# Innovative practices handbook

**Abstract website:**

**www.innopsy107.be**

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# Foreword

**The Belgian Reform in Mental Health Care: where are we now?**

Mental health care need substantial reforms in most countries .
WHO's Mental Health Atlas demonstrated that the financial resources allocated for mental health care are low, care remains principally a hospital-based system and the integration of mental health care in general health care is inadequate. The Comprehensive Mental Health Action Plan 2013-2020 adopted by the World Health Assembly in 2013 clearly articulates the objective of providing health and social care services in community based settings.
Against this background, the reforms carried out in Belgium in mental health care since 2010 are very welcome. Reforms never are easy and those in mental health care are especially difficult.
This publication describes not only what has been done in Belgium but also how it has been done. While the progress already made is commendable, the implementation processes and the overcoming of barriers are very useful to share.
It is clear that successful reform involves multisectoral action and multi-stakeholder collaboration. While providing effective treatment is an essential goal, provision of housing, social care and employment is critical for good recovery.
And doing all this, with the people who have mental disorders at the centre of all efforts, adds value. Indeed, participation of service users and relatives in all decision making and their empowerment are essential elements of the reforms. This also ensures respect for the human rights of persons with mental disorders and their families. Eventually, mental health care reforms decrease stigma against mental disorders and enhance recovery and integration of persons with mental disorders into all activities of the community.
Reform is a continuous process; I hope that Belgium will continue to make community mental health care available to all who need it and also to improve the quality of services. I also hope that the experience described in this publication will be helpful to many others who are making efforts in this direction in other communities and countries.

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# Introduction

**Mental healthcare reform in Belgium**

The Reform of the mental healthcare services, with a restriction in the residential hospital resources for the benefit of care in the community, and more widely for the benefit of users, has led the Belgian government, comprising its federal, regional and community entities, to consult each other and create their provisions together - as much on an organisational level as on a philosophical level - in order to propose the setting up of a "mental healthcare Reform" which aims to optimise current mental healthcare. This new offering is focused mainly on a community-based approach and vision (Besançon & col, 2009).

The health survey conducted by interviews in 2004 (Bellamy & coll, 2005) revealed that one person out of every four (24%) in the population aged 15 years and over, had already suffered mental distress and that for more than half of these people (13%), it was a relatively serious condition.
For one third of people unable to work for long periods or definitively, the cause of this incapacity is a result of a mental health problem.
This concerns about 70,000 people. The data from the health survey also shows that one Belgian out of every four experiences mental health problems (Gisle, 2008).

A subdivision by problem indicates that 8% of the population experienced periods of depression, 8% experienced physical disorders, 6% experienced symptoms of anxiety and 20% experienced sleep disorders. Also, 6% of people indicated that they experienced severe depression during the year preceding the survey.
When efforts are made to guide mental healthcare towards the society and the community, five movements corresponding to the basic philosophy in the process of being implemented in Belgium can be described (Guide, 2010).

Firstly, **desinstitutionalisation**, which involves restricting residential treatments in healthcare institutions and favouring the setting up of intensive and specialist out-patient treatment solutions as an alternative to hospitalisation, which aim to keep the mental health user in society.

Next, **inclusion**, which can be described as readaptation and rehabilitation in the frame of an essential collaboration with and between teaching, cultural, labour, social housing sectors, etc. Therefore, inclusion does not only concern mental health sectors, but all the professionals who intervene.

Next, **decategorisation** that is set up via health circuits and networks, a collaboration with and between adult healthcare, mental health services, the services for people with disabilities and justice. All of the contributors consult each other around the user, thus limiting silo management.

Then, **intensification,** which involves an intensification of care in hospitals corresponding to shorter hospitalisation periods and treatments with intensive care programmes which help to limit the user being sidelined.

Finally, **consolidation**, which is a regularisation of the different participating pilot projects, as much on a federal level as on a community and regional level, in the concept of the globalisation of mental healthcare. With the idea being to be able to structure the global treatment offering into a network.

**Local implementation, a networking model**

The vision of the reform is inspired by the global and integrated approach which defines all the functions in the frame of mental healthcare on the basis of an integrated model. The current organisation of mental healthcare should evolve gradually and make way for a network of alternative services distributed around the territory.

This implies the adaptation of each of the resources which, together, with a view to complementarity, are introduced in order to develop their model that is based both on the stakeholders' creativity and originality, as well as, and above all, which takes account of the reform's overall philosophy.
We insist on the fact that these fundamental functions require collaboration with all the stakeholders concerned at different levels.

This leads us to start by defining a minimum framework, which aims, on the one hand, at defining the different steps needed to build the collaboration network and, on the other hand, at defining the profile of the network coordinator as well as its essential role in the construction process.

The mental healthcare reform greatly modifies the landscape and the philosophy of the management of users with a mental health and/or psychiatric problem, by guiding the practices towards a vision focused on community management and towards recovery and does this by transforming the hospital offering - which appears to be one of the largest in Europe in terms of beds/inhabitant - into a treatment process that is closer to the user's daily life and environment.

This philosophy implies the taking into account of all the stakeholders that formalise work in a network, in which consultation is one of the foundations. The end goal is to keep people in their community and their original social fabric via the setting up of personalised therapeutic paths.

To that end, the model which we are setting up in Belgium is characterised by five functions (which reflect the frontline players, namely mobile, training and professional integration, hospital and housing teams) which provide a model that symbolises the network of alternative services.

The originality and specific nature of the model implemented (Guide, 2010) is that it associates the entire measure in a global and integrated vision, by including the resources of hospitals and services developed in the community, regardless of whether they are related to mental health or not.
Therefore, the organisation we are recommending concerns all of the stakeholders present within a defined territory which have to create strategies in order to meet all the mental health needs of the territory's population.

**Innovative practices handbook in mental healthcare**

During the manual's drafting, the following concepts were defined:

- The "innovative practices handbook" reflects the experiences developed or which already exist and which are integrated into the mental healthcare reform's projects.
- The handbook presents a description of "good practices", "innovative practices" and formative experiences based on the Reform's projects
- The experiences described may be a source of inspiration for other projects.
- It is a manual which relies on scientific data but which is focused on an empirical approach. The projects' experiences are described in a coherent and convivial manner and are supported by current recognised scientific data.
- It is a tool which presents the current situation in Belgium. It is not a "marketing" tool: the handbook deals with different subjects that play a role in the implementation of a community-based reform model.

**As well as the following objectives:**

- To serve as a support for network coordinators, members of network committees and function committees; facilitate the diffusion.
- To constitute a method of communication for all stakeholders: users, close professionals, both internally and externally, concerning the reform of mental healthcare in Belgium.

- To constitute a directory related to the training and scientific research programme.
- To enable an updated vision of the reorganisation of mental healthcare in Belgium on an international level (WHO, European Union, etc.), based on a community-based approach and users' needs.
- To emphasize the importance of cooperation between the different sectors of different authorities (federal, community and regional).
  **Global and integrated approach.**
- Highlight the evolutive nature of the mental healthcare reform.
- Give greater credence to the argument for the qualitative evaluation of projects.
- Promote the positive aspects of the Reform with concrete examples from the field (bottom-up).
- Establish the connection, in terms of innovative practices, with the new mental healthcare policy for children and teenagers.

**The innovative practices handbook targets the following public:**

- All actors involved in the Reform: coordinators, network committees, function committees, working groups,… responsible at different levels of implementation of the " innovation" in the projects.
- Representatives of users and relatives, users and relatives.
- The different stakeholders involved in the projects.
- Anyone interested in mental health reforms (national, international and communities).

**Innovative practices**

In this handbook we have chosen to use the term 'innovative practices'. There are several reasons for this:

- To emphasise the connection with the Belgian mental health Reform 'Towards a better mental health care system' and the care innovation that comes with it.
- To avoid any form of 'limitation'. In the bottom-up experimental phase of the Belgian mental health care reform, we wanted to avoid giving the impression that it was mandatory for this reform to effectively realise the outlined initiatives.
- Because the term emphasises the creativity and inventiveness of the sector. The given descriptions are meant to inspire, not impose.

The innovative practices outlined in this handbook are therefore in line with Prins' (2008) 'inspiring practical examples'.

Innovative practices, much like guidelines and evidence-based practices, can be considered as instruments contributing to a good quality of care (Cabral, 2010). However, generally speaking these innovative practices are not widely known or available for professionals.

That is why in this handbook, we aim to give a comprehensive overview of interesting, inspiring initiatives.

An identification of existing innovative practices in our country can contribute significantly to the shift in our mental health care system and to the improvement of care for mentally vulnerable people.

By revealing how some projects offer a successful solution to current problems, other organisations can make use of this collective knowledge and experience. 'There should be no reinventing of the wheel over and over again'.

It is important to take into account the specific context of the situation of the innovative practices descriptions, the critical preconditions and success factors, and to think of existing or possible outcome indicators and the transferability of these practices.

We wish to expressly emphasise that there is no conclusive, unequivocal or universal definition of an innovative practice. However, several criteria can be established for defining an innovative practice (Pel et al., 2011).

1. Naturally, innovative practices are innovating and ground-breaking. The practice brings new and creative solutions. It should be noted that the initiatives described in this handbook are not necessarily 'new', as they were already applied abroad and were sometimes already scientifically evaluated. The innovativeness applies to the implementation of these interventions or models in the context of the Belgian mental health care system.

2. Innovative practices are based on a certain degree of consensus with existing literature and expertise in the health care sector. Innovative practices may, but do not have to be, evidence-based.

3. Innovative practices adopt a convincing methodology and are practical. They are easily made explicit.

4. Innovative practices are easily and sustainably transferable. Innovative practices often depend on the context in which they were developed, meaning that taking over the practice in a different context is neither evident nor easy. Therefore, in this book, the institution(s) and context in which the described practice was developed is always discussed, so that any interested parties may approximate this.
   Naturally, not all services or networks in which the practice was successfully applied are mentioned in this handbook; instead the choice was made to discuss one or several services working intensively or successfully with the approach. Institutions and associations are to decide themselves whether this methodology suits their context or where it might be necessary to adjust the method. An innovative practice is adapted and improved by its users and working with innovative practices is to be regarded as a continuous process.

5. Based on experience and scientific evidence (limited), innovative practices can offer a meaningful and tangible improvement in the quality of care and life of users. The practice leads to meaningful and desired results.

6. Innovative practices are in line with the Belgian reform of the mental health care system and are associated with substantive strategic developments in the mental health care system. Social support for implementing the practice is equally important (Peter & Heron, 1993).

When describing the innovative practices related to selected themes in this handbook, we also try to provide a link with evidence-based professional literature on the theme. The practical findings are described in light of the theoretical reflections available on that methodology or approach.
Besides results from scientific research, experiences with implementation and critical success factors may also be discussed.

There is no need for an innovative practice to be developed further until it is proven that the intervention is effective and a good, clear and transferable example for other organisations. Nonetheless, it is important that in time a distinction is made between promising and less promising interventions.
Such a differentiation is important to promote the transfer of and research on promising, qualitative interventions which could be an added-value for the care system. In that sense, this book presents a first insight, and it is important to update ,in the future, the described practices and their impact on the care for people with psychological disabilities.

Preference was given to a modular tool.
Each module discusses a relevant topic which is considered important for the reform.

For this purpose, a long list was compiled with topics relevant to focusing and managing the reform 'towards a better mental health care system'.
This was carried out during several meetings with a project group, in which external (foreign) experts were included. Finally, this project group decided to start by developing modules on seven themes:

1. Housing
2. Cooperation with front care
3. Governance of networks
4. Participation and empowerment of users and relatives
5. Socio-professional inclusion
6. Mobile teams for users with acute psychological problems
7. Mobile teams for users with chronic, long-term psychological problems

The entire project is a "**work in progress"**: a programme of modules that are developed further is to be gradually established. The modules as a whole give an insight into the different aspects involved in such a reform.

After some time, it is possible to update the modules, for example when new practices concerning a theme are developed, or when outcome data become available.

At the beginning of 2015, a call for projects with interesting, inspiring practices was launched to include them in the handbook.

During the selection, besides content data other elements were also important. For example, one outstanding feature was that several practices mentioned were related to similar current themes.
This allowed the regional distribution to be taken into account.
Even though practices were sent in for all projects, the amount of project sheets submitted for each project differed. In the end, different practice descriptions could be selected from several projects. Some practices are the result of a close cooperation of different projects. For several themes, the project group asked that somewhat convergent practices, sent in separately, were written out together.

For each theme, several 'readers' with experience within that theme were approached. Together with the plan writing committee and the editorial board, they formed the editorial panel of the concerned module.
They read and evaluated the introduction and the discussion and several practice descriptions. This formed the basis for the requested revision of all editorial contributions and practice descriptions.

The editorial board read all final texts and decided in consensus on their inclusion in the handbook. The editorial team also monitored the unifying concept and form of the handbook, checked for repetition and overlapping…

The final version of the handbook consists of two parts: on the one hand there is the 'paper' book you are holding, on the other there is the website: www.innopsy.be.

In this book you will find, following this introduction, a brief outline of the themes of the different modules. Next you will find the project sheets (cfr supra), introducing the innovative practices in a very concise manner.
They offer an overview of interesting substantial and organisational reforms developed in the different experimental projects, which could serve as an inspiration to others.

For each practice, contact details are provided in order to obtain further information. The book ends with a limited reference list, which contains a limited number of key references per module, besides several general references on care innovation.

On the website the interested reader can find additional information.
As well as a more extensive introduction of the module theme, including references to scientific research, you can also find more extensive descriptions of the innovative practices.

A format for the practice descriptions on the website was designed, which could be used as a (flexible) guideline.

This included:

1. An introduction: firstly, an overall description of the context of the project/ innovative practice
   - The network and the region in which the practice is situated
   - A description of whether the roll-out of the practice relates to the entire network or a section (regional subnetwork, target group...)
2. Short description of the initiative's content (and relationship to the functions of the governmental programme)
3. A description of the actors which played an active role in the roll-out of the practice in question (position, sector, levels of positions in participating organisations)
4. An overview of concrete results and the scale in which it is operational
   - Not only a story about the underlying principles or theories
   - Describing to what extent the working method remains true to the initial plan or theory behind the collaboration method (where was theory corrected by practical experience?)
   - Nowadays, is it acting as a 'pilot project' or is it ready to be/is it already implemented network-wide?
   - Are there any records/numbers supporting the practice? What would be good indicators?
5. Finally, a conclusion: "what did we learn?"
   - A list of dos and don'ts based on own experiences
   - What are the specific lessons for this innovative practice, which lessons could be useful for other initiatives?

Via the listed contact details, interested persons can obtain additional informations. In doing so, we wish to stimulate further exchange of experiences, accumulated during the belgian reform of the mental health care system.

**Terminology and authorship**

In a multi-authored book such as this handbook, it is usual that the editorial board makes certain choices in the interests of uniformity.
This was done through the use of the 'formats' described above, which were used in a flexible manner.

The intention was not to impose a single model, but to ensure that all relevant information in the different descriptions was included.
Moreover, linguistic and terminological choices were made.

The authors were asked to use, as much as possible, gender-neutral terms .
To avoid lengthy he/she or his/her constructions, sometimes gender-specific terms were used. Unless explicitly stated otherwise, these terms always refer to people of both sexes.
Lastly, the authors were free in their choice to use certain terms.
When referring to people making use of mental health care services, the designations 'patient', 'client' or 'user' are all loaded with meaning.
Both users and professionals have commented on this and they have clearly different views.
From a survey of 133 English patients making use of community care, it became apparent that most people prefer to be referred to as 'patient' by general practitioners (75%) or psychiatrists (67%).
With nurses, social workers or psychologists, the terms 'patient' and 'client' were preferred equally.
Older users often preferred the term 'client' (McGuire-Snieckus, McCabe & Priebe, 2003).
Also in the terminology of 'mental disorder', 'mental health problem', 'psychiatric problems', 'psychological disability' the editorial board did not give a preference, however we are aware of the underlying visions and relationships with a medical or psychosocial model.

## Modules

1. Housing
2. Cooperation with primary care
3. Network governance
4. Participation and empowerment of users and relatives
5. Socio-professional inclusion

   Mobile teams
6. Mobile teams 2a
7. Mobile teams 2b

# 1.Housing

**Accommodation, housing, recovery**, a trilogy that is proving to be increasingly important. Already, in 1948, the Universal Declaration of Human Rights stated in its article 25.1 "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security". The right to housing is a fundamental human right recognised in many international and regional texts, constitutions and national laws.

In its summary report, the World Health Organisation presents factual informations highlighting the major health effects of inadequate housing.
It concludes on the need to recognise that housing has an impact on mental health and insists on the priority of the promotion of healthier, more accessible and sustainable housing through housing policies.
Therefore, housing is a social determinant of health and is surely a powerful means of integration in civil society.
This leads us to the idea that accommodation and housing are closely linked to the concept of recovery, something that is firmly rooted at the heart of the mental healthcare reform.
But first, people have to find a home!

This an extremely complicated process because of stigma.
Not allowing a person access to housing because he or she has a mental health problem is always a violation of a promulgated law.

The mental healthcare reform enables the integration and emergence of innovative partnership approaches which, in network practices, bring together all the stakeholders concerned. These are mental healthcare professionals, social and psychosocial professionals, social housing managers, representatives of users and their relatives, and even elected local authorities.
To achieve this, it is necessary to start by taking account of certain points:

- The lack of a global vision and communication between the responsible authorities in the field of mental health and housing.
- The lack of communication and the lack of knowledge between sectors.
- The lack of communication between mental health professionals and housing stakeholders.
- The impact of housing conditions on citizens' mental state.
- The lack of affordable housing to low income groups.
- The difficulty people have in maintaining their housing in good conditions.

Therefore, it is important, alongside specialist supervision initiatives, to encourage integrating and/or maintaining people with mental health problems in ordinary housing.

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## Housing hunter

Fr

Improve access to housing for the target population, namely people with a mental health disorder and/or living in a situation of poverty, through the hiring of a specialist stakeholder who "captures" estate in the private housing sector. Guarantees are provided for owners, in particular through the setting up of psychosocial support at home. This project is innovative through the hiring of a specific profile of person with training in real estate and marketing. It was founded on a partnership between the mental health sector (107 network), the poverty sector (social outreach) and the housing sector (social real estate agency). It is financed by Wallonia.

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## Transito

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"Transito" is an innovative initiative in that it offers a transitional living space as well as a space for helping people towards autonomy. The target group is interned users who have been released for a trial period and who have been accepted in a sheltered accomodation and are waiting for a place to become available.
This project should fit into a traditional sheltered accomodation; it is necessary to provide an upgrade of 0.75 full-time equivalents for 4 sheltered accomodations Transito places, namely 43,312.5 euros for 0.75 full-time equivalents with a bachelor degree (outreach worker, medical staff and/or social worker).
The project, which is entirely transposable to a target group of users under a mental health protection measure, is part of function 5: collaboration must be constant with stakeholders from the other functions, mainly the EOLIA mobile team, in its dual liaison and outreach mission.

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## IHP+

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This IHP+ (sheltered accomodation) targets a very fragile adult psychiatric population, whose symptoms are stable enough to allow release from hospital but whose capacities in terms of taking treatments and meals have not yet been acquired.
The IHP + is comparable to a "traditional" sheltered accomodation apart from the fact that medication are distributed and meals are provided.
Help for housekeeping can also be organised.
The IHP+ option should be part of a traditional sheltered accomodation; an upgrade of 1 full-time equivalent/8 places should be added to the sheltered accomodation's staff
(cost 55,000/year – bachelor degree medical staff, outreach worker or social worker). The partnerships are all activated by the sheltered accomodation, namely stakeholders involved in the 5 functions.
The IHP+ is not transposable to another practice.

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## Social housing project

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The "Social Housing" project is led by the SMES-B's Support unit in partnership with the SASLS (support service for social housing tenants) which places social workers at the service of Brussels-based social housing agencies (SISP). This project aims to favour access to care and support for tenants suffering from mental disorders, the consequences of which may result in their being evicted from housing.
This project is financed by the Brussels-Capital Region (Housing) and consists of the part-time secondment to the Support unit of a social worker from a social housing agency, with competence in mental health.
The innovative and transposable nature concerns the partnership method (secondment of staff) and the preventive aspect (maintenance in housing). It could be developed among private housing tenants who find themselves in situations of poverty and suffer from similar mental disorders.

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## Outreaching adults

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"The "Outreaching adults" project is car- ried out in partnership with the SMES-B's Support unit and the non-profit association Source (reception centre for the homeless and social restaurant). It aims to support those working for Source who have found themselves at a dead-end in their support mission and, therefore, aims to favour access to care for people who combine problems of social exclusion and mental disorders and have often reached breaking point with primary care institutions. This pilot project is financed by the Federal Public Service Health: 1.5 full-time equivalent for the support unit (psychiatrist, therapist, psychiatric nurse) and 1 full-time equivalent at Source (social workers). Its innovative character involves approaching people where they live as well as professionals where they work. The central position given to the construction of social links and mobility makes this project transposable to all institutions working with the target group.

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## Housing first

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The American model Housing First reverses the logic proposed and starts by settling the problem of housing, which it considers to be the starting point for a reintegration process. Housing First offers immediate access to housing (as a fundamental right) from the street, without any other conditions than those to which a traditional tenant is subject (therefore, for example, there is no obligation to manage/treat any illness or addiction). The objective is to keep the person in housing and ensure their well-being (reference is made to the notion of recovery, well known in mental health). To achieve this, the model provides adapted, intensive and multidisciplinary support. Although Housing First's practices concern, as a priority, the homeless who are among the most fragile (long time spent on the streets, problems with general health, mental health and/or addiction), they obviously challenge traditional policies used in the fight against homelessness which is often an impossible obstacle course for many extremely fragile people.
These innovative practices are being tested in Antwerp, Ghent, Hasselt, Brussels, Molenbeek, Liege, Charleroi and Namur.
In this experimental context, an evaluation team regularly meets the tenants and compares their path with that of homeless people who continue to use traditional support services.

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## Interference care team for SHC-tenants

The social housing agency (SHC) can refer care avoiders suspected of psychiatric troubles exclusively to the interfering mental healthcare team. Thereby, eviction is avoided in a preventive way. The target group consists of social housing tenants in an urban area that is increasingly attracting vulnerable people. Thanks to its psychiatric specialisation, the interference team that visits the tenants in an active, assertive and low-threshold way can develop a constructive recovery plan for the tenant. It is crucial to have sufficient time for the development of a trustful relationship and for the integration of care coordination.
The interference team focuses on performance, recovery and collaboration with the client's remote environment.

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## Specialised housing forms

On the initiative of sheltered housing within the networks Reling and Noolim, several pilot projects were set up in the Province of Limburg.
The pilot projects have the common feature of offering an alternative within function 5 (specialised housing) thanks to a flexible and differentiated housing offer. These flexible housing forms came about in a demand oriented way, focusing on perceived and described needs. They were integrated in care circuits, mostly for a specifically defined (sub) target group.
The psychiatrically vulnerable user thus has a more diversified offer of housing opportunities in addition to regular sheltered housing and to psychiatric care facilities. This allows the choice of a housing form that meets the possibilities and the perceived needs. In all pilot projects, tailored services and care are offered with the recovery vision as a starting point, organised in accordance with the principles of Individual Rehabilitation Oriented Action. Together with his environment and his care providers, the user defines his objectives and translates them in small feasible steps. Strengths, supportive possibilities and the supportive network are mapped. This leads to a global support plan tending towards the highest possible degree of autonomy, empowerment and growth.

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## Housing outside social systems and transit acceleration

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Facilitating and accelerating payable housing possibilities in the social housing agency (SHC) for people suffering from psychiatric problems (including addiction problems) is very important in the context of care socialization. Since outreaching is also part of mental healthcare, this cooperation is possible as the social housing companies can demand psychiatric assistance at home in order to allow the transition to independent living. For the residential mental healthcare, the win-benefit is that people can be dismissed from the residential facility sooner and in an ethically justified way, thanks to starting up outreaching assistance.

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## Regional crisis network

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The regional crisis network Southwest-Flanders is a regional association coordinated by the public social assistance service, searching for solutions for people in (complex) crisis situations.
Concretely, the network offers a crisis bed after the office hours to people for whom no other safe place was found to stay that night.
Subsequently, ambulatory services try to find a structural solution for the crisis. If it concerns complex crisis situations to which the regular assistance services cannot respond adequately, a multidisciplinary consultation (cross services and cross sectors) is organised at short notice, in order to search for solutions.
If necessary, the user can be assisted by a supportive coach.
This initiative is supported by several sectors (offering a crisis bed, staffing crisis consultations, offering a crisis room …) and is funded by the social assistance service, regional social assistance services and the provincial authority.
This initiative is transferable to other regions.
The willingness of different sectors to take common responsibility for crisis situations is essential.

# 2. Cooperation with primary care

Mental health and many mental disorders are strongly influenced by the social, economic, physical and cultural conditions in which people are living. 'Health is a state of complete **physical, mental and social** well-being and not merely the absence of disease or infirmity' (WHO, 1946). Access to qualitative health care ('Health for everyone') is an inalienable right and an essential element in the fight against poverty and inequality.

**Front line services** are the key.
They bring health care, as close as possible, to people's everyday life and form the first step in a continuous care process.
The WHO's 'Comprehensive Mental Health Action Plan 2013–2020' is based on the principle that **'there is no health without mental health'**.
One of the plan's objectives is to provide comprehensive, integrated and responsive mental health and social care services in community-based settings. The goal is to accommodate both mental and physical care needs and to promote the recovery of persons with mental disorders within general healthcare and social facilities (so with respect of the right to work, housing and education). Thereby, treatment and recovery plans are used, co-produced by the users and care providers, and wherever possible with the input of relatives.
Comprehensive care cannot be realised as long as mental health does not fit into primary health care. There are many reasons for integrating mental health into primary health care (WHO).

- Mental disorders occur frequently and have a significant economic and social effect on the community as a whole
- Mental and physical health issues are closely interconnected
- The treatment gap for mental disorders is enormous. Primary health care for mental disorders could help bridge this gap
- Mental health care integrated into primary health care improves the accessibility, reduces stigma and discrimination and reduces the risk of use of restrictive measures
- Mental health care integrated into primary health care is affordable, cost-effective and provides good health outcomes.

To integrate mental health care into general primary health care, the following guidelines need to be followed:

- Adequate training for primary health care workers on relevant aspects of mental health, alongside training of skills and supervision. Models of shared or collaborative care, in which front line workers and mental health care specialists carry out consultations and interventions, are promising methods for continuous training and support
- Primary care missions are to be clearly defined and achievable. Positions of primary health care workers may be extended as their skills and confidence increase.

- Specialised mental health care professionals and facilities must be available to support primary health care.
- Coordination is crucial to overcome the threats and challenges of the integration of mental health care into primary health care
- Sectors outside healthcare can effectively cooperate with primary health care workers to help mentally ill users towards recovery and full re-integration in society.

The belgian reform of the mental health care system begins with the expansion of service and professional networks, both in the field of mental health care and primary health care, which have the responsibility for the mental health care of all residents of a defined area. Such a network is based on a global and integrated vision of the mental health needs of the population.
Primary health care workers are to be involved in the realisation of different 'positions', based on the philosophy of complementarity of means and skills driving the entire reform.
They are part of a care network built around individual users and coordinated by clinical case managers ('experts'). This is driven by the physical and mental health needs of the users. Procedures must be introduced for communication and coordination concerning these users, in which all parties involved share the necessary informations. Coaching and advice is to be offered to primary health care workers.
Many disciplines are involved in providing primary health care, however, general practitioners are often regarded as a core discipline.
The large number of actors involves a risk of fragmentation and a lack of collaboration.
In Belgium, social welfare departements are important resources. They are easily accessible for people in precarious situations such as poverty.
Psycho-social support services in schools play an important role in the detection, diagnosis and guidance of children and adolescents with psychological issues (and their relatives).
Home care services and local service centres are also in contact with many people with mental health needs.
Networking and collaboration is essential to offer effective mental health care in this fragmented landscape.
In the context of the reform of the mental health care system, cooperation has evolved between general primary health care and the mental health care facilities, in many locations.
Several interesting innovative practices, leading to more holistic integrated care with attention for wider social and mental health care aspects, were developed within that context.

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## Front line carepath alcohol

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The front line care path alcohol is a working tool for the citizen as well as for the primary care worker, particularly the general practitioner, to detect, screen and help people having frequent problems within the front line.
It also gives an indication for referral to specialised care during the care path.
The objective is to improve knowledge and skills of the front line in the field of mental health and mental healthcare. By familiarising the front line to the approach of mental care problems, the secondary and tertiary lines care are able to concentrate on their core business, ie the treatment and assistance of people having serious psychiatric issues. The secondary and tertiary line care however have to fulfill and monitor the liaison function to the general practitioner practice by the psychiatrist in the context of a collaborative care-methodology. The first line care path came about thanks to the narrow collaboration in the working group expertise enhancement of the front line psychological function. The front line alcohol care path is transposable to other regions and networks, as well as to other fields to the benefit of mentally challenged people and of the first line that need a standardised and harmonised path for detection and treatment, and enhancing mental healthcare-related knowledge and skills.

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## Mobile Intervention Unit

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"Hirondelle" Mobile Intervention Unit: pilot project launched by AWIPH (agency for disabled persons) in December 2009. This is a mobile support team for stakeholders and living spaces for people suffering from a "dual diagnosis" (intellectual deficiency and psychiatric TC/tr). Team intervenes for people aged 16 years and over who come from the province of Liege.
The team comprises: 2 psychologists, 1 social worker (total of 1.25 full-time equivalent), under the supervision of a psychiatrist participating in team meetings (1x/15 days). On the request of professionals who undertake to remain involved in the situation, the CMI offers an analysis of the behavioural and mental disorders presented by the person and, if necessary, guides them towards general and specialist structures, work opportunities in their community, coordination between different professionals working around the user, etc. End goal: avoid the exclusion of our public, its transfer from one sector to the other, favour their well-being and integration into the community. NB: no direct therapeutic treatment, secondary line care actions.

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## SMES-B medical-psychological support unit for intersection between mental health and social exclusion

The Support unit is a measure of the SMES-B which aims to favour access to care and assistance for homeless people suffering from mental disorders.
It is a multidisciplinary team comprising a psychiatrist, a psychologist, a therapist and a social worker. The entire team works part-time and the project currently employs two full-time equivalents. The Support unit is financed by the French Community Commission, the Common Community Commission and the FPS Public Health. The partners are institutions from the psycho-medical-social network in Brussels and specifically those working with the target public. The innovative and transposable nature of the project resides in the construction and dissemination of inter-sectoral and network practices adapted to the needs of people who combine complex and intricate problems.

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## Consult desk

The mental healthcare consult desk of the Province of Vlaams-Brabant offers phone advices to general practitioner's and primary care help providers having questions on psychic or psychiatric problems in users.
The aim is to strengthen care providers in the primary care so that they (1) remain in charge of the care together with the user, (2) get a fast answer to their questions and (3) are able to refer the user in a targeted way.
The consult desk started in June 2013 as a phone desk, but also as an online helpdesk. Eight therapists having expertise in their field alternatively answer the phone during working hours.
The consult desk for mental health can be reached by dialling 070 21 05 21 or by mail. All info is on www.consultdeskggz.be. The consult desk still has an important growth potential regarding its publicity on one hand, and its working area on the other hand. The latter is currently restricted to the Province of Vlaams Brabant but an extension to the Flemish level is a realistic target if the necessary financial support is provided.

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## Collaboration between mental health and front line

This initiative is innovative because it unites general practitioners and psychiatrists around common goals:
- "integrated medical care" in the management of "mental health"
- the improvement of exchanges of medical data between MT and MPSY
- the improvement of primary care orientation towards mental healthcare.

It requires the organisation of regular common meetings with very concrete agendas and strict time management. The question of overloaded agendas is an aspect not to be neglected. The self-employed status of general practitioners would require, if things had to go further, that a financial contribution be paid to them for their participation. This practice appears relatively simple to transfer but depends greatly on the personality of each doctor.

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## Psychiatric Expertise team (PET)

The PET is part of function 1 (B). This initiative aims to develop early detection, early intervention and reference towards specialised mental healthcare in close collaboration with primary care providers. Besides we wish to support and coach our target group with the existing psychiatric expertise when facing (suspected) mental health issues.
To that purpose, PET unites the expertise of the psychiatric care teams in the home situation (user system-related networking) and of the so-called Front Door team of the mental health centre (indication setting, treatment plans,…).
In both sub-regions of the working area, central phone contact points were put up, the existence of which was clearly communicated to all front line care providers. They can be reached during office hours. Depending on the first evaluation, notified cases are discussed in one of the two multidisciplinary discussion groups. The 'patient oriented' group discusses notifications that are easily referable to ambulatory consultations, depending on their treatment needs. This group includes mainly mental healthcare expertise.
The 'network- oriented' group discusses notifications for which reference towards ambulatory consultations is not realistic, not useful or not advisable (e.g. when the user has unrealistic demands while the network is clearly facing considerable issues)

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# PATIËNT IN BEELD
# FOCUS ON THE USER

In collaboration with psychically challenged users and other primary care workers, 'Patiënt in beeld' developed a model for shared care.
The model starts from a recovery oriented vision of patients and the specific role of primary care. The intention was to provide optimal care continuity and to empower the user to orient his path as much as possible, starting from a common connection with the secondary and tertiary line care. The care model can be used by any care provider to choose the right type of help, tailored to the user, their situation and the possibilities of the help providers.
The project 'Moving on the Psy's prescription' was developed to keep patients moving even when they are not in hospital as this often plays an important role in the recovery process.
The general practitioner prescribes 'movement', and refers to a 'moving coach' who tailors his approach.
We keep pleading for extra support from a moving coach, (expertise and time) in order to allow further inflow of psychically challenged participants in the broader 'Moving on prescription' methodology.
The starting points for the project 'Patiënt in beeld' are collaborative care and staged care.
The project needs a part-time project worker who wants to work with the users' experiences in a policy and action oriented way, with and inside our care networks 'art. 107'.

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## Front line psychological function

Short-duration, low threshold and solution oriented help are basic assumptions of a front line psychologist. Psychiatric complaints without complications, such as appropriation problems, mood problems and stress complaints, are charted and discussed in a general way during maximum 10 sessions.
When the complaints are more complex, the situation is explored and the patient is referred according to the staged care principles.
Primary care psychologists are easily reached as they work from a front line centre, a nearby health center, a general practitioner practice or a social service.
In order to guarantee this staged care and efficient referring to specialised help, the front line psychologists collaborate in a mental healthcare network with the secondary and tertiary line.

# 3. Network governance

Over the past few years, **organisation networks** from different sectors of society have been developed in order to solve the complex problem of providing good quality out-patient care for citizens with mental health problems.
The Belgian Reform programme "Towards better mental healthcare" aims to achieve effective collaboration between different stakeholders within a defined region by means of a network.
The aim is for these networks to be sustainable.
In the programme, it is planned that individual organisations maintain their autonomy. However, they are involved structurally in the cooperation which aims to support the population requiring mental healthcare in the region concerned.
These networks are considered to be innovative tools which allow quality services to be offered, mainly, in the event that it is no longer possible for individual organisations to provide isolated integrated services in the long-term. In this case, networks enable the development of a much wider range of treatment with a view to improving care and risk management and sharing responsibilities. Networks constitute a method of organisation which helps to resolve complex social problems related to mental health through the coordination of the independent activities of institutions and their specific competences. A network of organisations develops when independent partners choose to become mutually dependent in order to contribute to the implementation of political goals.
As a general rule, a network is created when partners have to share resources (logistical, human, financial) in order to carry out common actions. In scientific literature, this form of collaboration is described as a "network entity". This type of network is deemed to be an appropriate method for organising public healthcare.

**"Governance" and "networks"** are concepts used in literature and in political texts. The question asked is how these types of network can contribute to achieving the goals in a sustainable manner and how to develop institutionalised networks.
In this context, the relevance of the governance of these networks becomes apparent.
Governance, in its most general definition, can be understood as a "management strategy" which helps to coordinate the activities of the different stakeholders in the network and pool resources in order to achieve a common goal.

**Mark Leys, June 2015**

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## The governance model: global, integrated, consultative, participative, horizontal and productive approach

The drafting of the guide "Towards better mental healthcare" provides for the development of inter-sectoral networks. Ensuring collaboration between different sectors – with different ways of functioning and different challenges – constitutes a real challenge. To succeed in this challenge in a truly innovative manner, it is necessary to introduce a transparent, structured model of governance which respects each sector.

In the context of the experience of Réseau Santé Namur, this model of governance was introduced according to a global, integrated, consultative, participative, horizontal and productive approach.

The network's internal operation is developed in such a way that it takes a global approach to the challenges of mental health, studies how these challenges are integrated into other challenges, consults all the partners involved in the network, favours the participations of users and their relatives, places the stakeholders involved on an equal footing and aims for the development of operational tools and procedures.

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## Governance and communication model of SaRA

In order to guarantee an efficient implementation of the SaRA-network, a dynamic collaborative and consultation structure was developed considering a good balance between acceptance and participation for network partners and sufficient decisiveness to operate as a network. SaRA has co-chairs and co-network coordinators (50% each) who were given a clear mandate from the network committee members.

Using various channels, the communication model of SaRA makes sure that the partners are elaborately informed on the developments and achievements of the network, including a website with targeted tabs and a clear structure, a newsletter reaching over 1,000 addressees, a biannual large scale partner consultation on currently relevant themes, explanation visits on SaRA and its offer, phone contacts.

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## Noolim, mental health care network Governance-model

The Noolim network organises mental healthcare for adults in the Eastern Limburg region, starting from a well-defined vision on providing care to mentally vulnerable people. The network is composed of residential and ambulatory mental healthcare partners, facilities and primary care representatives, organisations in the field of employment, users and family representation, and players from the welfare sector. The network aims to create an added-value for the mental healthcare client, the network and staff of all facilities participating in the network. Our key values are: connection, transparency and dialogue.

In order to achieve its mission, the network developed a governance-model. It is a broad participative model aiming at connection, ownership and responsibility of all network partners. This governance model allows us to choose for decentralisation and coordination of competencies, for management structures with clear roles and responsibilities, with particular attention to transversal connections between functions.

The model gives the user and his relatives a prominent voice.

# 4. Participation and empowerment of users and relatives

In the past, users with mental health disorders rarely had the opportunity to voice their opinion on the organisation of care and the course of their lives. They, and their relatives, were only marginally involved in decisions made about them. Today, they continue to be victims of discrimination or exclusion in many areas of life, whether social, cultural, professional, etc.
Nevertheless, changes in how the question of mental health is represented among professionals, society and users themselves, as well as their relatives, have helped to change cultures. Gradually, there has been a shift from the notion of a "patient" who is passive, dependent on the knowledge and power of professionals, to that of a “user”, who is active, responsible, a stakeholder in his programme who is involved in his recovery process”.
At an international level, different policies emphasise the particular importance of users personal and collective role and participation at all levels of the organisation of care.

The term **participation** describes several challenges and forms of action:

- User's adhesion to the project which concerns them. The main impact sought is to allow users to express themselves, encourage their active mobilisation, join in with the projects that concern them
- Participation targeting the "coproduction" of projects with users. Its main challenge is to build or significantly change the project or the scope of action by associating users in all the phases: definition, design, coordination, evaluation.

**"Empowerment"** is a recent notion. Today, this voluntary approach to take control of one's life, is understood as being a fundamental principle for the promotion of health in general and, in particular, for people who use mental healthcare services.
This notion makes reference to the level of choice, decision, influence and control which mental health service users may have over the events of their lives.

In the frame of the mental healthcare reform and, more specifically, within the "Project Participation of users and relatives", associations of users and relatives are asked to produce recommendations which represent advice for "good practices" giving their point of view about the organisation and functioning of these networks.
Over the past few years, they have worked closely towards an extremely ambitious goal, namely to bring their expertise to the reform and, thus, contribute to improving care.

The many innovative practices initiated throughout the territory bear witness to this.

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## The involvement of users and their relatives, the committee of users and the committee of relatives

The networks created in the context of the "Towards better mental healthcare" reform are stimulated to organise the participation of mental health users and users' relatives. To that purpose, Réseau Santé Namur has developed several methods for implementing this participation: the inclusion of representatives of users and their relatives in each of the network's constituent bodies and the creation of the committee of users and the committee of relatives. These committees are open, respectively, to users and users'relatives wishing to share their experience of the organisation of mental healthcare and draft recommendations for professionals. Through these two methods, and others, users and their relatives participate in the dynamic of co-construction, in the stages of project development and in the network's decision-making processes.

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## Incontri

Equally made of professionals and volunteers with experience in the mental health sector, our non-profit organisation works to prevent and destigmatise mental illness in the sector of teaching and training, the world of employment and in institutions.
This approach takes the form of meeting modules based on reciprocity and the exchange of knowledge and skills.
The main stakeholders of these modules are life experts for whom involvement is the opportunity to benefit from social visibility and enrich the collective consciousness with their own unique experiences.
To that end, in each activity, we ensure that the target group is not able to make a distinction between the non-profit members and the volunteers. This choice corresponds to our intention to create meeting spaces within which people define themselves through a
capacity-based discourse as opposed to a deficiency-based discourse.

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## Together Belgique

The non-profit association Together is an association of users and former users of mental health services in the widest sense.
The association's objectives are very varied. The aim is, on the one hand, to organise representation within strategic assemblies, set up user committees and, on the other, to develop leisure clubs. Currently, the association benefits from an optional subsidy from the Walloon Region which, among other things, enables a part-time coordinator to be hired. However, it is the users themselves who work for the organisation and ensure the roles of coordinator, secretary, etc. This practice helps to promote social roles and is a model for preventing and combatting the isolation of people through the varied range of leisure activities proposed.

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## The human library

The Human Library is a “social perception” initiative addressing the broad public. In the local library, one can lend ‘living books’, people who have an experience in mental healthcare: as an (ex-)user, a family member or a care provider. By reading a short review of the life story of each person, library visitors can select living books and enter into discussion with them.
The Human Library aims at lifting the taboo on people who have psychiatric difficulties and improving the image of mental healthcare.
This initiative requires the collaboration of various mental health actors from the region, as well as the collaboration of local libraries. The latter offer the space and make publicity (in the city magazine, among others). The Flanders Association for Mental Health care provides the concept and practical support. The budget for this initiative is restricted to printing flyers or posters and buying small gifts for the “living books”. This initiative can easily be replicated to other libraries provided sufficient volunteers be found.

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## Support group In Balans

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This support group is an organisation of the mental healthcare network in South-West Flanders. Evening gatherings are addressed to the family members of people who have a personality problem, with the purpose of enabling contact between social peers. Each time a lecturer is invited to talk about a specific aspect of the issue.
Afterwards, an informal meeting allows the family members to chat.
The initiative is paid for and organised by the mental healthcare partners from the network.
For each evening meeting , a 250 euro budget and 5 to 6 staff members are provided. The Talking Shop is organized 4 times per year, in a neutral location in Kortrijk. This initiative can be replicated in other regions.
The support groups can also approach relatives of users who present other health problems. This needs to be tailored locally.

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## Support group De Stem

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'De Stem' is a support group on the theme of psychosis.
It started in september 2010.
Such an initiative for family and insiders, organised by various (some 17) care partners, was unique at that time.
This project was a pioneer in its own field.
It combines content information and social peer contact. The content information is very diversified as to both the themes and the methods. (see www.praatkaffee-destem.be for the program of the previous meetings: imagery, poetry, art, film, testimonials, panel discussions etc.).
During social peer contacts, mutual recognition and support are crucial.
'De Stem' talking shop is piloted by a steering group composed of care providers made available by their organisations, and family members.

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## Le B'eau B'art

The B'Eau B'Art, a therapeutic bistro, is managed jointly by mental healthcare users and professionals. It is based on the life experience of the users who go there and their inventiveness.
It is designed for people with fragile mental health who want to form relationships, find an activity or simply spend a quiet moment in good company. It allows people to find a social goal.
The club is located in the heart of Tournai. It is open from Monday to Friday, as well as one evening and one Saturday a month.
It works thanks to the partnership between several institutions which devote staff to it, a voluntary subsidy from the Walloon Region and the benefits from sales. The practice is easily transposable, even though it is different every time. The greatest challenge is finding partners willing to invest (premises, staff, furniture, etc.).

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## Experience experts in mobile teams

Since 2013, the working budget of SaRA allows two remunerated experience experts to work for mobile team De Link and mobile team De Vliering.
Initially 0,5 full-time equivalents in each team, and since 2015 0,75 full-time equivalents in De Link.
They ensure equivalency and offer hope and encouragement as role models to users who are psychically challenged on their way to personal recovery. A precondition to fulfill this function is to give 'body' to this new discipline, embedded in a broad learning context that is largely supported (mental healthcare, education etc.) as well as transfunctional cooperations. The concept of remunerated peer workers in a mobile team is developed to the extent that it is transferable to other organisations.
This function is funded by the working budget of SaRA, granted by the authority concerned, and, for mobile team De Link, it is partly funded by own assets.

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## Recovery Academy

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The Recovery Academy has an open training offer on various themes concerning psychological recovery. Professionals and people having experience work together on an equal basis.
The lectures run in collaboration (co-production), are co-delivered and are focus on co-learning.
In other countries, the establishment and working of a recovery academy is concerned as one of the important steps in organising recovery oriented mental healthcare (Implementing Recovery through Organisational Change 2013).
Education, participation and empowerment are important principles in this offer. The initiative is complementary to what currently exists in terms of treatment, training, education and supportive care. There is a need for research on success factors and a structural framework for rolling out a recovery academy within the mental healthcare networks.

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## A tandem in the recovery landscape
## DENK: knowledge through experience

Experience experts and help providers interactively search the meaning of *recovery*. DENK conceived and developed the workshop on its own, the objective being to help Flemish help providers to work in a more recovery oriented way. Starting from their own experiences and stories, the members of DENK try to optimise recovery oriented care. This working form is solid because ex-users train care providers, thus reversing the roles.
It is no longer the professional who explains to his client what to do.
The result is a positive exchange, enhancing the feeling of 'togetherness' while developing recovery supportive care. Each network having an organised group of experience experts can start up such a project.

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## Users desk

The users desk is an initiative taken by 'Het PAKT' in collaboration with the Province of Eastern Flanders and the working group "Experience sharing and de-stigmatization". This desk employs two process tutors (a help provider and an experience expert) and six volunteers.

There are three funding sources, i.e. own incomes, a project grant from Het PAKT, and a project subvention from the Province of East-Flanders.

The collaboration with the proximity house Poco Loco and the Working group Experience sharing and de-stigmatization results in a positive kind of exchange. During the process, people can participate in various subprojects. The different partners create an environment allowing the users desk to grow in a bottom-up, organic way.

The methodology of this initiative is most certainly transferable to other regions and it would be very supportive for local experience experts.

# 5. Socio-professional inclusion

According to WHO, good mental health is a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community.
Stigmatisation is "one of the greatest problems experienced by people suffering from psychiatric disorders." It has an negative effect on self-esteem, contributes to the deterioration of family relationships and prevents people from **socialising, obtaining housing, finding a job**"
The main aspect of a disability related to mental disorders and also the common cause of a relapse is a situation of isolation and a person's loss of social status and citizenship. It often goes hand-in-hand with the end of a stabilised and programmed treatment. Yet, many studies have shown that people are able to live in the community if they receive the appropriate and flexible support they need. According to some of these studies, the number of people returning to hospital was reduced by 92% through the setting up of adapted community monitoring.
By modifying the environment and favouring the development of targeted skills and the right support, it is possible to improve, quite radically, the reintegration of these people and post-hospital monitoring.
The action plan for mental health in Europe highlights the challenges over the next five to ten years. It will be to draft, implement and evaluate the policies and legislation that will lead to actions which help to improve the well-being of the entire population, avoid mental health problems and favour the integration and functioning of people suffering from these types of problems.
**Psycho-social rehabilitation** is a systematic method which aims to help users to choose the environment in which they want to live, train or even work, and enable them to achieve a feeling of success. It is also designed to adapt the aids needed to do this with success and satisfaction.
Finally, psycho-social rehabilitation is part of the healthcare offering.
Therefore, the aim is to help the user to develop the skills needed in order to live in the environment which he himself has chosen and to obtain the support he will need to achieve his goals.
The challenge is to integrate users into all aspects of the community and to enable them to participate. The aim sought is to provide the aid needed in order to function better in these communities and restore or build a positive identity in the social roles they have chosen.
If the aim is psycho-social rehabilitation and increasing users' success so that they are able to function in the environment they have chosen, with as little professional intervention as possible, it is necessary to consider that it is a process that starts and ends with the users and attaches prime importance to participation and persons' choices.
Furthermore, the aim is to compensate for or remove functional deficits and to overcome the interpersonal and environmental barriers associated with a disability. Finally, the goal is to restore their ability to live independently by removing social disadvantages such as exclusion and "unemployment".

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## Job coaching in mental healthcare

The project 'job coaching in mental healthcare North-Western Flanders' has contributed to the implementation of employment oriented mental healthcare. Having a job, regardless of its form, is a very powerful lever for integration in society. Customisation is the key to the achievement of this goal. Intensive collaboration with the employment sector is essential, as well as (if necessary on the long-term) support to both the user and the employer. The partial transfer of competences to the regions in the field of mental healthcare creates a synergy momentum between mental healthcare and employment. Job coaching in mental healthcare can only be successful if the choice is made to let this project grow and if a viable network of customising firms and employment care centres are guaranteed.

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## Werk werkt!
## Work works!

WerkWerkt! represents a methodology that responds to the wishes of people in search of remunerated employment and training.
Many psychiatrically challenged people who have no job and have received no education, want to work or study.
The methodology includes two major innovations: it replicates all principles of Supported Employment and a new approach in trans-sectorial collaboration (Knaeps, 2013).
Two functions were created to enhance the integration between employment and mental healthcare (the second pillar of the project): the employment therapist and the employment expert. They form a mini-team constituting the crucial stepping stone to care providers (psychologists, psychiatrists, general practitioners,…) and to employment authorities.
The employment therapist is usually a care provider focusing on symptom treatment, on consultations with the psychiatrist, on the separation between private and professional life…
The employment expert searches vacancies, consults the employer, is present on the work floor...

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## Cap Insertion

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The "Cap Insertion" module was designed for a specific target public suffering from mental health problems and wishing to return to the labour market.
The objective of the module is to galvanise people and unite them around the same objective: professional integration. This module offers about ten well-targeted themes which do not content themselves solely with theoretical notions around work, this module is designed to be a practical tool in which the move to the implementation of personal integration projects is very real.
The user becomes responsible for his reintegration!
In addition to the internal dynamic created in the team, an external network is also developed and becomes involved in this mission.

## Job-Art Reling

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The Job-Art initiative implies that various mental healthcare partners and the employment coach of the national health insurance authority provide resources in order to offer a front line, network-broad, specific and complementary path- and career support package to a target group which does not easily find its way to existing regular actors, mainly due to mental vulnerability. The team of 3,4 full-time equivalents develops an IPS-methodology based approach, supported by both users and employers. Given the complementarity of the offer, it seeks and facilitates collaboration with the Flemish employment authority through (network based) consultation and front office work in local employment shops.
The core mission is encouraging remunerated employment. The team, acting as a specialised mental healthcare employment case manager, fulfills a bridge function between mental healthcare and employment, in communication with the case managers in care facilities.
The experience teaches that in many places in (care) facilities, people spend time and energy on employment rehabilitation, but that they do so in a rather isolated way.
Bringing together these experiences and resources has an added value in order to optimise the offer, the return and the accessibility for users.

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## Zowezo-Team

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The cooperation model between the official Flemish employment authority, the specialised service for employment path support and SaRA, as well as the integration of the employment coach in this cooperation model and the creation of the so-called ZoWeZo-team, aim at a methodological intersectoral collaboration, enhancing a professional reintegration of psychiatrically challenged people. The network partners concerned are stimulated by this cooperation model and the activities of the ZoWeZo-team to achieve better alignment and collaboration. This collaboration also optimises the function of the employment coach (1 full-time equivalent funded by the health insurance authority). The methodological intersectoral cooperation is transferable to other regions (for example, in the Kempen Network, a comparable model exists and the establishment of a local ZoWeZo-team is being explored) and if adjustments are made it is also transferable to other target groups.
The application of the roadmap was developed on the basis of experiences of the specialised employment service with the target group of heart patients).

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## Op the brug
## On the bridge

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Two staff members (respectively 100% and 80% full-time equivalents) are employed by this project in order to make a link between mental health care and the users'local environment: they provide both leisure activities and community activities. From a non-cathegorial and non-problematic starting point (integrated basic practice), this offers the opportunity to consider how psychologically vulnerable people can find a place in society and how they can be supported in their participation in leisure time activities.
Every day this practice proves its added value. It starts from a simple methodology that is easily applicable in every integrated and low-threshold practice as a close collaboration between an organisation in the mental healthcare network and other (welfare) partners in the neighbourhood.
This practice needs a budget to recruit staff, as well as a close commitment of a mental health care organization as a 'home base', and an annual working and activity budget.

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## Optimizing collaboration with the employment actors

In the mental healthcare network in Southwest Flanders, collaboration with employment actors (from the social economy, among others) gets considerable attention. Historically, both sectors have strong mutual interests, but a more intensive collaboration was developed in the context of article 107.
This resulted in the organisation of three concrete study workshops focusing on cooperation between the sectors and on better knowledge of existing services.
Each of these workshops responded to concrete questions and needs in one or both sectors. They were practically set up in collaboration between the sectors, and the contents were established in common consultation.
Each workshop constituted a win-win for all actors concerned.
The large amount of subscriptions and the intensified contacts that resulted from them make us conclude that they effectively enhanced the collaboration between both sectors to the benefit of psychically challenged people that are looking for a job.

# Mobile teams

**Mobile teams: treatment teams in the home environment in a subacute or acute condition for long-term and severe psychiatric problems**

Within the mental health care system, the major part of the budget continues to go to (large) residential facilities, without a clear responsibility for the population of a defined area. The location where the care is offered does not match the needs.
In response to this situation, WHO calls for an 'optimal mix of mental health care facilities'. Scientific research supports a balance between hospital and community care (Balanced care model; Thornicroft and Tansella, 2009).
There is broad consensus regarding the need for the mental health care system to shift from a model based on traditional, large psychiatric institutes to a modern, inclusive care system with a special focus on the community, supported by acute psychiatric departments in hospitals.

In the literature, four different types of mobile teams are distinguished:
- The crisis teams, as an alternative to acute psychiatric admission
- The 'community mental health teams' are meant for the majority of users with severe psychiatric disorders and offer long-term support as an alternative to a long-term hospital stay
- The 'assertive outreach' teams offer more intensive community support for the group of people with very severe long-term psychiatric disorders, often in combination with addiction problems, who are difficult to reach
- Finally, for some time now, there are mobile teams for people with an early psychosis (McGorry e.a. 1996). These teams are excluded from the scope of this contribution

Burns (2010) stresses that (mobile) teams do not improve the outcome or prevent hospitalisation themselves: they are a way to offer effective, evidence-based interventions. Therefore, he finds that more attention should be given to the interventions delivered by these teams and especially to the functioning of these teams, ensuring effective interventions are offered which would not be offered in other circumstances. In addition, he acknowledges that the restorative approach highly focused on the person should complement the required professional expertise.
In the 'Guide to a better mental health care system', a distinction is made between outpatient intensive processing teams/mobile teams for persons with acute mental health problems, and teams focused on persons with complex, severe and long-term psychiatric disorders. Even though these two types of teams are based on community foward-looking initiatives (for example the 'Training in community Living model' in Madison, Wisconsin - Stein & Test, 1980; Pieters, 1992) they both do differ in target population (all persons eligible for an acute psychiatric admission vs a selected subgroup of persons with long-term, clear care needs) and in time scale of the interventions (short-term acute over a few days to weeks vs long-term care).
We will now use the division of the Guide to describe the several approaches accompanying it.

# 6. Mobile teams 2a

**Mobile crisis teams focused on people with acute psychiatric problems**

From the late 1990s onwards, crisis teams were broadly developed in the United Kingdom. They are known as 'Crisis resolution and home treatment teams' (Johnson en al., 2008).

The primary purpose of the crisis teams is to prevent or shorten psychiatric admissions. In many countries, such teams function as a 'gatekeeper' to the residential psychiatric system: without assessment by this team, hospitalisation is impossible. Moreover, the team actively searches for hospitalised users who can be discharged. The concrete treatment goal is to start or resume outpatient treatment or to offer other types of (part-time or day) short-term treatment.

The crisis team is usually made aware of users in crisis by the general practitioners (or other primary health care workers) or by employees of other mobile teams. A large proportion of the referred patients are new to the mental health care system. Firstly, the crisis team diagnoses these new patients, after which - if necessary - an (outpatient) follow-up process is determined. For users in crisis, care continuity is always the goal of the practitioner. The crisis team does not offer independent treatment, however through cooperation and consultation it enables practitioners to continue treatment during crises or disturbances.

The multidisciplinary crisis team, consisting of (psychiatric) nurses, psychiatrist, social worker(s), and other disciplines (psychologist, ergotherapist, …) offers short-term intensive psychiatric home care (with diagnosis and treatment). The interventions consist of practical support, medication and family therapy.
The guidance of a crisis team usually lasts a maximum of 6 weeks.
Van Veldhuizen (2004) describes the different phases within this process:

- Start-up phase: the crisis team begins without waiting time. During a care consultation with referrer, user and relatives, treatment goals and means are clarified, care and security are organised and roles are defined. This is laid down in a treatment plan.

- Acute home care phase: the first weeks are the most intensive. Daily or more frequent home visits are possible. Given the intensity of the care, different team members visit the user at home.
  Usually, one team member will take on a coordinating role and is in contact with the user, the relatives, the therapist and the general practitioner. Communication within the crisis team is crucial.

During this phase, team members actively offer support and help during concrete issues (for example within the home). During this phase, it might be preferable that other disciplines accompany the team during home visits (psychiatrist, social worker, psychologist or systemic psychotherapist).

- Stabilisation phase: once the situation has calmed down, the frequency of the home visits is reduced. The final treatment plan is laid down and discussed with the user, the relatives and the therapist.

- Phase-out phase: finalisation and contact with other necessary resources are actively pursued, the reorientation of the user is an option.

- Conclusion and report: the further continuity of treatment elsewhere has been finalised and a written final report (discussed with the user) is sent to the therapist and general practitioner.

Within their own environment, the user (and his/her relatives) is supported by the crisis team to actively participate in the treatment, so that behavioural change and new insights are gained from this crisis.
If there is an ambulatory therapist, he shall retain the responsibility for the treatment. If no ambulatory therapist is (yet) available, the psychiatrist of the crisis team shall temporarily take on this task.
At the same time, the team urgently searches for an ambulatory therapist, enabling a 'warm transfer' while the crisis team is still involved.

The crisis team operates flexibly. Therefore each user must have an accessible treatment plan, clearly describing everyone's tasks and responsibilities. The 24/7 phone and agreements concerning the 'Bed on Recept' are also part of this.
Other important themes in the functioning of the crisis teams are risk assessment, treatment adherence, constraint and pressure and some transcultural aspects.

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## Pléiade 2a

The crisis management team reacts according to the situation encountered by the persons and/or their family.The team works in close collaboration with the beneficiary and the network's members, whether they are non-professionals, such as the family, or professionals. This network may be active, created or remobilised at the time of the application. Consequently, the stakeholders involved in the work may come from the mental health sector as well as from the primary care services.
These may be referrals/applicants, but also relay points involved in the subsequent management of people. The application and management are studied by a multidisciplinary team. The team individualises each person and intervenes during a period of +/- 1 month.
The team works together and uses various methods to carry out its mission, such as mobility, intensiveness, temporality, the adaptability of the healthcare providers, the notion of hand-overs, home hospitalisation, etc.
In terms of the practice's transferability, the network feels that it is interesting to highlight the importance of the network's involvement and its collaboration in receiving its working methods.

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## Mobile Crisis Team

The Mobile Crisis Team in Leuven provides a worthwhile alternative to (forced) psychiatric crisis admission, as a multidisciplinary team of psychiatric nurses, social workers, psychologists and psychiatrists uses a combined polyclinic and outreaching care offer.
In this way, this team gives shape to the function 2a in the Leuven and Tervuren regions, funded by the withdrawal of recognised psychiatric beds in the article 107 facilities. The mobile crisi team complements the offer in crisis psychiatry in close cooperation with the psychiatric service in emergency services and in crisis admission departments in the region.
The Leuven mobile crisi team successfully translated foreign models to the Belgian context.

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## The Mobile Crisis Team

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The mobile crisis team Northwestern Flanders was started up on March 12, 2012 as a pilot project in the context of article 107. Its action lies within article 107's function 2, having PZ OLV Brugge and PC Sint-Amandus Beernem as promotors. The team was established in collaboration between five different partners (3 psychiatric hospitals and 2 general hospitals).
The mobile crisis team offers the possibility to support and treat (young) adults having an acute psychiatric issue in their home context. The Mobile Crisis Team collaborates with an extensive network of partners and has the key objective to prevent or to shorten residential admission or to prevent relapse. This multidisciplinary team includes:2 psychiatrists, a team leader, a clinical psychologist, three social workers and eight psychiatric nurses. Calls can be submitted by the general practiotioner, the psychiatrist in charge, emergency services or the Psychiatric Expertise Team and are being taken within 24 hours.

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## User support procedures by mobile team professionals

The partners of the network have imagined the support work provided for users by 2A and 2B teams as a process, a series of phases:
Analysis of demand → Support or reorientation → End of support.
This process has been designed to be practical, accessible and uniform for the teams: we used the "Mindview" programme for the form and applied our process management training for the content. This process helps to structure the different steps in our team monitoring based on the initial demand through to the establishment of relays with the network.
It helps to clarify the organisation of monitoring by the mobile teams by connecting the clinical sense of support, the treatment path, the treatment dossier and the coding of data in order to report on our activity.

# 7. Mobile teams

# 2b

**Mobile crisis teams focused on people with severe long-term psychiatric disorders**

In order to offer accessible care for people with complex mental health needs in the home environment, ambulatory care is insufficient.
To prevent hospitalisation and especially frequent repeat admissions, and to reduce the length of hospital stay, home-based care, in the form of home visits, proves to be a necessary element (Burns et al., 2007).
Outreaching mobile teams form the basis for community-based care, and its establishment introduces a new form of mental health care.
In its most simple and basic form, it concerns generalistic, multidisciplinary teams providing care at home within a geographically defined 'catchment area', preferably focusing on users with severe mental disorders (SMD).
In a large number of studies and systematic reviews, these mobile teams offer clear advantages compared to hospital care (Thornicroft & Tansella, 2009).

- Accessibility to mental health care for persons with SMD is greater in community care than in traditional psychiatric hospitals.
- The functioning of these teams is associated with greater user satisfaction and meets their needs more accurately. They ensure better care continuity and more flexibility of the service provision. They help to identify and treat early recurrence.
- Mobile teams reach an equal and sometimes better outcome regarding adherence and quality of life.
- Studies also suggest that community care for acute psychoses in general is more cost-effective than clinical care.
  When good community initiatives are further expanded, users moving from the hospital to the community experience less negative symptoms, a better social life and an increased satisfaction.
- Mobile teams are not superior regarding symptom reduction or improvement of social functioning.

Within these mobile teams, 'case management' is usually used as a way to offer care and treatment in a coordinated and integrated manner.
Detailed, individual care treatments, developed in consultation with the users, including warning signs of recurrence and crisis plans, in cooperation with primary health care workers and medical health care specialists, offer long-term support to users with SMD.

Assertive Community Treatment (ACT) is a form of intensive clinical case management by multidisciplinary teams offered to SMD users in their home environment.

The model developed from the 'Training in community living' model in Wisconsin, USA (Pieters 1992) and, from the start, has been the subject of intensive scientific studies. The target group were « recurring users », whom, without intensive guidance, were continuously readmitted to psychiatric institutions.

Several distinctive elements distinguish ACT from traditional case management, and are factors which are decisive for sticking to the model of the ACT approach:

- A caseload of approximately 10 users per full-time equivalent;
- Out-of-hours service (8 am to 10 pm) and at weekends;
- Guidance mainly at home and in the community instead of at the office; Assertive approach with practical support;
- No drop-out, but engagement to maintain continuous care;
- Daily team meetings and planning of care vs weekly team meetings
- Making full use of skills in the team (psychiatrist, ergotherapy, addiction knowledge and experiential expertise)

ACT teams remain involved during admission (inreach).
They follow a team approach, in which all team members work with every user. This requires fast, daily communication and might entail that one team member coordinates the care and is the contact person for the user, his/her relatives and other practitioners.
These teams also offer great support to families and relatives .
They make use of evidence-based interventions. Regular monitoring of medication, cognitive behavioural therapy, psycho-education and family interventions are standard interventions, alongside specialised interventions such as Individual Placement and Support (IPS) to find and maintain employment.

Expert knowledge about addiction problems is necessary with the target group of the ACT teams. Moreover, a restorative attitude is important, and the mobilisation of experts of experience is regarded as a success factor, also to prevent the use of coercion and pressure.
In the Netherlands a 'hybrid' form of ACT and the traditional community team has developed, under the name 'function ACT' (FACT), recently renamed 'Flexible ACT' (Van Veldhuizen, 2007).
Such teams combine the individual case management approach of the community teams with a more intensive ACT team approach for the users in crisis, and combine features of the two approaches, seamlessly switching between the two. This approach prevents discontinuity in care for the group of users difficult to reach who improve after a period of ACT treatment, but who however often become critical during a less intensive approach by a different team. This approach would also benefit more rural areas, in which the target group of an ACT team is too scattered across a large region.

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## Pléiade 2b

The ongoing monitoring team is designed for people with complex and chronic psychiatric problems. The care provides help and support for people in their choice of life and work and improve quality of life and social integration, as well as support for independence and the chance to stay in the community chosen. The work of the reference team supports the continuity and quality of care for the out-patient user in partnership with its network, whether this is non-professional, such as the family, or professional; this network may be active, created or remobilised during the monitoring phase.
In concrete terms, the team will support an application process from a stakeholder from its network through an initial contact and monitoring, witch is preceded by a meeting. The team uses various methods to carry out its mission, such as mobility, flexibility, duration, adaptability of the healthcare providers, the notion of hand-overs, etc.
In terms of the practice's transferability, we feel that it is interesting to highlight the importance of the network's involvement and its collaboration in receiving our working methods.

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## Crisis plan and BOR in mobile team

For each user supported by a mobile team, a crisis plan is established in consultation with the user. Such a plan determines what a user can do when he experiences signals that he is not OK, which caregivers or care providers he can rely on, and which residential facility he can address for a "Bed on Request" (BOR). This BOR-agreement is established between the user, the mobile team and a residential facility. The residential facility commits to having a bed at the disposal of this particular user in case an admission is necessary.
We talk about a BOR-admission as soon as the BOR-agreement is effectively used. The BOR-admission lasts for maximum seven days and has the objective of giving the user a moment of rest, to intensify treatment or to guarantee the user's safety by enhanced supervision.

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## Inuk

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The closure of 30 beds at the CHS CNDA enabled the setting up of a mobile team comprising 10.5 full-time equivalents for users with complex and chronic pathologies. The objectives of this created team creation are: the rationalisation of care, the continuity of therapeutic monitoring and support for this via hand-overs. But also the improvement of contacts and relays upstream and downstream of hospitalisation in order to support or reinforce the network around the patient. The mobile team aims to provide therapeutic support for the patient in his environment by using his mental resources and functional and social skills in order to improve his quality of life. Originally, the mobile team was mainly activated through function 4, but, today, requests arrive from all sides. The mobile team's privileged partners are primary care contributors (general practitioners, medical centres, mental health services, psychiatrists, etc.). However, cooperation are created with a growing number of partners either from the mental health sector or not and from all horizons. There is an increasingly large connection between the different functions as defined in the Reform. Ideally, the budget allocated to the mobile team's functioning should allow it to cover its travel, communication, logistics needs; the budget should be drawn up taking account of the large distances covered in view of the wide area served. Also, the human resources should be on a level with the intervention requests, subject to having delay management.
These three years of functioning, which offer a wealth of formative experiences, have provided us with extensive experience in mental health in the community; we still have a great deal to learn and we still have much to discover, but we feel ready to share our practices in order to contribute to the creation of other teams.

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## Mobile team Leuven

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The Mobile Team was established in order to fulfill the mental healthcare function 2B in the care regions of Leuven, Tienen, Diest, Aarschot and Tervuren. There are important differences between these five care regions. Five generalistic teams, considerably different in size, were established in order to offer specialised on-demand care to 4100 people having a severe psychic issue. On every intervention these teams focus on recovery, on rehabilitation, on the care network, using experience expertise, sharing case-load and recovery enhancing tools. They collaborate structurally with the numerous welfare and front line organisations and consider the family as a full care partner. For users suffering from a personality issue and care avoiding clients, complementary projects were developed.

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## Involving the relatives experience expert

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Similes, a psychosocial association for family and friends of psychological vulnerable people, trains family members of users to become experience experts. The network gradually involves the relative experience expert in three subsequent levels: the Macro level, to get a clear view of the network and the various partners, in which the expert represents the voice of the family in the steering group and the different Function Consultation committees; the Meso level to monitor the user related discussions, in which the expert gives input to the mobile team from the family perspective; and finally the Micro level in which the expert starts supporting individual families on request of the help providers. These home visits are restricted to maximum 6 contacts in order to avoid that the expert becomes a help provider. Involving expert is innovative as such: bringing innovating insights to the professionnals and play an important role in the recovery process of family members to whom he can give advice and hope from their own experience perspective. When necessary, the experts participate in the mobile team briefings or consults the responsible team manager. Meanwhile, a second expert is being trained.
This function offers good opportunities in self-development and also strengthens the expert personally, it offers a positive bond of trust with the help providers and with the users as experience experts. So everyone benefits.

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## Finalising mobile B-team supervisions by means of a pilot flame function

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“Supervise as long as needed, no longer than necessary” is the motto of the Mobile B-teams in the RELING network. Starting from that recovery-supporting vision, we want to avoid that people are permanently being monitored by specialised mental healthcare actors. However, long term supervision paths are difficult to finalise and often the caregivers and other care partners in the network are reluctant to see the mobile B-team terminating support.
In order to achieve this in a smoother way, we use the ‘pilot flame function’. The supporting system indicates someone to fulfill the pilot flame function when the mobile B-team quits the user care network.
The mobile B-team guarantees to return to the care scene immediately and in a seamless way as soon as the user or his network has a new need for advice, coaching or care. This will happen without an intake or waiting period.
In the meantime, patients and supporting networks have understood that a swift restart of the supervision by the mobile B-team is indeed possible, and that gives them the necessary self-confidence.

# Conclusions

The reorganisation of mental health offers is based on the needs of the users and their relatives. This is a new approach, at operational and cultural level. All actors involved are associated in this vision and create a new movement which is mostly aimed at follow-ups within the community and they are focused on recovery.

Whether they belong to the field of residential or semi-residential health care, or outside the field of mental health care, all partners worked hard to implement dynamic networks in which experience and expertise complement mutually.

The Guide to Innovative Practices is a work that shows everyone's will to be involved in this collective movement, and these include authorities, institutions, services, professionals, users and families as well as society.
The authors capitalised on this creativity, which is the result of the development of new patterns and initiatives, and of the trust and synergy between partners that are convinced of this new orientation of mental health care, while taking the global and integrated approach into account.

This manual of innovative practices includes a wide variety of innovative offerings under the form of summaries.
At the same time, a website has been created, showcasing the full versions of those innovative practices. It is also a project constantly evolving, regarding the modules developed in the manual but also with the project to address other topics as:

- Training to accompany changes
- Communication tools
- Individual service plan, individualised support plan, the notion of referrer
- User's electronic file, means and formats of communication
- Intensification of residential care in case of crisis
- The role of the general practitioner and the connection with front care

We would like to deeply thank all those who actively took part in this project. We hope it will be the starting point for many exchanges of practices across the country and that this manual will also inspire other countries or regions that are reorganizing their health care system.

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You can find here a limited number of references per module.
A complete list of sources is available on the website.

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