Maes, 2015). Each sector is subsidized by different governmental administrations and has its own target population, history, regulations, traditions and intern
dynamics. Across services, this has resulted in the compartmentalization and fragmentation of the caregiving landscape, characterized by turmoil and incoherence due to several state reformations within the past decades aiming to achieve a more uniform system across sectors, and a more shared view on treatment approaches. However, despite of these efforts, these services continue to a lack of shared view and coherence (Grietens, Mercken, Vanderfaeillie, & Loots, 2007; Stroobants, Vanderfaeillie, & Andries, 2014; Vanderfaeillie & Maes, 2015; Vervotte, 2006).

Accordingly, interventions within services are generally characterized by a lack of framework to guide treatment for children and youth, and by a tradition of ambivalence about empirical values and EBPs (Vervotte, 2006). The current treatment practices within services are generally client-centered, non-directive supportive, and eclectic. Therapists combine a mixture of therapeutic techniques from different theoretical orientations and rarely follow any particular clinical treatment model (Grietens et al., 2007; Stroobants, Vanderfaeillie, & Andries, 2013). Increasingly, these practices are cause for concern. First, these concerns are based on evidence that suggests that Treatment as usual (TAU; where therapists use an eclectic approach), might only have a limited effect (Weiss, Catron, & Harris, 2000; Weiss, Catron, Harris, & Phung, 1999; Weisz et al., 2013; Weisz, Jensen-Doss, & Hawley, 2006). Also, these concerns are based on the observation that these practices lead to patients staying in the caregiving system for long periods of time because there are no clearly set goals for treatment, resulting in long waiting lists preventing others to receive the help they minimally need (Vervotte, 2006).

Consequently, there is an urgent need for a more shared, short-term and effective treatment approach. Policy makers decided to incorporate EBPs as one way to achieve this (Vervotte, 2006). They planned to implement and evaluate EBPs on a large scale across
services and sectors. During this process, several services became interested in ABFT. In the following paragraphs, we describe efforts to implement ABFT in (1) home-based services of the Flemish CWS, and within (2) a young adult psychiatric residential care unit of the Flemish MHS.

**ABFT in home-based services of the Flemish CWS**

*Implementation context.*

The Flemish CWS is one of the largest sectors of the caregiving system in Flanders, and focuses on ensuring the health and safety of high risk children ranging in ages from birth to 21 years old growing up in a ‘problematic home situation’ (Vanderfaeillie & Maes, 2015). In line with the Convention on the Rights of the Child (1989), the Flemish CWS places a strong emphasis on keeping families united. To this end, CWS increasingly preferred home guidance programs over residential care. Consequently, home-based guidance is the fastest growing branch of the CWS (Jongerenwelzijn, 2014).

Home-based services provide weekly home visits to support children and families struggling with multi-faceted problems (Grietens et al., 2007). These services specialize in treating vulnerable children who are growing up in families that face chronic, socio-economic and psychosocial difficulties (e.g. economic deprivation, parental psychopathology or substance abuse, child maltreatment). The main objective of home-based services is to strengthen the resilience of the at risk child and family by restoring or improving problematic family relationships and dynamics (Grietens et al., 2007; Stroobants et al., 2013; Vanderfaeillie & Maes, 2015). In order to achieve this goal, home-based services aim to work from a family systems approach to improve communication and parenting skills, and to reinstate security in the intra familial relationships. While these treatment goals are admirable,
the services lack a clearly articulated and shared framework to pursue this mission (Stroobants et al., 2013; Vervotte, 2006). In response to these concerns, policy makers gained interest for ABFT.

More specifically, they appreciated ABFT as a framework that directly targets the relational conflicts that are exemplary for the families who are treated in home-based services and that appeared to fuel the conflicts and crises that interfere with treatment success. In fact, the experience was that these cycles of accumulating crises and conflicts easily drew therapists’ treatment focus away from main treatment goals. For these reasons, ABFT’s strong goal-driven focus appealed to policy makers. They hoped that this would help counselors to be less distracted from the main treatment goals.

Second, without some kind of guiding principles, therapy with this multi-problem population tended to last a long time. Data suggest that only 21% of therapies lasted less than 6 months, while 25% lasted 6-12 months, 21% lasted 12-18 months, and 33% continued beyond 18 months and sometimes even up to three years. Consequently, this created long waiting lists due to which families often had to wait up to a year to receive care (Grietens et al., 2007; Vervotte, 2006). In light of these concerns, ABFT raised interest because it already had proven to be effective in working with the most difficult multi problem families in a period of 16 weeks, even when including severely depressed and suicidal adolescents, adolescents whose parents suffer from severe psychopathology, and adolescents with sexual trauma history (Diamond, Creed, Gillham, Gallop, & Hamilton, 2012). Therefore, ABFT’s short-term treatment approach seemed promising to address this problem of treatment duration and long waiting lists.

Third, research data showed that there were high rates of depression, suicidality and relational trauma in adolescents involved in home-based services of the CWS. Unfortunately,
after home-based guidance these problems remained largely unaltered (Grietens et al., 2007; Stroobants et al., 2014). In contrast, several RCTs had shown that ABFT can be highly effective in reducing depressive symptoms and suicidal ideation (Diamond et al., 2010; Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002; Weisz, McCarty, & Valeri, 2006; Weisz et al., 2013). Therefore, policy makers hoped that ABFT could help better support these emotionally disturbed adolescents and their families.

Based on the above arguments, policy makers decided to implement ABFT on a large scale in home-based services of the Flemish CWS as a short-term and effective program that fits within CWS’s family systems approach to strengthen the resilience of at risk depressed, suicidal and/or traumatized children and their family. A three-phase implementation plan was prepared. First, we planned to bring the ABFT-developers over to Belgium for a free one-day workshop open to all home-based services’ counselors and administrators to introduce and inform them about the intervention model. Second, for agencies interested in actually implementing ABFT in their practice, we planned to offer two additional workshop days for a more in-depth training. At the end, counselors would be selected for further training that consisted of biweekly group supervision, an advanced workshop (6 months later) and feedback on videotaped sessions. Finally, these therapists would be involved in a large scale outcome study. In the following paragraphs we will discuss how the operationalization of this implementation plan unfolded, the obstacles and barriers we have encountered, and the solutions we have developed to address them.

**Implementation challenges.**

To help us understand implementation challenges, we relied on the Consolidated Framework for Implementation Research (Damschroder et al., 2009). This framework sets out a number of domains at the level of individuals, organizations and the larger ecological
systems to consider when thinking about implementation. These domains include (1) the implementation process (2) attitudes, feelings and beliefs about the intervention of the individuals involved, and (3) the political context within which caregiving organizations reside (outer setting).

At the level of the implementation process, policy makers were hopeful that implementing EBP (and more specifically, ABFT) on a large scale would address the services’ urgent need for a more shared, short-term and effective treatment approach. However, this top-down approach of large scale change ignored the voice of the individual counselors who were supposed to carry out this therapy. They were not involved in the decision making process, nor consulted about what they wanted or needed. Consequently, the top-down imposition of an EBP was not warmly welcomed. On the contrary, counselors felt that ABFT was being forced on them.

This tension became clear at the level of counselors’ attitudes about the decision of policy makers to implement EBP. University researchers that were involved in the implementation of ABFT visited the home-based services the month before the planned ABFT 3-day workshop with the goal to inform them about the project and invite them for the workshop. CWS counselors were highly skeptical towards the use of any EBP, including ABFT. Moreover, counselors were convinced that implementing EBPs would be hard to reconcile with their traditional client-centered, non-directive supportive and eclectic treatment approach, which they labeled as their right for autonomy, flexibility and creativity during the treatment of their clients. Counselors were also concerned about the government’s possible hidden agenda. They feared that this change would force them to work harder without providing the necessary economic support for the enhanced workload.

As a consequence of this tension and resistance, policy makers decided to put the project on hold. Instead of a universal dissemination and offering of ABFT, policy makers
decided to put out small grants that agencies could apply for to import any EBT as wanted (Stroobants, Vanderfaeillie, & Andries, 2013). Only a few of the agencies chose to do ABFT. The unexpected reconfiguration of political and financial support interfered with the execution of the implementation plan for those agencies who choose to further implement ABFT.

**Implementation strategies to overcome challenges.**

Before the government stopped the project, we were able to organize the first workshop day as planned. Because we already sensed the tensions and resistance, we organized this day with the goal to address and overcome them. This day not only allowed us to introduce ABFT to all home-based service counselors and administrators, but, throughout that day, we organized meetings between administrators, counselors and the research team to make sure that all individuals could express and discuss their concerns. Results of an acceptability study assessing attitudes towards EBP in general and ABFT specifically before and after that workshop showed that these strategies significantly improved the counselors’ attitudes towards EBP and ABFT, and increased CWS counselors’ motivation to learn about these models and to use EBPs in their daily clinical practice (Santens et al., under review). This finding was in line with Greenhalgh and colleagues (2004) observation that implementation success is conditional upon whether services and counselors feel that they are active participants rather than passive recipients from the start of the implementation process. In hindsight, this has been a major learning experience for us, as it showed us how important it is to involve counselors and local administrators in the entire process that leads to the decision to implement EBPs in general and the choice of which EBP (in this case ABFT) would be most valuable to implement.

Although the ABFT implementation project was officially stopped by the government exactly at the end of the first workshop day, counselors of several services attended the two
other workshop days (after all, they were organized, and three ABFT trainers were in the country). These counselors were left inspired by the ABFT-model, and three services tried to further implement ABFT. These three agencies were enthusiastic about, and heavily invested in the ABFT-model. They were resolute to have ABFT as evidence-based framework guide their clinical work, and, managed to invest money and time into biweekly to monthly supervision from the ABFT-developers.

The lack of financial and organizational government support created new implementation challenges within the services. The services’ resources were too limited to get the counselors trained to the level of adherence that allowed them to be certified ABFT therapists, and to organize a sound structure of ongoing support. In addition, staff turn-over challenged sustainability of the project. Results of a qualitative study investigating counselors’ experiences about the implementation process of ABFT (Santens, Hannes, Diamond, Levy, & Bosmans, in prep) showed that some of the initially trained ABFT counselors left the project because of (1) reorganizations within the agencies, (2) burnout due to the high caseload within these services, (3) counselors indicating that the emotional work of ABFT to change fundamental attachment structures and working through trauma was more intense than they felt capable of doing, or (4) that the short-term character of the model did not resonate with them. New staff was hired, but needed again full ABFT training, which led to a constant cost that burdened the services’ resources. In light of the latter challenge, we became increasingly aware of the need for (1) a Belgian center that could provide ABFT training as a crucial step in further dissemination of ABFT in Belgium, and (2) a sound structure of ongoing fidelity assessment, supervision, and support. These observations and experiences were in Novins and colleagues’ (2013) review in which they showed that quality of implementation and dissemination efforts of EBPs depends on ongoing fidelity assessment, supervision, and support. This is important because it increases the likelihood that expected
intervention effects are obtained, and has important benefits regarding reduced staff burnout and improved staff retention.

In spite of these challenges, it was promising that the three home-based services persisted and continued to provide ABFT as a treatment strategy. In the same qualitative study mentioned above (Santens et al., in prep), therapists and team leaders expressed enthusiasm about the ABFT model, stating that they had the feeling that they were finally doing the profound work they felt that was needed in these families. Counselors indicated that ABFT fitted within the work they are doing and with the needs of the families they work with. Finally, they were delighted about the fact that ABFT provided a roadmap to guide their clinical practice and to approach those challenging multi problem families from an attachment perspective. These experiences made them eager to continue working with the ABFT model (Santens et al., in prep).

Current state. Currently, the three home-based services that have been providing ABFT until today have collected pre-post data on adolescent depression for 61 ABFT cases. Since 2013, a Ph.D student has been funded by the KU Leuven to help exploring dissemination and implementation of ABFT in the Flemish CWS with the goal of conducting an open trial to evaluate ABFT effectiveness in these services. Preliminary results of a feasibility study evaluating pre- and post- ABFT data were promising. Although therapy adherence was not optimal, results suggested significant decreases in depressive symptoms reported by both adolescents and parents, with medium to large effect sizes ranging from .53 to .81 (Santens et al., under review). Although a more rigorous research design including a comparison to control group(s) is needed to draw stronger conclusions, results of this study suggest that ABFT can be feasible within the context of home-based services and acceptable to patients.
ABFT in a psychiatric residential care unit for young adults in the Flemish MHS

Implementation context. Depression and suicide are serious and increasing public health issues in the Flemish young adult population. For young adults, depression is one of the leading causes of illness and disability, which, at its worst, can lead to suicide. Furthermore, suicide is the leading cause of death for 19 to 24 year-olds in Belgium (Agentschap Zorg en Gezondheid, 2014). In Flanders, many depressed and suicidal young adults are hospitalized because of suicide attempts, because they report high-risk suicidal ideation, or because of severe functional impairment in their daily lives due to depressive symptoms. In spite of depression’s impact on wellbeing and mortality in young adults, there is a surprising dearth of treatment studies for hospitalized depressed young adults.

In Belgium, when young adults need to be hospitalized for depression and suicidality, they are generally admitted to psychiatric residential care units that work with adults of all ages. Recently, one hospital organized a unit that specifically focuses on young adults (Asster, Sint-Truiden). However, this unit adopted intervention strategies developed for older adult residential care. Consequently, their care was organized based on the assumption that young-adults are mature and autonomous individuals who take responsibility for their own treatment. Additionally, no information about patients was shared with patients’ parents, which is customary in adult psychiatric care. However, the nursing staff struggled with requests of parents who urged to remain involved in the intervention and medical progress of their children. Also, nursing staff and therapists frequently experienced that patients’ maladaptive functioning was often linked to relational issues with parents for which nursing staff had no appropriate intervention strategy. Moreover, they felt that young adults were projecting dysfunctional dynamics with their parents on the staff (e.g. rejection, preoccupation). Nursing staff lacked a framework to understand and cope with these dynamics. Finally, the unit had high rates of rehospitalisation due to patients’ relapse. They observed that patients who got
better during inpatient treatment, tended to relapse once they went back to the maladaptive dysfunctional family dynamics that contributed to the development of pathology. This raised the inpatient nursing staff, therapists, and leadership team’s interest to implement a more family-based, attachment-informed treatment approach.

In close consultation and collaboration with the unit’s nursing staff and therapists, and building on the above mentioned issues, the hospital managers explored ABFT as a potential strategy to introduce an effective family-focused treatment strategy to meet these patients’ caregiving needs. This decision was supported by research showing that, contrary to popular belief, successful autonomy development happens when young adults can negotiate autonomy and maintain a secure base of family attachment (Kins, Beyers, Soenens, & Vansteenkiste, 2009). Even in young adulthood, insecure attachment and the lack of an available and supportive caregiver is a fundamental factor in young adults’ risk to develop depression. The hospital managers consulted the nursing staff and therapists about the idea of implementing ABFT. All team members actively and enthusiastically consented to this ABFT implementation project. This led to the development of an Attachment-Based Residential Care (ABRC) program for these patients, based on the principles of ABFT.

The goal of the ABRC project is twofold. The first goal is to develop new ABFT-informed therapeutic strategies that are suited for young adults, tapping into the specific developmental needs of this transitional phase. This will include developing therapeutic tools to activate hospitalized young adults’ need to improve their attachment relationships with their primary caregivers. The second goal is to create and provide an attachment-based therapeutic environment for interactions between the staff and the patients. This will result in the development of a Nursing Staff Manual.
The project only recently started (May 2015). The clinical team coordinator of the psychiatric unit is currently in the process of getting trained and certified as ABFT therapist, in close collaboration with and supervision of the ABFT developers. Furthermore, as learned from the ABFT implementation project in CWS that active participation of all individuals involved in the decision making process from the start is important, the whole clinical and nursing staff team attended a 3-day introductory workshop of ABFT by the ABFT training coordinator. Also, the clinical team coordinator is experimenting together with the nursing staff team on how to adopt ABFT principles in the milieu. The bottom-up decision making process from beginning until today facilitated the implementation process because of high intrinsic motivation and participations of all individuals involved.

Current state.

To date, although the implementation process is still in its infancy, effects have already been noticed at different domains. Nursing staff acknowledges valuing clients and their problems differently and discussing cases at a deeper level. They see intensity of treatment increasing, clients sharing more openly their emotions and team members offering more understanding and warmth. Young adults witness that they experience change in interactions at home and in their relationships. They express to appreciate the intensity of the sessions. Parents witness to never have had these kind of conversations with their kids before. They appreciate these sessions to be profoundly different and to result in new ways of talking to each other. They value the new emotion coaching skills. Parents deeply appreciate being involved in treatment in an active way.

Current training infrastructure in family therapy models

As a result of an increasing number of presentations and publications on ABFT in Flanders, an increasing number of Flemish therapists expressed interest to follow the
complete ABFT training and become certified ABFT therapists. However, becoming a trained ABFT therapist following the certification procedure of the ABFT developers is difficult due to practical and financial challenges. Practically, the language barrier of having supervision and tape review in English, the online supervision structure, and time zone differences restrained Flemish therapists from following the ABFT training program. Financially, the ABFT training costs are not in congruence with the financial capacities of the average Flemish therapist. To adequately meet and sustain these training requests, we felt we needed a local infrastructure to support these efforts. Rather than solely rely on the ABFT training center in Philadelphia, a local group could provide the training in Dutch and in our time zone. Therefore, we have taken the initiative to develop a one-year ABFT training at the KU Leuven. To set up this training, we received a grant of the Flemish Government as part of the ‘Flemish Suicide Prevention Action Plan’ (Agentschap Zorg en Gezondheid, 2012) that aims to reduce the number of suicides with 20% by 2020. Policy makers committed to invest in the 2-year startup of a self-sustaining Belgian ABFT-training center as they saw ABFT as an evidence-based answer to the need for a family approach in treatment of suicidal adolescents.

The government-funded 2-year startup of this training center consists of the following phases. First, 10 experienced therapists have been selected to be trained during year one by the official ABFT training center of the ABFT developers (Philadelphia, USA) to become certified ABFT therapists. Next, during year two, we will select five of them to be trained as official ABFT trainers/supervisors. With those five newly trained ABFT trainers/supervisors, the self-sustaining training center will be able to train 20 new ABFT therapists on a yearly basis, nationally and maybe even internationally.

Before setting up our own ABFT training, we first explored whether ABFT training could be organized with the existing, and well established family therapy training centers in Flanders. To date, eight training centers are recognized by the Belgian Professional
Association of Marital and Family Therapy (in Dutch, the Belgische Vereniging voor Relatietherapie, Gezinstherapie, en Systeemcounseling – BVRGS), the leading professional association of family therapists in Flanders representing around 900 members who have successfully finished a recognized four-year marital and family therapy training program. Directors of those training programs expressed enthusiasm when we introduced them to the ABFT model, indicating that they recognized therapeutic strategies of the ABFT model as what they were already doing but with less of a framework to it to get to the core issues more quickly. However, the leading training centers are mainly organized according to post-modern principles, characterized by a client-centered, experiential and narrative approach with therapists as ‘facilitators’, rather than ‘experts’. Leading training centers are generally offering a more generalistic, aspecific, transdiagnostic framework introducing participants to a rich variety of therapeutic approaches with the main focus on how to establish an authentic therapeutic relationship with different members of the family system. EBP seem marginalized by many training programs. Consequently, none of the existing family therapy training programs in Flanders saw a possibility to integrate ABFT within their current training organization. Nevertheless, since we started searching potential candidates to become trained as ABFT therapists and trainers of the ABFT training program, there has been an increased interest from the BVGRS to collaborate. This makes us hopeful that, once the training starts, we will be able to integrate ABFT training within the Flemish family therapy training context.

Finally, we experience a clear and explicit interest from the Cognitive Behavior Therapy (CBT) organizations in Flanders and the Netherlands. This has resulted in three ABFT-informed workshops that every new Flemish CBT trainee receives as part of their CBT training. Moreover, this has led to invited keynotes and publications about ABFT and ABFT-informed therapy that are well received by the CBT therapists. Also, in the course of our attempts to set up an ABFT training, many CBT therapists expressed their interest to follow
the training. We think this demonstrates the power and attractiveness of ABFT to a wide range of therapists, and this stems us hopeful that the ABFT framework will eventually be made available to the high number of families in Flanders that could benefit from this therapy.

**ABFT between Magritte and Poirot: dissemination dreams, challenges, and solutions in Belgium**

Interest in ABFT in Belgium continues to grow. The road thus far has been bumpy and the near future continues to be challenging. Thus far, three CWS home-based services continue to apply ABFT with much energy, enthusiasm, and satisfaction. Moreover, the recent ABFT implementation project in the psychiatric residential care unit for young adults demonstrates that the ABFT model gets further spread in Flanders. Preliminary research findings suggest that ABFT successfully reduces adolescent depression even though treatment adherence might not be optimal, and that counselors like using ABFT in their daily practice. The grant obtained from the Flemish government to further support ABFT dissemination, should become an important stimulus for the future of ABFT in Belgium.

Consequently, this state of affairs illustrates how ABFT in Belgium is reflected in the typically Belgian archetypes of René Magritte, a famous surrealist painter, and Hercule Poirot, Agatha Christie’s renowned detective. On the one hand, it often feels as if we are painting surrealistic pictures like René Magritte did: many of our goals look promising and beautiful in our dreams, and seem to be an illusion at first. On the other hand, we follow the footsteps of Hercule Poirot because we keep on racking our “little grey cells” trying to put pieces of a puzzle together and find creative ways to overcome challenges in order to turn those dreams into reality. Thus far, we have been successful to overcome these hurdles, which, in our opinion, illustrates that an increasing number of Flemish therapists and policy makers highly appreciate ABFT as a therapeutic model that provides an important therapeutic answer to a clearly felt lacuna in the current Flemish intervention landscape.
References


Footnote

1 Belgium is a federal state consisting of three Communities based on the language: the Flemish, French and German-speaking Communities. Flanders is the Dutch-speaking region in Belgium representing 6.251.983 of the 10.839.905 inhabitants. Each Community has its own Government.
Powers associated with the Communities are Culture, Education, Health Policy, Youth Protection, Social Welfare, etc. Flanders represents 6,251,983 of the 10,839,905 inhabitants. Additionally, the Federal Government continues to act as an umbrella government for policy matters that are relevant for all communities (like the ministry of health care).