

The Belgian Reform of Mental Health: Changing the Face of Psychiatric Hospitals

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This presentation¹ focuses on the ongoing reform of psychiatric and mental health care delivery in Belgium. It starts by mentioning particularities of the system's development, then it defines the reform's objectives and policy instruments used to reach these objectives and, finally, it indicates specific issues and outcomes resulting from the implementing.

Organisation of the Belgian system for psychiatry and mental health

The system includes an ambulatory sector composed of community mental health services and a residential sector composed of psychiatric hospitals, both public hospitals (n=57) and private non-profit hospitals (n=13); psychiatric wards in general hospitals, Initiatives of Sheltered Housing (ISH, n=85) and Psychiatric Nursing Homes (PNH, n=42), and pilot-projects launched in the early 2000th.

Past developments in the system

In brief, the system development can be conceived as:

- A progressive process of *paradigm shift* (Hall, 1993) from residential to community psychiatry;

¹This presentation relies on sociological qualitative researches on changes in the Belgian organisational and institutional system of mental health and psychiatric care. Those researches had been carried out from 2008 onwards, first in the framework of the European Research projects *Know&Pol*, and then in the framework of my doctoral thesis. They include documentary analysis (policy briefs, organisational documents, and meeting proceedings); semi-structured interviews with policy-makers, civil servants, mental health professions, boards of psychiatric and mental health care structures, and services users groups' coordinators; and direct observations of public events and meetings between professionals taking place on the occasion of the two last policy initiatives; the "therapeutic projects and the horizontal consultation" and the "reform 107".

- This process started at the outset of the seventies with a first reform of psychiatry and continues in the framework of the ongoing reform, which supports a shift from an institutional care model to a functional care model.
- This process combined sustained changes in care structures with stability in the institutional and financing system.

Structural changes have been achieved through successive reforms which succeeded in implementing Community Mental Health Services in 1975; Initiatives of Sheltered Housing and Psychiatric Nursing Homes in 1989; and alternative care functions as psychiatric home care in 2001 and therapeutic consultation in 2007.

Stability in the institutional organisation is reflected in the dominant position of psychiatric hospitals in the system. This entails, to put it simply, that the biggest part of the public budget of psychiatry and mental health is allocated to psychiatric hospitals which are responsible, in turn, for financing and managing alternative facilities such as the ISH, the PNH.

Historical and social explanations for stability in the institutional configuration

This situation can be explained by historical factors:

- the importance of religious congregations in developing psychiatric institutions during the nineteenth century (Liégeois, 1991),
- the success of those institutions in converting themselves into non-profit organisations and in increasingly professionalising their clinical staffs and equipment throughout the 20th century;
- Their representation in a federal agency, the National Institute for Health and Disability Insurance, playing a central role in decision making in public health;
- Their strategy of allowing changes while keeping control over the implementing at local level.

Sociological explanations for changes in the structural configuration

Next to proponents of residential psychiatry, informal networks of actors supporting the community model emerged over time. They have relatively stable sociological properties. They are heterogeneous networks, made of different kinds of mental health professionals knowledgeable about alternative practices in mental health, thanks to their specific training and/or involvement in international NGOs or organisations such as the WHO. They also include policy makers as well as civil servants committed to the values and knowledge of community psychiatry; services users groups; social movement as the mental health movement, and non-profit organisation supporting new approaches, such as psychiatric rehabilitation.

Such networks could promote projects of reform, which had then been adapted to the Belgian system, based on residential psychiatry, before of being implemented at local level. During the last decades, along with the growing influence exerted by the European Commission and the WHO on the member countries' mental health policies (Freeman, Smith-Merry, & Sturdy, 2012; Sturdy, Freeman, & Smith-Merry, 2013), those networks have benefited from increased means to stimulate new policy initiatives.

Combining factors of stability and factors of change: rising heterogeneous local care systems

The combined action of networks supporting community psychiatry and of proponents of residential psychiatry has led policy makers to rely on implementation strategies leaving room for local appropriation. This brought about significant discrepancies between initial policy objectives and final outcomes on the one hand, and between local care systems on the other hand. In effect, depending on the relative importance of proponents of changes at local level, successive reforms were implemented more or less extensively.

The ongoing reform as a typical product of the Belgian system: devising innovative models of care

The policy programme has been conceived by a think-tank appointed by the minister of public health. In devising the reform, the think-tank relied on policy

learnings achieved on the occasion of past reforms of psychiatry, on training in psychiatric rehabilitation, and on knowledge of the WHO' activities and of changes in OECD-countries psychiatric and mental health systems. Members of the think-tank have also supported the participation of services users groups in mental health policy-making from the outset of 2000th.

The Functional Model

The policy programme, sets out in a single policy Guide, entails moving from an institutional model toward a functional model based on integrated and responsive networks. By relying on such networks, existing mental health and psychiatric services should provide the following five care functions in a given geographic area:

- First, *“prevention and promotion of mental health care, early detection, screening and diagnostic activities”* (Guide 2010)²
- Second, *“intensive treatment for both acute and chronic mental health problems”* provided by *mobile teams immediately and intensively intervening in crisis situations*” (idem);
- Third, rehabilitation programmes with a focus on recovery, social inclusion, *“independent functioning in daily life”* and the acquisition of *“new cultural, social or professional roles”* (idem);
- Fourth, residential intensive treatment for acute and chronic mental health problems;
- Fifth, alternative housing facilities intended to people *“with limited opportunities for integration into the community”* (idem).

Particularities of the functional model:

First, the following quote illustrates that the functions are devised in a way to promote collaborative instead of competitive relationships between community and residential services and institutions:

“The model we wish to introduce, with a global vision as starting point, ensure the integration of the resource of hospitals and the resources of

² “Guide towards bettered mental health care by the realization of care circuits and networks” (2010) Interministerial Conference Public Health, psy107.be

(ambulatory) services existing in the community. Such a model implies that all actors within a specific, defined area must be involved in the organization of the model” (Guide 2010, p.10).

Then, it is worth noting that the stress put on mobile teams derived from proposals made by services users groups on the occasion of previous pilots in mental health, and from the service users’ families and carers’ request to policy makers for developing mobile psychiatric teams, following the Termonde incident, where a psychotic slaughtered children in a day nursery.

By contrast, the emphasis on rehabilitation reflects the specific knowledge of the think-tank, thus connecting the reform to international moves towards recovery-oriented practices.

On the whole, by connecting the reform project to internal needs and external trends, its proponents attempted to increase their legitimacy in front of institutions and professional groups claiming their legitimacy to direct the change process.

The ongoing reform as a typical product of the Belgian system: devising intricate policy instruments

The reform started in 2010, through exploratory projects expected to refine the five functions according to local needs and specific care systems, by developing working groups called committees of function.

Committees of function had to meet every month to define new work procedures supporting the implementing of the functional model. They involve mental health and primary cares front-line professionals.

Some of them, especially those focusing on mobile teams and the rehabilitation functions, were trained by public health authorities leading the reform. Vocational training course have also been organised in countries whose community systems inspired the Belgian reform, esp. Switzerland, France and the United-Kingdom.

Thus, public authorities are explicitly empowering new mental health professionals, providing them with adequate knowledge resources to impact on the change process. Services users groups are undergoing similar kind of empowerment through their “participation project”, which includes the involvement of their representatives into function committee and the writing of policy proposals for the improvement of users’ participation in care delivery.

By contrast, the means of financing the reform, by asking psychiatric hospitals to reallocate part of their budget from financing psychiatric beds to supporting the development of mobile teams and possibly additional functions, provides them with good reasons for influencing the reform's implementing.

Implementing the reform: what does it mean?

In this context, implementing the reform primarily means developing idiosyncratic local care networks, depending on the hospital promoting the project and the specific features of local care systems.

- Diversified local care systems, encompassing many community facilities, mean increased available resources to develop the five functions. However, provided that those structures have developed independently from one another, this also means impediments to reach agreement on common work procedures. Urban networks are particularly concerned by such challenges and opportunities. Rural networks are rather concerned by developing structures and staffs to fulfil new functions, especially rehabilitation.
- On the whole, the presence at local level of mental health professionals *knowing that* other kinds of treatments are also appropriate to mental health and *knowing how* to implement such treatments, represent useful resources in implementing the functional models. In fact, local networks lacking of such *knowledge broker* (Meyer, 2010), are undergoing difficulties in finding appropriate means to develop the five functions.

Implementing the reform means rising conflicting professional legitimacy:

- The legitimacy of experience (or practical knowledge) is claimed by public authorities leading the reform, mental health professionals supporting changes and services users groups. Most of time, using this legitimacy entails references to concrete experiences to justify the need for taking new actions, instead of relying on organisational routines to prevent new actions from happening.
- The legitimacy of academic knowledge is claimed by professionals reminding the need for paying attention to professional and legal

obligations, for instance medical confidentiality, when implementing the new functions.

- Conflicts between those contrasted kinds of legitimacy are particularly visible when new care instruments, such as individual care plans, are discussed by the committees of functions. In fact, such instruments involve different kinds of relationships between professionals, and between professionals and services users. Those relationships emphasize accountability and transparency principles, next to the trust relationship and professional *inference* (Abbott, 1988) induced by the model of *medical professions* (Freidson, 1988).
- Sorting out such conflicts requires local agreements, combining the two kinds of professional logics in a way that fit with local needs. Such *ad hoc* agreements lead professionals to be particularly cautious about inscribing them in documents, for instance network agreements defining the nature of their relationships for a period of time. As a result, it happens that implementing the reform means more discussing the meaning of every word to be written down than translating the resulting agreement into new work practices.

Implementing the reform means rising long-standing ideological conflicts

Most of time, such conflicts involve proponents of private psychiatry and those of public psychiatry. The former mainly relies on the pragmatic logic of action just mentioned, while the later rely on professional rhetoric to defend their position. Thus, ideological conflicts significantly overlap with the knowledge conflict.

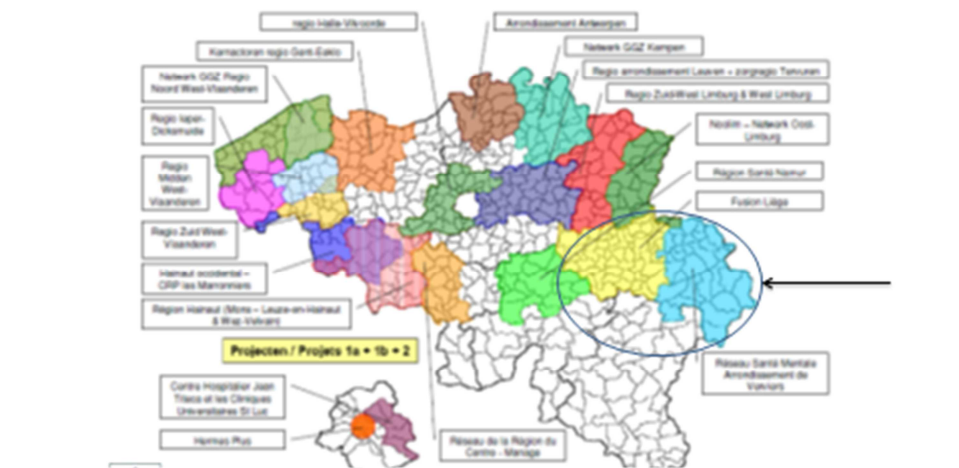
In this respect, the two most striking issues concern the activation of psychiatric mobile teams and the implementing early diagnoses and screening functions. Regarding the issue of who has the right to request the mobile teams' interventions, proponents of a pragmatic logic of action are claiming the right for services users and carers to "activate" mobile teams, while claimants of the institutional logic are insisting on the requirement for going through medical doctors, either GPs or psychiatrists.

Concerning the issue of early diagnoses and screening functions, it mainly involves Community Mental Health Services. On the whole, community services are overloaded with existing demands for psycho-social treatments and, given that they

receive no additional subsidies to participate in the reform, they are simply unable to implement those functions. More specifically, while part of them agrees on the need for developing early diagnoses and screening functions, part of them argues that taking this steps means moving toward increased social control.

Implementing the reform means nineteen successes in implementing mobile teams

As showed by the following map, nineteen pilots spread over the country are testing the new model care by implementing the five functions.



The “yellow” and “blue” pilots represent contrasted ways of implementing the reform. Their main characteristics are summarized in the following table. Short comments are then provided. In the framework of this outline of the reform, we focus on mobile teams (function 3). However, the reform is not limited to this function and other innovative devices and practices are developing in every exploratory project (see the website www.psy107.be).

	The “yellow pilot”	The “blue pilot”
Geographic area	+ 1900 square metres	+2000 square metres
Population	787, 502 inhabitants	280, 203 inhabitants
Promoter hospitals	Private hospital A- 15 A-Beds* Private hospital B-30 T-Beds Public hospital C-30 T-Beds	Private hospital B-30 T-Beds Public hospital C-30 T-Beds
Mobile teams and associated devices	2 mobile teams for acute treatments /2 mobile teams for chronic treatment	1 mobile team A 1 mobile team CT A guidance platform Family cares
Active file Mobile Teams A	2x35 users	1x59
Teams B A&B	2x185 users	1x103 1x38

30 T-Beds or 15 A-Beds=10 full-time workers, including nurses, psychologists, social workers, and paramedical staffs

Though they are developing in geographic areas of similar size, the yellow and blue pilots are directed to very different populations; the yellow pilot being intended to a large and urban population, and the blue pilot to a rural population of limited size.

The two pilots have at least two promoter hospitals, including private and public hospitals. This results from the explicit request made by policy makers to local actors to develop local network through partnerships involving all the institutions existing in a given area.

Either promoter has frozen³ a given number of psychiatric beds, in order to be able to reallocate the corresponding resources to the development of mobile teams. There is no simple correspondence between the number of frozen beds and the size of the mobile teams. However, on average, by freezing either 15 psychiatric beds for acute treatments (A-Beds) or 30 treatment beds (T-Beds), psychiatric hospitals are able to develop mobile teams composed of about ten full-time workers, including psychologists, nurses, social works and paramedical staffs.

On the basis of 75 frozen beds, including 60 T-Beds and 15 A-Beds, the yellow pilots is implementing 2 mobiles teams for acute treatments, and 2 mobile teams for chronic treatments. Each team tends to work in connection with the hospital

³ With a view to allow for progressive change, but also to avoid strong opposition from psychiatric hospitals, public authorities asked them to “freeze” a given number of psychiatric beds, instead of directly closing the necessary number of beds to implement the functional model. Public authorities expected hospitals to freeze at least 30 treatment beds or 15 acute beds, to be able to develop both chronic and acute mobile teams.

from which it comes from, and the four teams divide the territory up among one pair of chronic-acute teams focusing on the centre of the geographic area, and another pair focusing on the periphery. Though public authorities deplore this division along traditional organisational and ideological lines, it appears adequate to local needs. Moreover, thanks to the meetings of the functions committee, the members of the four teams are meeting every month to share about their practices and think about common procedures. The works of the four mobile teams is thus integrated in some ways.

With its 60 frozen beds, the blue pilot developed one mobile team for acute mental health problems, one mobile team for chronic problems, and one team addressing both acute and chronic problems. The two former are related to one of the promoter hospital and focuses on the north of the geographic area, while the latter is related to the second promoter and focuses on the south. Moreover, given the particularities of the local care system and particular concerns expressed by local managers and professionals, the three teams of the blue pilot are connected to two complementary devices. On the one side, they are connected to a guidance platform which is referring users to one of the three teams, or to community services, or to psychiatric (day) hospital. In this way, among the 257 users of the guidance platform in 2013, 96 have been referred to psychiatric hospitals, 67 to mobile teams, 68 to community/ambulatory services, and 11 have been asked to meet with the multidisciplinary teams of the platform a second time. On the other side, family cares having existed for long in the south of the territory covered by the pilot, this particular kind of (community) services is integrated to the pilot's functioning.

Finally, the active file of the mobile teams are following similar path, the active file of chronic teams being much higher than those of the acute teams. This fact rises, in the two pilots, the difficult issue of putting an end to the mobile teams interventions, with a view to not reproduce the same routines than in residential settings.

Conclusion:

For a few decades, policy makers have been attempting to stimulate change through pilot-projects "promoted" (i.e. financed) by psychiatric hospitals. However, provided that their initial objective is, in fact, to displace resources from the residential sector toward the community sector, policy makers have been disapproving the hospitals' influence on the implementing of policy programmes.

Consequently, seeking for means of directing the process of change in the desired direction, they are using resources from above and outside the system –especially references the WHO and to changes in OECD-countries mental health system- as well as resources from inside the system – among other front-line professionals trained in a way to *embody* (Freeman & Sturdy, 2014) the leading values of policy initiatives.

At the local level, those professionals –equipped with new practical experiences and references to knowledge produced by international organisations- are directly confronted with actors resisting to changes. Consequently, during the function committees, they come to endorse power, ideological and knowledge struggles which are not made explicit by policy makers, and in which they are not primarily interested. In fact, whether front-line professionals participate in policy initiatives it is most of time for the legitimate purpose of improving their conditions of work and their position in the system.

Thus, such means of reforming psychiatric and mental health systems raised question about the division of work and sharing of responsibilities between policy makers, social institutions, and professionals.

However, we have seen that, practically, it achieves stimulating change and the development of new professional practices, especially the mobile teams. Moreover, and in more abstract term, reviewing the literature on the implementing of community psychiatry in OECD-countries made clear that it is by no way a clear and one-way process, but a process inducing incremental changes, the progressive making-up of a stock of practical knowledge deriving from situated experiences (Freeman in Rowe et al., 2011), and the momentary convergence of social, political, cultural and scientific waves (Semrau, Barley, Law, & Thornicroft, 2011; Thornicroft et al., 2008). In this respect, the Belgian reform seems to occur at the right time in the right place. However, we assume that neither adequate sociocultural context nor proliferating pilots and networks suffice to enable change if they are not used in a way to allow for the collective learning of new pattern of relationships.

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