Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

KCE REPORT 318

ORGANISATION OF MENTAL HEALTH CARE FOR ADULTS IN BELGIUM

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KCE REPORT 318
HEALTH SERVICES RESEARCH

ORGANISATION OF MENTAL HEALTH CARE FOR ADULTS IN BELGIUM

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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
AViQ	Agence pour une Vie de Qualité (Wallonia)
BMF – BFM	Budget des Moyens Financiers – Budget Financiële Middelen
CA	Conjoint analysis
CAD	Centra voor Alcohol en andere Drugproblemen (Flemish Region)
CAGE	Cut Down, Annoyed, Guilty, and Eye-opener
CAR-CRA	Centra voor Ambulante Revalidatie - Centres de Rééducation Ambulatoire
CAW	Centrum voor Algemeen Welzijnswerk (Flemish Region)
CGG – SSM	Centrum voor Geestelijke Gezondheidszorg – Service de Santé Mentale
CI	Confidence interval
CIDI	Composite International Diagnostic Interview
CLB – PMS	Centrum voor Leerlingenbegeleiding – Centre Psycho-Médico Social
CMI	Cellule Mobile d’Intervention (Wallonia)
COCOF	Commission Communautaire Française (Brussels Region)
CRéSaM	Centre de Référence en Santé Mentale (Wallonia)
DGO5	Direction Générale Opérationnelle Intérieur et Action sociale (Wallonia)
EC	European Commission
EPD	Elektronisch PatiëntenDossier (Flemish Region)
EPSI – UCUP	Eenheid voor Psychiatrische Spoed Interventie – Unité de Crise et d'Urgences Psychiatriques
ESEMeD	European Study of the Epidemiology of Mental Disorders
EU	European Union
EUCOMS	European Community based Mental Health Service providers
FDGG	Federatie van Diensten voor Geestelijke Gezondheidszorg

FOD – SPF	Federale OverheidsDienst – Service Public Fédéral
FTE	Full Time Equivalent
GDP	Gross domestic product
GGC – COCOM	Gemeenschappelijke GemeenschapsCommissie – Commission Communautaire Commune (Brussels Region)
GHQ-12	General Health Questionnaire
GOC	Gespecialiseerde OpleidingsCentra (Flemish Region)
GP	General Practitioner
GTB	Gespecialiseerde Trajectbepaling- en Begeleidingsdienst (Flemish Region)
HIS	Health Interview Survey
IBW – IHP	Initiatieven Beschut Wonen – Initiatives d’Habitations Protégées
ICT	Information and Communication Technologies
IMA – AIM	InterMutualistisch Agentschap – Agence InterMutualiste
ISPA	Initiative Spécifique Personnes Agées (Wallonia)
JA	Joint Action
JA MH-WB	Joint action mental health and well-being
LOS	Length of stay
MH	Mental health
MHC	Mental Health Care
MPG – RPM	Minimale Psychiatrische Gegevens – Résumé Psychiatrique Minimum
MS	Member states
MT	Mobile Team
NIHDI	National Institute for Health and Disability Insurance

NRZV – CNEH	Nationale Raad voor Ziekenhuisvoorzieningen – Conseil National des Établissements Hospitaliers
OCMW – CPAS	Openbaar Centrum voor Maatschappelijk Welzijn – Centres Publics d’Action Sociale
OECD	Organisation for Economic Cooperation and Development
PAAZ – SPHG	Psychiatrische Afdeling in een Algemeen Ziekenhuis – Service Psychiatrique d’Hôpital Général
PDVS – SAPV	Politionele Dienst Voor Slachtofferhulp – Service d’Aide Policière aux Victimes
PHC	Primary Health Care
PVT – MSP	Psychiatrisch Verzorgingstehuis – Maison de Soins Psychiatriques
PZ – HP	Psychiatrisch Ziekenhuis – Hôpital Psychiatrique
PZT – SPAD	Psychiatrische Zorg in de Thuissituatie – Service Psychiatrique d’Aide à Domicile
RCA	Recovery Self-Assessment
RIZIV – INAMI	Rijksinstituut voor ziekte - en Invaliditeitsverzekering – Institut National d’Assurance Maladie Invalidité
SAR WGG	Strategische Adviesraad Welzijn, Gezondheid en Gezin
SASPP	Services d’Aide et de Soins aux Personnes Prostituées (Wallonia)
SCL 90-R	Symptom Checklist 90 – Revised
SCOFF	Sick, Control, One Stone, Fat, and Food
SDG	Sustainable Development Goal
SE	Standard error
SEL(GDT) – SISD	Samenwerkingsinitiatieven Eerstelijnsgezondheidszorg (Geïntegreerde dienst voor thuisverzorging) – Services Intégrés de Soins à Domicile
SEM	Self-Explicated Method
SEPAM	Service d’Ecoute pour Personnes Âgées Maltraitées (Brussels Region)
SHNA	Structures d’Hébergement Non Agrées (Wallonia)

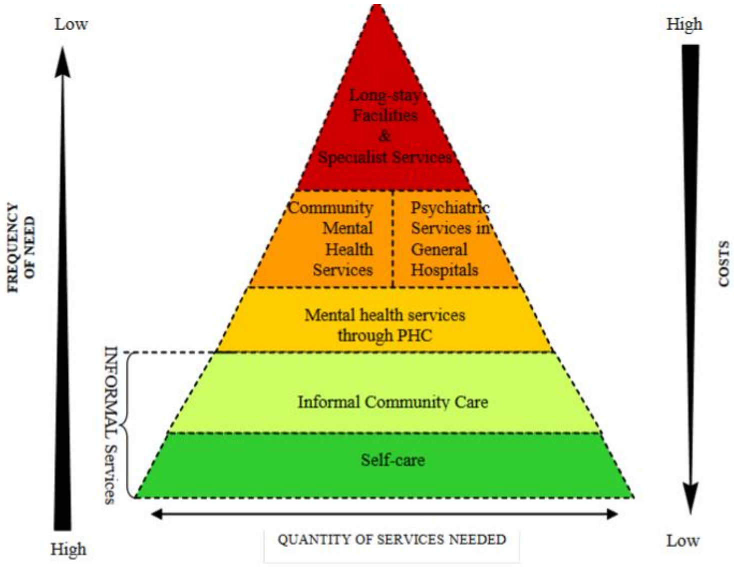
SMI	Severe Mental Illness
SRA	Service Résidentiel pour Adulte
STB	Suicidal thoughts and behaviours
Steunpunt GG	Steunpunt Geestelijke Gezondheid
UN	United Nations
VAD	Vlaams expertisecentrum Alcohol en andere Drugs (Flemish Region)
VGC	Vlaamse Gemeenschapscommissie
VIP2	Vlaams Indicatorenproject voor Patiënten en Professionals
VVGG	Vlaamse Vereniging voor Geestelijke Gezondheid (Flemish Region)
WHA	World Health Assembly
WHO	World Health Organization

■ SCIENTIFIC REPORT

CHAPTER 00 – OUTLINE OF THE STUDY

1 BACKGROUND

Figure 1 – WHO optimal mix of services pyramid framework



Mental health is a fundamental component of good health. The World Health Organization (WHO) defines mental health as ‘a state of well-being in which every individual realizes 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 her or his community’. Consequently, mental health problems range from the worries we all experience as part of everyday life to serious long-term conditions.

The WHO pyramid Framework for mental health[1] pleads for a comprehensive care offer and continuity of care. From a policy viewpoint every government needs to evaluate whether its mental health care system is effective and efficient and provides easy access for every civilian. Also for Belgium this exercise is important, especially in the light of recent social and political phenomena.

In past decades the organisation of mental health care in Belgium underwent several reform waves with the main aim to further orient mental health care towards a reduction of residential hospital care in favour of recovery and reintegration treatment in the community. In order to attaint this objective, policies to promote five core foundations (i.e. deinstitutionalisation, inclusion, decategorisation, intensification, and consolidation)[2] were developed.

In 2016, the inter-cabinet working group (IKW – GTI) 'task force on Mental Health care' asked the KCE to look at the provision of mental health care services and the needs of the population. The current study focused on an in-depth analysis of the organisation of mental health services in Belgium with a need to clearly visualize the present care offer and to evaluate the organisation and continuity of care for the future decade.

2 RESEARCH OBJECTIVE

The objective of this study was to describe the Belgian mental health care offer in order to take into account possible gaps and overlaps between existing services and to assess the Belgian landscape against internationally defined frameworks. The results of this report should assist policy-makers in setting priorities and making strategic decisions regarding the organisation of mental health care. (https://www.kce.fgov.be/en/study-program/study-2016-52-hsr-organization-of-mental-health-care-for-adults-in-belgium , last accessed 04/06/19)

The study gives an overview of the Belgian mental health care landscape for adults including: (1) the care offer (the different organisations and service providers), (2) the identification of gaps and overlaps between service providers and how they may affect the five core foundations of the mental health care reform, 3) benchmark the Belgian situation in relation to the internationally developed frameworks for the provision of mental health care services for adults, and 4) the acceptability of future organisational measures/changes.

3 OUTLINE OF THE STUDY

This study contains several parts of which the methods and results are fully described in the following chapters:

Chapter 1

Detollenaere J, Cornelis J, Devriese S, Mistiaen P, Ricour C. Description of the Belgian mental health care within the general health care organisation.

Chapter 2

Detollenaere J, Gisle L, Mistiaen P. Prevalence of mental health problems.

Chapter 3

Detollenaere J, Bruffaerts R, Gisle L, Mistiaen P. Comparability of ESeMED and HIS.

Chapter 4

Ricour C, Cornelis J, Detollenaere J, Devriese S, Mistiaen P. International frameworks for mental health service organisation.

Chapter 5

Laguesse R, Lambert M, Van Nuffel R, De Coen M, Van Speybroeck J, Bontemps C. Mapping mental health care services in Belgium.

Chapter 6

Thunus S, Neyens I, Walker C, Hermans K, Smith P, Nicaise P, Van Audenhove C, Lorant V. Strengths, weaknesses, gaps, and overlaps in the current mental health care supply: a focus group study.

Chapter 7

Smith P, Nicaise P, Neyens I, Hermans K, Thunus S, Walker C, Van Audenhove C, Lorant V. Values and sets of possible organisational solutions: a choice-based stakeholder analysis survey.

Chapter 8

Cornelis J, Detollenaere J, Devriese S, Mistiaen P, Ricour C. Acceptability of possible recommendations for future mental health care organisation in Belgium: a stakeholder survey.

4 LIMITATION/SCOPE OF THE STUDY

The focus of this project excludes the evaluation of health care needs, because of the lack of reliable data on prevalence and incidence of mental health disorders, and especially the lack of knowledge about the severity of these mental health disorders and the corresponding care needs.

In consultation with the inter-cabinet working group (IKW – GTI) ‘task force on Mental Health care’, mental health care for children and mental health care specific for elderly were left out of scope of this study, as well as prevention of mental health problems and mental health promotion. Mental health care for children was already studied in earlier KCE-reports [3-5], as well as mental health care for elderly [6]. Although prevention of mental health problems and mental health promotion were considered as important issues, they were left out to keep the scope of the study manageable within the time limits of the project. Of course these limitations will need to be taken into account when Belgium wants to further improve and design a future coherent mental health care system.

Neither effectivity analyses of the several mental health therapies/approaches were performed, because of the large number of these. For each approach a separate (literature) study would be needed.

Also no research has been done on the role conception and actual role performance of the several mental health care providers.

Finally we did not perform a budget impact analysis of eventual changes jn the mental health care system due to the complexity of the financing of the mental healthcare system in Belgium and due a lack of data.

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CHAPTER 01 DESCRIPTION OF THE BELGIAN MENTAL HEALTH CARE WITHIN THE GENERAL HEALTH CARE ORGANISATION

Authors: Detollenaere J[1]*, Cornelis J*[1]*, Devriese S*[1]*, Mistiaen P*[1]*, Ricour C*[1]*.*

[1] KCE

1 GENERAL ORGANISATION OF THE BELGIAN HEALTH CARE SYSTEM: AN OVERVIEW

The Belgian policy system has, due to the first institutional state-reform (1970-1980), two main levels of organisation, i.e. (i) the Federal level and (ii) the level of the federated entities (the communities and the regions). Over a period of 46 years, 6 state reforms took place, transferring the responsibilities for a broad range of matters to the federated entities. [1, 2] Today, there are three cultural communities: (i) the French Community, (ii) the Flemish Community, and (iii) the German Community; and three regions: (i) the Brussels-Capital Region, (ii) the Walloon Region, and (iii) the Flemish Region. In the bilingual Brussels-Capital Region, three commissions take care of the community oriented matters i.e. (i) the Flemish Community Commission (Vlaamse Gemeenschapscommissie (VGC)) for the Dutch speaking residents, (ii) the French Community Commission (Commission communautaire française (COCOF)) for the French speaking residents, and (iii) the Joint Community commission (Gemeenschappelijke Gemeenschapscommissie (GGC) – Commission communautaire commune (COCOM)) for matters that are neither under the Flemish nor the French Community regulations.

Responsibility for health care policy is shared between the Federal Government, exercised by the Federal Public Service Health, Food Chain Safety and Environment, the Federal Public Service Social Security, the National Institute for Health and Disability Insurance (NIHDI), and the Dutch- , French-, and German speaking community/region Ministries of Health. [3] The successive state reform operations and the resultant division of the responsibilities regarding health care, significantly influenced mental health policy in Belgium. It increased in general the complexity of the health care system and directly influenced its financing. To keep an overview of this complex health care system, coordination is done by the “Interministeriële Conferentie Volksgezondheid – Conférence Interministérielle Santé publique” (IMC – CIM) in which ministries from the different policy levels regularly meet.

1.1 Principles of health care organisation in Belgium

The Belgian health care system is based on the principle of equal access and freedom of choice, using a compulsory national health insurance, and offering a comprehensive care package.[4] Patients generally pay costs upfront and are reimbursed a proportion of the charges through their sickness/health fund (ziekenfonds – mutuelle).[3, 5] Compulsory health insurance can be completed with a private insurance to cover the totality of the costs.

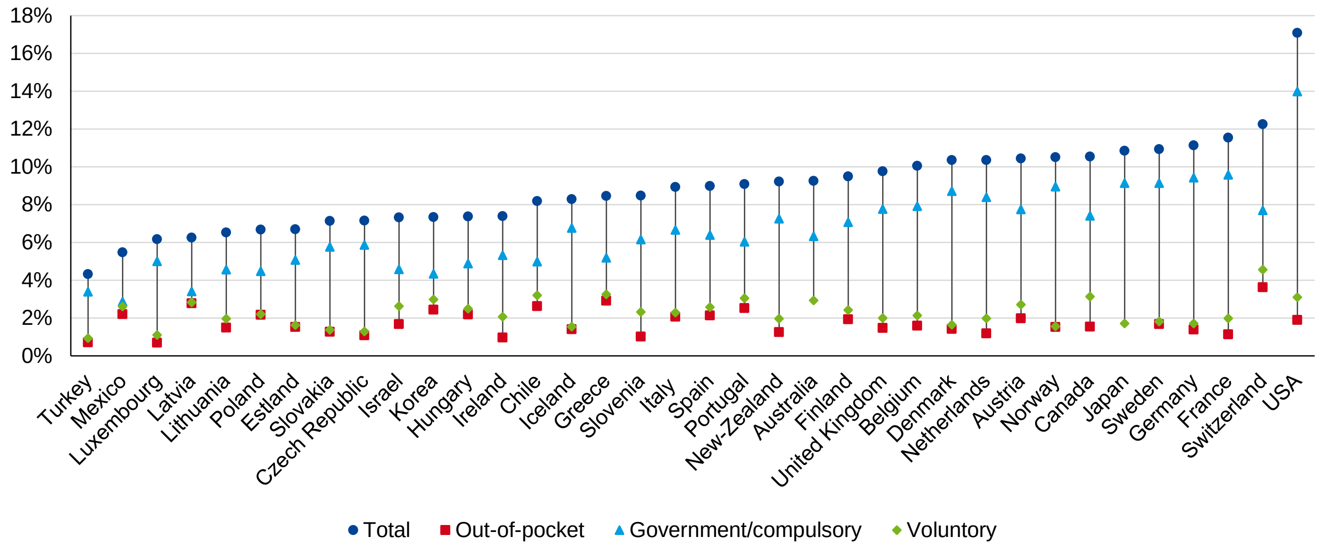
1.2 Financing of the Belgian health care system

The Belgian health care system is primarily funded through social security contributions and taxations. Since 1995, the government decides each year on the legal growth norm applied to the public health care system. Consequently, a global budget and partial budgets are fixed by the General Management Committee (Algemene Raad – Conseil Général) and the Committee for Health Insurance (Verzekeringscomité – Comité de l’assurance soins de santé) where all the health care stakeholders are represented (care providers like physicians or dentists, sickness/health funds, organisations of employers, trade unions representatives, and health care institutions such as hospitals). In parallel, during Conventions and Agreement Committees, the insurers (sickness/health funds) and the care providers organise the health care system on the field. In the context of the budgetary procedures, they have to determine, each year, the needs of each health care sector (specialists and general practitioners, hospitals, drugs, nursing homes, rehabilitation, etc.).

Belgian health professionals are mainly remunerated through a fee-for-service system, which applies to medical and medico-technical services and paramedical activities. The basic feature of the Belgian hospital financing is its dual remuneration structure: services of accommodation (departments) and nursing activities are financed through a fixed prospective budget system based on diagnosis-related groups (DRGs); whereas medical, medico-technical and paramedical services predominantly rely on the fee-for-service system.

The national expenses for health care in Belgium can be divided into four parts[6]: (i) the compulsory insurance system (contributions, Federal Government, Communities and Regions, and the local public authorities), (ii) the private insurances (additional services and insurance offered by sickness/health funds, social insurer groups, and private insurers), (iii) the uninsured out-of-pocket payments made by patients, and (iv) the payments made by business and non-profit companies (occupational health care, prevention). The total amount of expenses made for health care in Belgium in 2016 is estimated to be 10% of the gross domestic product (GDP) (Figure 2). NIHDI paid about 7.9% of the GDP, while patients paid about 2.1% themselves.

Figure 2 – Health spending, in % of GDP, 2016



Source: OECD [7]

The regulation and financing of the statutory insurance system belongs to the responsibility of the Federal Government, and the sickness/health funds are responsible for reimbursement of the health care costs of their members. Since 1995, Belgian sickness/health funds receive a prospective budget from the NIDHI to finance the health care costs of their members. They are held financially accountable for a proportion of any discrepancy between their actual spending and their so-called normative, i.e. risk-adjusted health care expenditures. Patients in Belgium also participate in health care financing through out-of-pocket co-payments.[8] Flemish citizens also contribute to the Flemish social protection by paying a fee yearly, this money is then used as a care budget for people who have increased care needs over a long period of time.[9]

2 ORGANISATION OF THE MENTAL HEALTH CARE SYSTEM IN BELGIUM

2.1 Historical overview

2.1.1 Mental health care organisation in its early days

Before 1948, mental health care in Belgium was predominantly organised by religious congregations with the main aim to “isolate mentally ill patients in care institutions” (afzondering van geesteszieken in opvanginstellingen – internement des malades mentaux dans des établissements d’accueil), as stipulated by the “insane law” of 1850. In that period, the organisation of this system was supervised by the Ministry of Justice. The Federal Government decided in 1948 to transfer mental health care institutions to the Ministry of Public Health. However, at that moment there was no specific reimbursement system for treatment of mental health disorders. In 1953, the NIHDI started with a specific reimbursement of mental health care. Psychotherapy was introduced into clinical practice and ‘madhouses’ became psychiatric hospitals, which had to meet recognition standards from 1963 on. Infirmaries were replaced by departments focussing on the treatment of specific disorders or target groups.[10]

From the early seventies of the last century, a distinction was made between chronic and acute mental health care. Mid-seventies, day- and night hospitalisation and psychiatric departments at general hospitals (PAAZ – SPHG) were founded. In 1975, the centres for community mental health care (CGG – SSM) were recognized by law. In the years to follow, several influencing factors i.e. the rise of psychosocial problems in the community, the emergence of new or more specific care demands and the inability to respond to them, and the saturation of traditional care structures (due to length of stay and rise of chronic care), led to a strong need for reorganisation of Belgian mental health care. At the same time, European initiatives promoted the search for alternatives for internment of mentally ill people. It became clear that Belgium needed a radical change of the model of mental health care with emphasis on de-institutionalisation of the classic psychiatric wards. [11] Mental health care became more active outside psychiatric hospitals and broadens its workforce by implementing other health care professionals. However, in Belgium, the ambition to integrate mental health care in the community and develop network organisations is complicated by the fragmentation of the responsibilities between the Federal government and the federated entities. In 2000, mental health care (in terms of psychiatric departments in general hospitals and psychiatric hospitals) receives a juridical basis in the hospital law. [10]

2.1.2 Reforms in Belgian mental health care

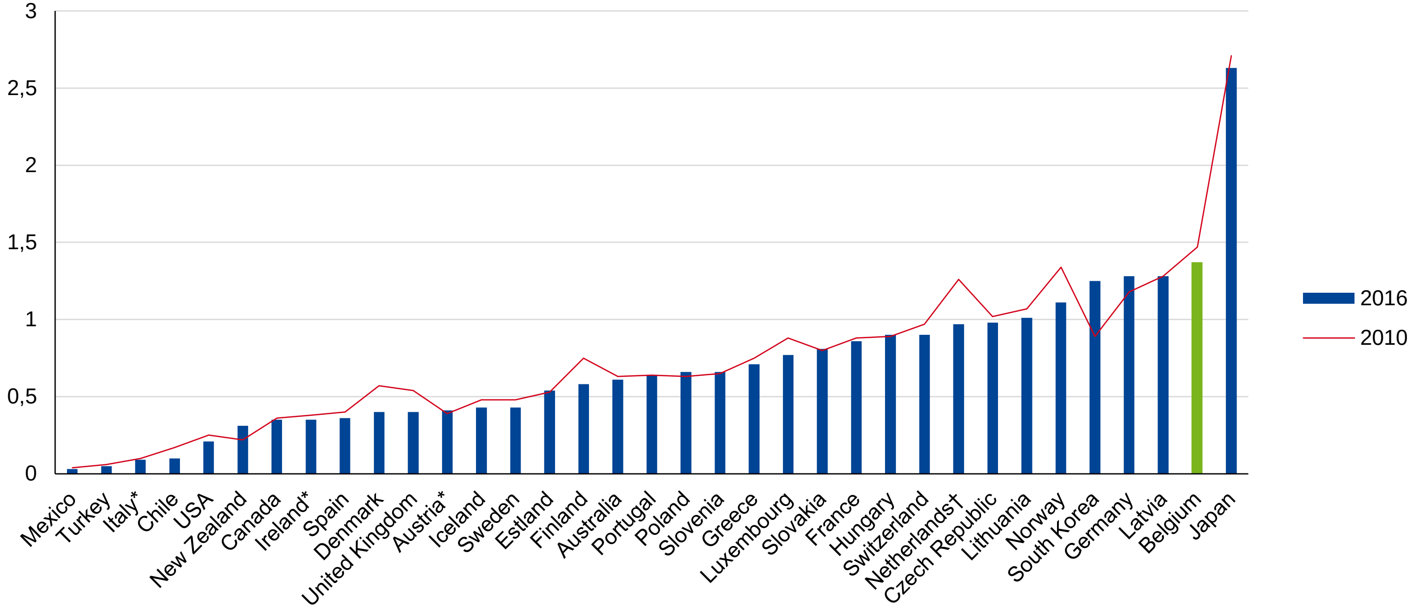
The organisation of (predominantly adult) mental health care in Belgium has been transformed over the last decennia by several reform waves. [4] During the first wave in the nineties, psychiatric beds were reconverted to offer chronic patients with mental health problems appropriate sheltered living outside the psychiatric hospitals. [10-13] Reconversion of beds is an approach where "classic psychiatric beds" are transformed in beds, services or care facilities in the same organisation or institution, but, with another objective. New mental health care facilities were created such as psychiatric care homes (PVT – MSP), initiatives for sheltered living (IBW -– IHP), and to a lesser extent, psychiatric home nursing (psychiatrische thuisververpleging - places de soins psychiatriques en milieu familial). [10, 12, 14, 15] In addition, in this reform, the conditions for the creation of "consultation platforms" (overlegplatforms - plates-formes de concertation psychiatrique) were stipulated. [14, 15] These platforms had the main goal to facilitate the dialogue regarding regional coordination of the different existing and new form of medical and psychosocial supply for persons with a mental health problem.

Furthermore, in 1999, a second wave of the reform endorsed additional reconversions of hospital beds to psychiatric care homes and sheltered living facilities. Per thousand inhabitants 0.6 beds were planned for the psychiatric care home and 0.5 places per thousand inhabitants for sheltered living facilities. This second wave initiated a massive voluntary reconversion of "classic psychiatric beds" to PVT – MSP and IBW – IHP beds (and partly to psychiatric home nursing beds). The main aim was to build a horizontal structure focused on specific subgroups of patients with mental health problems (children, adolescents, adults, elderly, persons with a drug and/or alcohol addiction, persons in forensic psychiatry, and disabled persons with severe psychiatric disorders). This horizontal structure had the intention to develop a specific care circuit and network for each of these subgroups in order to promote and enhance specialisation, transmural care and to increase the capacity of chronic psychiatric care. Over a period of 10 years, 3 400 psychiatric beds were reconverted to alternative beds/facilities (i.e. 350 VP beds for psycho-geriatrics, 596 A-beds for neuro-psychiatry, 120 K-beds for children, 135 A-beds for day-hospitalisation, 422 PVT - MSP beds, and 364 IBM – IHP places). [16] Moreover, several semi-ambulatory structures were set up, such as day centres, day hospitalisation, and night hospitalisation. Although the numeric result of the reconversion operation was quite successful, the residential nature of the new structure continued to dominate the Belgian mental health care system. [11]

Based on a number of advices of the National Council for Hospitals (Nationale Raad voor Ziekenhuisvoorzieningen – Conseil National des Établissements Hospitaliers) (NRZV – CNEH) [17-20], it was decided in 2002 to organise the mental health care offer in Belgium according to the principles of target audiences and networks providing tailored, patient-centred and integrated care, directed to the patient in his personal living environment. [21] Psychiatric home care teams (PZT – SPAD), activation projects to get back to work, initiatives to provide counselling and the discharge management in psychiatric hospitals were set up. Most of these projects were re-conducted in the so-called "therapeutic projects". During the Interministeriële Conferentie Volksgezondheid [22] it was decided to set up therapeutic networks and additional transversal consultation platforms. These therapeutic networks had to be developed at the patient level aiming to construct specific care circuits for specific patient populations. In parallel, transversal consultation platforms developed collaboration at the organisational and population level and facilitated consultations between therapeutic networks. All institutions in the field of mental health care were obliged to organise recurrent internal network consultations and meetings to facilitate delivery of coordinated care.

Most of the initiatives from the previous wave were re-conducted in the third wave via the so-called ‘therapeutic projects’ that started in 2007. This three year governmental program is intended to implement an ‘integrated health services model’ in clearly defined catchment areas, providing services adapted to the needs of the patients and promoting their rehabilitation in society while guaranteeing continuity of care. [23, 24] Despite these therapeutic projects/networks and transversal consultation platforms, Belgium has still the second highest ratio of in-patient psychiatric beds among OECD countries, i.e. 1.37 beds per 1.000 inhabitants (Figure 3). [25]

Figure 3 – Psychiatric beds in hospitals, per 1 000 inhabitants



Source: OECD [25]

** The OECD database did not provide 2016 data for this country. Therefore, 2015 data is used for the visualisation of the 2016 data point.*

† The OECD database did not provide 2010 data for this country. Therefore, 2012 data is used for the visualisation of the 2010 data point.

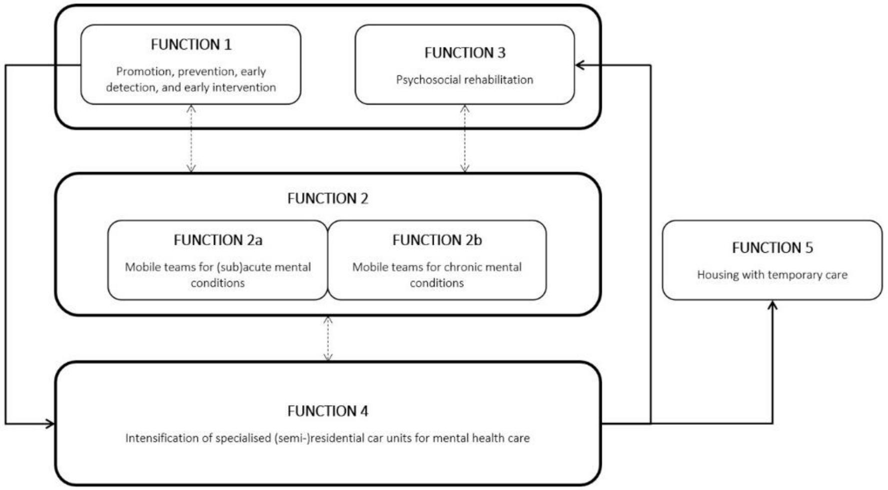
Therefore, in 2010, the next step of the reorganisation of mental health in Belgium was initiated by launching the Article 107 projects. By means of articles 11 and 107 of the Belgian Hospital law [26], care networks/circuits and innovative projects can be financed temporarily and on an experimental base. The Federal Government would guide the development of “experimental projects” (labelled as Art. 107 projects in the remainder of current chapter) as a temporary step to realise networks (care actors who legally-formalised cooperate and provide care to specified target groups) and care circuits (care programs organised by means of a network) within the structure of the hospital financing. In fact, these Art. 107 projects replaced the concept of the “therapeutic projects” and aimed at further implementing a community based approach of MHC. Hereto, ‘beds’ in psychiatric hospitals were ‘frozen’ and the deliberated budget and resources were transferred to the created art 107 networks to realize the 5 functions (see Figure 4) and especially the further development and creation of mobile teams. This resulted so far in a decrease of recognised beds in psychiatric hospitals from 12 779 in 2010 to 11 566 in 2019 (10.7%). Starting from a global vision, these projects had to ensure a high qualitative integration of resources from hospitals and (ambulatory) community services, implying that all actors in a certain region should be involved. The network partners had to find solutions that met the specific regional mental health care needs. These projects used a stepped care approach so care was provided from a subsidiarity perspective (principle that health problems should be dealt with at the most immediate and less-specialised level). With the Art. 107 projects, the government aimed to orient mental health care towards a progressive reduction of residential hospital care in favour of recovery and reintegration, and to provide/embed mental health care in the community. [10, 11] In order to attain this objective, Art. 107 projects had to promote five main foundations: [27]

1. deinstitutionalisation: limit residential treatment by the setup of ambulatory specialised and intensive psychiatric care;
2. inclusion: intensify collaboration between the fields of education, culture, labour, social housing, and key players in mental health care;
3. de-categorisation: realisation of strong care networks and care circuits consisting of adult mental health care bodies, care for the disabled, and justice departments;
4. intensification of in-hospital care: resulting in short(er) hospital stays, minimising the abruption of the patient-community interplay; and
5. consolidation: regulation and coordination of existing pilot projects in an overarching concept of mental health care.

These foundations need to be embedded in the realisation of five functions (Figure 4):

1. function 1: promotion, prevention, early detection, and early intervention in mental health care;
2. function 2: mobile treatment teams that can move towards the patient (at home or elsewhere in his social environment);
3. function 3: provision of mobile team for psychosocial rehabilitation;
4. function 4: intensified specialised (semi-)residential car units for mental health care; and
5. function 5: provision of specific housing and accommodation.

Figure 4 – Five functions of Art. 107 projects



Source: authors' own reproduction, based on Directoraat-Generaal Organisatie van de Gezondheidszorgvoorzieningen [16]

In order to facilitate communication between the health care professionals on the field and the coordinating institutions to amend the Art. 107 reform and to formulate recommendations, the IMC – CIM founded the inter-cabinet workgroup (IKW – GTI) "Taskforce mental health care". The IKW – GTI consist out of political representatives of the IMC – CIM Public Health and the competent administrations. In October 2018, 20 pilot projects were operational within the Article 107 reform of which 12 in Flanders, 1 in the Brussels Capital region and 7 in the Walloon region (Figure 5).

Figure 5 – Overview of the Art. 107 projects in Belgium

Source: Werkgroep "werkingsgebieden" van het overlegorgaan 107 [28]

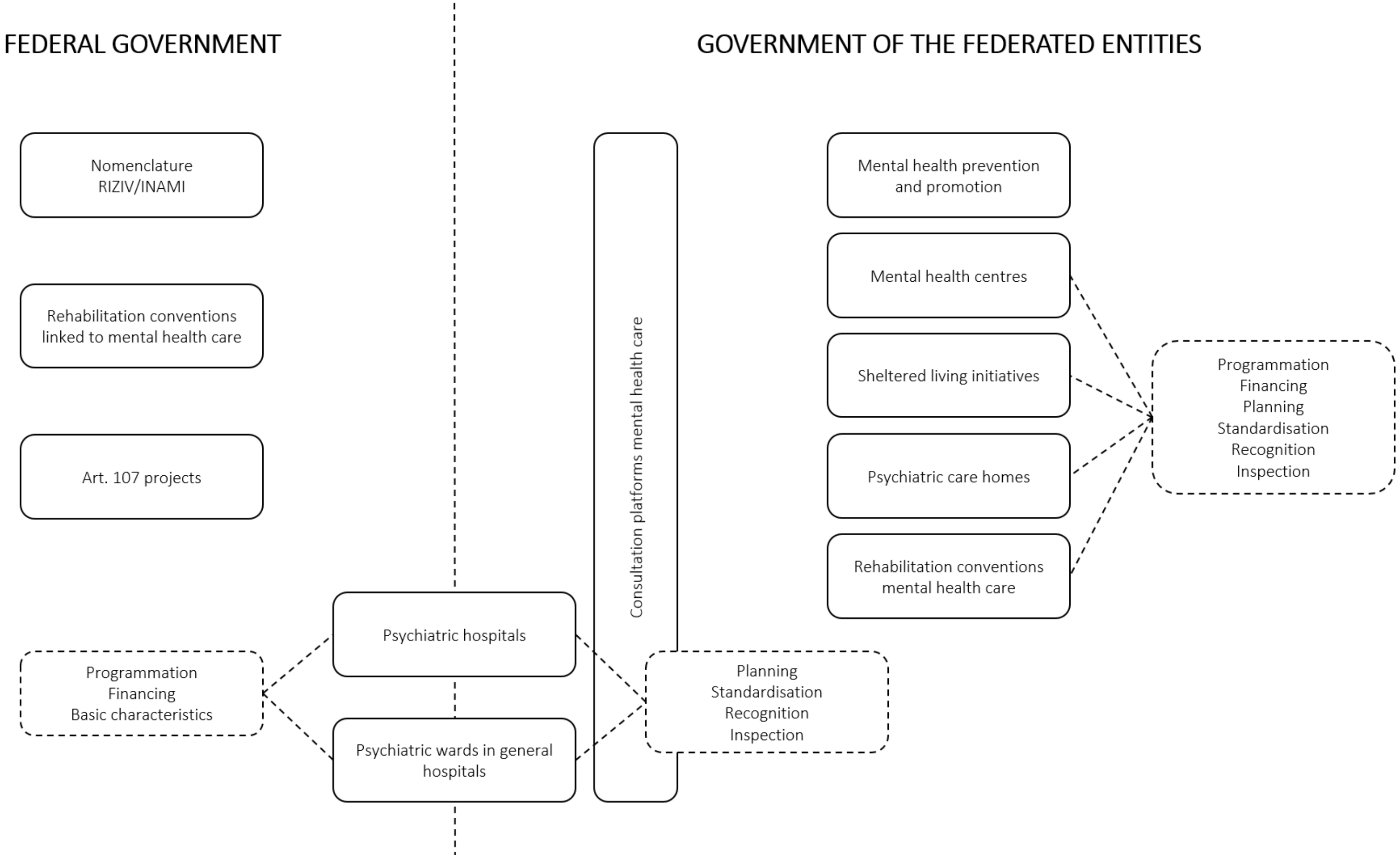
2.1.3 Sixth institutional state reform

The organisation of both the general- and mental health care system is quite complex; it is at least partially explained by responsibilities shared across one federal and six federated ministries of health and their respective administrations. [12] This fragmentation is a barrier for the development and implementation of a comprehensive and long-term vision on mental health policy.

The first of July 2014, the 6th institutional state reform in Belgium was a fact. From that moment on, a broad range of responsibilities were transferred to the federated authorities. Concerning mental health care, before this institutional state reform, the Federal Government was initially responsible for the definition of accreditation standards, programming, and financing of sheltered living initiatives (IBW – IHP), psychiatric care homes (PVT – MSP), and consultation platforms for mental health (Overlegplatforms Geestelijke Gezondheidszorg – Plateforme de Consultation Soins de Santé Mentale). CGG – SSM were already under the responsibility of the communities. However, after the 6th institutional state reform, the responsibilities for sheltered living initiatives, psychiatric care homes and consultation platforms for mental health care were transferred to the communities. Psychiatric hospitals and in-hospital psychiatric departments in general hospitals were still subject to the specific hospital legislation (which is a federal responsibility). Furthermore, the price agreements and conventions (collectively fixed tariffs within the NIHDI between sickness/health funds and the representative organisations of health professionals) were also transferred from the federal level to the federated communities/regions. An overview of the responsibilities regarding mental health care after the 6th state reform can be consulted in Figure 6.

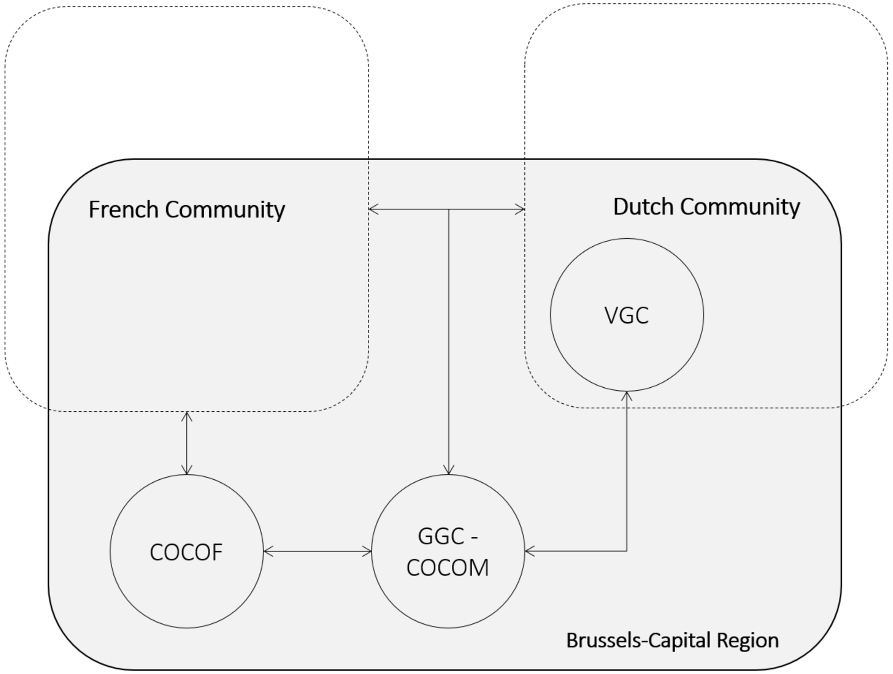
In particular, the situation in Brussels is complex and fragmented (Figure 7). Policy and delivery of mental health care in Brussels is the responsibility of five policy institutions.

Figure 6 – Overview responsibilities mental health care after 6th State Reform



Source: authors' own reproduction, based on Vlaamse Overheid [29]

Figure 7 – Political entities responsible for mental health care in Brussels



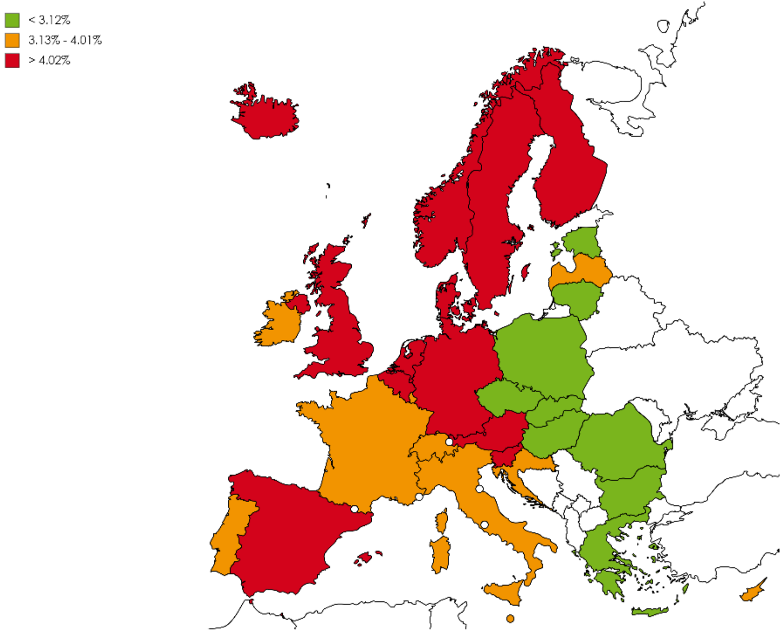
All federated authorities emphasise the need to continue the mental health care shift from institutionalised care to care provided and embedded in the community (reconversion of beds). In order to maintain this process, the 6th institutional state reform allows the federated authorities to conclude bilateral agreements with the Federal Government regarding this reconversion process.

2.1.4 Spending on mental health care (problems)

In 2015, according to the OECD, the overall costs related to ill mental health were about 5.05% of the GDP in Belgium, equalling €20.740 million. [30] With this number, Belgium is one of the European countries with the highest overall costs related to mental health problems (only the Netherlands, Finland, and Denmark report higher costs) (Figure 8). These overall costs break down into the equivalent of 1.33% of GDP (or €5.447 million) in direct spending on health systems, 1.42% of GDP (or €5.845 million) on social security programmes, and 2.30% of GDP in indirect costs related to labour market impacts (referring to lower employment and lower productivity) (Figure 9). However, we can suspect that these costs are underestimated, as several additional costs have not been taken into account (for example social assistance benefits, reduced employment rates or working hours for informal caregivers, etc.).

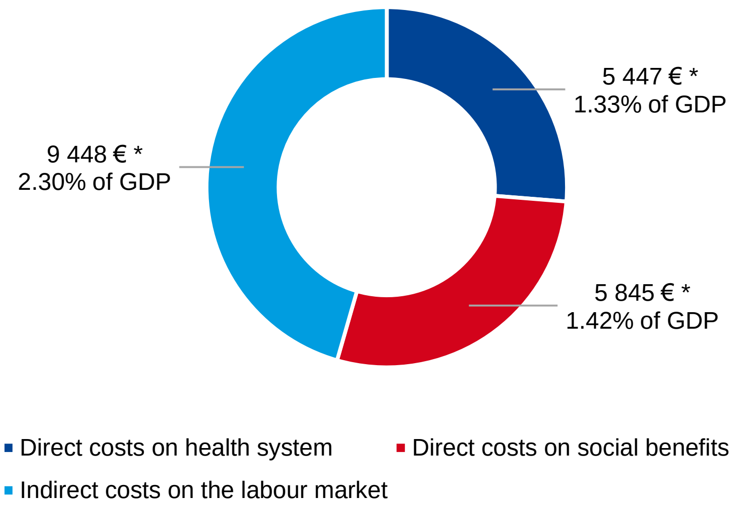
Notwithstanding the initial aims of the Art. 107 projects, Van Daele and Van Audenhove [31] identified in 2010 that the majority of the mental health care budget still goes to psychiatric hospitals. According to more recent numbers of 2017, €1.26 billion of the total health care budget is attributed to mental health care (Figure 10), of which 1.1 billion is devoted to psychiatric hospitals (Figure 11).

Figure 8 – Overview of total costs of mental health problems in Europe, as a share of GDP, 2015



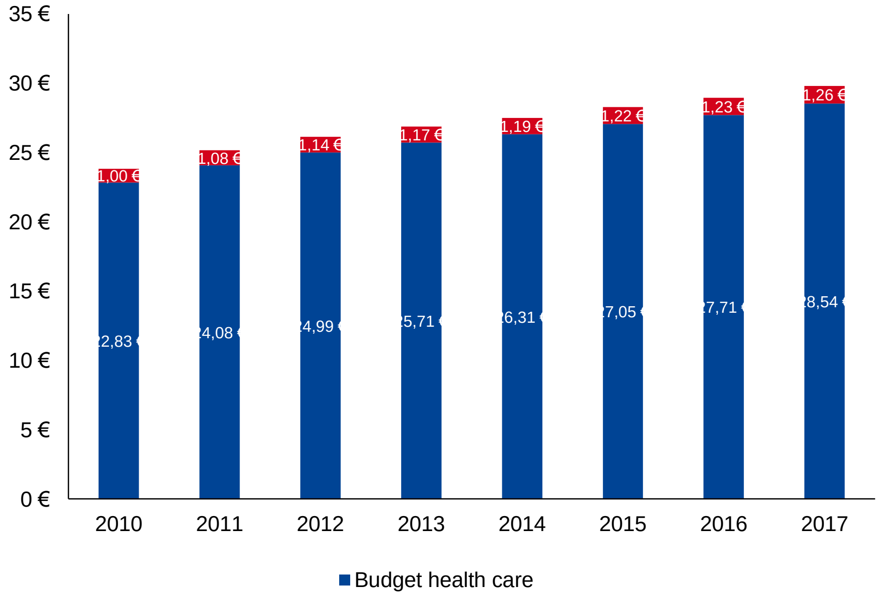
Source: authors' own reproduction, based on OECD [30]

Figure 9 – Estimates of direct and indirect costs of mental health problem, 2015



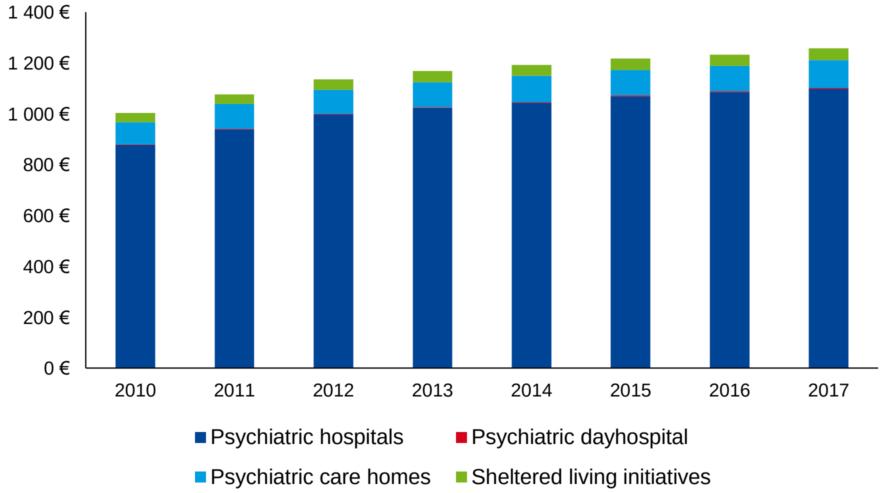
Source: OECD [30]
** In million EUR*

Figure 10 – Budget health care and mental health care in Belgium, in billion EUR, 2010-2017



Source: NIHDI (Dienst Geneeskundige verzorging - Directie actuariaat en budget) 32

Figure 11 – Composition of the budget mental health care, in million EUR, 2010-2017



Source: NIHDI (Dienst Geneeskundige verzorging - Directie actuariaat en budget) 32

2.2 Evaluation of the Belgian mental health care system

2.2.1 Evaluation of the mental health care system in general

Belgium has the second highest number of psychiatric beds compared to the number of inhabitants among OECD countries (Figure 3) [33] and more than 80% of the financial resources for mental health care are going to residential care [34]. However, it is impossible to evaluate the expenditure towards these financial resources, mainly because of the lack of numbers both at system and service delivery levels (to individual patients as well as the population as whole). [12, 35-39] We go into more detail on this lack of data in Chapter 2 and Chapter 3.

Since 2015, the Flemish “Agentschap Zorg en Gezondheid” aims to enlarge the available data on quality of mental health care by including five quality-indicators in the “Vlaams Indicatorenproject voor Patiënten en Professionals” (VIP²). These quality-indicators are (i) medication prescriptions completeness, (ii) implementation of suicide prevention policy, (iii) use of experiential peers (experiential wisdom, derived from personal knowledge of service users and carers), (iv) implementation of the Flemish patient survey mental health care (Vlaamse Patiëntenpeiling GZZ), and (v) timely ambulant contact after discharge from residential care. In the most recent wave (2017) of VIP², only the first four quality-indicators were collected. It is not mandatory for the (mental health care) facilities to participate in VIP². Each facility chooses which domains it wants to expose to the VIP² evaluation (all indicators within the selected domains are then measured, not a selection). In 2017, 105 health care facilities (from hospital, residential and primary care setting) participated in VIP². In its most recent recommendations, “Agentschap Zorg en Gezondheid” recommends the use of experiential peers, not only at the policy and process level, but also at the micro level (individual patient care), more information provision to patients and patient participation to enhance patient satisfaction. [40]

In addition, the Flemish “Agentschap Zorg en Gezondheid” is responsible for the surveillance of the 20 CGG’s in Flanders. Between October 2017 and February 2018, they evaluated the care offer of all 20 CGG’s for adults on four main topics: (i) the availability of a treatment plan per patient/client, (ii) multidisciplinary functioning, (iii) outcome monitoring and client feedback, and (iv) detection and interventions with suicidal behaviour. The main conclusion of this evaluation report is that there are large differences in care between CGG’s, without clear arguments. Also, there is a big variance in the quality of medical records; in almost all CGG’s there is a lack of systematically drafting a treatment plan with warning signs and interventions with clients who are at-risk for suicide. [41] In line with this, a recent analysis of the inspection reports of psychiatric hospitals demonstrated that three out of four psychiatric hospitals cannot show that the care they provide is based on sound scientific research. [34]

2.2.2 Evaluation of the Art. 107 projects

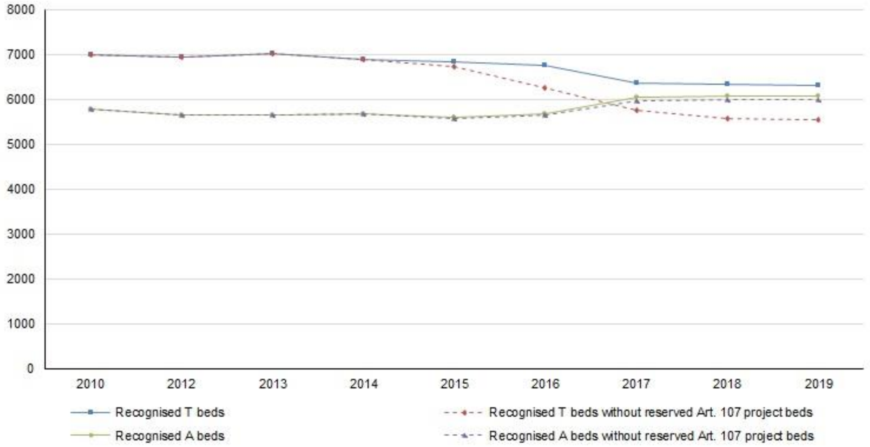
At the start of the Art. 107 projects, it was foreseen to evaluate their implementation and effects, which has been conducted by a consortium of researchers from Katholieke Universiteit Leuven, Université Catholique de Louvain, and Vrije Universiteit Brussel in 2014. [27] This evaluation was built around four different perspectives focussing on the characteristics of the (i) networks, (ii) patients, (iii) health care professionals, and (iv) informal caregivers. [42] Although the Art. 107 reform was intended for the entire Belgian population with mental health problems, the main results revealed that the reform seemed to target severely mentally-ill patients characterised with social deprivation and poor social functioning. In addition, services in the Art. 107 projects did not seem to share a common vision about the type of patients that should be prioritised within the network. Job satisfaction among health care professionals seemed relatively high, contrasted by the low satisfaction rate among informal caregivers. Informal caregivers emphasised the high workload and lack of support.

Additional research demonstrated the fragmentation in the reforms in mental health care, and showed lacks in accessibility, freedom of choice for patients, training of the workforce, and coordination/collaboration. [43-48] A fundamental message in this body of evidence is the potential of general practitioners (GPs) in the area of mental health care, which is now a major shortcoming in the process. [43-46, 49] Research targeting the care provided in mobile teams revealed overall a high satisfaction rate. [49] Moreover, Lorant, Grard [50] demonstrated that the Art. 107 project outcomes not really correspond with the main goals of the reform policy. Patients within the Art. 107 projects had a slightly better perception of continuity of care, but there was no significant association with hospitalisation rates, social integration, and quality of life.

As mentioned before, in the art 107 projects, ‘beds’ in psychiatric hospitals were frozen and the deliberated budget and means are used by the art 107 projects. E.g., on 1 July 2019, 1671 beds were frozen and ‘used’ for mobile care teams.

So far, the recognised T-beds in psychiatric hospitals decreased from 7001 in 2010 to 6326 in 2019 (dd. 1 July 2019). The recognised A-beds in psychiatric hospitals increased from 5 778 in 2010 to 6 087 in 2019. However, an increase of recognised beds in non-psychiatric hospitals can be observed (N=2 787 in 2010 versus N=3 421 in 2019, sum of A- and T-beds)), equalling 18.5% (N=634). Figures 12 and 13 show these trends.

Figure 12 – Evolution number of beds in psychiatric hospitals, divided into bed-types, 2010-2019 [a]



Source: SPF Health, Food Chain Safety and Environment
Note No data available for 2011, K-beds excluded

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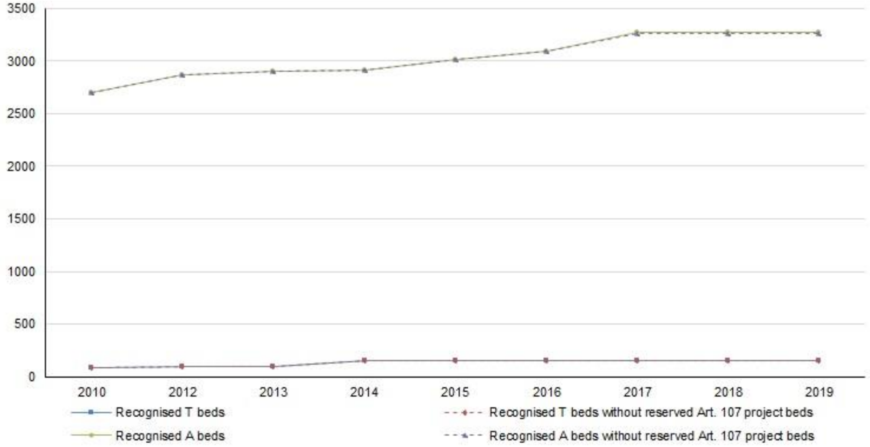
[a] Notwithstanding the Art. 107 projects were initiated in 2010, we could not find any data regarding the amount of beds reserved for the Art. 107 projects for the period 2010 - 2014.

Figure 13 – Evolution number of beds in non-psychiatric hospitals, 2010-2019 [b]

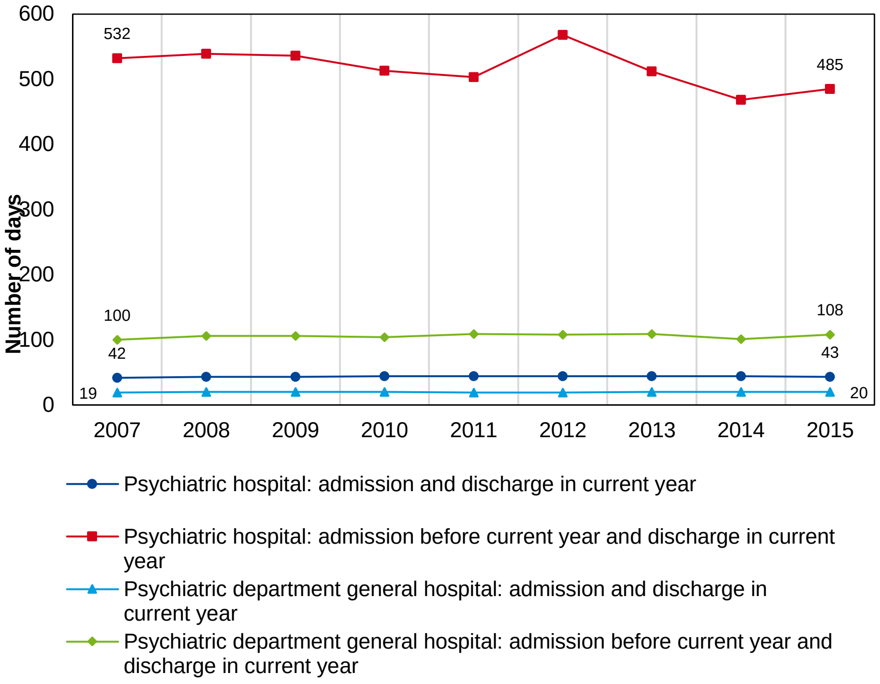


Source: SPF Health, Food Chain Safety and Environment
Note No data available for 2011, K-beds excluded

One of the five foundations of the Art. 107 projects was the intensification of in-hospital care, resulting in shorter length of stay (LOS). Important to note is that, depending on the consulted database, contradicting messages are reported. According to the MPG-RPM data, Figure 14 demonstrates the decrease of the mean LOS for patients who resided longer than one year in a psychiatric hospital from 532 days in 2007 to 485 days in 2015. Nonetheless, the mean LOS in psychiatric departments of general hospitals and patients who resided less than one year in a psychiatric hospital did not decrease substantially following the onset of the Art. 107 projects.

Contradictory, according to the FinHosta database, LOS in psychiatric hospitals has decreased from 84.7 days in 2006 to 63.9 days in 2017. [51]

Figure 14 – Evolution length of stay in psychiatric hospitals and psychiatric departments in general hospitals, in mean number of days, 2007-2015



Source: FOD Volksgezondheid Veiligheid van de Voedselketen en Leefmilieu [52]

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[b] Notwithstanding the Art. 107 projects were initiated in 2010, we could not find any data regarding the amount of beds reserved for the Art. 107 projects for the period 2010 - 2014.

2.3 Priorities and plans for mental health care

2.3.1 Priorities and plans at the federal level

According to research in 2014, 20% of the Belgian citizens experienced psychiatric or mental health unmet needs during the last year. [53]. One third of these patients indicated that psychiatric or mental healthcare was not available or not accessible because of financial reasons. [46, 53, 54] Nonetheless, in Belgium, there is a long history of evidence advocating for an affordable and accessible psychological care in the first line. [4, 33, 36, 53-55] In response, the Federal Government issued a bill in May 2018 in which a visit to a clinical psychologist can be reimbursed from March 2019 on. An annual budget of 22.5 million euros has been earmarked for these reimbursements. The reimbursement of clinical psychologists, however, is subject to several conditions:

1. for adults aged between 18-64 years;
2. who suffer from common mental health disorders (i.e. depression, anxiety, and alcohol abuse);
3. who are referred by a general practitioner (GP) or a psychiatrist;
4. clinical psychologist should be linked to an Art. 107 network; and
5. with a maximum of 4 consultations per year (once renewable by a GP or psychiatrist).

Following the most recent KCE report on mental health care for elderly [23], all Belgian ministers responsible for health signed a joint statement to develop a new mental health policy for elderly. [56] This joint statement will be used as a starting point to integrate the Belgian residents older than 65 years in the already existing Art. 107 projects. Last, in the estimated health care budget for 2019, the federal minister earmarks 1.4 million euro to establish eight additional mobile teams. [57]

2.3.2 Priorities and plans at the federated level

There is a variance in political vision for mental health (care) at the federated level. It can be observed that some regions outlined priorities and plans regarding mental health (care) to some extent, while other regions are still developing them.

2.3.2.1 Flanders

Flanders developed a comprehensive mental health action plan for 2017-2019 [29]. This strategic planning started from the vision described in the WHO mental health action plan 2013-2020 [58]:

> *“A world in which mental health is valued, promoted, and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high-quality, culturally appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatisation and discrimination.”*

This WHO vision is translated into the following cross-cutting principles of the Flemish mental health action plan:

- An **inclusive community**, in which participation, subsidiarity, and community care has a central role.
- **Intersectoral care** facilitating a close collaboration between social care, housing, education, etc. This close collaboration focuses on a continuous care process across the borders which divide generalist and specialised care, somatic and mental health care, etc.
- **Global, integrated and comprehensive care package** ranging from self-care to intensive and specialised care. Central within this care package are the (health) needs, context and goals of the patient.
- **Accessible and affordable care**
- **Network oriented care model** guaranteeing continuity of care in an interprofessional collaboration

One of the main actions in the mental health action plan is the introduction of a new coordinating institution that joins the forces of Flemish mental health care providers: the "Steunpunt Geestelijke Gezondheid". [29] This "Steunpunt" is established from January 2019 on and its main objective is to coordinate care and promote collaboration between the partners who are involved, both from a client perspective and from a context perspective. (Part of) the following institutions will be merged in the "Steunpunt Geestelijke Gezondheid (Steunpunt GG)": Vlaamse Vereniging voor Geestelijke Gezondheid (VVGG), Zorgnet-Icuro, Te Gek!?, Federatie van Diensten voor Geestelijke Gezondheidszorg (FDGG), and Netwerk Cultuursensitieve Zorg. It will support the mental health care organisations and professionals on the field, develop best practices, and contribute to imaging of mental health.

Second, Flanders established two Flemish action plans for suicide prevention (2006-2010 and 2012-2020 plan). [59, 60] The main goals of this plans are to:

- **promote mental health** of the entire Flemish population
- **maximise the care offer** for people at risk of suicidal behaviour;
- **develop networks** to enable follow up of risk-patients;
- **share relevant knowledge** and information with other care professionals; and
- **advocate suicide prevention** within local networks.

Nevertheless, despite the good signal of the Flemish strategic action plan, the "Strategische Adviesraad Welzijn, Gezondheid en Gezin" (SAR WWG) emphasised the lack of a long-term vision and its inability to exceed ad hoc policy. [2] The SAR WGG identified several priorities that need attention, such as reduction of the stigma that is attached to mental health care and improving accessibility and affordability of the mental health care. In order to realise these objectives, both the Federal and Flemish government will have to increase the financial resources attributed to mental health care (as this mental health care budget is no longer viable). In addition, the SAR WGG stresses the importance of ambulatory mental health care (in addition to residential care). Too often, admission to residential facilities is required because of the lack of alternative care or waiting times. Next to the forthcoming reimbursement of the psychologist at the Federal level (see 2.3.1), the SAR WGG recommends to invest in the development of mental health care in primary care, CGG – SSM, rehabilitation, psychiatric care homes and sheltered living initiatives.

Both mental health action plan and action plans for suicide prevention are from September 2018 anchored in Flemish policy by the approval of the new "Decree Mental Health Care". [61] The new decree focuses on the following main topics:

- **Destigmatisation:** enhancing of the knowledge among citizens on mental health. Flanders made 200 000 euro available for the elaboration of first aid courses for the general public to combat psychiatric and mental problems.
- **Experiential peers:** the decree emphasises the importance of experiential peers both in mental health care and policymaking.
- **Networks mental health care:** this decree realises a legal base for the acknowledgement, programming, and composition of pilot Art. 107 projects.
- **Common language:** the decree focuses on an unambiguous language that will be used in the networks mental health care.

2.3.2.2 Wallonia

"Agence wallonne de la santé, de la protection sociale, du handicap et des familles", in short "Agence pour une Vie de Qualité" (AVIQ) was created by the Walloon Government. This agency is competent in Wallonia, particularly in the field of health policy, including mental health. [62]

In February 2019, AVIQ published the Walloon action plan regarding prevention and health promotion until 2030[c]. One of the key points of this plan is the promotion of mental health and wellbeing, for example, by preventing addiction (and decreasing its related risks) and by decreasing suicide rate to 10%

AViQ plans to collect data on care trajectories of patients in mental health care and is currently writing (2019) a memorandum in which objectives on mental health issues are identified. In addition, the Walloon minister responsible for health is currently revising the decree regarding mental health care services. At the time of writing of this report, the publication of this decree is expected for the next legislature.

2.3.2.3 *Brussels*

As previously mentioned, several political entities are responsible for (mental) health in Brussels (Figure 7), leading to fragmentation in policy decisions and health care delivery. At the start of the Art. 107 reform, there were two Art. 107 projects developed. However, to facilitate centralisation and uniformity these two Art. 107 projects merged to one with four antennas spread over Brussels territory. Additionally, in its 2018 health plan, Brussels aims to create “la ligne 0.5”. This is a specific structure in which organisations like Dokters van de Wereld – Médecins du Monde operate to refer fragile people to classical health care facilities. In this “ligne 0.5” Brussels also stipulates a big role for the “plateforme de concertation en santé mentale”. [63]

2.4 Key messages

- Over the last decades, the Belgian mental health care system went through several reforms. Main aims of these reforms were:
    - a shift from intramural towards extramural care to enhance the treatment of people with mental health problems into the community;
    - (re)socialisation of mental health care to change the perception of the society (destigmatisation) towards mental health;
    - a shift from a medical model towards a holistic biopyschosocial model of care;
    - differentiation of mental health care and promotion of person-centred care tailored to the patients’ needs;
    - and specialisation of care to improve the approach for specific sub-groups in mental health care.
- Following the 6th institutional state reform in Belgium, a broad range of responsibilities were transferred to the federated authorities. This leads to fragmentation and is a barrier for the development and implementation of a comprehensive and long-term vision on mental health policy.
- Belgium is one of the European countries with the highest overall costs related to mental health problems (i.e. 5.05% of the GDP, equalling €20.740 million).
- Belgium has the second highest number of psychiatric beds compared to the number of inhabitants among OECD countries and more than 80% of the financial resources for mental health care are going to residential care.

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[c] http://labos.ulg.ac.be/apes/wp-content/uploads/sites/4/2017/01/18189_WALAPSant%C3%A9_v_05_11.pdf

- There is not systematic registration in Belgian mental health care, leading to a lack of numbers at both system and service delivery levels.
- Notwithstanding the target of the Art. 107 projects (i.e. the entire Belgian population with mental health problems), these projects seem to target severely mentally-ill people with social deprivation and poor social functioning. In addition, evaluation-studies highlight the lack of common vision within the Art. 107 projects, a high satisfaction rate among caregivers working in these Art. 107 projects, a low satisfaction rate among informal caregivers and the potential of GPs in mental health care.
- Regarding federal policy plans, from March 2019 on, four consultations with a clinical psychologist can be reimbursed for adults aged between 18-64 years, suffering from common mental health disorders, referred by a GP/psychiatrist, and when the clinical psychologist is partner of an Art. 107 project. In addition, Belgian residents older than 65 years will be integrated in the Art. 107 projects and 8 additional mobile teams will be established.
- There is a variance in political vision for mental health (care) at the federated level. Some regions outlined priorities and plans regarding mental health (care) to some extent, while other regions are still developing them.

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CHAPTER 02 PREVALENCE OF MENTAL HEALTH PROBLEMS

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1 INTRODUCTION

Mental health problems are common around the world and burdensome for both individuals and society. Treatment of mental health problems has become imperative, however given the high prevalence of lifetime mental health problems (i.e. estimation between 25% and 50% in the general population), it is necessary to (re)allocate resources to those who need it most. [1, 2] A crucial step in this process is to document the prevalence of mental health problems, care needs and its related service use. Comparable studies on prevalence and service use stem from the beginning of the 21st century, with the Belgian part of the European Study of the Epidemiology of Mental Disorders (ESEMeD) and the Health Interview Survey (HIS) as landmark studies. Both studies reported a high prevalence of mental health problems, as well as low service use and high unmet need for these conditions. [3, 4] HIS has collected more recent data in its 2004, 2008, and 2013 waves. In times of rapidly changing health policies worldwide, it is important to gain recent estimates on both prevalence of mental health problems as well as the use of services for these conditions. One could question the sufficient comparability of the ESEMeD 2001 estimates and the 2001 HIS database, to facilitate transposition to the more recent estimates of the HIS wave 2013. However, as will be discussed in the next chapter, the level of comparability of both databases is limited. However, the HIS is the only validated and longitudinal source for data on mental health problems and its related service use in Belgium. Therefore, current chapter will only present data from the HIS data.

2 METHODS

The Belgian HIS is a cross-sectional survey which is repeated every 4-5 years and is coordinated by Sciensano. It aims to include 10.000 respondents nested in 6.000 households in the French, Dutch, and German speaking households. The purpose of the HIS is to assess the health status of the Belgian population and to identify the main health problems as well as the determinants and behaviours that could influence them. The first wave of the HIS was launched in 1997 and repeated in 2001, 2004, 2008, 2013, and 2018. [5] At the moment of writing current chapter, data of the 2018 wave were not yet available or published, therefore, data up to the 2013 wave will be presented.

In addition, the National Institute for Health and Disability Insurance (NIHDI) reports yearly the statistics on the acknowledgement of the invalidity statutes in Belgium. Invalidity is (partially or fully) attributed by the Medical Counsel for Invalidity. [6] The database divides the nature of the invalidity in categories and facilitates to extract data on invalidity because of psychiatric problems. The statistics on invalidity for psychiatric problems, between 1997 and 2014 (latest available data point) will be presented in current chapter.

2.1 Prevalence of mental health problems

The HIS uses different scales and instruments to investigate mental health problems. **Mental distress** is estimated by the 12-item scale of the General Health Questionnaire (GHQ-12), to which a higher score on this scale equals a higher likelihood of mental distress. [7] Mental distress is defined when two or more items of the GHQ-12 are positively scored. When the scale reaches the threshold value of 4 (or more) the respondent is considered to have a **mental disorder**. [8-10]

Anxiety, depression, sleeping problems, and eating disorders are characterised as **emotional problems** in the HIS. Anxiety problems, depression, and sleeping problems are identified using the respective subscales of the Symptom Check List 90-R (SCL 90-R). The SCL 90-R is a 90-item questionnaire addressing symptom distress during the seven days prior to the survey, rated on a 5-point Likert scale rating from “not at all” to “extremely”. [11] The anxiety, depression, and sleeping problem subscales contain 10 items, 17 items, and 3 items respectively. Furthermore, important to keep in mind is that these SCL 90-R subscales should be interpreted as a screener for these emotional problems, indicating “risk of” rather than “diagnosis of”. From the 2013 wave on, HIS also collects data on eating disorders (both anorexia nervosa and bulimia nervosa, without collecting separate information). Eating disorders are measured by the 5-item screening instrument SCOFF (Sick, Control, One Stone, Fat, and Food). [12] Respondents are assumed to have an eating disorder when two of these 5 items are present.

Additionally, the prevalence of a **problematic alcohol problem** is measured by the four CAGE (Cut Down, Annoyed, Guilty, and Eye-opener) questions. [13] Alcohol consumption is considered problematic if at least 2 of the 4 questions are positively answered. [14]

Lifetime and past 12 month suicidal thoughts and behaviours (STB) are identified with four questions probing the existence of suicidal thoughts and suicidal attempt in the past 12 months or at any time in respondents’ life. [15] The lifetime STB indicator is included in the HIS since the 2004 wave, whereas the 12 month prevalence of STB since 2008.

2.2 Mental health care service use

Mental health care service use is assessed with a variety of questions: respondents were asked whether they had consumed any **psychotropic medication**, **tranquilisers or sleeping tablets**, or **antidepressants** in the past 2 weeks. In addition, respondents with a **self-reported depression** in the past 12 months were also asked whether they had **consulted a health care professional**, **used medication,** or received **psychotherapy** for this depression. [15]

3 RESULTS

3.1 Prevalence of mental health problems

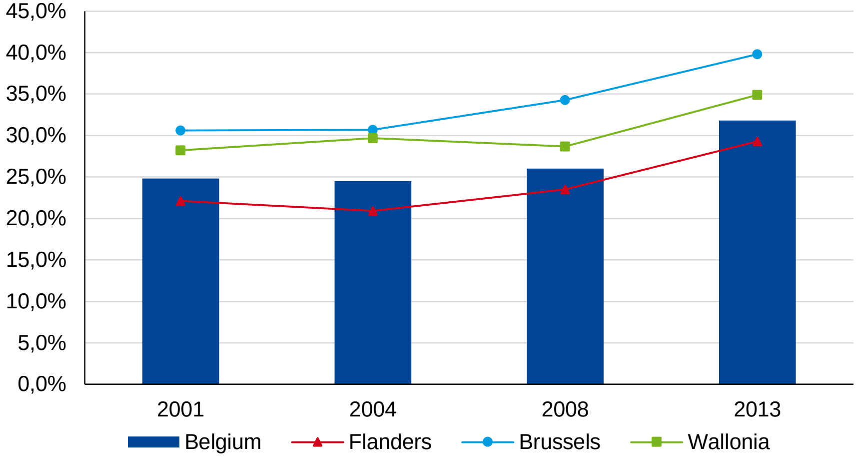
Key messages

- **The prevalence of mental health problems has increased substantially between 2008 and 2013. This increase can be observed in all regions.**
- **In general, residents of Brussels and Wallonia report more mental health problems compared to Flemish residents.**
- **Psychiatric problems are the most important cause of invalidity in Belgium.**

3.1.1 Mental distress and mental disorders

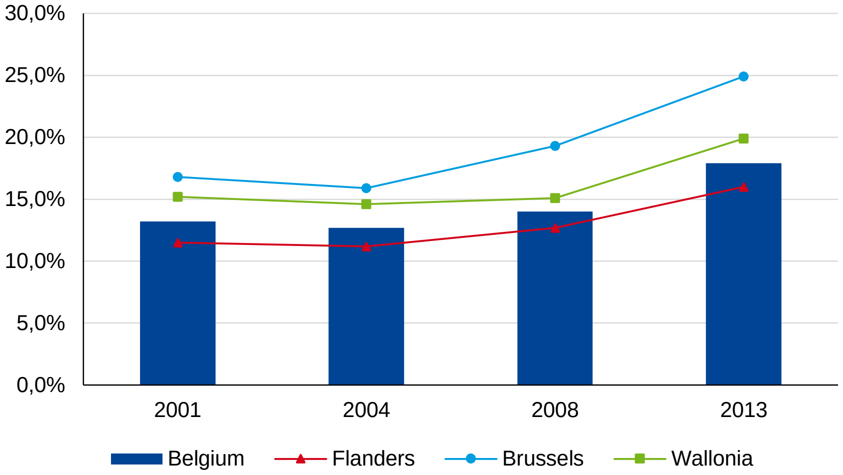
One out of three persons (equalling 32% of the Belgian population) reports mental distress (GHQ score +2) in 2013 (Figure 15). Moreover, Figure 16 shows that 18% of the Belgian residents has a mental disorder (GHQ score +4). Both estimates are increased during time, especially between 2008 and 2013. The prevalence of mental distress and mental disorders is highest in Brussels, followed by Wallonia and Flanders.

Figure 15 – Prevalence of mental distress (GHQ score +2) in Belgium and across regions (2001 - 2013)



Source authors' own reproduction based on Drieskens, Charafeddine [16]

Figure 16 – Prevalence of mental disorders (GHQ score +4) in Belgium and across regions (2001 - 2013)



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3.1.2 Emotional problems

Table 1 demonstrates (i) the evolution in emotional problems during time and (ii) splits the estimates on regional level. The results show that approximately 10% of the Belgian population suffers from anxiety problems in 2013, 14.8% shows signs of depression, 29.6% has sleeping problems, and 8.4% shows signs of an eating disorder. Up to 2008, the Belgian prevalence of these emotional problems remained stable. However, as with the prevalence of the other mental health problems, the estimates have increased substantially between 2008 and 2013. Regarding regions, it can be observed that prevalence of emotional problems in 2013 is highest in Brussels, followed by the Wallonia, and Flanders.

Table 1 – Prevalence of emotional problems in Belgium and across regions (2001 - 2013)

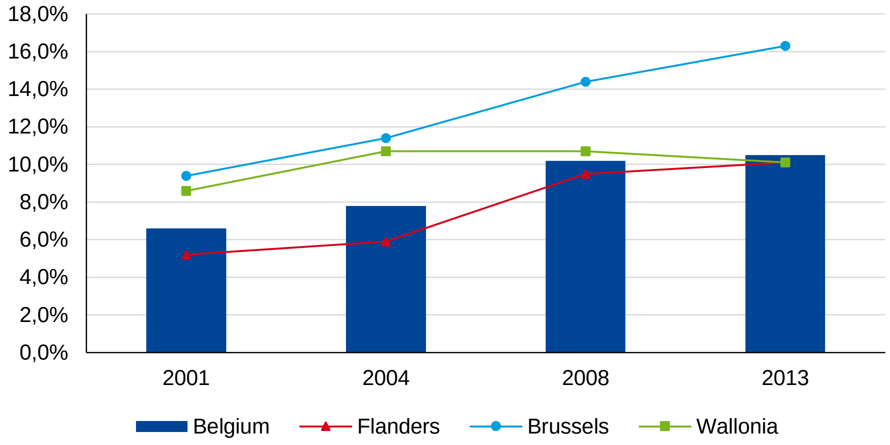
	2001	2004	2008	2013
ANXIETY PROBLEMS (SCL 90-R)				
Belgium	6.3%	6.1%	6.5%	10.1%
Flanders	5.3%	5.3%	5.8%	9.2%
Brussels	7.2%	7.0%	9.1%	11.7%
Wallonia	7.9%	7.3%	7.2%	11.4%
DEPRESSION (SCL 90-R)				
Belgium	8.6%	8.0%	9.5%	14.8%
Flanders	7.7%	6.8%	8.2%	13.3%
Brussels	10.0%	9.5%	13.8%	18.2%
Wallonia	10.1%	9.7%	11.0%	16.8%
SLEEPING PROBLEM (SCL 90-R)				
Belgium	20.2%	19.9%	21.3%	29.6%
Flanders	19.8%	19.6%	19.7%	28.3%
Brussels	21.2%	18.8%	25.1%	33.1%
Wallonia	20.9%	20.7%	23.7%	31.5%
EATING DISORDER (SCOFF)				
Belgium	-	-	-	8.4%
Flanders	-	-	-	6.5%
Brussels	-	-	-	12.6%
Wallonia	-	-	-	11.2%

Source authors' own reproduction based on Drieskens, Charafeddine [16]

3.1.3 Problematic alcohol problems

In Belgium, one person on ten (10.5%) encountered problematic alcohol problems at least once in their lifetime (Figure 17*)*. In Brussels, approximately 16% is confronted with problematic alcohol problems. There is no large difference between Flanders and Wallonia, in which 10% of the populations encountered problematic alcohol problems in their life. The prevalence of alcohol problems increased during time, however, for Wallonia, we observe a small decline.

Figure 17 – Prevalence of problematic alcohol problems in Belgium and across regions (2001 - 2013)



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3.1.4 Suicidal thoughts and behaviours

The proportion of people who reported suicidal thoughts (either during their lives or in the last year) increased between 2008 and 2013 (Table 2). On the other hand, the percentage of people who actually tried to commit suicide (in their lives or in the last year) did not change. In 2013, 5% of the population said that they had seriously thought about committing suicide in the past 12 months and reported that 0.4% actually attempted suicide during this period. Of the Belgian population, 4% indicated having taken at least one suicide attempt during their lifetime. In Flanders, the prevalence for suicidal thoughts and attempts are lower throughout life than in the other two regions.

Table 2 – Prevalence of STB in Belgium and across regions (2004 - 2013)

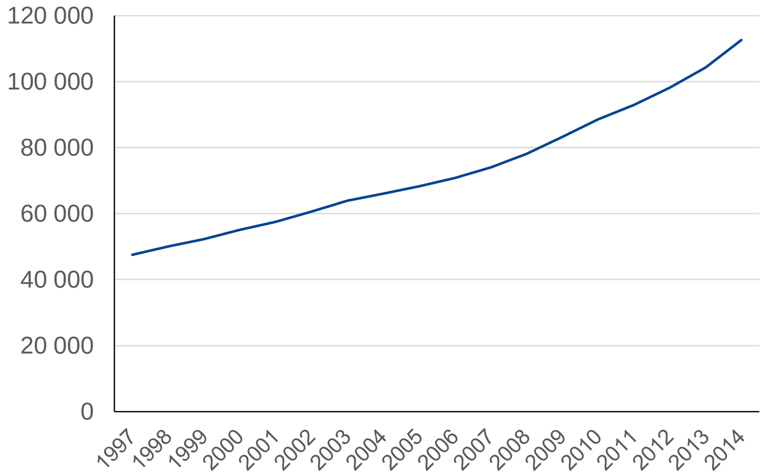
	12 MONTH PREVALENCE SUICIDAL THOUGHTS		LIFETIME PREVALENCE SUICIDAL THOUGHTS			12 MONTH PREVALENCE SUICIDAL ATTEMPT			LIFETIME PREVALENCE SUICIDAL ATTEMPT		
	2008	**2013**	**2004**	**2008**	**2013**	**2004**	**2008**	**2013**	**2004**	**2008**	**2013**
Belgium	3.6%	5.0%	12.2%	11.7%	13.8%	0.4%	0.4%	0.4%	12.2%	11.7%	13.8%
Flanders	2.9%	4.9%	9.8%	9.8%	12.6%	0.3%	0.4%	0.5%	2.3%	4.0%	3.4%
Brussels	5.5%	5.5%	16.6%	16.1%	17.5%	0.6%	0.5%	0.6%	5.6%	6.2%	5.8%
Wallonia	4.5%	5.1%	15.5%	14.4%	15.5%	0.6%	0.5%	0.3%	5.9%	6.4%	5.5%

Source authors' own reproduction based on Drieskens, Charafeddine [16]

3.1.4.1 *Invalidity because of psychiatric problems*

According to NIHDI [6], psychiatric problems are the most important cause of invalidity in Belgium (Figure 18). In 17 years (from 1997 to 2014) the number of invalid people because of psychiatric problems increased with 57% (from 45.507 to 112.648 invalid people).

Figure 18 – Number of invalid people because of psychiatric problems in Belgium, 1997-2014



Source NIHDI [6]

3.2 Mental health care service use

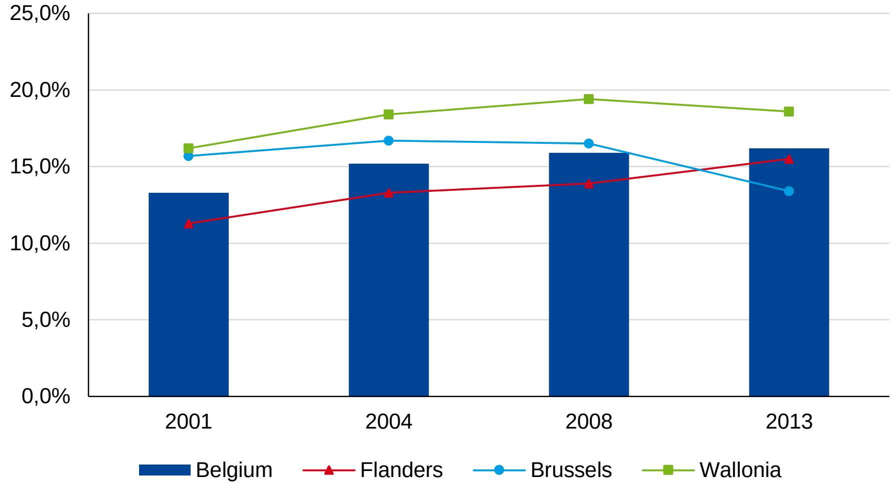
Key messages

- **Most frequently used treatment in Belgium is the use of antidepressants, which is still increasing during time.**
- **Persons at risk for depression receive less mental health care services in 2013.**
- **Flemish residents at risk for depression get the least mental health care compared to their counterparts in other regions.**

3.2.1 *Use of medication*

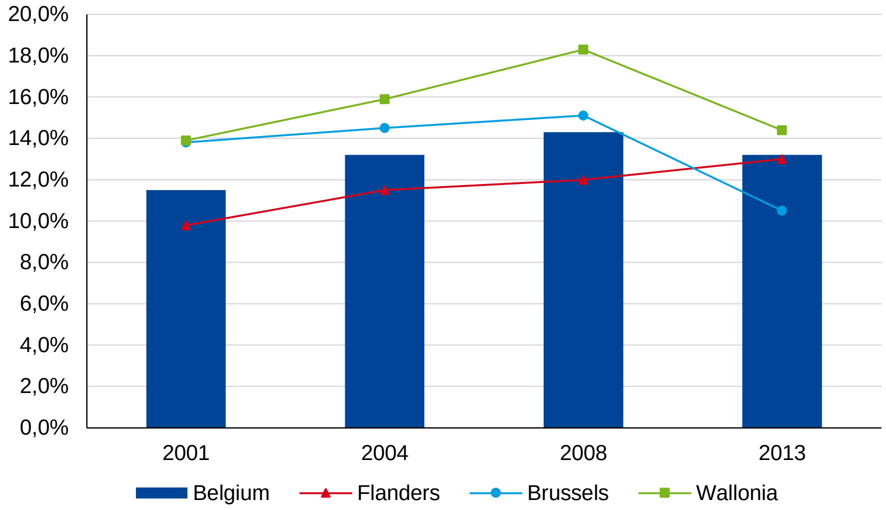
In 2013, approximately 16% of the Belgian population reported the use of psychotropic medication in the two weeks prior to the HIS survey *(*Figure 19*)*. More specifically, 13% reported the use of tranquilisers or sleeping tablets (Figure 20*)* and 8% reported the use of antidepressants (Figure 21), with some using both. The use of psychotropic medication is higher in Wallonia (18.6%) than in Brussels (13.4%) and Flanders (15.5%). This difference is mainly explained by the higher use of antidepressants in Wallonia (9.5% versus 6.9% and 6.7% respectively in Brussels and Flanders). In the period 2001 – 2013, the use of tranquilisers and sleeping tablets has remained quite constant among the Flemish inhabitants and has even decreased in Brussels and Wallonia. In contrast, the use of antidepressants shows a rising trend in all three regions.

Figure 19 – Use of psychotropic medication in Belgium and across regions (2001 - 2013)



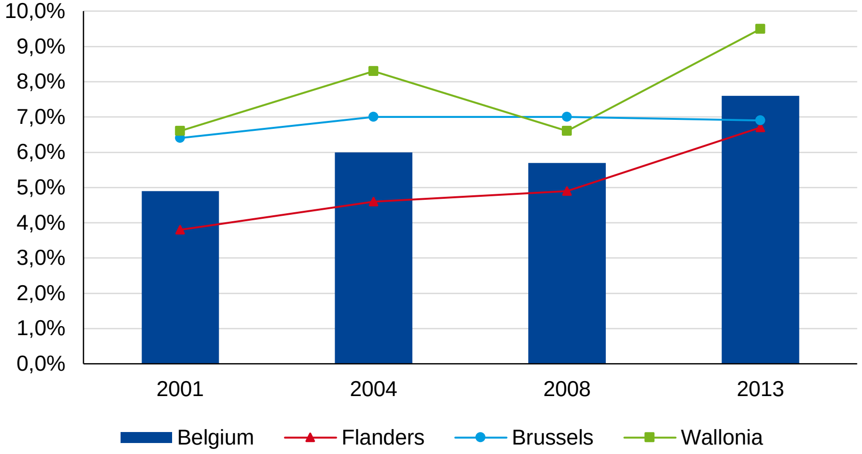
Source authors' own reproduction based on Drieskens, Charafeddine [16]

Figure 20 – Use of tranquilisers or sleeping tablets in Belgium and across regions (2001 - 2013)



Source authors' own reproduction based on Drieskens, Charafeddine [16]

Figure 21 – Use of antidepressants in Belgium and across regions (2001 - 2013)



Source authors' own reproduction based on Drieskens, Charafeddine [16]

3.2.2 Mental health care services use among adults at risk for depression

According to the most recent data of 2013 (Table 3), 81.1% of the Belgian residents at risk for a depression consults a health care professional, 72.1% uses medication, and 27.8% of them receives psychotherapy. It is noteworthy that these percentages are all lower than those from the previous HIS waves. We can, therefore, conclude that the Belgian residents at risk for depression currently receive less mental health care. Concerning region, Flemish residents at risk for depression receive the least mental health care compared to the residents of Wallonia or Brussels.

Table 3 – Mental health care use among adults at risk for depression in Belgium and across regions (2001 - 2013)

	CONSULTATION WITH HEALTH CARE PROFESSIONAL		USE OF MEDICATION				USE OF PSYCHOTHERAPY		
	2008	**2013**	**2001**	**2004**	**2008**	**2013**	**2004**	**2008**	**2013**
Belgium	88.0%	81.1%	75.3%	84.0%	81.9%	72.1%	18.9%	40.5%	27.8%
Flanders	90.6%	78.2%	71.7%	85.8%	79.9%	66.6%	22.4%	42.2%	23.1%
Brussels	89.8%	84.3%	72. 6%	75.9%	80.4%	72.3%	16.1%	44.6%	39.6%
Wallonia	84.2%	84.0%	80.3%	84.6%	85.2%	79.8%	16.0%	36.5%	30.3%

Source authors' own reproduction based on Drieskens, Charafeddine [16]

4 CONCLUSION

This chapter confirms the high prevalence of mental health problems and the lower use of mental health care services in Belgium in 2013, compared to previous HIS waves. With regard to the prevalence of mental health problems, data from the previous HIS waves (2001 – 2008) shows a quite stable trend. In addition, according to statistics of NIHDI, psychiatric problems are the most important cause of invalidity in Belgium. Furthermore, the most recent HIS data of the 2013 wave indicate a deterioration of mental health in the Belgian population. The percentage of people with anxiety problems, depression, and/or sleeping problems has experienced a strong increase between 2008 and 2013. In general, the prevalence of mental health problems shows a better situation in Flanders compared to Brussels or Wallonia. Moreover, more people report having suicidal thoughts, although the figures for suicide attempts remain constant. A parallel increase in the use of antidepressants is also observed, while the use of tranquilisers and sleeping tablets remains constant or even decreases. The use of psychotropic medication is not without danger. It can lead to habituation, addiction, concentration/memory problem, or increased risk of falling. It is, therefore, recommended to use psychotropic medication carefully, requiring a comprehensive clinical evaluation and timely follow-up. Furthermore, the data reveals that persons at risk for depression receive less mental health care (in terms of consultation with a health care professional, medication, or psychotherapy) in 2013 compared to the previous HIS waves. We cannot conclude if this decrease in use of mental health care services for persons at risk for depression is desired or undesired. The Belgian population has access to a wide range of therapies (for example e-health therapy), which also could influence the risk of depression. Unfortunately, the HIS data does not provide data on other therapies. Together with the previously mentioned deterioration of mental health, these results should function as a flashing alarm for policymakers that Belgian mental health care is failing in providing timely care to people in need, especially in times of economic and social crises. [15] The evaluation of the prevalence of mental health problems and its related service use through a health survey entails a number of limitations. Because the HIS includes only non-institutionalised respondents, only the so-called common mental problems are included and not the more severe mental problems such as psychotic disorders or disorder due to a medical condition. This could suggest that the estimates we provide should be interpreted as lower-end estimates of the real prevalence of mental problems in Belgium. The HIS estimates are based on screening instruments for mental health problems (through symptom scales) or through subjective answers. The validity of subjective assessments could be biased dependent upon recall time periods or frequency, all leading to a modest underestimation. [17] Objective diagnostic tools (such as used in the ESEMeD study are often more nuanced. In addition, the most recent estimates date from the 2013 wave, which could be outdated. At the moment of writing current report, data of the 2018 wave were not yet available or published. Last, there are no validated estimates available on the outcomes and quality of interventions in mental health care. Taking all this limitations in mind, it can be concluded that the quality of the available knowledge on mental health needs and its related services use is rather low.

5 KEY MESSAGES

- One third of the Belgian adult population faces a mental health problem
- The prevalence of mental health problems has increased substantially between 2008 and 2013. This increase can be observed in all regions.
- In general, residents of Brussels and Wallonia report more mental health problems compared to Flemish residents.
- Nothing is known about care needs of people with mental health problems

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CHAPTER 03 COMPARABILITY OF ESEMED AND HIS

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1 INTRODUCTION

Mental health problems are common around the world and burdensome for both individuals and society. Treatment of mental health problems has become imperative, however given the high prevalence of lifetime mental problems (i.e. estimation between 25% and 50% in the general population), it is necessary to (re)allocate resources to those who need it most. [1, 2] A crucial step in this process is to document the prevalence of mental health problems, care needs and its related service use. Comparable studies on prevalence and service use stem from the beginning of the 21st century, with the Belgian part of the European Study of the Epidemiology of Mental Disorders (ESEMeD) and the Health Interview Survey (HIS) as landmark studies. Both studies reported a high prevalence of mental health problems, as well as low service use and high unmet need for these conditions. [3, 4] HIS has collected more recent data in its 2004, 2008, and 2013 waves. In times of rapidly changing health policies worldwide, it is important to gain recent estimates on both prevalence of mental health problems as well as the use of services for these conditions. Therefore, the question arises to what extent data from the HIS are comparable with the, so far, only population-based study that was specifically designed to gather general population estimates in basic psychiatric epidemiology in Belgium (i.e. the ESEMeD study). Obtaining such information is vital for providing effective mental health care for a broad population and (re)allocate services for those with high needs. Present chapter will, for this reason, investigate the comparability of mental health problems in the ESEMeD and HIS database.

2 METHODS

2.1 The European Study of the Epidemiology of Mental Disorders (ESEMeD)

The ESEMeD is a national representative (in terms of age, gender, living, and working conditions) survey which was conducted between April 2001 and June 2002 among Belgian residents (aged 18 years or older) in Flanders and Wallonia. The survey included 2.419 respondents (reflecting a response rate of 50.6%). [5] The goals of ESEMeD was to gain detailed information on the prevalence of mental health problems and the related service use in the non-institutionalised Belgian adults. [6] Regarding prevalence of mental health problems, the ESEMeD survey used the validated third version of the Composite International Diagnostic Interview (CIDI 3.0), a structured diagnostic interview to assess 12 month prevalence of mental health problems. Service use was assessed by the CIDI 3.0 treatment module concerning 12 month prevalence from any type of professional for mental health problems. An overview of the included variables and their operationalisation can be consulted in Table 4.

2.2 The Belgian Health Interview Survey (HIS)

The Belgian HIS is a cross-sectional survey which is repeated every 4-5 years and is coordinated by Sciensano. It aims to include 10.000 respondents nested in 6.000 households in the French, Dutch, and German speaking households. The purpose of the HIS is to assess the health status of the population and to identify the main health problems as well as the determinants and behaviours that could influence them. The first wave of the HIS was launched in 1997 and repeated in 2001, 2004, 2008, 2013, and 2018. [7] However, at the moment of writing current report, the data of the 2018 wave were not yet available or published. Therefore, we will compare the ESEMeD study with the most recent one from HIS (i.e. 2013 wave). Prevalence of mental health problems was measured by different scales/instruments and questions. For a detailed overview of the included variables and their operationalisation, we refer the reader to Table 4.

3 RESULTS

In the first step of this comparison, the instruments and questions of both the ESEMeD and HIS study were considered linguistically. Because some of the mental health problems or service use facilities were not available in either the ESEMeD or the 2001 HIS wave, the operationalisation within the 2013 HIS wave is also taken into account.

Table 4 – Overview of the variables on prevalence of mental health problems and related service use in both ESEMeD (2001), HIS (2001), and HIS (2013)

NR		MEASURE	SOURCE		
			ESEMeD Instrument (timeframe)	HIS (2001) Instrument (timeframe)	HIS (2013) Instrument (timeframe)
1	Mental health problems	**Depression**	CIDI 3.0 mood disorder module (12 month prevalence)	SCL 90-R depression risk screener (current risk/past week)	SCL 90- R depression risk screener (current risk/past week)
2		**Self-reported depression**	--	Self-reported depression (12 month prevalence)	Self-reported depression (12 month prevalence)
3		**Anxiety problem**	CIDI 3.0 anxiety disorder module (12 month prevalence)	SCL 90-R anxiety risk screener (current risk/past week)	SCL 90-R anxiety risk screener (current risk/past week)
4		**Alcohol problem**	CIDI 3.0 substance abuse module (12 month prevalence)	--	Self-reported daily number of alcohol beverages (12 month prevalence)
5		**Suicidal thoughts**	CIDI 3.0 suicidality module (12 month prevalence)	--	Main questionnaire (12 month prevalence)
6		**Suicidal plans**	CIDI 3.0 suicidality module (12 month prevalence)	--	--
7		**Suicide attempt**	CIDI 3.0 suicidality module (12 month prevalence)	--	Main questionnaire (12 month prevalence)

8	**Service use for mental health problems**	**Consultation with psychiatrist**	CIDI 3.0 service use module (12 month prevalence)	--	--
9		**Consultation with psychiatrist/neurologist**	--	Main questionnaire (2 months prevalence)	Main questionnaire (2 months prevalence)
10		**Consultation with psychologist**	CIDI 3.0 service use module (12 month prevalence)	Main questionnaire (12 month prevalence)	Main questionnaire (12 month prevalence)
11		**Consultation with general medical provider**	CIDI 3.0 service use module (12 month prevalence)	--	--
12		**Use of psychotropic medication**	--	Main questionnaire (2 weeks prevalence)	Main questionnaire (2 weeks prevalence)
13		**Use of medication for self-reported depression**	--	Among those who indicated “yes” on question 1 (12 month prevalence)	Among those who indicated “yes” on question 1 (12 month prevalence)
14		**Visit to health care professional**	--	Among those who indicated “yes” on question 1 (12 month prevalence)	Among those who indicated “yes” on question 1 (12 month prevalence)
15		**Started with psychotherapy**	--	Among those who indicated “yes” on question 1 (12 month prevalence)	Among those who indicated “yes” on question 1 (12 month prevalence)
16		**Human services professional**	CIDI 3.0 service use module (12 month prevalence)	--	--
17		**Complementary and alternative medicine**	CIDI 3.0 service use module (12 month prevalence)	--	--
18		**Any service use**	CIDI 3.0 service use module (12 month prevalence)	--	Self-constructed: receiving services from at least one provider in the field of mental health care (2 week prevalence)
19		**Unmet need**	Self-constructed: meeting criteria for mental problem/STB and not receiving services (12 month prevalence)	--	Self-constructed: meeting criteria for mental problem/STB and not receiving services (current)

CIDI 3.0 refers to the third version of the Composite Diagnostic Interview. [8]
SCL 90-R refers to the Symptom Check List 90-R. [9]

Table 4 summarises the operationalisations of the mental health problems and its related service use in the ESEMeD and HIS study. It becomes immediately clear that ESEMeD and HIS use different instruments or questions, usually with a different timeframe. As an illustration, we enclosed the phrasing of the CIDI 3.0 anxiety disorder module (used in the ESEMeD) with the SCL 90-R anxiety risk screener (used in the HIS) in Table 5. This table shows that, next to the measured timeframe, the results of both instruments are not comparable cannot be compared with each other.

The only comparable measures could be suicidal thoughts and suicide attempts (indicated in green in Table 4). These variables ask for the same type of behaviours and use also the same time frames for these behaviours. However, also for these variables a different instrument is used in both questionnaires.

Table 5 – Comparison instruments measuring (risk of) anxiety

CIDI 3.0 ANXIETY DISORDER MODULE (12 month prevalence)	SCL 90-R ANXIETY RISK SCREENER (current risk/past week)
The next questions are about longer periods of feeling worried, tense, or anxious. In the past 12 months, did you have a period of a month or more when most days you felt worried or tense or anxious about everyday problems such as work or family?	**How much have the following problems distressed you during the past week, including today?** Feeling fearful Heart pounding or racing Nervousness or shakiness inside Trembling Suddenly scared for no reason Feeling tense or keyed up Spells of terror or panic Feeling so restless you couldn’t sit till The feeling that something bad is going to happen to you Thoughts and images of a frightening nature
Did that period go on for at least six months?	
How many months out of the last 12 did you feel worried or tense or anxious most days?	
During (that/those) month(s), were you worried, tense, or anxious every day, nearly every day, most days, about half the days, or less than half the days?	
And on the days you worried or were tense or anxious, did you usually feel that way all day long, most of the day, about half the day, or less than half the day?	
People differ a lot in how much they worry about things. In the past 12 months, did you have a period when most days you were a lot more worried or tense or anxious than most people would be in your same situation?	
Did that period go on for at least six months?	
How many months out of the last 12 did you feel worried or tense or anxious most days?	
During (that/those) month(s), were you worried, tense, or anxious every day, nearly every day, most days, about half the days, or less than half the days?	
And on the days you worried or were tense or anxious, did you usually feel that way all day long, most of the day, about half the day, or less than half the day?	

During the last 12 months, what sorts of things did you mainly worry about?
How often did you find it difficult to control your worry?
How often was your worry so strong that you couldn't put it out of your mind no matter how hard you tried?
Now look at this card. This is a list of problems some people have during periods of feeling worried, tense or anxious. In the past 12 months, during your period of worry, were you often restless?
In the past 12 months did you tell a doctor about feeling worried, tense, or anxious when you also had some of the problems on the list?
Can you remember your exact age the very first time in your life you had a period of worry, tension, or anxiety like the one you had in the past 12 months (that lasted six months or longer) and you also had some of the other problems we just reviewed?
How old were you?
About how old were you the first time you had a period of this sort?
What's the earliest age you can clearly remember a particular time when you had a period of this sort?
And how recently did you have a period of this sort?
In the past 12 months, how upset have you been with yourself for feeling worried, tense, or anxious?
Think about how your life and activities were affected in the past 12 months by your worry, tension or anxiety. Did these things interfere with your life and activities?
About how many days in the past 12 months were you totally unable for the whole day to work and carry out your other normal activities because of your worry, tension, or anxiety?
Did that day occur in the past four weeks?
How many of these days occurred in the past four weeks?
About how many (other) days in the past 12 months did you cut back either on the amount of work you got done or on the quality of your work because of your worry, tension, or anxiety?
On a scale from 0 to 100 where zero means being totally unable to work and 100 means working a full high quality day, what number describes the quantity and quality of your work during that day/those days?

	Did that cutback day occur in the past four weeks?
	How many of these cutback days occurred in the past four weeks?
	About how many (other) days in the past 12 months did it take an extreme effort to perform up to your usual level at work or at your other normal daily activities because of your worry, tension, or anxiety?
	Did that day occur in the past four weeks?
	How many of these days occurred in the past four weeks?
	And about how many days in the past 12 months did your worry, tension, or anxiety seriously interfere with your personal or social life?
	Did that day occur in the past four weeks?
	How many of these days occurred in the past four weeks?

4 CONCLUSION

Although both ESEMeD and HIS contain valuable information on the mental health problems and use of services for mental health problems of Belgian citizens, the level of comparability of both databases is limited. The reasons for this limited comparability is three-folded:

1. Different instruments: the most important reason of this lack in comparability is the use of different instruments. The ESEMeD uses the validated CIDI-3.0 which is specifically developed for studies within the general population. Whereas the HIS uses different scales and instruments to measure mental health problems and its related service use.
2. Different timeframes: timeframes used in both the ESEMeD and HIS differ significantly. The ESEMeD uses the timeframe of 12 months (the gold standard in psychiatric epidemiological research) whereas the HIS uses the timeframe of one week to screen current mental disorders.
3. Diagnostic versus symptom assessment: both instruments are used for research. However, the CIDI 3.0 is a diagnostic instrument and is internationally validated to measure mental health problems. [8] Whereas the instruments used in the HIS are either symptom assessments (such as the SCL 90-R for e.g. anxiety and mood disorders) or self-reported occurrence measures (such as 12 month prevalence of depression or daily intake of alcoholic beverages).

Therefore, it can be concluded that the data generated in both studies do not allow to compare the prevalence of mental disorders and service use for mental health problems in Belgium between 2001 and 2013. The only comparison which could be made is the prevalence of suicidal thoughts and suicide attempts. These variables ask for the same type of behaviours and use also the same time frames for these behaviours. However, also for these variables a different instrument is used in both questionnaires. Hence, the only reliable and most recent estimates on prevalence of mental health problems and its related service use are those from the 2013 HIS wave. The HIS data-collection was repeated in 2018, nevertheless, the results of this wave are not yet published.

5 KEY MESSAGES

- Although both ESEMeD and HIS contain valuable information on the mental health problems and use of services for mental health problems of Belgian citizens, the level of comparability of both databases is limited.

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CHAPTER 04 INTERNATIONAL FRAMEWORKS FOR MENTAL HEALTH SERVICE ORGANIZATION

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1 INTRODUCTION

In 2002, the ministers of health and social matters published a joint declaration on the future policies on mental health. This declaration was partly based on the WHO annual report 2001. [1] The Belgian government found inspirations from the international frameworks to elaborate the current Belgian reform on mental health care more than 10 years ago (NRZV [2] and personal communication with B. Jacob (SPF), 23/04/19). Previous KCE reports have analysed the situation of adults' mental health care in Belgium (KCE reports 103B, 123B, 144B, 146B and 265 [3-7]). However, none has described the international frameworks or compared the Belgian situation with the international recommendations. A recent update on the content of the frameworks and their comparability with the Belgian situation is justified.

This chapter aims to give insight into (i) the currently applied international frameworks (1.1, 1.2 and 1.3) and (ii) the status of the Belgian mental health service organisation in the light of the international frameworks (1.4. and 1.5.).

In order to achieve these aims, we intentionally focussed on documents concerning mental health care organisation of the World Health Organization (WHO), the WHO Regional Office for Europe (WHO/Europe), the European Union (EU), the United Nations (UN) and the Organisation for Economic Cooperation and Development (OECD), as those institutions present a very global and comprehensive view. Thus, the content of this chapter is highly inspired from those official documents as indicated by the references. The official websites of the WHO, WHO/Europe, EU, UN and OECD were searched for the last official plans, programs or frameworks about mental health care organisation. The search was done up until September 2018.

In the different sections of this chapter, we will first provide a general overview of the policy development on mental health and wellbeing during the 21st century. Secondly, we will describe 4 frameworks more in detail. Thirdly, we will present the last OECD report on mental health. Fourthly, we will discuss the status of Belgium in the different surveys organised by the WHO, the EU, the UN and the OECD. And finally, we will compare concepts of the Belgian MHC organisation with concepts of the WHO frameworks.

2 OVERVIEW OF THE FRAMEWORK DEVELOPMENT DURING THE 21TH CENTURY

We provide in this section a short overview of the different developed frameworks as an introduction to section 1.2 in which some plans are more extensively described. This overview comes from two documents: the annex 2 of the WHO/Europe Action Plan [8] and the background part of the EU framework for action on mental health and wellbeing [9].

Since 2002, mental health was adopted as a priority by the World Health Assembly (WHA) of the WHO. In 2005, member states (MS) of the EU accepted the European Declaration and Action Plan named “Improving the mental health of the population: Towards a strategy on mental health for the European Union”. Consequently, the WHO/Europe set an agenda for action to tackle stigma and discrimination and to develop community-based services [8].

In 2008, several plans were developed[8] such as (1) WHO/Europe mapped policies and practices for mental health[10]; (2) the “European Pact for Mental Health and Well-being” of the European Commission (EC), providing recommendations on 5 topics: (i) mental health in youth and education, (ii) prevention of depression and suicide, (iii) mental health in older people, (iv) promoting social inclusion and combating stigma, and (v) promoting mental health in workplaces[11] and (3) the UN Convention on the Rights of Persons with Disabilities was entered into force [12] entitling people with disabilities, including disabilities caused by mental impairments, to full and effective participation in society, protected from stigma and discrimination.

In 2011, the UN General Assembly recognized that “mental health problems are of major importance to all societies and are significant contributors to the burden of disease and the loss of quality of life, and have a huge economic and social cost”[13]. Later, the WHA passed a resolution requesting a comprehensive global mental health action plan covering services, policies, legislation, strategies and programmes to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower people with mental disorders to live a full and productive life in the community. [14] This resolution was adopted in 2013 as the WHO mental health action plan 2013-2020. (see 3.1) [8, 15].

In the frame of the Health 2020-WHO/Europe policy for health and wellbeing[16], a call for action to strengthen mental health promotion programmes and for further research to adapt to new challenges related to mental health was made. The WHO/Europe action plan[8] (see 3.2) was written in 2015 to correspond to the four priority areas of the Health 2020 policy, directly contributing to its implementation.(http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/policy-frameworks; last access 25/04/2019).

Also in 2015, the promotion and protection of mental health and wellbeing became public health priorities embedded within the Sustainable Development Goals (SDG) of the UN (see 3.4). Goal 3.4 specifically targets mental health; it seeks to reduce premature mortality from non-communicable diseases by one third through prevention and treatment by 2030, and to promote mental health and wellbeing (https://www.un.org/sustainabledevelopment/health/ https://www.un.org/sustainabledevelopment/health/; last access 25/04/2019).

From 2013 to 2016, the 3rd EU-Health Programme funded the Joint Action on Mental Health and Well-being (JA MH-WB) [17]. This JA MH-WB resulted in 5 reports on 5 topics (depression, suicide and e-health; community-based approaches; mental health at workplaces; mental health and schools; and mental health in all policies). It took the JA MH-WB three years to develop the EU framework for action which was published in 2016[9].

3 DESCRIPTION OF THE DEVELOPED INTERNATIONAL POLICIES

In this section, the policies in subsection 1.1 which are currently in application are discussed more in detail focussing on the objectives, targets and actions.

3.1 The WHO Mental Health Action Plan 2013-2020

In 2013, the WHO published the Mental Health Action Plan 2013-2020 [15]. The WHO action plan is designed to provide guidance for national action plans at country level. [18, 19]. The article 20 describes clearly **the vision** of the WHO action plan: “a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination” [15]. The WHO action plan was elaborated through consultations with member states, civil society and international partners. It has been designed to create synergy with other relevant programmes [15].

The **overall goal** of the WHO action plan is “to promote mental wellbeing, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders”[15]. Four major objectives were elaborated according to 6 **principles**: universal health coverage, human rights, evidence-based practice, life course approach, multi-sectoral approach and empowerment of persons with mental disorders and psychosocial disabilities. The 4 **objectives** focus on governance, on services, on prevention/promotion, and on information systems, evidence and research. Based on these objectives, 6 **global targets** were set up and should be reached by each WHO member state in 2020 (see Table 6).

Table 6 – Mental Health Action Plan 2013-2020: objectives and global targets[19]

Action Plan objective	Action Plan target (by the year 2020)
Objective 1: **To strengthen effective leadership and governance for mental health**	**Target 1.1:** 80% of countries will have developed or updated their policies or plans for mental health in line with international and regional human rights instruments
	Target 1.2: 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments
Objective 2:To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	**Target 2:** Service coverage for severe mental disorders will have increased by 20%
Objective 3: **To implement strategies for promotion and prevention in mental health-based settings**	**Target 3.1:** 80% of countries will have at least two functioning national, multi-sectoral mental health promotion and prevention programmes
	Target 3.2: The rate of suicide in countries will be reduced by 10%
Objective 4: **To strengthen information systems, evidence and research for mental health**	**Target 4:** 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems

Indicators to measure the process to achieve the targets of the action plan

Indicators were established for each objective in order to measure progress towards the targets [19]. Below, we provide a global view of the indicators. Tables including all the indicators are provided in Appendix 1.

For the targets 1.1 and 1.2 (objective 1), the indicator is “Does it exist in my country a national policy or plan and/or a law for mental health?”

Additionally to this general indicator, secondary indicators are: “Does that policy/plan and/or laws respect the following items?”

- To promote transition towards community-based mental health services?
- To respect human rights of people with mental disorders?
- To promote a full range of services and supports to enable people to live independently and be included in community?
- To promote a recovery approach to mental health care?

For the target 2 (objective 2), the indicator is: “What is the proportion of persons with a severe mental disorder who are using services (%)?”

In addition, 9 other proxy indicators for the target 2 were also suggested in the WHO Mental Health Atlas 2017[19] in order to help countries to evaluate themselves:

- What is the number and proportion of persons with a severe mental disorder who received mental health care in the last year in my country?
- What is the health expenditure on mental health in my country?
- What are the number of mental health workers in my country? The type of mental health workforce identified by the WHO go beyond the classical definition of mental health professionals. It includes psychiatrists, child psychiatrists, other specialist doctors, nurses (e.g.psychiatric nurse); psychologists, social workers, occupational therapists, speech therapists, and other paid mental health workers.
- What are the number and proportion of general health care staff trained in mental health in my country?
- What are the number and type of formal collaborations with other departments, services and sectors, including service users and family or caregiver advocacy groups? The formal collaborations suggested by the WHO is very broad and diverse: Service users/family/caregiver advocacy groups; Traditional/indigenous healers; Faith based organizations/institutions; Professional associations; Private sector organisations; International NGOs; Local NGOs; Academic sector/institutions; Media sector; Employment sector; Housing sector; Ministry of the interior/home affairs; Ministry of education; Ministry of justice; and Ministry of social affairs/social welfare.
- What is the number of mental health care facilities at different levels of service delivery in my country?
- What are the number and proportion of admissions for severe mental disorders to inpatient mental health facilities that a) exceed one year and b) are involuntary?
- What is the proportion of persons with a severe mental disorder discharged from a mental or general hospital in the last year who were followed up within one month by community-based health services ?
- What is the number of persons with a severe mental disorder who receive disability payments or income support?

For the targets 3.1 and 3.2 (objective 3), there is two indicators: “Does it exist functioning programmes of prevention and promotion in mental health (universal and targeting vulnerable groups)?” and “What is the number of suicide deaths per year?” The different types of programmes concerns: (i). mental health awareness/anti-stigma/human rights protection; (ii) suicide prevention, (iii) violence prevention, (iv) early childhood development/stimulation, (v) parental/maternal mental health promotion, (vi) school-based mental health promotion, and (vii) workplace mental health promotion. As shown by the second indicator, suicide prevention receives a particular attention.

For the target 4 (objective 4), the indicator is: "Does it exist a core set of mental health indicators routinely collected and reported every two years in my country?". Example of indicators which can be included in the core set: training and human resource levels, availability of psychotropic medicines and admissions to hospitals.

Factors that cause barriers or are facilitators to the implementation

According to article 14 of the WHO action plan, "health systems have not yet responded to the burden of mental disorders"[15]. Worldwide, the gap between the need for treatment and its provision is large. In high-income countries, 35 to 50% of people with severe mental disorders receive no treatment. This percentage is even worse in low and middle income countries. Spending on mental health is less than US$2 per person a year with 67% of the financial resources allocated to stand-alone mental hospitals. Redirecting this funding towards community-based services including general health care settings would allow better and more cost-effective interventions[15].

"The limited number of medicines and the lack of trained personnel to deliver non-pharmacologic interventions represent barriers to appropriate care for people with mental disorders", as explained in the article 17 of the WHO action plan[15].

"The roles of the different stakeholders are often overlapping across the areas of governance; care services; promotion and prevention; and information, evidence and research. The assessment of the needs and capacity of the different stakeholders/partners is essential to clarify the roles and actions of each other" [15].

"Knowledge, information and technical tools are necessary but not sufficient", according to the article 19 of the WHO action plan. Strong leadership, enhanced partnerships among leaders and the commitment of resources towards implementation are also required in order to move from evidence to action and evaluation[15].

In general, the coordination of mental health services with actors within and beyond the health sector is challenging. The multi-sectoral approach of the WHO action plan asks to organise partnership with stakeholders from all relevant sectors including users, families and carers. The involvement of those stakeholders has to occur in the development and implementation of policies, laws and services in the domains of promotion, prevention, treatment and rehabilitation. The sectors that should be involved are health, education, employment, justice, housing and social wellbeing[15].

Suggested actions to obtain the four objectives in accordance with the six principles of the WHO action plan

The WHO action plan 2013-2020 [15] suggests a large list of actions with options for implementations. These actions are listed in Table 44, available in the Appendix 2 of Chapter 4. For each suggested action, some to all of the 6 above-described principles are included (universal health coverage, human rights, evidence-based practice, life course approach, multi-sectoral approach and empowerment of persons with mental disorders and psychosocial disabilities).

3.2 WHO/Europe Action Plan 2013-2020

In 2015, the WHO Regional Office for Europe (WHO/Europe) published the European Action Plan 2013-2020[8]. Member states, experts, leading actors and non-governmental organizations participated to develop this plan which covers mental health and mental health problems across life-course except for substance use disorders[8].

The WHO/Europe insists on the fact that the WHO/Europe Action Plan[8] is interdependent and integrated with other WHO strategies and policies as the European policy framework for health and wellbeing (Health2020) [16]) and the European strategies for the prevention and control of non-communicable diseases[20].

The main **challenges** about mental health common to European member states of the WHO/Europe are[8]:

- To maintain the wellbeing of the European population
- To achieve higher confidence in the care through safe, acceptable and effective treatment by competent workforce.

- To highlight the need for improvement, innovation and change.
- To organise care and treatment in local settings, expending the role of primary care givers in partnership with multidisciplinary mental health staff.
- To avoid large mental hospitals which can lead to neglect and institutionalisation.
- To increase the knowledge and the awareness on the interaction between mental and physical health.
- To guarantee access to care of good quality.
- To commit with the rights and empowerment of services users and their family.

The WHO/Europe action plan decides to address European mental health issues according to the **values** of fairness, empowerment, safety and effectiveness. Seven objectives were set up in relation with several outcomes (see Table 7). For each objectives, systemic and coherent actions were also suggested to European countries (see Table 45 in the appendix 3 of Chapter 4). Each country is invited to prioritise its actions according to its population's needs[8].

Table 7 – Objectives and outcomes of the WHO/Europe action plan 2013-2020[8]

Objectives	*Outcomes*
Objective 1. Everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk	• (a) raised **awareness of mental well-being** and factors that support well-being in lifestyles, in the family, at work, in schools and kindergartens, in the community and in wider society; • (b) increased **support for mental health needs in antenatal and postnatal care**, including screening for domestic violence and alcohol abuse; • (c) increased **capacity in primary care** to enhance mental health promotion, prevention and early recognition of mental disorders and low-threshold psychological support; • (d) increased **return to work** of people with mental health conditions; • (e) **reduced suicide rates** among the population as a whole and in subgroups related to age, sex, ethnicity and other vulnerable groups; and • (f) agreed and implemented means of **measuring well-being** and the determinants of well-being **(in addition to measure mental disorder**) throughout the life-course.
Objective 2. People with mental health problems are citizens whose human rights are fully valued, respected and promoted	• (a) all human rights are guaranteed and **protection against discrimination** is safeguarded for people with mental health problems; • (b) opportunities associated with full citizenship, including **employment, housing and education for people with mental health problems are equal to those of other people**, taking into account adjustments required to compensate for any disability; and • (c) people subjected to involuntary care and/or treatment have **access to free information and legal advice**.
Objective 3. Mental health services are accessible, competent and affordable,	• (a) mental health services are organized in order to **facilitate a (normal) life in society** and comprise a spectrum of care, **integrating specialist mental health and generic services**;

available in the community according to need	• (b) **primary care can ensure correct** early diagnosis, treatment and referral for people with mental disorders; • (c) community-based mental health services are **accessible to all groups** in the population; • (d) **large institutions**, associated with neglect and abuse, **are closed**; • (e) **hospital care is therapeutic**, offering a range of treatment, care and support tailored to individual needs, **rather than simply confining patients**; • (f) mental health services are provided in **decent settings**; • (g) mental health services offer **appropriate care** for different age groups; • (h) **family** capacity and needs are **assessed** periodically, and training **and support** provided; • (i) a **multidisciplinary workforce** is available in sufficient numbers; and • (j) mental health services can be accessed **without unfair financial barriers**.
Objective 4. People are entitled to respectful, safe and effective treatment	• (a) all mental health **treatments**, whether medical, social or psychological are therapeutic, and **respect the dignity and preferences of the** service **users** and, where indicated, their families; • (b) **effective treatments** are made **available** on criteria of both efficiency and fairness; • (c) the **workforce** is properly qualified and **competent**, able to maintain a high morale; and • (d) international cooperation is established between governments and professional stakeholders to **benchmark training, competencies and standards of care**.
Objective 5. Health systems provide good physical and mental health care for all	• (a) people with mental health problems have a **life expectancy equal** to the age-/sex-matched general population; • (b) **access** of people with mental health problems **to physical health services** such as cardiovascular diseases, diabetes, cancer and dental care and the quality of the physical health care they receive is equal to access for the general population; and • (c) **mental health problems** in people with physical diseases are recognized and **treated adequately**.
Objective 6. Mental health systems work in well-coordinated partnership with other sectors	• (a) people with mental health problems receive the **benefits and services to which they are entitled**; • (b) patients can **access** care, including **specialized services**, through an integrated assessment procedure; • (c) funding systems offer **incentives for efficient ways of working**; and • (d) the expertise of service users and family members is used to allocate resources for their care.
Objective 7. Mental health governance and delivery are driven by good information and knowledge	• (a) **indicator** sets for outcomes are selected, **relevant to the needs** of the target audience; • (b) **quality and safety is independently inspected**, involving service users and families; • (c) **research is coordinated and disseminated internationally**; • (d) staff numbers, distribution and their causes are known; and • (e) definitions of **terminology are internationally agreed**.

In conclusion, the WHO/Europe calls on national, intergovernmental and nongovernmental organizations, including user- and family associations and professional associations, to support the implementation of this action plan. It urges member states to improve the mental health and well-being of their entire population and reduce the burden of mental disorders; to respect the rights of people with mental health problems, promote their social inclusion and offer equitable opportunities to attain the highest quality of life; and to strengthen or establish access to and appropriate use of safe, competent, affordable, effective and community-based mental health services[8].

3.3 Framework for action on mental health and wellbeing 2016

Under its 3rd EU Health Programme (2013-2016), the European Commission (EC) launched a joint action on mental health and wellbeing (JA MH-WB), and mandates the NOVA medical School of Lisbon to coordinate the writing of a framework for action and to collect good practices among Member States (MS). It involved 25 MS as well as Iceland and Norway. One Belgian organization took part of it: the Federal Public Service Health, Food Chain Safety and Environment. The objective of the JA MH-WB was to contribute to the promotion of mental health and wellbeing, the prevention of mental disorders and the improvement of care and social inclusion of people with mental disorders in Europe. But its main purpose was to build a framework for action in mental health policy at the European level[9].

The European Framework for Action on Mental Health and Well-being constructed by the JA MH-WB.

The framework for action is based on the policy recommendations developed by the JA MH-WB in collaboration with EU agencies, the WHO and other international organizations[9]. Although addressing the mental health issues were primarily the responsibility of MS, a common European framework for action can provide orientation based on best European knowledge and evidence. As such, the framework for action aims to improve the effectiveness of mental health policies implementation in EU and MS. However, it is important to highlight that the framework for action is not complete as it only addresses the five areas on which the JA MH-WB had worked (Promoting the integration of mental health in all policies; Promoting mental health at the workplaces; Promoting mental health in schools; Promoting action against depression and suicide, and promoting the implementation of e-health approaches; Developing community-based and socially inclusive mental health care for people with severe mental disorders). It therefore leaves out several further aspects in mental health, such as mental health during infancy or in the elderly. The objectives and actions suggested in the Framework for action on MH and WB are listed in Table 46 in the appendix 4 of Chapter 4. The objectives are the following:

- Ensure the setup of **sustainable and effective implementation of policies** contributing to promotion of mental health and the prevention and treatment of mental disorders. An example of action related to this objective is: “*Allocate the resources commensurate with the real needs of the populations*”

- Develop **mental health promotion and prevention and early intervention** programmes, through integration of mental health in all policies and multi-sectoral cooperation. An example of action related to this objective is: “*Take action against depression*”

- Ensure the **transition to comprehensive mental health treatment and care of high quality in the community** that is accessible to all, emphasizing the availability of mental health care for people with mental disorders, coordination of health and social care for people with more severe mental disorders as well as integrated care for mental and physical disorders. An example of action related to this objective is: *“Put in place community-based and socially inclusive mental health care, through well-coordinated primary care, specialised mental health services and social services”*

- Strengthen **knowledge, the evidence base and good practices** sharing in mental health An example of action related to this objective is: *“Collect data on coverage and outcomes of evidence-based interventions to treat mental disorders, prevent mental disorders and promote mental health”*

- **Partnering** for progress An example of action related to this objective is: *"Empower users of mental health services as partners in all steps of mental health policy and its implementation"*

The MS and EU were invited to first, take note of the recommendations in the European framework for actions, second, to implement them in line with their specific needs and resources, and third, share information about these implementation activities and good practices[9]. MS could consider the following examples of implementation activities[9]:

1. Reviewing whether their mental health policy framework and mental health legislation are in line with international obligations and taking steps to ensure this, where necessary;
2. Preparing a report on the mental health of the population and relevant policy activities;
3. Creating, where necessary, structures for and organisation of at least one coordination meeting per year involving health and further relevant policy areas, in line with the principle of "mental health in all policies";
4. Strengthening action, in line with specific needs and resources in MS, in at least one of the identified policy recommendations of each of the five fields covered by the action framework.

In order to create a mechanism for the dissemination of the recommendations resulting from the Joint Action and to promote the exchange of information on implementation activities and good practices in MS, the EC has put in place the EU Compass for Action on Mental Health and Well-being which is a web-based mechanism used to collect, exchange and analyse information on policy and stakeholder activities in mental health.[21]

3.4 Sustainable Development Goals of the United Nations and the Convention on the Rights of Persons with Disabilities

United Nation developed the Sustainable Development Goals (SDG) to achieve a better and more sustainable future for all. It is planned that all SDG have to be done by 2030. The SDG 3 targets a good health and wellbeing for all at all ages. (https://www.un.org/sustainabledevelopment/health/; last access 25/04/2019) Among the numerous efforts that are needed to be done to address many different persistent and emerging health issues, the target 3.4. specifically stipulates that by 2030, premature mortality from non-communicable diseases must be reduced by one third through prevention and treatment and through promotion of mental health and well-being. The indicator that countries should use to evaluate their progress to the target about mental health is the suicide mortality rate. (https://sustainabledevelopment.un.org/sdg3; last access 25/04/2019)

The UN also adopted the Convention on the Rights of Persons with Disabilities and its Optional Protocol (A/RES/61/106) on 13 December 2006 in New York. The Convention entered into force on 3 May 2008.[22]. It stipulates that "Persons with disabilities include those who have long-term physical, **mental**, intellectual or sensory **impairments** which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[12]

The EU MS and the EU as a whole have signed the UN Convention on the Rights of Persons with Disabilities, which guarantees to people with long-standing mental disorders important rights. Yet, in many places these rights were not fully implemented and people has to face stigma and discrimination[9].

The Convention is intended as a human rights instrument with an explicit social development dimension. It adopts a broad categorization of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms.[22].

In conclusion, some major concepts are shared by the different organizations (WHO, WHO/Europe, EU, UN). When a comparison is made between the principles or objectives of each, themes as community-based care, users' empowerment, multi-sectoral approach of mental health care and promotion of human rights are present overall. An "all stages of life" approach, a quality-based approach supported by evidence and good practices, and a universal coverage are also highlighted among the principles and objectives of the frameworks. Some concepts are not expressed by all organizations but at least by two: (i) the effectiveness of governance in MHC, (ii) a good accessibility and availability of MHC, (iii) an effective prevention and promotion of MH, (iv) MHC which are comprehensive, (v) a good coordination of MHC with the healthcare system, (vi) a recovery-oriented vision, (vii) a socially-inclusive approach fighting stigmatization and discrimination, and (viii) the necessity of data collection to improve MHC system.

3.5 OECD evaluation of the impact of mental health illness in OECD countries

In 2013, the Organisation for Economic Cooperation and Development (OECD) analysed the social and economic impact of the burden of mental health illness in the OECD countries [23]. This report highlighted that "making mental health count" has to be a priority for all OECD countries. [23] In general, they concluded that the current weak state of mental health in most OECD countries health systems is not acceptable. The report addresses the high cost of mental illness, weaknesses and innovative developments in the organisation of care, changes and future directions for the mental health workforce, the need to develop better indicators for mental health care and quality, and tools for better governance of the mental health system[24]. The report also argues that there is still a long way to go to make community-based mental health care that achieves good outcomes for people with severe mental illness without losing the focus on people with mild-to-moderate mental illnesses [24]. The OECD provided recommendations for all OECD countries which are listed hereunder: [23]

Better measurement of mental health and mental health systems is needed

- Improving the mental health of the population and mental health systems depends upon good information about mental wellbeing and the prevalence of mental ill-health.
- There is a need for better internationally comparable cost data and better data on spending outside of hospitals.

Evidence-based treatments should be scaled-up

- Increased use of innovative evidence-based treatments, such as psychological therapies and eMental Health will help address the treatment gap for mild-to-moderate disorders.
- Scaling-up effective treatments can represent good value-for-money, as the economic benefits of spending on better mental health care will be seen in increasing productivity and helping people with mental illness go back to work.
- Countries must ensure that treatment efficacy drives decisions about which services to put in place, rather than historical or social trends in the mental health care sector.

The primary care sector can play a bigger role in securing better mental health

- Care for mild-to-moderate disorders in primary care should be strengthened through training for primary care practitioners, promoting collaboration between primary care and specialist services, putting in place primary care-appropriate clinical guidelines, and using financial incentives to promote care provision.
- A stronger co-ordinating role for primary care is a key way that OECD countries should look to deliver more integrated care for severe mental illness.

Provider incentives should be aligned with desired outcomes

- Conceptual frameworks and measurement tools are needed to define good outcomes for mental health care, and should be used to track and benchmark services.
- Data should be used as part of provider contracts and payment systems, to define policy, and to monitor targets.
- Provider payment systems that encourage desirable provider behaviour and good outcomes should be used much more widely.

4 STATUS OF BELGIUM IN THE DIFFERENT SURVEYS ORGANISED BY INTERNATIONAL ORGANISATIONS

Mental health ATLAS 2017-Belgium profile is a summary of the data collected by the WHO in the frame of the second ATLAS survey on mental health which evaluates the indicators defined in 2013 in the WHO mental health action plan.[25] The summary of the data are available in Table 47 in the appendix 6 of Chapter 4. In short, Belgium mental health system governance gives satisfaction by the existence of mental health policy, specific legislation, and inspections of facilities. The multi-sectoral collaboration is also stipulates with service users and family or caregiver advocacy groups. Concerning mental health financing, while no total expenditure on mental health is reported, the inclusion of mental health care and treatment in the national health insurance is well recognised. The evaluation of human resources in mental health is partial because it only concerns formal mental health care professionals (psychiatrists, psychologists…) while WHO survey includes other less classical type of mental health workers. All the required data about outpatient care were lacking while pretty much all required data on inpatient care were given as total inpatients facilities, number of beds, annual admissions (voluntary and involuntary), and length of stay. The data about follow-up after hospital discharge and the number of severe mental disorder treated cases were, however, missing. [25]

EU compass group published the **good practices** among MS every year on a specific theme. In 2018, the EU compass focuses its attention on the theme “community-based mental health service”.[26, 27] The mental health care delivery system reform in Belgium was chosen to be described as an example of good practice. A summary of the reform is presented including barriers, facilitators and advices for other member states interested in this type of practice. The involvement of users and relatives is seen as a facilitator as well as a bottom-up approach. Barriers seem to be related to the slowness of the change which has to be seen in a long term vision, notably changes on network practices and consultation with users; and to the complementary financing from psychiatric hospitals of the community-based mental health care. [26]

UN 2017 voluntary national review of the high-level political forum on sustainable development give a general overview on the health and wellbeing status of the Belgian population. Concerning mental healthcare, Belgian authorities report in the UN review that Belgium has shifted from traditional, large psychiatric institutions to a modern, inclusive care system with increased focus on the community. Multidisciplinary outreach teams provide care to people with mental health problems, avoiding hospitalisations. This initiative allows the user to choose where they wish receive treatment and care. Belgian authorities also report that the capacity of specialized centres and the access to conventional care for internees are now facilitated through the recent Federal Masterplan on internment. [28]

OECD Better Life index ranks Belgium above average in work-life balance and in subjective wellbeing and health. (http://www.oecdbetterlifeindex.org/countries/belgium/; last access 25/04/2019) Belgians give a 6.9 on 10 on the scale about general satisfaction with life while the OECD average is 6.5.

OECD Health Policy Overview: health policy in Belgium is a short report published in 2016 and which highlights the main topics which have to be cared in Belgium as reducing inequality in access to health care services; promoting appropriate clinical practice; tackling behavioural risk factors; and making mental health count. Two major points are brought to the attention of the readers about mental health. [29]:

- Severe and moderate mental ill-health affect one in five young (15-24y) people in Belgium
- Belgium has a high rate of suicides, ranking at the fifth place of OECD countries

To handle those tricky points, OECD suggests to improve data collection to track quality of mental health treatment and to align payment incentives at primary care and inpatient levels to encourage good mental health care. [29]

5 THE BELGIAN ART 107 REFORM PRINCIPLES IN THE LIGHT OF SOME OF THE INTERNATIONAL FRAMEWORKS

The art 107 reform on mental health care organisation allows, since 2010 in Belgium, the financing of experimental projects to realise networks and care circuits derived from hospitals budget. The aim of the reform is to orient mental health care towards a reduction of residential hospital care in favour of recovery and reintegration treatment in the community. In order to attaint this global objective, five core foundations (i.e. deinstitutionalisation, inclusion, decategorisation, intensification, and consolidation) must be developed.[30] Interestingly, some concept common to the different international frameworks are also shared by the art 107 reform on MHC organisation as a community care approach, a recovery-oriented approach and a socially inclusive approach, which are, for example, literally expressed in the EU framework. The similarities of concepts between international frameworks principles and/or objectives and the core foundations are illustrated in the Table 8 hereunder.

Table 8 – comparison between the core elements of the art 107 reform and the objectives of international frameworks

Art 107 reform core foundations	WHO	WHO/Europe	EU framework	UN
Desinstitutionalisation	Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	Objective 3. Mental health services are accessible, competent and affordable, available in the community according to need	Objective 3: Ensure the transition to comprehensive mental health treatment and care of high quality in the community that is accessible to all, emphasizing the availability of mental health care for people with mental disorders, coordination of health and social care for people with more severe mental disorders as well as integrated care for mental and physical disorders	
Inclusion		Objective 2. People with mental health problems are citizens whose human rights are fully valued, respected and promoted		Persons with disabilities include those who have long-term physical, **mental**, intellectual or sensory **impairments** which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others
Decategorisation	Principle 5: multisectoral approach	Objective 6. Mental health systems work in well-coordinated partnership with other sectors	Objective 2: Develop mental health promotion and prevention and early intervention programmes, through integration of mental health in all policies and multi-sectoral cooperation	
Intensification				
Consolidation				

In addition to the federal art 107 reform, the Flemish plan on mental health care shows also a good adequacy with international frameworks as it highlights the empowerment of patients through experiential peers involvement; destigmatisation, comprehensive and integrated MHC with high level of inter-professional collaborations, the multi-sectorial approach, and accessible and affordable mental health services. And the launching of two suicide prevention plans in Flanders highly participates to meet the target 3.1. of the WHO objectives for 2020.

Limitations

Following the decision taken on the scope of this study, not all the international frameworks for mental health service organization are described but only the more general, comprehensive and actual ones.

Due to the fragmentation and recent redistribution of the competences about mental health service organisation among the different Belgian authorities, a systematic and detailed comparison of all the actions/recommendations suggested by the different international frameworks with the current always in progress policies, legislations and action plans in Belgium is not possible.

6 KEY MESSAGES

- Several recent international frameworks for mental health service organisation exist and present quite similar objectives. The keywords the most used are empowerment, multisectoral, community-based, prevention and promotion of human rights.
- The Belgian reform on mental health organisation shares objectives with those of the international frameworks.
- The evaluation of Belgium MHC organisation to reach the objectives is currently not always possible because of a lack of data in epidemiology and services use which prevents to use several indicators set by the different international frameworks.

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CHAPTER 05 MAPPING MENTAL HEALTH CARE SERVICES IN BELGIUM

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1 LEXICON

The lexicon summarises the terms used in this report to describe the services, which may vary along context, frames of reference, authors or Region. Apart the official definitions taken as such, the others are operational definitions, based on the literature but specifically adapted for this report.

Mental Health	"state of wellbeing 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 her or his community" [1].
Mental Health Actors = Mental Health Providers	Services or professionals or institutions delivering mental health care
Accredited and funded structures	Services and/or institutions receiving formal recognition and a permanent funding.
Non-accredited funded structures	Services and/or institutions receiving a non-permanent funding, without formal recognition through accreditation.
Service	Autonomous separate entity, or care unit/department within a larger institution.
Institution	Structure (of help and/or care) composed out of several services.
Structure	General term for a service or institution.
Mental health care sector/field	Field of public health that encompasses all the modalities of care for mental health problems[2].

Mental health care (MHC)	According to Belgian legislation, any intervention delivered by a recognised mental health care professional practicing in a liberal setting or in a government accredited and funded service or institution for MHC (Arrêté royal 10/07/1990 fixant les normes d'agrément applicables aux associations d'institutions et de services psychiatriques). In this chapter, mental health care also includes any intervention delivered in any service or institution in which at least one recognised mental health professional works, except in the case of GPs' care.
Mental health problem	Every element causing a person not to be in a state of good mental health such as being defined by the WHO: "a state of wellbeing in which every individual realizes 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 her or his community". Mental health problems vary according to the symptoms, the severity, the duration and the disability they cause: (i) a level of distress, suffering or functional disability; (ii) a substantial impairment of mental functioning, of thought, mood and behaviour, as well as a severe degradation of emotional and relational capacities extending into time). The term 'mental health problem' will be used generally in this chapter. It covers the use of other terms such as psychological or psychiatric problems. However this terminology will not be used in the case of citation of definition or quotation.
Primary health care	Level of care that is the gateway to the health care system; that provides generalist, comprehensive, ongoing, integrated care accessible to the entire population; and that coordinates and integrates services required at other levels of care.
Mental health care professionals	Psychiatrists and clinical psychologists as well as remedial educationalists (Loi 10/07/2016 réglementant les professions des soins de santé mentale, last accessed 25/03/19).
Programming norms	Standards allowing to plan the offer to be developed according to pre-defined criteria.
Psychoeducation	Training for patients and their families to inform them about the psychiatric disorder they face to and to promote their abilities to cope with. Psychoeducation deals with acceptance of the disease, active cooperation in treatment and rehabilitation, acquisition of skills that compensate for deficiencies related to psychiatric problems [3].
Psychological support/help	Guidance provided by a mental health professional to support the person's ability to overcome difficulties they encounter. [4]
Psychotherapy	A form of mental health care treatment that uses, in a logical and systematic way, a coherent set of psychological interventions, which are anchored in a psychological and scientific frame of reference, and which require an interdisciplinary collaboration (Loi 10/07/2016 réglementant les professions des soins de santé mentale, last accessed 25/03/19).
Psychosocial	Related to the interaction between the psychological dimensions and the social environment.
Psychosocial professional	Every professional that is not included within the mental health professions (ex: social workers, speech therapist, psychomotor therapists, marriage and family counsellors, criminologists, etc.) that are active in the mental health sector, interacting with mental health professionals, to support the link between the psychological and the social environment (Plate-forme des Professionnels de la Santé Mentale, last accessed 26/03/19)

Psychosocial guidance/help	Intervention linking psychological dimensions and the social environment.
Related sectors	Sectors addressing diverse needs of the population (social help, employment, justice, housing...) and not mainly targeting mental health even if they can sometimes offer mental health care.
Social help	Social help as described in the law of the Public Centres for Social Action is a universal right granted in the name of human dignity by a society that considers it its duty to help the most deprived (Loi organique 08/07/1976 des centres publics d'action sociale, last accessed 26/03/19). The help provided by the OCMW/CPAS can take a variety of forms: financial help, employment, debt mediation, psychosocial help, housing, medical assistance, home care, etc.
Mental Wellbeing	General sense of fulfilment for an individual by the satisfaction of good mental health enabling the individual to achieve his or her full potential.
MHC offer	All institutions, organisations, services and professionals delivering MHC as well as involved in research or training in MHC.

2 INTRODUCTION

2.1 Context

The organisation of mental health care (MHC) was recently reformed in Belgium, targeting treatment, recovery and reintegration of adult patients with mental health problems. This chapter aims to give a clear description of the available services (including type, regional location, funding mechanisms and targeted population) in Belgium. Therefore, the main goal of this chapter, within the overarching study “Organisation of mental health care for adults in Belgium”, is to describe the current MHC offer in Belgium and how is it organised. This part of the report is carried out by “le Centre de Référence en Santé Mentale (CRéSaM)” and “de Vlaamse Vereniging voor Geestelijke Gezondheid (VVGG)”, in collaboration with the Belgian Healthcare Knowledge Centre (KCE).

2.2 History

To understand the current offer, it is useful to look at the history of the MHC organization in Belgium. The offer of MHC developed over time, in particular according to the evolution of knowledge and the perception of madness in society. Until the 1970’s, psychiatric hospitals (Psychiatrisch Ziekenhuis-PZ – Hôpital Psychiatrique-HP) were the main place of care for psychiatric problems.

In Belgium, the transition to community care began in 1975 throughout the creation of psychiatric wards in general hospitals (Psychiatrische Afdeling in een Algemeen Ziekenhuis-PAAZ – Service Psychiatrique d’Hôpital Général-SPHG). At the same time, community mental health centres (Centrum voor Geestelijke Gezondheidszorg-CGG – Service de Santé Mentale-SSM), with multidisciplinary teams, were created to provide outpatient MHC for anyone with mental health problems.

Around 1990, psychiatric hospitals were forced to lower the number of psychiatric beds. Two new care forms were developed: sheltered living (Initiatieven Beschut Wonen-IBW – Initiatives d’Habitations Protégées-IHP) and psychiatric care homes (Psychiatrisch Verzorgingstehuis-PVT – Maison de Soins Psychiatriques-MSP) [5].

In 2007, a pilot project called “the therapeutic projects” began as well as “the concertation around the psychiatric patient”. The goal was to provide integrated care by developing an integrated model of collaboration to meet the needs of patients, to ensure continuity of care and to enhance patient integration into society.

Concertation around the psychiatric patient brings together different stakeholders (from residential and ambulatory settings) from several sectors (mental health care, social help and health care), in order to better adapt the management of the patient outside the hospital [6].

Since 2010, the MHC reform was launched based on the results of the therapeutic projects and the concertation around the psychiatric patient [7]. The main goal of the reform was to encourage care in the community through the creation of regional networks and the creation of mobile teams.

The reform pursues 5 general objectives i.e. deinstitutionalisation, inclusion, decategorisation, intensification and consolidation, which every network tries to reach in order to meet the MHC needs on its territory. Each network must organise itself to fulfil at least the following 5 functions [8]:

- Function 1: prevention activities, promotion of MHC, early detection, screening and diagnosis
- Function 2: intensive outpatient treatment teams, both for acute psychological problems (2a) and chronic problems (2b)
- Function 3: rehabilitation teams working at the reintegration and social inclusion
- Function 4: intensive residential treatment units, both for acute and chronic psychological problems, when a hospitalisation is essential
- Function 5: specific residential formulas allowing the provision of care when the organisation of the necessary care at home or in a substitutable home is impossible

As a continuation of the reform of MHC for the adults, the Inter-ministerial Conference on Public Health (Interministeriële Conferentie Volksgezondheid-IMC – Conférence Interministérielle Santé Publique-CIM) of the 10th December 2012 validated the "Joint Declaration for the Implementation of MHC Networks and Circuits for Children and Adolescents ", the starting point for a new mental health policy in children and adolescents. More recently, in November 2018, all competent ministers signed a joint declaration for the realization of a new mental health policy for the elderly in Belgium [9].

2.3 Boundaries of Mental Health Care

In order to define the MHC offer in Belgium we will first define what are mental health and mental health problems. Those definitions also contribute to the identification of MHC providers.

According to the definition of the WHO, **mental health** is “a state of wellbeing 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 her or his community” [1]. This definition of mental health is not limited to the absence of pathology or disease and integrates the notion of wellbeing. As wellbeing is a general sense of fulfilment by the satisfaction of good physical and/or mental health enabling to achieve his or her full potential, this induces a more positive and large vision on mental health and on what a mental health problem can be.

Every element causing a person not to be in a state of good mental health is considered as a **mental health problem**. Mental health problems vary according to symptoms, severity, duration and the disability they cause. The term ‘mental health problem’ in this chapter covers the use of other terms such as psychological or psychiatric problems/diseases/disorders.

According to the law, **mental health care** (MHC) is any intervention delivered by a recognised mental health professional practicing in a liberal setting or in a government accredited and funded service or institution for MHC (Royal Decree 10/0/1990 Arrêté royal fixant les normes d'agrément des initiatives d'habitation protégée pour des patients psychiatrique, last accessed 26/03/2019). However, the aforementioned WHO definition of mental health and the most recent reform of the Belgian MHC sector implies a broader consideration of the services categories involved in MHC, allowing to describe the **mental health offer**. One of the recommendations of the WHO is that "*national mental health policies should not limit their scope to mental disorders. They also need to recognise and take into account the broader factors that promote mental health. This includes integrating mental health promotion into public and private sector policies and programs. In addition to the health sector, the following sectors should also be involved: education, employment, justice, transport, environment, housing and social protection*" (WHO Mental health: a state of well-being, last accessed 26/03/19) [1].So it goes well beyond the official categories of the mental health sector as set out in the Royal Decree of 1990 (http://www.ejustice.just.fgov.be/eli/arrete/1990/07/10/1990022335/justel, last accessed 27/03/19) on consultation platforms in mental health, namely psychiatric hospitals, general hospital psychiatric services, sheltered housing initiatives, psychiatric care homes and mental health services to which were subsequently added the national institute of health insurance (RIZIV/INAMI) accredited centres.

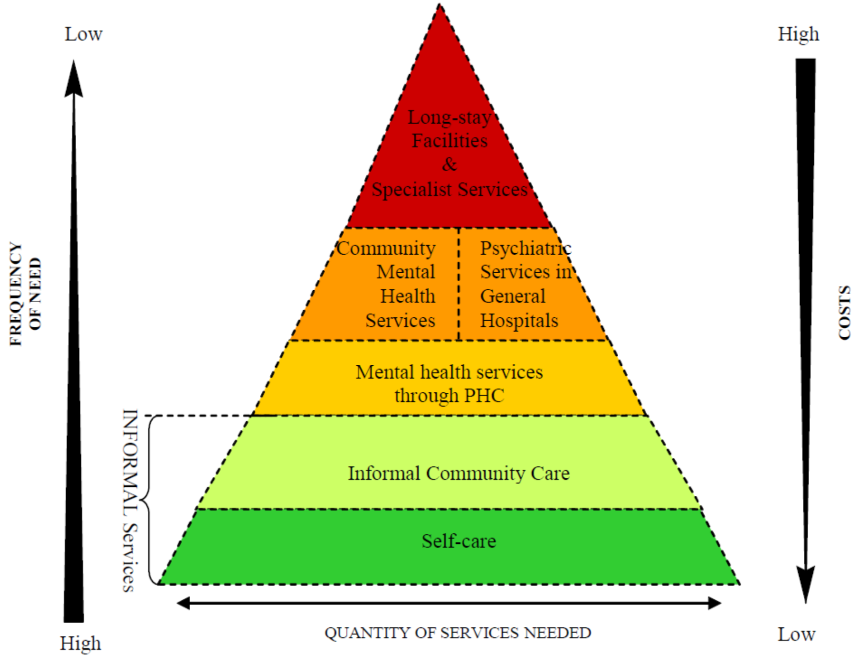
In this chapter on the description of the care offer, the following providers were added to the official categories defined by the law:

- a set of actors in the field of mental health, particularly located in primary health care (PHC);
- a set of actors such as associations of users and relatives located in informal community care;
- a set of actors related to other sectors (such as welfare sector, handicap sector, employment, housing …) who can offer, in some extent, a MHC mission or intervention;
- a set of actors, identified through the review of the partner list of the Psy107 networks, that does not provide MHC but who play a role in reintegration.

The WHO proposes a “Service Organisation Pyramid for an Optimal Mix of Services for Mental Health" (Figure 22), presenting a model of an ideal distribution of services in a MHC offer. The more general and less expensive services are found in larger proportion at the base of the care system, while the more specialised and expensive services are found in smaller proportion at the top of the MHC system (the cost are related to the society, not to the patient). In the pyramid, the different levels are:

- Self-care level which includes all the actions taken in our life to achieve a good mental health, by himself or with the help of family or friends. This point will not be developed in this report.
- Informal community care level which includes services provided in the society that are not part of the 'formal' health and welfare sector but contributes to prevent people from needing care at a higher level of the pyramid. It groups services in different sectors such as the police, schools, non-governmental associations, and user and family associations.
- Mental health through Primary Health Care (PHC) level which groups all the attentions given to mental health issues into primary health care services for early detection of mental disorders, management of stable psychiatric patients etc. It increases the accessibility of the MHC sector and offers a holistic vision of mental health and somatic health.
- Community mental health services and psychiatric services in general hospitals level which also includes "formal" services dedicated to mental health such as day centres, rehabilitation services, mobiles crises team, therapeutic and residential supervised services etc.
- Long stay facilities and specialist services level which includes services that offer specialized MHC in a residential setting over a long care period.

Figure 22 – WHO Service Organisation Pyramid for an Optimal Mix of Services for Mental Health [10]



This chapter follows, on the one hand, the principles proposed by the WHO with its definition of mental health and the pyramid for an optimal mix of services, and, on the other hand, the principles suggested through the Psy107 reform and the vision of integrated care in the community this reform proposes.

3 METHOD

3.1 Type of data and structure of their description

Data was collected to describe the MHC sector and more specifically the organisation of MHC at the different belgian governmental levels.The description of the MHC offer is given by level and region.

The term « service » is mainly used. This term refers to a unit, corresponding to an autonomous entity that can be determined by legal framework.

The term « institution » is used mainly to refer to hospitals, so as to distinguish it from the services provided within each hospital. The term is used as well to refer to penal institutions.

3.1.1 Distribution of services/institutions by levels

The structure of the presentation of the services and institutions offering MHC is inspired by the WHO pyramid (see Figure 22). However, the pyramid comes from the health sector and does not always take into account other sectors that, as already discussed in the previous section, sometimes can offer MHC or that target people with mental health issues. For this reason, some services obtained from related sectors that partly have a mental healthcare objective were added in the level « Mental health through PHC »

An exception is relevant for certain justice sector services, of which the main objective is mental healthcare. These services have been classified in the corresponding levels of the pyramid.

The services/institutions distributed across the 4 upper levels of the pyramid will be presented in the section 3:

- Informal community care level;
- Mental health trough PHC and “MHC in related sectors” level
- Community mental health services and psychiatric services in general hospital level
- Long stay facilities and specialised services level

3.1.2 Regions

Each service category will also be described by Region. Since 1975, Belgium has been in the process of transferring authority from the federal government to the regional governments (Brussels, Flanders, and Wallonia). Over the years, education, culture and health have become totally or partially under federated authority and the Regions have developed their own policies on these matters. Gradually, the organisation and funding have evolved differently according to the Regions. Therefore, the data are presented by Regions. An overview of the competent authorities for the different categories can be found further in Table 15.

3.1.3 Data

The data about services and institutions active in the field of mental health were collected, according to their availability, on the basis of the following items:

- **Description** of the function (outpatient or residential, target public, type of care, type of professionals)
- **Competent authorities** (for the agreement and the funding)
- Summary of the available **quantitative data** (budget, full time job equivalent (FTE), number of services, number of users, care capacity, duration of the treatment, etc.)

In certain cases, additional data specific to certain categories of services or regions are given in the annexes. As appropriate, the presentation will specify possible categories and sub-categories of services (e.g. in psychiatric hospital) and their relationship to each other.

3.1.4 *Overview of the situation*

Different tables will then summarise the data collected as follows:

- Service categories according to their function within the Psy107 networks.
- Distribution of the offer according to the regions and the competent authorities.
- Distribution of the offer according to the global budget, number of services and treated population.

3.1.5 *Associations and networks involved in mental health*

An overview of the various networks and associations with their role (organisation, consultation, reflection, etc.) in the MHC sector will be given.

3.1.6 *Transfer of competences*

This section describes the competences with regard to mental health that have been transferred to the regional authorities by the sixth state reform. It contains the available information related to the future management of these competences.

3.2 Scope (and limits of the scope)

3.2.1 *Scope*

This part of the study provides an overview of the offer of MHC for adults**,** structured around the different levels in the organisation of offer as illustrated by the WHO pyramid.

3.2.2 *Limitations*

It does not provide a full coverage of offers of MHC for children and adolescents, although there might be overlaps between services and institutions for young people and those for adults. The mobile teams for children and teenagers, set up within the framework of the new policy, are described, as well as the helplines for young people, the SOS Children's teams and the Trust centres for Children abuse, which can give support to adults close to children in difficulties.

Neither is the issue of prevention or mental health promotion, even if some of the services, in addition to assistance and care missions, also play a role in prevention and promotion. In the case where services have clearly stated preventive missions, these will be mentioned but not described.

According to lack of data, the scope of the study does not include information on the needs of users, their trajectory within the MHC system, the adequacy between needs and use or the adequacy between needs and offer.

The study is limited to categories of services or institutions and is therefore not a directory of all the services present on Belgian territory, nor of the particularities of each service.

While networks and platforms are addressed in this report, particularly the networks formalised as part of MHC reform, it was not assessed how they operate or how services interact with each other across networks. The Psy107 partner lists have been extracted from the activity reports to complete the overview of the offer but no detailed analysis of these networks nor their state of progress were given.

The financial contribution of patients could not be investigated in this chapter. This aspect is certainly fundamental in terms of accessibility but is also very complex. Several parameters should have been taken into account, in particular reimbursements by health insurances, additional insurances, the question of the third-party payer, the methods of access to free payment in certain sectors/services, the intervention of the RIZIV – INAMI, the distinction between fixed-price or fee-for-service payment systems, etc., in a context of ongoing changes in legislation in this area.

The study does no go into the evaluation of the waiting lists for the different categories of services. This information is very dependent of the policy defined by each service and cannot therefore be generalized to a category.

The description of the evaluation of services by quality indicators or their designed tools was not conducted.

As the recent KCE study on "How to improve mental health care organization for the elderly" focusses on the MHC for older adults, this target group is not specifically developed in this report. For specific information, we kindly refer the reader to [11].

The description is systematically and according to the data availability organised by each competent federated entities. However, as the German-speaking Community on its behalf comprises less services, the data related to the latter have been integrated to the concerned federated entities. The tables do not always include a separate column for the German-speaking community.

3.3 Data discussion

The analysis of the data will put in perspective:

- Precaution about data collection;
- Multiplicity and diversity of the offer;
- Local and regional realities;
- Gaps in data;
- Complexity of the offer;
- Overlap;
- Accessibility;
- Residential and outpatient MHC;
- Territorial coverage;
- Partnership; and
- Collaboration between networks according to age groups.

It will also refer to:

- the organisation of the MHC system in Belgium and its evolution; and
- the pyramid of the optimal distribution of services proposed by WHO.

3.4 Sources of data

Information was collected through different sources depending on the type of service between December 2017 and June 2018.

For psychiatric hospitals, psychiatric wards in general hospitals/specialised hospitals (Psychiatrische Afdeling in een Algemeen Ziekenhuis - PAAZ – service psychiatrique d'hôpital général - SPHG), initiatives of sheltered living (Initiatieven Beschut Wonen - IBW – Initiatives Habitation Protégée - IHP), psychiatric care homes (psychiatrisch verzorgingstehuis - PVT – Maison de soins psychiatriques - MSP), information was collected through the minimal psychiatric data system (Minimale psychiatrische gegevens - MPG – Résumé Psychiatrique Minimum - RPM). The data are available at and were analysed by a partnership between the CRéSaM and the VVGG with support of KCE.

For the other services with an accreditation (regional or community services of mental healthcare or medico-social services), a request was sent to the competent authority, but the information was not always available or accessible (see Table 15 for more details) within the defined deadlines.

Moreover, when services do not receive public funding, they are not subject to mandatory data collection. In order to obtain comprehensive data, we requested the support of different associations (see below).

Data on private consultations subjected to RIZIV – INAMI reimbursment were obtained via the permanent sample (the permanent sample follow the health expenses of a representative group of the belgian population since 2002 (https://aim-ima.be/L-Echantillon-Permanent-EPS), last accessed 27/03/19) and by contacting the Intermutualistic Agency.

The support of the different “consultation platforms in mental health” (‘overlegplatforms geestelijke gezondheidszorg’ – ‘plateformes de concertation en santé mentale’) in the three Regions , as well as the support of federations or associations and the Psy107 networks was requested for all the categories of services. Contacts have been established with these various associations and federations by e-mail and telephone..

Data collection was also based on:

- official websites of the competent administrations as well as their activity reports;
- regulatory texts (decrees and laws) by sector;
- and activity reports of the networks.

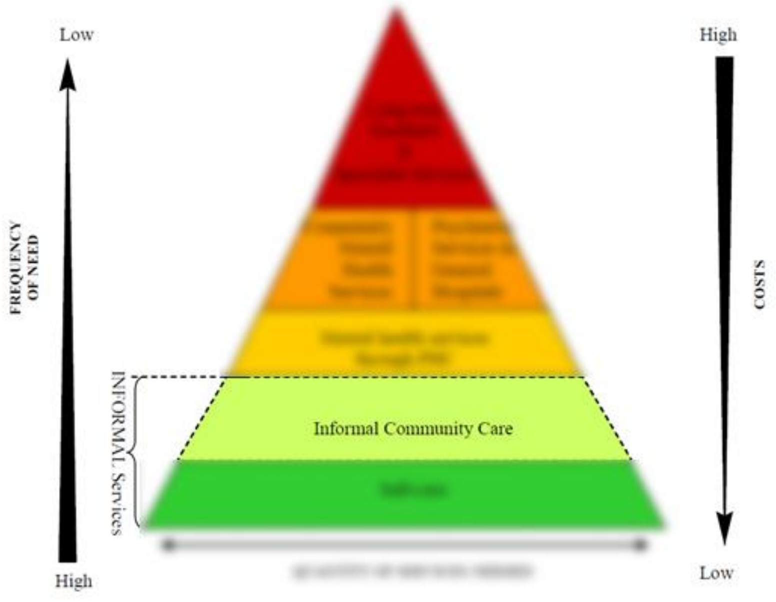
Some information was based on personal communication. These are integrated into the presentation of services and in the analysis of the data.

4 DESCRIPTION OF SERVICES CATEGORIES

This chapter describes the services according to the organisation of the WHO pyramid as stated within the methodology part. According to this pyramid, the services are presented starting with the most generalist towards the most specialised services.

4.1 Informal community care

The structures belonging to the informal community care do not deliver mental health care but contribute to mental health. In this section are described the associations for patients and their relatives (though already formalised in Belgium) and services from various societal sectors who pay special attention to persons with MH problems and which are Psy107 network partners. Besides are the non-accredited accommodation structures (Structures d’hébergement non agréées - SHNA). Often criticised, some of these dwellings nevertheless play a role in the accommodation of certain persons with mental health difficulties. These structure should be in part regulated in the future. These structures are integrated in this point as they do not specifically accommodate people with MH problems.



4.1.1 User associations and family associations

Description: The associations of mental health patients and family members of people with mental health problems are important actors for the mental health sector. Their main objective is to contribute to the well-being of patients and their relatives by setting up various projects of support, mutual help and information.

Through their federation, these associations are involved in the reorganisation of MHC in Belgium since the therapeutic projects reform and in the recent participation project with the goal to improve family and user representation in the MHC sector and at the political level [12, 13]. Within the framework of MHC reform for adults, the participation project provides recommendations based on the patients and families vision about the organisation and the functioning of the networks.

Competent authority and funding: the federations of patient associations and the association of relatives receive a federal and regional funding (as an optional funding). They are not recognised as such within the framework of a decree or a law.

Numbers: through their implication in the participation project, the patient association UilenSpiegel (patient association – Flanders) and patient associations' federation Psytoyens (federation of patient associations – Wallonia and Brussels) gather initiatives all over the country via a survey in 2017. The results shows that there were, in 2017, more than 15 patient associations and that these associations organise various types of activities. For example, they organize more than 25 patients talk groups [13].

The association of relatives "Similes" deploys various sections in the 3 Regions (10 in Wallonia, 2 in Brussels, 20 in Flanders) proposing in particular talk groups of relatives and training courses (psycho-education).

In 2018, the Psy107 networks had as well set up 7 patient councils (6 in Wallonia, 1 in Flanders), 9 councils of relatives (2 in Flanders, 7 in Wallonia), 2 patient-relative councils (1 in Wallonia, 1 in Brussels) [13].

4.1.2 Society

4.1.2.1 Psy107 network partners:

This section is based on the analysis of (Psy107 reform) network partners as mentioned in the annual reports of the different Psy107 networks. The data covers 20 of the 23 existing networks (7 in Wallonia, 1 in Brussels, including the 4 antennas, 12 in Flanders). The analysis that has been realised is relatively brief, as the goal of this chapter is not to develop a detailed description of each network. The data give an idea of the way in which the various domains of society are concerned about mental health issues.

Description: Many partners from various sectors are involved in the 5 aforementioned functions of the Psy107 networks. This high number of diverse services encompasses society as a whole. Within each sector, few services offer MHC. Those services will be described later in the chapter.

However, in this section are described the services from these sectors which pay a specific attention to the people with mental health problems without delivering care. These are listed here below, grouped by sectors when appropriate:

- social sector: various services as home assistance or services specifically for migrants of the Public Centre for social welfare (OCMW - Openbaar centrum voor maatschappelijk welzijn – CPAS -Centres publics d'action sociale)
- disabled sector: integration assistance services, day care services, …;
- health and health promotion: health care insurance (RIZIV-INAMI), « Lokale Multidisciplinaire Netwerken » (LMN),
- help to people: coordination of home assistance (Coordination de soins à domicile-thuiszorg coordinatië), nursing homes (WZC-MRS) …;
- housing: companies of social housing, …;
- employment: the organisation of work-based learning, the public services responsible of training and employment (ONEM, FOREM, Actiris, VDAB, RVA)…;
- help to youngsters / childhood sector;
- education and lifelong learning;
- justice and police;
- culture;
- local authorities: cities, municipalities and provinces;
- the competent authorities in the various sectors;
- the non-profit sector;
- well-being in general.

Number: Over 160 services, institutions, or professionals are Psy107 networks partners. Their involvement as network partner shows at least the importance these services may have in dealing with mental health issues and refers to the fact that society as a whole contributes or may contribute to the mental health of the population (even if it is difficult to have a precise idea of the type of collaborations organised between these partners and mental health care providers).

4.1.2.2 Societal services with straight ties to MHC but not Psy107 partners:

There exist as well a significant number of services coming from sectors related to mental health, or belonging to the non-profit sector or to local authorities (cities and municipalities) which are not formally partners of the Psy107 networks (no signed convention) but which develop projects, initiatives, … with straight ties to MHC. These projects are often very local, so it is not possible to provide a global overview of them. Different kind of actions are undertaken and group:

- providing information through website, magazine, info sessions, or a community healthguide.
- providing (financial) support
- giving attention to the prevention of psychological problems and the recognition of psychological problems, making psychological problems negotiable, and referring persons with psychological problems (e.g. by education of employees of social services and projects with the local government as initiator or partner).

4.1.3 Non-accredited accommodation structures

Non-accredited accommodation structures (Structures d'hébergement non agréées - SHNA) also called "pirate houses" are structures that provide housing to people with difficulties to live autonomously, some of which may have mental health problems or addiction troubles (RTBF info 14 Oct 2016, last accessed 27/03/19). The Walloon Region had mapped around 40 SHNA's in 2011, more recent information is not available. Around 20 SHNA's would exist in Brussels. No SHNA are found in Flanders.

The total number of persons that found housing through these structures is difficult to assess, but is estimated to around 3000 persons (Le VIF 4 April 2018, last accessed 27/03/19).

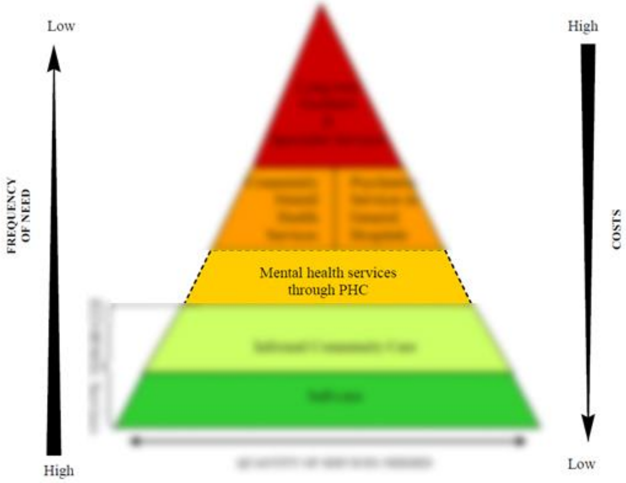
To deal with the various problems represented by these SHNA's, Wallonia has just passed a new decree that aims at inserting in the "Code wallon de l'action sociale et de la santé" a regulation related to the collective housing of persons in long-term difficulties. The text has been passed on 28 March 2018 [14] and provides minimum norms for these structures but does not assign any budget.

In Brussels, there is no discussion about a special decree to legalize this type of structure. Brussels would rather raise the amount of accredited shelter homes. The SHNA's who do not fulfil the conditions for the accreditation as shelter homes will have to close. [15]

The category « informal community care » resumes the user and family associations that are well represented, developed and partially formalised in Belgium, as well as the general services to the population (social, employment, education, housing, etc.) that are sensitive to mental health problem. These services have been identified in the Psy107 networks partner lists. In addition, SHNA's are represented in this category. Often criticised, these dwellings nevertheless play a role in the accommodation of certain persons in difficulty. Overall, a lot of services of various sectors are concerned with MH problems and have a role to play in collaboration with the services of the MHC offer.

4.2 Mental health services through primary health care and related sectors

This part of the study addresses all services that offer MHC and that are part of primary health care or of sector other than the health sector. As the pyramid represent services belonging to the mental health sector, we added a "related sector" category that groups services with a MHC offer outside of the MH sector. In a way similar to what primary health care could offer with a holistic vision of the patient, the MHC services from the related sectors provide an offer that is much diversified.



4.2.1 General practitioner

Description: Although there is currently no gatekeeping system in Belgian health care system, the general practitioner (GP) plays an important role as he is often the first contact person in case of health problems and follow up.

Competent authority and financing: The GP has to successfully complete a theoretical and practical training (including some mental health knowledge) after which he has to register to the medical council and make an accreditation request to ensure that his services are reimbursed according to the Belgian system. Article 3 of the coordinated legislation of May 10th, 2015 (http://www.ejustice.just.fgov.be/eli/loi/2015/05/10/2015A24141/justel, last accessed 27/03/19) defines the GP profession. Medical acts provided by GP are (partly) reimbursed based on nomenclature by the RIZIV – INAMI. All the reimbursed health related acts are entered in the IMA – AIM database (reimbursed medical acts, reimbursed pharmaceutical products, reimbursed acts performed during hospitalization …) [16]. Since 2015, GP have to apply the third party payment for the patient benefiting of the enhanced intervention (RIZIV/INAMI Régime du tiers payant pour médecins généralistes, last accessed 27/03/19)

Numbers: On December 31st, 2017 15 989 GPs (Flanders (n=8 982); Wallonia (n=5 428); Brussels Region (n=1 582)) were accredited[17]. About 30% of the Belgian persons suffering mental health problems is searching professional support [18, 19]) of which 30% consults a GP and 43% contacts a GP and a psychiatrist. This implies that in more than seven cases out of ten , the GP is involved in the detection, diagnosis or treatment of persons with mental health problems [20].

Medical homes

Description: Medical homes (wijkgezondheidscentra – maisons médicales) in Brussels and Wallonia consist out of a multidisciplinary team that provide primary health care and promotes health as well as prevention in a holistic approach (physical, psychological and social dimensions), to the inhabitants of a neighbourhood. They promote team working, prevention and care actions, community health, networking and observatory of health in primary care. The medical homes in Flanders share the same principles and goals.

In Wallonia, medical homes are called “integrated health association” (“associations de soins intégrés”). The multidisciplinary team encompasses at least two GPs, a nurse, a physiotherapist, and a receptionist and secretarial service (Code wallon de l’action sociale et de la santé 29 Sept 2011 , last accessed 27/03/19). Often, they also include a psychologist. The association can be a public or private organization.

In order to be accredited as a medical home in Brussels, the service must include a multidisciplinary team of at least two GPs, a reception and secretarial staff and a paramedical or social staff. The main activity of the service is developing an integrated health care. The minimum framework includes a FTE for a reception function and half FTE for a community health function. The service ensures the collaboration of social workers and psychotherapists (Commission communautaire française 5 Mars 2009 Décret relatif à l'offre de services ambulatoires dans les domaines de l'action sociale, de la famille et de la santé, last accessed 27/03/19) . Medical homes also often employ other health care providers, including psychologists, with no intervention fee for their beneficiaries.

In Flanders, medical homes deliver about the same services as in Brussels and Wallonia. The Flemish government has no specific legislation for medical homes. Their team always consist of several GPs and at least one nurse. According to needs and objectives, they can have in their team a dietician, physiotherapists, psychologists, social worker(s) and/or health promotion workers.

Competent authority and financing: The accreditation and a part of the funding of the medical homes depend on the Regions which can provide additional funding to the income based on the patients (from the RIZIV – INAMI). The RIZIV – INAMI funding comes in two different ways: “lump-sum” or “fee for service” based. In case a lump-sum convention is signed, RIZIV – INAMI pays a lump-sum proportional to the registered number of patients who are offered free services by the association. The calculation of the lump-sum is based on an average fee for medical consultations, physical therapy and nurse care per registered patient.

In the case of “fee for service”, each patient pays for the provided medical interventions and get reimbursed based on the nomenclature by the RIZIV – INAMI. In 2018, 82.5% of the medical homes were using the lump-sum funding (in the Wallonia-Brussels federation) [21]

In Brussels, the COCOF funds the 1.5 FTE for the reception and community health staff (Commission communautaire française 5 Mars 2009 Décret relatif à l'offre de services ambulatoires dans les domaines de l'action sociale, de la famille et de la santé, last accessed 27/03/19)

The Flanders authorities do not provide funding for medical homes.

Numbers: In 2016, 132 integrated health associations were accredited in Belgium. There were 63 in Wallonia. In Brussels, 38 medical homes were recognised by the COCOF (Commission communautaire française 5 Mars 2009 Décret relatif à l'offre de services ambulatoires dans les domaines de l'action sociale, de la famille et de la santé , last accessed 27/03/19). In 2018, there were 31 medical homes in Flanders (including 2 in Brussels) for which most of the patients (95.1% of 70262) are in the lump-sum system.

Amongst the French speaking medical homes which are member of the main medical homes federation, 61 (out of 110) have a psychological offer. Within which 30 are located in Brussels, 11 in the region of Charleroi, 17 in the region of Liège, 2 in Namur and 1 in the Walloon Brabant.

In Flanders, the range of contacts per medical home was varying from 565 patients to 6850 patients, serving in total 70262 patients (data of the 1/1/2016 for 2015). On December 31th 2015 the Flemish medical homes employed 624 persons, standing for 366,03 FTE (Vereniging van Wijkgezondheidscentra, feiten-en-cijfers, last accessed 27/03/19) .

More data are available on the medical homes in Appendix 3 (Medical Homes) of Chapter 05

4.2.2 Centre for general welfare

Description: The Centers for general welfare (Centrum voor Algemeen Welzijnswerk - CAW) are services that mainly exist in Flanders and one CAW exist in the Dutch-speaking part of Brussels. The CAWs group a range of tasks ensured by different categories of services in Wallonia and Brussels (See Table 15).

On the 8th of May 2009, a decree was issued on general welfare (welzijnswerk) that captures three goals (Codex Vlaanderen, Decreet 08 Mei 2009 betreffende het algemeen welzijnswerk, last accessed 27/03/19):

- improvement of and help to access social basic provisions and specialised care facilities;
- helping to prevent problems with social integration and satisfactory personal functioning; and,
- reaching solutions to the problems of their clients.

The CAW has to achieve three core tasks:

- reception (“onthaal”);
- general prevention; and
- psychosocial guidance.

Target population

Adults can go to a centre for general welfare (CAW) when they encounter difficulties in one or more theme’s that CAW capture (https://www.caw.be/, last accessed 27/03/19):

- wellbeing;
- health;
- relation, family and environment;
- administration and money;

- autonomy;
- victims and offenders (from violence, abuse, traffic accidents and crimes);
- living;
- work and leisure
- migration.

Competent authority and financing: A CAW-team consists of a variety of specializations, e.g. social workers, psychologists, educators, sociologists and pedagogues. They all get an education about the way a CAW works. When necessary, the CAW refers to other institutions or caregivers.

Care is free, but when shelter is provided, the persons pay an amount per day. For persons with a low income, the public centre of social action (OCMW-CPAS) covers the cost.

CAW have incomes from different sources. The Flemish government funds CAW through global financial envelope to provide an agreed range of care. Local authorities offer additional income for specific tasks. The CAW can get also temporary funding for projects (see Appendix 4 (Centre for general Welfare) Chapter 05 for details).

Numbers: In Flanders and Brussels there were 11 CAW's. They have their distinct working area. There are different reception points (onthaalpunten) where people can go to with their questions, during opening hours and with an appointment (See Appendix 4 (Centre for general Welfare) Chapter 05 for details) (https://www.caw.be/hoe-wij-helpen/onthaal/, last accessed 27/03/19). The employees in the CAW represent a total of 2122.78 FTE.

CAW also works with almost as much volunteers as they have payed employees, namely 2.514. They can be found in management, in operations, behind the screens with support, and in administrative and logistic services (See Appendix 4 (Centre for general Welfare) Chapter 05 for details).

In 2015, 96.403 persons asked help from a CAW from which 90.762 persons benefit from the reception function and 27.350 persons from the guidance function. In total, 279.961 contacts were taken between users and the CAWs. See Appendix 4 (Centre for general Welfare) Chapter 05 for more details on the type of contacts.

In 2015 clients receiving guidance most often had mental health problems (25.5%) followed by material and financial problems (23,5%). Together they standed for half of the problems (See annexes 10.4 for more details).

In guidance there were different clusters of offered care. The largest cluster was these of individual guidance, psychological and personal problems and basic rights (30%). The second place was for residential shelter (15.5%), followed by assisted living (14%).

Secured shelter in the CAW

The CAW serves different kinds of secured shelter based. They offer different kinds of secured shelter, e.g. crisis shelter, shelter for women or men solely, shelter for families, shelter with secret address, shelter for youth, winter shelter, etc. These secured shelters are spread all over Flanders and Brussels.

Tele-Onthaal in the CAW

Tele-Onthaal (https://www.tele-onthaal.be/, last accessed 27/03/19) is recognised by the Flemish government and falls under general welfare work. Because of the nature of the problems of the users, this service is also linked with mental healthcare.

Users can contact Tele-Onthaal 24/7 with all their questions and problems, through the phone number 106 and through chats on the website. The assignment of Tele-Onthaal is in the first place to offer an answer and helping conversations (helpende gesprekken) to everyone who seeks a friendly ear. These conversations can be done by phone or chat. In 2017 there were 122.956 calls (on average 337 per day) of which 109.139 by phone and 13.817 chat sessions), compared to 115.531 in 2015 [22]. Users who need more than a one-time contact were referred to professional care (in 27% of the cases). Users who already get professional help receive more continuous help to get through difficult moments.

All the contacts were provided by volunteers (632 volunteers, equivalent on 68 FTE). There is a Tele-Onthaal service in every Flemish province. All those are part of the federation of Tele-Onthaal services in Flanders.

Around 19.8% of the calls and 23.5% of the chat conversations covered the topic “health”. Respectively 60% and 83% of it describe mental health problems. Suicide was mentioned in 6.1% and 11.8%, respectively.

Helpline (Hulplijn) 1712.

The helpline 1712 is a cooperation between the CAW and the trust centres (see 4.2.7) on child abuse and neglect. This helpline serves for citizens who have questions about all kinds of violence and (child) abuse. In 2017 there were 4.812 calls (86.41% by phone and 13.09% by email) (Hulplijn 1712, jaarverslag 2017, last accessed 27/03/19), most of them concerned child abuse.

More data are available on the CAW in annexe 10.4

4.2.3 Family planning centre

Description: The family planning centre (centre de planning familial - CPF) are out-of-hospital settings providing reception, information, education and support for individuals, couples, families, group animation, in particular youth, in the frame of life, sex and relationship. They organise psychological, social, medical and legal consultations, with a multidisciplinary team providing at least the functions ensuring the medical, psychological, legal, social, reception and animating functions. Psychologists perform various tasks, including follow-up, mostly on an ad hoc basis, but sometimes also long-term, animation, awareness, ... (Wallex Wallonie Code réglementaire wallon 04 Juillet 2013 de l’action sociale et de la santé, last accessed 27/03/19 ; http://www.ccc-ggc.brussels/fr/aide-aux-personnes/centres-de-planning-familial, last accessed 27/03/19) .

Competent authority and financing: The regional authorities recognise the family planning centres. In Wallonia, the funding is 13 032 480 euros[23]. In Brussels, the COCOF [24] dedicates a budget of 7 609 000 euros in 2017

Numbers: In 2016 there were 70 (plus 8 antennas) family planning centres in Wallonia, with a total of 69,3 FTE psychologist [25] and 27 in Brussels. 47,26 FTE psychologist were count in the centre accredited by the COCOF [26]. There were also 2 centres from the joint community commission (Commission Communautaire Commune-COCOM – Gemeenschappelijk gemeenschap commissie-GGC) in Brussels [27].

This service is provided by the CAW’s in Flanders (see 4.2.2).

4.2.4 Health Relays

Description: A health relay is an optional part of the social relays which are associations from public, associative and/or private actors in Wallonia targeting the underprivileged. [28]. Health relay try to improve the accessibility to care for people in social exclusion situations. They offer care access to people who have, for 50% of them, psychological difficulties, linked to drug or alcohol abuse, or depression. They can also allocate funding to projects or partnership with similar goal. Their duty is included within the larger mission of the social relays. Together, they form a network promoting the combat of the great precariousness.

Some health relay employs MHC providers such as psychologist or psychiatrist. Some other develop collaborations with services such as community mental health service (Centrum voor Geestelijke Gezondheidszorg-CGG - Service de Santé Mentale-SSM).

Competent authority and financing: The competent and financing authority is the regional government in Wallonia. The social relay receives extra funding when a health relay is organised [28].

Number: in 2017 there were 7 social relays were organised in Wallonia whose 6 offer a health relays service. They cover the regions of Charleroi, La Louvière, Liège, Mons, Namur, Tournai and Verviers. Altogether, their budget was about 9 million euros from Wallonia [29].

These structures do not exist in Flanders and Brussels as such.

4.2.5 Aid to maltreated elderly persons

Description: In Wallonia, “Respect Seniors” is an organisation for the fight against abuse of the elderly, it has a toll-free number (0800 30 330) offering support to callers, information and training for professionals. There is an antenna in each province of Wallonia, where a social assistant and a psychologist collaborate (http://www.respectseniors.be/, last accessed 27/03/19).

In Brussels, the former « Service d’écoute pour Personnes âgées maltraitées (SEPAM) », newly called “Ecoute Senior” offers to elderly people at least 60 years of age, and victims of any form of maltreatment a friendly ear, information, orientation, support and coaching. It is basically a telephone aid service for any person affected by a situation of maltreatment. But the service also coordinates the work of professionals concerned by a situation of maltreatment (work in network) and raises the awareness of the general public of the maltreatment’s prevention. The multidisciplinary team contains social workers, psychological assistants, ombudspersons and legal experts (Service public francophone bruxellois, Service d’écoute pour personnes âgées maltraitées, last accessed 27/03/19). In addition, “Home-Info” offer a Dutch-speaking helpline called “Brussels meldpunt ouderenmis(be)handeling”, with the same mission (Infor-Homes, ecoute-seniors, last accessed 27/03/19).

Competent authority and financing: Respect Senior is accredited and funded by the walloon Government. Ecoute Senior is accredited by the COCOF. Brussels meldpunt ouderenmis(be)handeling is supported by Brussels region and the Vlaams Gemeenschap Commissie (VGC).(http://www.home-info.be/v4.0/welkom - last access 09/04/2019)

Numbers: In 2017, in Wallonia, of the 3 383 calls received, 2 074 involved abuse, and 29.6 per cent of these involved the psychological aspect of abuse. 8.8% of the alleged victims are women, 19.1% of men, 9.2% of groups of people and 2.9% not specified in the file. Almost 25% of calls received comes from seniors [23]. The service employs 19 persons for a total of 16 FTE on December 31st, 2017 [30].

In Brussels in 2017, the SEPAM received 1280 calls, of which 819 were about abuse. These call lead for a part to the opening of a file in 292 cases. The abuse can be perpetrated either at home or in another living pace such as MR/MRS [31].

As far as we know, there is no specific comparable service in Flanders. The goals of Helpline are being looked after in a general way by the CAW’s (see 4.2.2).

4.2.6 Helplines

This section about helplines describe the 3 helplines available in the French community. Helpline in Flanders is provided by the CAW (see 4.2.2).

4.2.6.1 Helpline for young people

Description: “103 Ecoute-Enfant” is a telephonic service (number 103) that answers questions of children, adolescents, but also of anyone else having questions or worries about themselves, or even about somebody else, given that a child is involved (http://www.103ecoute.be/, last accessed 27/03/19)

Competent authority and financing: Through the Decree on the accreditation and funding of childcare services, the Wallonia-Brussels Federation [32], has accredited a service covering the whole French speaking Community.

Numbers: According to the Activity Report 2016 of "103-Ecoute-Enfant" [33], almost 20% of the calls were made by adults, either meant for themselves (in 25% of cases, they are calling about emotions and feelings), or concerning a child (for almost half of the calls in this context, the topic addressed concerns the relationship between the parent / guardian and the youngsters).

In Flanders, a special phone number has been developed for reporting child abuse. We have integrated this description in the section about the CAW (see 4.2.2).

4.2.6.2 Helpline for adults

Description: The French-speaking helpline for adults (http://www.tele-accueil.be/, last accessed 27/03/19) centre provides a space for speaking and listening to anyone who experiences a crisis situation or a difficulty at the moral, social or psychological level. The helpline centres inform and redirect to the appropriate services if necessary [23].

Competent authority and financing: In the French community, helpline centres are accredited and funded by Wallonia and the COCOF. They are combined in the Federation of helpline centres

Numbers: in 2016, there were 6 centres in the French community (5 in Wallonia and 1 in Brussels).

In Wallonia, there were more than 60 volunteers trained and supervised by professionals who take turns to respond to the difficulties stated by the callers. During the year 2016, the centres received 68,500 calls [23].

In 2014 in Brussels, there were more than 90 volunteers who responded to more than 21,000 calls. They are trained and supervised by a team of 8 employees.

In 2014, for French-speaking Belgium, the main reasons of calling were relationship difficulties (28%), problems related to mental health (26%), loneliness and isolation (17%) and physical health issues (8%) [34].

In Flanders, this service is provided by the CAW’s (see 4.2.2, Tele-Onthaal).

4.2.6.3 Helpline for conjugal violence

Description: The helpline for conjugal violence (https://www.ecouteviolencesconjugales.be/, last accessed 27/03/19) provides free and anonymous support, and an information and orientation service. The helpline is intended for the victims, the offenders and their entourage, as well as any person confronted with conjugal violence in a private or professional context.

Competent authority and financing: The helpline is funded by the Wallonia and the region of Brussels (COCOF) (RTBF 23 Février 2017, last accessed 27/03/19).

Numbers: In 2014, the number of calls received was 3,347, or 13 per day. Of the calls received, 79% came from Wallonia and 21% from Brussels. The listening and support goal was met in 53% of the calls the information and / or orientation goal was met in 47% [25].

This service is provided by the CAW’s in Flanders (see 4.2.2).

4.2.7 Child abuse

Description: In the Wallonia-Brussels Federation, SOS Children's teams (équipe SOS-Enfants) have the mission of preventing and handling situations where children are victims of physical, psychological, sexual, institutional neglect and/or abuse (Parlement de la Fédération Wallonie-Bruxelles, Décret 12 mai 2004 relatif à l'aide aux enfants victimes de maltraitance, last accessed 27/03/19). The multidisciplinary teams (GPs, psychologists, social workers and lawyers) are also competent to counsel the families of the children.

The multidisciplinary team evaluates the situation when receiving a call and, if necessary, provides appropriate help through psychological and / or psychosocial support, or even psychotherapeutic treatment of the child / youngster (victim or perpetrator of abuse) and / or (future) parents. These interventions may be realized as a one-time-only consultation or a longer-term support.

Teams can also respond to requests of information, advise (for stakeholders) and awareness. They also ensure the setup of talking groups, trainings and conferences, intended for a large (non)professional public concerned with child maltreatment.

In Flanders, “Trust centres” (Vertrouwenscentrum Kindermishandeling, last accessed 27/03/19) for prevention of child abuse, are points of contact for every possible situation with violence on children (e.g. child abuse, - neglect or sexual abuse). Their main task is to provide information on child abuse and to provide care. The notifications can come from caregivers and civilians, whether or not referred by Helpline 1712. They concern under aged, but also adults (18+) and often both (see below the “Numbers” paragraph). The trust centres for preventing child abuse first try to estimate the severity and extent of the problem. Therefore, they contact professionals who can judge the situation (e.g. general practitioner, Centrum voor Leerlingen Begeleiding - CLB, youth services,…) and/or contact the child, parents and/or other persons involved. Other tasks of trust centres for preventing child abuse are training and awareness raising, but also to report authorities about the developments, bottlenecks, shortages and needs concerning child abuse.

Competent authority and financing: In the Wallonia-Brussels Federation, the competent authority is the ONE (L'Office de la Naissance et de l'Enfance , last accessed 27/03/19), a public interest organisation under the supervision of the Government of the French Community.

On the 17th of May 2002, the Flemish government concluded a decree with the specifications of the “Trust centers” tasks. The funding is done by “Kind en Gezin”.

Numbers: In 2016, there were 14 SOS Children teams in the Wallonia-Brussels Federation (12 in Wallonia, 2 in Brussels). There were 58 FTE psychologists and 4.7 FTE child psychiatrists employed for the 14 teams (L'Office de la Naissance et de l'Enfance , last accessed 27/03/19).

In 2016, the number of patients amounted to 2053 for the 14 teams. The budget dedicated to child abuse action in 2016 was 8 432 509 euros [26].

In Flanders, there are six trust centres for preventing child abuse and neglect, one in each province of Flanders and one in Brussels. Every trust centre offers free, appropriate, non-juridical care through a multidisciplinary team (e.g. psychologists, social workers, criminologists and doctors). In total there are 94 persons who work for the trust centres for preventing child abuse, of which 26 psychologists and 5 GPs. It is unknown how many FTE there are (Vertrouwenscentrum Kindermishandeling, last accessed 27/03/19).

In 2015 there were 6922 emergency reports. Of them, 6787 involved (at least) one minor. In 2,7% of the cases there was also an adult involved (Vertrouwenscentrum Kindermishandeling, last accessed 27/03/19).

4.2.8 Mental health in the related sectors

Within the related sectors are listed a set of services whose primary mission is not MHC and whose jurisdiction does not fall within the scope of mental health sector. However, they offer, in some extent, help and care in mental health via the presence of mental health professionals in their teams who can either work with their users or with their teams and professionals to support them when faced with the psychological suffering of their users. These structures are part of social, justice, handicap, employment or housing sectors.

Thus, beyond structures from the MH sector, there is a development of a set of initiatives participating - de facto – to the care offer, even if these structures of related sectors declare that they are not within the framework of MHC, or even don’t want to be in.

4.2.8.1 Social sector

The "social sector" refers to the various services that offer social assistance to citizens. The federal authority is in charge of social security (FOD Sociale Zekerheid – SPF Social Security) and social integration (FOD Maatschappelijke Integratie – SPP social intégration) providing substitute income, income supplements or allowances.

The OCMW – CPAS (Loi organique 08/07/1976 des centres publics d'action sociale, last accessed 26/03/19) are public services that organise social assistance in each municipality of the country. Their mission is to provide individuals and families with the help (material, social, medical, medico-social or psychological) due by the community. In addition to individual assistance, the law provides that the OCMW – CPAS may establish and manage social, curative or preventive services (e.g; debt mediation service, transit housing, social restaurant, rest home, etc.) (http://www.ocmw-info-cpas.be/, last accessed 27/03/19).

In addition, the federated entities accredit and/or funds various assistance services in the fight against poverty, equal opportunities, and integration. The assistance type varies according to the different services: financial aid, material assistance, housing assistance, and psychosocial support.

The list of services is not exhaustive. We listed the services for which information was available on MHC. However, the assistance provided within each service in the same category varies, depending on, among other things, the staff employed (psychologist employed or not). The social sector also differs from one Region to another in terms of the MHC offer.

Shelter

Description: The missions of the shelters (Maisons d'accueil) are to provide an intake of people with social difficulties and to offer a housing limited in time in a structure with public facilities as well as an adapted support in the acquisition or recovering of their autonomy. In Wallonia and Brussels, some of the shelters have a specific mission dedicated to women who are victim of conjugal violence, as well as for their children. Some of these shelters offer the service of a psychologist. (Service public francophone bruxellois, Maison d'accueil, last accessed 27/03/19).

Competent authority and financing: The regional authorities are responsible for the accreditation and the funding of the shelters. In Wallonia, the article 97 of the Walloon Regulatory Code of Social Action and Health makes a specific funding possible for a shelter dedicated to women victim of conjugal violence (Wallex Wallonie, Code réglementaire wallon 4 Juillet 2013 de l'action sociale et de la santé, last accessed 27/03/19).

Numbers: In 2016, there were 15 shelters for victims of conjugal violence accredited and funded by the Wallonia, with a total of 699 places. Some of them hired psychologists within their team. [23]

In 2018, there were 15 shelters accredited and funded by the COCOF (no data on staff members). Six sheltered houses were accredited and funded by the COCOM [35]. In Flanders, the shelter houses are covered by the CAW's (Secured shelter, see 4.2.2). Each CAW has at least one sheltered facility.

Help and care for prostitutes

Description: In Wallonia, the "Services d'aide et de soins aux personnes prostituées" (SASPP) helps and supports any person concerned by prostitution. Their mission is to offer psycho-social support, recognition, social integration, improvement of wellbeing and quality of life of persons working in prostitution, as well to improve their access to care and to reduce hygienic risks (Wallonie Action Sociale, Services d'aide et de soins aux personnes prostituées , last accessed 27/03/19).

In Brussels, various associations are working with person concerned by prostitution. They develop aid, coaching, care and awareness-raising goals, to make society aware of the reality of prostitution. Some of these associations can count on volunteers. The data related to the various associations does not allow us to form ourselves an exact idea of the number of hired professionals and of the type of psychological help that may be given. [36].

In Flanders, Payoke, seated in Antwerpen, is the only non-profit association that is active on prostitution. They describe their main goal as "The reception and support of all the victims of trafficking in human beings". They act following several laws on human trafficking (Loi 10 Aout 2015 modifiant diverses dispositions en vue de renforcer la lutte contre la traite et le trafic des êtres humains et contre les pratiques des marchands de sommeil, last accessed 27/03/19 ; Loi 15 Juin 2006 relative aux marchés publics et à certains marchés de travaux, de fournitures et de services, last accessed 27/03/19), and the national action plans on human trafficking 2012-2014[37]. Their actions consist in offering information to victims of human trafficking in Belgium, legal and psychosocial support. They give temporary ambulatory and residential support. They aim to raise awareness of the general public.

Competent authority and financing: In 2017 in Wallonia, the regional authorities accredited and funded the services for a budget of 672 000 euros. In Brussels, the COCOF and the COCOM partly funded the aid services to persons in prostitution. Payoke is funded by the federal authority, the Flemish authority and receives a funding of the National Lottery.

Numbers: In 2017, there were 3 services in Wallonia. Two FTE were funded for the three teams. In Brussels there were at least 4 associations of this type. In 2016, Payoke staff had 11.6 FTE. 1 FTE is a detachment from CAW Antwerpen [38].

Plural gender non-profit association

Description: the association "Asbl Genres pluriels" aims at the support, the visibility, the valorisation, the enhancement of the rights and the fight against the discrimination of the transgender/persons in transition/gender fluids. The association organises the reception and the support of the target public and their entourage through permanently-manned office, support groups, individual psycho-social interviews. In 2015, the association extended its offer by proposing psychosocial, psychotherapeutic and sex-therapeutic support [39].

Competent authority and financing: Various authorities provide the association's budget: Brussels-Capital Region (30 335,51 euros), COCOF (24 143,08 euros), F.W.B. (22 250,00 euros), Walloon Region (20 000,00 euros), Federal government/IEFH (17 493,33 euros) [39].

Numbers: In 2015, there was only one association covering the regions of Wallonia and Brussels.

In Flanders, there is no exact equivalent but there is a Centre for Sexology and Gender (Centrum voor seksuologie en gender, last accessed 27/03/19) at the University Hospital Ghent that is known for their expertise in gender dysphoria. The Transgender Info Point (http://transgenderinfo.be/, last accessed 27/03/19) aims at offering information about transgender issues to the public, as well as to professional care providers and referrers. A line of treatment and a care plan (for the whole of Belgium) is being developed. The public can raise questions on gender issues by phone and email.

The support services for partner violence and / or gender-based violence

Description: This specialised services funded by Wallonia provide outpatient support for victims and perpetrator of violence between partners and/or gender-based violence. This support includes the reception, the information, and the social, legal, administrative and psychological help. The mission of these services is de-victimisation and empowerment of victims of violence, the empowerment of perpetrators of violence, the prevention of recidivism and the safety of family and friends.

Competent authority and financing: In Wallonia, a decree on the accreditation of services and devices to manage violence between partners and violence based on gender has been published in 2018(Service Public de Wallonie, Décret 01 Mars 2018 insérant un Titre VIII dans le Livre Ier de la Deuxième partie du Code wallon de l'Action sociale et de la Santé relatif à l'agrément des Services et dispositifs d'accompagnement des violences entre partenaires et des violences fondées sur le genre , last accessed 27/03/19) The decree aims at consolidating and developing services and mechanisms for outpatient support to victims and perpetrators of violence between partners and/or gender-based violence by recognizing them for the first time [40]. The budget amounts to five hundred thousand euros in 2018; this budget will be raised through new recognitions. In Brussels, for non-judiciary perpetrators, the funding is from the COCOF. For the perpetrators under judicial coercion on the French-speaking territory: the funding comes from the Wallonia-Brussels Federation.

In parallel, on 11 July 2018, the government of the Wallonia-Brussels Federation approved a preliminary draft decree aimed at preventing and combating violence against women. The preliminary decree aims in particular to improve the implementation of intra-French-speaking and national plans to combat violence against women by strengthening collaborative work in the Wallonia-Brussels Federation and by securing part of the funding of the voluntary sector active on these issues. Four hundred thousand euros are earmarked each year for the implementation of this plan (RTBF 11 Juillet 2018, last accessed 27/03/19).

Numbers: In 2016, there were 13 services devoted to victim of partner violence in Wallonia. One service is devoted to support non-judicial perpetrators. The Walloon Region funds those services up to 268 843,44 euros in 2016 in addition to APE points ("aide à la promotion de l'emploi"- The Aid for the Promotion of Employment is a Walloon aid, funded in the form of points) worth 3093,70 euros each (as of 01/01/2018) to employers in the non-market sector [41]. A supplementary funding is given by the "Direction de l'Egalité des Chances" [23]. On 11 July 2018, the government of the Wallonia-Brussels Federation approved a preliminary draft decree aimed at preventing and combating violence against women. The preliminary decree aims in particular to improve the implementation of intra-French-speaking and national plans to combat violence against women by strengthening collaborative work in the Wallonia-Brussels Federation and by securing part of the funding of the voluntary sector active on these issues. Four hundred thousand euros are earmarked each year for the implementation of this plan (RTBF 11 Juillet 2018, last accessed 27/03/19).

This service is provided by the CAW's in Flanders (see 4.2.2).

4.2.8.2 Disability

The handicap sector refers to the aid provided to disabled people, as defined here below.

"People with disabilities are defined as people who have long-term physical, mental, intellectual, or sensory disabilities whose interaction with various barriers may hinder their full and effective participation in society on the basis of equality with others."[42, 43].

In Belgium, the competence on assistance to persons with a disability is divided between the Federal and the federated entities. First, the Social Security SPF and the General Directorate for the Disabled (direction Générale Personnes handicapées) provide specific budget and aids to limit as much as possible the impact of disability. But the four federated institutions take on the majority of competences in the field of disability policy: Vlaams Agentschap voor Sociale Integratie van personen met een handicap, Agence pour une vie de qualité (AViQ), Service Personne Handicapée Autonomie recherchée – Service Phare, Dienststelle für Personen mit Behinderung (DPB) [43].

The MHC offer for disabled people is similar to the one available for the entire population. Moreover, among the various accredited and funded aid services by the Regions, some are more likely to meet the mental health needs of their beneficiaries, in particular the accommodation services and support services which employ psychologists. In addition to their function of coordination or team support, these psychologists also provide psychological support to beneficiaries.

In Flanders, a recent reform of the care for persons with a disability integrated all services into "flexibel aanbod meerderjarigen" structure which offer a range of services: individual guidance including psychosocial help; day support and residential support and/or care. The persons can switch from one service type to another according to the change of their needs. The services can also be delivered on a partial time base (https://www.participate-autisme.be/go/nl/ondersteuning-zoeken/de-praktische-gids/fiche.cfm?id=253&search=alpha&letter=F; last access 18-04-2019). The Flexibel Aanbod Meerderjarigen system was decided in order to answer the implementation of the personal assistance budget. In Flanders some residential services and support services are grouped in multifunctionele centra but are only accessible to adults until 25 years.

Residential services

Description: Residential services (Woonondersteuning – service résidentiel pour adultes (SRA)) are living spaces that are primarily reserved for people with a major disability. They benefit from a therapeutic and educational framework that allows them to live well. Activities adapted to the people and their needs are proposed according to their life plan. Educators and caregivers are present 365 days a year, and 24 hours a day.

Competent authority and financing: The federated entities are in charge of the funding and the agreement of these services.

Numbers: In 2016, there were, in Wallonia, 102 residential services and 3523 persons taken in charge by the services. The overall budget for shelter and accommodation services amounted to 462 393 709 euros. They employed 66.43 ETP psychologists or psycho-pedagogues and 3,98 ETP psychology assistants.

In 2016, there were 20 residential services funded by the COCOF in Brussels offering 408 places for a budget of around 19 million euros [26]. There were also 6 services funded by the COCOM.

In Flanders there were, in 2015, 7210 persons with a handicap living in one of the 82 multifunctional centres [44].

Support services

Description: The support services (Individuele begeleiding – Service d'accompagnement) help adults with a disability to achieve their life project, which may lead to a greater autonomy of these patients. In these services, the psychologists work as a member of the support team as well as a support for their own team.

Competent authority and financing: The regional authorities are in charge of the funding and the agreement of these services.

Numbers: In 2016, there were, in Wallonia, 42 support services which followed 4826 persons. In Brussels, there were 24 services within which 19 are dedicated to adults [45] [26]. In Flanders there were 8256 persons registered for having received support at home, delivered by 26 services. Parallel, 23 399 persons received support in the comprehensive care offer called Flexible offer for adults (Flexibel aanbod meerderjarigen), which includes 213 providers in all [44].

4.2.8.3 Justice

Justice for adults in Belgium is mainly the responsibility of the Federal Public Service Justice. The following institutions are dealing with mental health issues: prisons, and more specifically psychosocial services (see 4.3.10) within these institutions, forensic psychiatry (see 4.4.2.1) and social defence institution (see 4.4.2.3). The competent authority is the General Direction of Prisons. Through the 6th state reform, the houses of justice and partner organisations are now subject to the Wallonia Brussels Federation and the Flemish community.

The FPS Public Health also intervenes within the framework of care path for internees (see 4.3.2.4 *Mobile teams care path for internees)*

The target public of this section "Justice" is on the one hand, the detained population, on the other hand, the internees and finally, the litigants, whether they are authors, victims or relatives.

Assistance to litigants

Description: In the Wallonia-Brussels Federation, the Decree of 13 October 2016 [46] on the accreditation and funding of partners providing assistance to litigants described 6 missions that can be performed by the assistance to litigants services (aide aux justiciables): front-line legal aid, social assistance, help with the communication, support with the implementation and follow-up of the judicial decisions and psychological help. These partners are recognised by the Government for the implementation of the tasks provided for by the decree (Article 1 paragraph 8). The psychological assistance is defined as "any help intended to psychologically support the litigant so that he finds a new balance of life" (Article 8). There are 3 types of services: support to the litigant to deal with the consequences of a criminal offense or specific problems related to his/her particular situation, specialised and personalised therapeutic support to the author to integrate him/her in a process of change, and specialised and personalised therapeutic support focused on the direct consequences of the trauma and on the assimilation of the shock.

Competent authority and financing: Accredited services receive a funding from the Wallonia-Brussels Federation for a service, based on the number of care interventions. The services have to manage between staff costs and operating costs. The total amount of funding for psychological aid is 3 309 000 euros.

Numbers: In 2016, there were 22 assistance for litigant services that had a psychological assistance mission in Brussels and Wallonia [46]. In 2018, there were 7 similar services in Brussels accredited by the COCOM [27].

In Flanders this is an assignment of the CAW. Every CAW has a team in the surrounding of a prison. In the region Halle-Vilvoorde, where there is no prison, they offer help to non-justiciable clients and their families.

Police assistance service to victims

Description: The police assistance service to victims (Politionele dienst voor Slachtofferhulp – Services d'Assistance Policière aux Victimes - SAPV) are services that are within the scope of the duties of the police. These services are provided by each local police station within every police zone, and by the federal police in every judicial district.

These are first-line services. They can be provided as an immediate support after the facts of which a person has been the victim.

Competent authority and financing: The authority of these services mainly falls within the federal government (FPS for Home Affairs), and to a certain extent, within the federated entities. In this way, the "Direction générale opérationnelle Intérieur et Action sociale" of the Wallonia region funds a yearly subsidy of 30 000 euros for 67 on 70 zones of police; the social worker funded within this context holds a degree in criminology, sociology, psychology or is a social worker.

Numbers: One in every local police.

4.2.8.4 Housing

Description: Different projects of housing for people with mental health problems exist in Belgium. A first example is "housing first" (http://www.housingfirstbelgium.be/en/ last accessed 27/03/19) which offers access to immediate housing, with no conditions other than those applicable to any tenant and without intermediate steps, for a public weakened by homelessness chronicity and mental health and/or addiction problems. An adapted, intensive and multidisciplinary support is proposed to enhance the maintenance of housing and the recovery.

A second example are the respite homes that provide time and space to come at ease again. They offer a time-out with support to anybody with mental health problems. 'Namaste-house' is the only organization who offers in Flanders this type of care. The Namaste-house is a private initiative, run by a general coordinator, who coaches volunteers. These volunteers are trained psychotherapists (http://namaste-huis.be/, last accessed 27/03/19). The weekly process of the residents is supervised by team members of CAW East-Flanders and two community mental health centres (CGG).

Competent authority and financing: Housing first was developed as part of the Second Federal Plan to Combat Poverty [47] created the conditions for the implementation of Housing First practices in Belgium, experimenting from September 2013. Since June 2016, the Regions have been investing in maintaining Housing First practices in pioneer cities and expanding them. Wallonia funds 120 000 euros for 3 teams. Brussels Region funds 4 teams. Flanders does not provide funding for these initiatives, considering this mission as part of the missions of the CAW.

Namaste-house is a private initiative and is a partner of 'PAKT' (Psy107 network). The coordinator is supported by two half time staff members detached by a CAW and a community mental health centre. The price of a stay depends on the income of the patient and some health insurance provides a partial refund. The additional funding of the Namaste-house comes from donations.

Numbers: For Housing first, there were, in 2018, 12 projects receiving aid from the Regions in Belgium. In Wallonia, there were 3 centres, in Charleroi, Liège and Namur. There are 2 more centres coming in the future in Mons and Tournai. In Brussels, there were 4 centres. In Flanders, there were 5 centres in Antwerpen, Oostende, Gent, Hasselt and Kortrijk. Of the 12 teams, 5 hired one (or two) psychologist(s) (FTE psychologist: 1 in Gent, ½ in Charleroi, ½ in Namur, 2 in Brussels).

There was one Namaste-house in Ghent.

4.2.8.5 *Employment*

Description: Various employment organisations are partners of the Psy107 networks and are also addressed in the section 4.1.2 concerning society. Besides these partners, other employment-related initiatives are explicitly meant for a public with mental health problems or psychiatric problems. Some of them are supported by centres [48] or organisations [49] for socio-occupational integration recognised by the regional authorities.

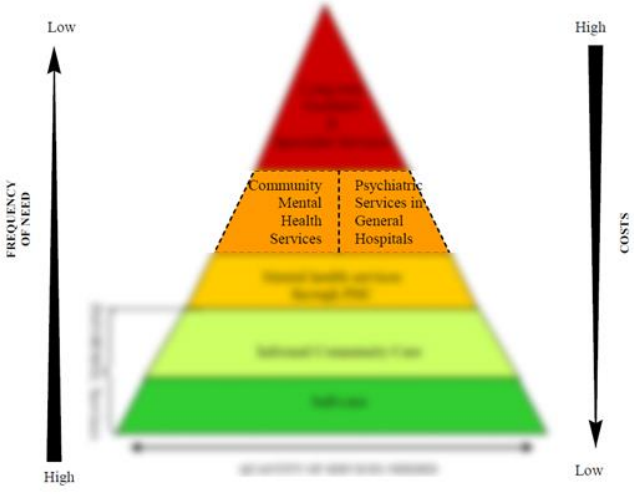
In Wallonia, private organisations develop projects aiming at the occupational integration of persons with mental health problems, most often in partnership with mental health actors, and with the support of optional funding. In Wallonia and in Brussels, the services responsible of public training and employment give special attention to the people that shows signs of mental health problems. They consequently develop collaborations with certain actors in mental health.

In Flanders, people with a physical, psychological and/ or mental limitation can get guidance by GTB (Gespecialiseerde trajectbepaling- en begeleidingsdienst) to a suitable, and preferably payed job and assistance for keeping that job. When a payed job is not possible, they help to find a suitable alternative. During the job the employer and employee can get advice and support. GTB works close with the “Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding” (VDAB) and other services like specialized education centres (Gespecialiseerde Opleidingscentra - GOB). In 2016, GTB guided 7.942 persons. The average guidance lasts 1,5 years (https://www.gtb-vlaanderen.be/over-gtb/, last accessed 27/03/19).

The category “Mental health through PHC and related categories” corresponds to the foundation of the MHC system through the logic of the WHO pyramid. This section identifies, describes and maps the general services wherein a mental health offer can be provided. Beyond the health care sector in general, services of different sectors as social, disability, justice, housing and employment sectors are also included in the description of this level. The offer in the relative sectors has a high variability and is often directed to a rather special than general public.

4.3 Community mental health services and psychiatric services in general hospital

This section includes the services that provide community MHC such as the SSM – CGG’s, the mobile teams, a set of services for specific target groups, the private practice of mental health professionals, as well as the community residential services: psychiatric services of general hospitals (Psychiatrische Afdeling in een Algemeen Ziekenhuis (PAAZ) - Service Psychiatrique en Hôpital Général (SPHG)), initiatives of sheltered living (Initiatieven Beschut Wonen (IBW) - Initiatives d’Habitations Protégées (IHP)) and psychiatric care homes (Psychiatrisch Verzorgingstehuis (PVT) - Maison de Soins Psychiatriques (MSP)). These services represent primarily the official MHC offer in the community.



4.3.1 *Community mental health centres*

Description: Patients with a mental health problem can be referred to a community mental health centres (Centrum voor Geestelijke Gezondheidszorg - CGG – Service de santé mentale - SSM) by any health care professional, a centre for student counselling (Centrum voor Leerlingenbegeleiding - CLB – centre psycho-médico-social -PMS), professionals from first line, services from other sectors or a family member or acquaintance. Patients may take the initiative themselves to consult a mental health centre. http://www.cresam.be/sante-mentale/les-ssm/quest-ce-quun-ssm/, last accessed 27/03/19; https://www.zorg-en-gezondheid.be/centra-voor-geestelijke-gezondheidszorg, last accessed 27/03/19). These community mental health centres provide ambulatory specialised care. Care is provided by a multidisciplinary team (minimal team consists of a psychiatrist, a psychologist, a social worker and a reception service) entailing a bio-psycho-social approach of the patient's problems. The care provided in these centres encounters screening, early detection and curative aspects. It covers all age sub-groups: adults, children and the elderly.

Federated authorities gives support to the community mental health centres that developed specific initiatives for defined population or particular methodologies, such as specific initiatives for older persons ('Cresam, Initiatives spécifiques "Personnes âgées", last accessed 27/03/19) addiction, guidance and treatment of the sexual offender, early childhood, exile situation,... In Wallonia and in Brussels, community mental health services can also create therapeutic club for people with severe or chronical psychiatric or psychologic problems. These clubs organize stabilizing activities for patients.

Patients' financial contribution depends on the type of intervention that is provided. For non-medical consultations a maximum co-payment, varying according to the patient status, is imposed. For a consultation with psychiatrist, the reimbursement rules established in the RIZIV-INAMI nomenclature of health care services are applicable.

Competent authority and financing: community mental health centres are the responsibility of the Regions or the Communities. The criteria for recognition ('erkenningsnormen' – 'normes d'agréement') are the responsibility of various federated institutions, i.e. the Flemish Government, the Commission Communautaire Française (COCOF), Commission communautaire commune (COCOM) – Gemeeschapelijk GemeenschapsCommissie (GGC), the Walloon government ('Gouvernement wallon') and the German community. Authorities in charge provide funds to cover the costs of the staff (mostly employees) and of operations.

Numbers: Flanders, the COCOF, the COCOM-GGC and Wallonia accredits 20 (whose one in Brussels), 22, 5 and 65 centres respectively. There is also 1 center accredited in the German community (FOD Volksgezondheid, Centra voor geestelijke gezondheidszorg, last accessed 27/03/19). An accredited center can have various antennas.

In Wallonia in 2016, there were 946 funded employees in community mental health centers (SSM) for about 468 FTE. It is subdivided in 165,4 FTE for the psychologic function, (+ 6.5 FTE psychologist in the German community), 104,6 for the social function and 39,5 FTE for the medical function (psychiatrists) (+4/5 FTE in the German community) [23]. The services also hire staff on own funds or establish agreements with self-employed persons. The adult users' population was composed of 57% woman and 43% man, the mean age of the patient was 40. The main diagnosis of the patient was a depressive episode [25].

From 2012 to 2015, there were 27 844 new adult patients admitted in community mental health centres (SSM). In 2016, the number of care interventions amounted to 2010,35h for the psychologist and to 499,46h for the psychiatrist [50]. Within the German community, the centre realised 1590 consultations, of which 52 were new intakes and 48 were follow-ups of patients [51].

The budget for 2016 was amounted to 31 905 000 euros. [25]

In Brussels, for the services from COCOF, there were 78.6 FTE psychologists and 37,4 FTE psychiatrists. The planned budget for the year 2018 amounted to 16 000 000 euros. In 2016, the 22 centres followed a total of about 20.300 patients (including children) [52]. The number of adult intakes in 2015 was 14.555. The number of programmed appointments (whether the patient came to the appointment or not) amounted to 135 046 for adult population (with psychiatrists, psychologists, social assistant, …. all added up) [53]. 5 SSM are funded by the COCOM-GGC.

In Flanders, in 2018, there were 802.4 FTE paid through the financial envelope of 'Agentschap Zorg en Gezondheid' and 219,9 FTE paid through other sources or as independent employees (see Appendix 5 of chapter 05). The overall budget of the community mental health centres (CGG) was 70 000 000 euros. [54].

By means of EPD-registration (electronic health record), data about the care use in community mental health services (CGG) were gathered for all centres [55] and allow to give detailed characteristics of care in community mental health services (CGG) in Flanders:

In 2017, 56.784 people were helped in a community mental health centre (CGG), of which 29.174 were new clients. The total number comes down to almost 1100 less than in 2016. But within the period 2012-2016 the number of patients had raised by 1.2% a year on average.

There were 985 periods of care more than there are clients because some clients had more than 1 period of care a year. When someone gets a treatment for more than 2 different problems or a treatment in the beginning of the year and another one at the end, it makes two different periods of care.

There was an increase in treatment duration and in the number of interventions (hulpactiviteiten). In 2016 there were 538.345 interventions (hulpactiviteiten) during 58.886 periods of care. This implies approximately 9 interventions per period per care a year (see Appendix 5 of Chapter 05).

The total number of staffs was, in 2016, 1.022,3 FTE. After years of growth, it became stable since 2014. The psychologists form the greatest group of staff (406.35 FTE, 40%), followed by the social workers (26%). Psychiatrists are present with 60,3 FTE (6%)[56](see Appendix 5 of chapter 05) for more details).

- The average number of FTE per community mental health centers (CGG) was 51.1.
- 260.2 FTE, or 42% of the 614.5 FTE, for direct client contacts (cliëntenwerking) focuses on adults (18-59 year) without specific problems.
- 38,2 FTE or 7% focuses on the care of the elderly (60+)

Most of the CGG-staff does direct client contacts (cliëntenwerking) (see Appendix 5 of chapter 05 for more details). Sixty percent of the FTE are directly involved in face-to-face contacts, group therapies or client support. Those professionals consists of mainly 3 disciplines categories:

- The largest group are psychologists: More than half of the therapeutic staff (356.7 FTE from the 614.5 FTE) are psychologists. On average there are 17.9 FTE psychologists in a CGG (showing a range from 7.9 FTE till 37.0 FTE).
- There has to be a psychiatrist in each CGG. This psychiatrist can be self-employed or receive a salary. In total there are 60.3 FTE psychiatrists in all CGG. On average there are 3.0 psychiatrists per centre (showing a range between 1.0 and 8.6 FTE).

- Twenty-six percent are social workers, and 6% have another profession.

Table 9 – Summary of the available quantitative data on the community mental health centres (SSM - CGG)

2016	Wallonia	German community	COCOF	Flanders	COCOM
Number of SSM-CGG	65	1	22	20 (+1 in Brussels)	5
Number of funded employees	946				
Total FTE	468			1022.3	
Psychologist FTE	165.4	6.5	78.6	406.35 (40%)	
Psychiatrist FTE	39.5	4/5	37.4	60.3 (6%)	
Social workers FTE	104.6			(26%)	
Number of users			20300 (2016) 14555 Adults (2015)	56784 (2017)	
Number of new users		52		29174 (2017)	
Number of users in follow-up		48			
Time of care spent by the psychologists	2010.35 h				
Time of care spent by the psychiatrists	499.46 h				
Number of interventions		1590	135046	538345	
Number of care periods				58886	
Budget	31 905 000		16 000 000	70 000 000	5 229 000 (2018)

4.3.2 Mobile teams

In this section we describe the various existing mobile teams (MT):

- Psychiatric home care teams
- MT for adults (in the Psy107 networks)
- MT for children (in the new child and adolescents policy)
- MT care paths for internees
- MT of intervention

4.3.2.1 Psychiatric home care teams

Description: Created in 2002, the psychiatric home care teams (Psychiatrische Zorg in de Thuissituatie - PZT – Service Psychiatrique d'Aide à Domicile - SPAD) are structurally linked to the initiatives of sheltered living (IBW/IHP) since 2009. Initially, the PZT – SPAD aimed to "care for persons (patients) with psychiatric symptoms, referred, detected and diagnosed by care professionals, who are in need of and might benefit from specific care to maintain themselves in their home situation and the specific tasks of the team were defined as "reception, screening, diagnosis, treatment, counselling, activation, psycho-education and other care to people that can be treated in their home situation" [57]. Today, the PZT – SPAD teams can develop specific expertise depending on the needs of their catchment area. The main tasks include i) coaching professionals working in the first line of care, ii) coordinating actors around the patients and iii) providing direct support to patients in their home environment (CM, psychiatrische thuiszorg, last accessed 27/03/19; FIHP, Les soins psychiatriques pour personnes séjournant à domicile, last accessed 27/03/19).

Competent authority and financing: Since 2009, the PZT – SPAD budgets are allocated via the initiatives of sheltered living. [58] The PZT – SPAD can receive further resources from different actors or networks working in their catchment area [59, 60]. The PZT – SPAD are now regionalised. They are defined as part of the IBW – IHP but there is no law defining them up to now.

Numbers: In 2016, the Belgian budget was just over 9 000 000 euros for 44 teams. Additional funding from the social agreement of the public sector (accord social du secteur public-sociaal akkoord van de publieke sector) allow to hire staff. The teams are not all the same as the FTE varies from 2.5 to 4.75 (personal communication from UNESSA).

The projects have found a new working framework in the function 2 of the Psy107 reform, i.e. "*treatment teams in home setting as alternative for hospital stay in case of sub-acute (2a) and chronic (2b) problems*." Because of the Psy107 reform, some PZT – SPAD were partially (but there is no available number) integrated in the mobile teams within the Psy107 networks [61].

4.3.2.2 Psy107 Mobile teams for adults

Description: Two types of mobile teams for adults have been created with the Psy107 reform: one team for people in crisis with long term mental health problems (2A) and another team for chronic mental health problems (long term and severe) (2B). The patients that are within the scope must be between 18 and 64 years old for the adult mobile team. The teams are multidisciplinary and deliver mental health care on demand in the patient's environment, either in a crisis period, or continuously. The call can be made by the patient himself, by a relative or by a professional. The intervention will take place in collaboration with the other persons/professionals involved. The teams also help the patients to develop or to activate their network support.

Competent authority and financing: The responsible and funding authority is the Federal government through the mechanism of "freezing" of psychiatric beds. The Budget of Financial Means (Budget des Moyens Financiers (BMF) – Budget Financiële Middelen (BFM)) of the hospital taking part in the Psy107 network is unchanged, but the part of the budget corresponding to the frozen beds is used for the creation of mobile teams.

Numbers: In 2016, the inter-ministerial workgroup (InterKabinettenwerkgroep (IKW) – Groupe de Travail Intercabinets (GTI)) defined the programming norms for the mobile team 2A and 2B. For the 2A team, the amount of FTE is 12/150.000 inhabitants and 9/150.000 inhabitants for the 2B team. The total number of FTE amounted 976 for Belgium (107 in Brussels, 558 in Flanders and 311 in Wallonia). The number of FTE needed can be converted in number of mobile team per network. The total amount of 2A team was calculated to 46.1 and for 2B team to 47, for all the Belgian territory (totally, 93.1, of which 10.2 in Brussels, 53.1 in Flanders and 29.6 in Wallonia) [62].

Additional data were gathered from the survey on the mobile team performed in 2016 [63]. This study had concerned 18 networks (netwerk Leuven-Tervuren, réseau PaKT, netwerk Kempen, netwerk Noord West Vlaanderen, netwerk Reling, réseau Accolade, netwerk Noolim, réseau Halle-Vilvoorde-Brussel, netwerk Zuid West Vlaanderen, réseau SarA, réseau PRIT, réseau Bruxelles Est, réseau Fusion Liège, réseau Hainaut Occidental, réseau santé Namur, réseau région Hainaut, réseau Psy107 Verviers, réseau de la région du centre). The results are the following:

The **2A mobile teams** received 7340 referrals, which led to 6738 patients that have been taken in charge during 2016 [64].

Out of the 7340 referrals, 420 have been hospitalised (5.7%) directly before being followed. For the patients that were followed by a team, 970 patients required to be hospitalised during the follow-up.

The visits of the mobile team can be stopped for various reasons. This has been the case for 5804 patients in 2016 (86.1% of the patients). In the majority of the cases the interruption have been concluded by mutual agreement between the team and the patient (87.6%). The end of the intervention was in 6.8 % initiated by the patient, in 3.1% by the team and in 2.5% interventions were ended due to other reasons.

During 2016 the **2B mobile teams** have been observing 6337 patients. The 2B mobile teams were contacted 3272 times, which led these teams to take in charge 2124 new patients.

Two hundred twenty four out of the 3272 patients that contacted the team have been hospitalized (6.9%) before being observed. Some of the patients that were followed by a team, were hospitalized, that was the case for 944 of them. For different reasons, the care can be interrupted. This has been the case for 2003 patients in 2016 (31.6% of the patients). This decision was taken in agreement with the team and the patient in 66.9% of the cases. The decision to end the interventions came from the patient in 17.2 % of the cases, from the team in 11.2% of the cases and in 4.9% of the cases for another reason [64].

More data are available on the Mobile Team in Appendix 6 of chapter 05.

4.3.2.3 Mobile teams for children

The new mental health policy for children and adolescents provides various activity programs. Among these, a program specifically targets outreached MHC for children and adolescents through the organisation of mobile crisis care, of assertive assistance and care coordination. Children and adolescents in crisis, who need urgent, intensive and mobile care represent a first target group. This care is intensive and at short-term. A second target group are children and adolescents belonging to particularly vulnerable groups that are difficult to reach, or young people with psychiatric problems who are subject to a court decision. They are characterised by complex and multiple problems. Mobile care is indicated if the standard care offer does not meet the needs of the child or adolescent. Care can be intensive and short as well as long-term [65].

Each of the children and adolescents networks has set up one or two mobile teams in this context (mobile crisis team, long term mobile team).

These teams are mentioned in this report as they support to a critical age group between childhood and adult life, the 16-23-years-old.

4.3.2.4 Mobile teams care path for internees

Description: The federal government's multi-year plan (2009) with regard to internees[66], aims to keep stays in closed institutions as short as possible, especially to avoid prison overcrowding. The purpose of this plan is to provide adequate care to internees, in particular by removing them from penitentiary institutions so that they can benefit from optimal social integration. The multi-year plan fits into the model of MHC reform. It includes the setting up of the internees care path coordinator for in-patients and the external internees care circuit coordinators for patients outside residential institutes as well as the implementation of a internees care path mobile team ; one by court of appeal, so 5 on the Belgian territory. The care path of these mobile teams (Equipes mobiles trajet de soins internés – Mobiele team geïnterneerden zorgtrajecten) was set up to promote the transition to the conventional care circuit, provide support to the internees and to their social reintegration. The new internment Masterplan launched in 2016 foresees an extension of these teams to all the Regions in July 2018[67].

The missions of the mobile teams care path for internees are to:

- build / strengthen a care path fit for each internee, regardless of his/her profile;
- provide MHC in the living environment;
- prepare reintegration into society;
- avoid returning to prison;
- ensure continuity of care.

Teams vary according to the composition and organisation of each court of appeal. Some have hired psychologists. The mobile teams develop several antennas by court of appeal. There is a will to include the internee care path within the Psy107 networks in the aim to destigmatise the internment.(https://www.health.belgium.be/fr/internement - last access 15/04/2019)

Competent authority and financing: The mobile teams care paths for internees are set up by the Federal and have been operating since the 1st of January 2014. Their relevant authority is the FOD – FPS Public Health. The funding is made via B4 agreements, renewed each year. Each hospital hosting the team is responsible for the distribution of its budget.

Number: There are 5 teams, which include the one in Brussels: The Brussels team consists of two sub-teams, a French-speaking and a Dutch-speaking. 25 psychiatric hours per week are funded for each team.

4.3.2.5 Mobile team of intervention

Description: In Wallonia and in Brussels, the mobile teams of intervention (Cellule mobile d'intervention - CMI) guide the entourage of people with a 'double diagnosis', meaning people who have an intellectual disability and a mental health problem (behavioural problems and / or psychiatric problems). Their main goal is to enhance the inclusion of people with disabilities and behavioural problems within four axes of work:

- Support services for people with mental disabilities and with serious behavioural problems
- Bringing a better knowledge of the mental pathologies and the specific attitudes that they require
- Improving the collaboration between the disability field and the psychiatry field
- Helping to set up the organisation of a coordinated offer of disability and psychiatry services.

The mobile intervention teams differ according to their management and the option at the beginning of the project: team of the hospital or not, with 1st line intervention for the families or not, the therapeutic approaches, limits in terms of treatment duration, meant for a specific target group…[68]

Competent authority and financing: In Wallonia, the teams are the result of a call for proposal initiated by the ex-AWIPH (agence wallone pour l'intégration des personnes handicapées). The funding and the recognition of these services is subject to the regional and federal government. A legal framework is in preparation and should be active in Wallonia in 2018 [23].

Numbers: In 2016 5 teams are funded by the Walloon Region and 2 mainly by the federal authorities [23]. In the German Community one team is funded and had 2 psychologists in the team.

In Brussels, there is a mobile team of intervention, funded by the FPS public health and the COCOF [23, 45].

In Flanders these Mobile team of intervention do not exist as such. There are other forms of initiatives that focus on people with a double diagnosis:

- Handicum (www.handicum.be): training organisation that focuses on people with a disability and their entourage.
- SEN (Steunpunt Expertise Netwerken): wants to promote the expertise of professionals and services in Flanders related to prevention, diagnoses and treatment concerning people with a disability. This service was, in 2018, merged with other structures involved in the sustainability and equity of the society. The fusion of those structure is called SAM (Steunpunt Mens en Samenleving- www.samvzw.be- last access 18-04-2019)
- Outreaching teams: Outreaching coaching for (young) adults with an intellectual disability and mental health and/or behaviour problems started in 2009. Their purpose was to reduce (serious) behavioural problems to enhance the social integration, to improve the mental health, and in doing so, to lower the lack of inclusion. Also, outreach teams aim at avoiding inappropriate hospitalisation. This is realized by supporting health care professionals and family of persons with a mental disability. Since July 2016 these teams are integrated in the mobile teams of the Psy107 networks. Per province is one psychiatric hospital that offers a specific residential care in cooperation with the mobile teams.

4.3.3 Day centre

Description: The MHC offer includes day centres (dagcentra/ structures de jour). The name « day centre » is not a structure defined within a clear legal frame. The investigations made in the context of this study have highlighted a large number of structures that offer mental health care, aiming mainly at the resocialisation of persons with psychiatric or severe psychological problems.

Besides the therapeutic clubs described in 4.3.1 which depend on a community mental health centre (SSM – CGG), day centres also involve therapeutic workshops, psycho-social clubs, resocialisation workshops, centres that organise daily activities, etc. The objective of these projects is to offer support, social bonding, structured activities, etc. They are aimed at the rehabilitation of people with MH problems, with a view to destigmatisation. Art often plays an important role in the day centres as mediator of self-expression.

Competent authority and financing: These initiatives may depend on psychiatric or general hospitals, on IHP's, on therapeutic communities. Their funding goes through various ways. Some of them receive an optional fund from the federated entities, others provide their own funds, etc. Sometimes, the personnel is provided by the institution that sets up the project. These persons may involve mental healthcare professionals, educators, volunteers, or patients themselves. Given the diversity of the operating contexts of these projects, it is impossible to provide an exhaustive presentation of all of them.

Numbers: there is no number available for this category, given the diversity of forms and frameworks possible.

4.3.4 Services on addiction

The sector of the addiction is very complex to describe. It encompasses a multitude of services that can provide assistance to patients. Some services depend on different levels of authorities and may also have several sources of funding. Part of the mental health offer is provided by the hospital sector, the community mental health centre (CGG – SSM) and the specialised rehabilitation centres with convention (RIZIV – INAMI agreements, see 4.3.8). The offer proposed by the hospital sector may be residential or ambulatory. The addiction offers described here should be added to the other categories of services mentioned in the chapter. They are very varied and are organised differently from one Region to another. Another important actor is the addiction networks (see 6.6), whose purpose is to improve the quality of care and assistance and to promote continuity of care.

Description: The services offering specialised addiction care have several missions: they provide information, psychosocial support, psychotherapeutic and medical interventions, care, and reductions of the risks. They work with people suffering from addiction (to licit or illicit psychotropic products, alcohol, tobacco and gambling) and their entourage.

Competent authority and financing: The services are accredited and funded by the federated authorities.

In Wallonia, to the formal funding way, can be added an optional funding from the former “Fonds Assuétudes”. Wallonia formally funds 27 services and gives 20 optional funding.

In Brussels, the COCOF accredits and funds 15 active addiction services (14 + 1 (Federation of services), its budget amounts to 4 636 000 euros [69, 70].

Since in Flanders addiction care is part of the mental health policy, there are no specific service providers other than sections of psychiatric hospitals, teams on community mental health centres and the centres with a convention with RIZIV – INAMI.

On the other hand, there is VAD (Vlaams expertisecentrum Alcohol en andere Drugs, see 6.6.2) that act as an umbrella organisation for all the organisations that are working on alcohol and other drugs. Their main goals are awareness raising, building (inter)sectoral networks and support qualitative approach of the alcohol and drug theme. With the Druglijn (Drugs line) they offer a free accessible channel (mail, phone, chat, skype) for questions on all kind of legal and illegal drugs. By collecting data on drug use they present regularly reports on the evolution of drug use [71].

4.3.5 Exile services (Wallonia and Brussels) / Psychological care for refugees (Flanders)

Various types of services exist to help the migrants. This section targets exclusively the services that offer a psychological support to this public.

Description: In Wallonia, besides the specific "Exile" mission in the community mental health centers (CGG – SSM), there are independent services devoted to this public organised by regional authorities. They aim at the integration of foreigners or people of foreign origins, by fostering the equality of chances, citizenship, access to public and private services, etc. The services help and provide psychological support to migrants. In Brussels, the main offer is CGG – SSM-based while Woman'Do is a psychotherapeutic service specialised in helping exiled women in precarious situations, fleeing violence.

Flanders provides psychological support for migrant children (for example refugees), or children from 0 to 18 years from families with a past in migration. The care is offered by the association 'Solentra' (https://www.solentra.be/nl/). Solentra is part of Paika, the psychiatric department of the university hospital of Brussels for infants, children and adolescents. Solentra gives diagnostic and therapeutic support for refugees, children of migrants and their families. Solentra makes psychological care more accessible and efficient, using the PACCT©-method (Psychiatry Assisting the Cultural diverse Community in creating healing Ties). Their main goal is to strengthen and broaden the (im)migrant families' safety net by mobilizing (in)formal sources in the surroundings of these children. Solentra's aim is to support caregivers when they suspect heavy psychological problems in a child.

Competent authority and financing: The services in Wallonia get optional funding from the regional authorities. Fedasil centres can also offer a reimbursement of mental healthcare to asylum seekers.

In Brussels, the Woman'Do service gets a funding from the COCOF [69].

In Flanders, the service is organised by the university hospital of Brussels. The CAW also have a varied offer to refugees and persons in exile (see 4.2.2).

Numbers: Besides the 3 specific initiatives from the community mental health centres (SSM/CGG), three services are counted in Wallonia. There is 1 service in Brussels in addition to the community mental health centres (SSM/CGG) initiatives. For Flanders there are 15 persons who work for Solentra, of which 13 psychologists (https://www.solentra.be/nl/teamleden/).

4.3.6 Ambulatory private or hospital-related practice of mental healthcare professionals

MHC professionals might have an ambulatory private or hospital-related practice. This activity can be in addition with an activity in another type of services categories or can be their sole activity. Whether they are psychiatrists, psychologists or psychotherapists, they mainly offer consultations. A certain amount of these professionals work "together" in polyclinics or private centres but those multi-practices centres are different from SSM-CGG. The services are sometimes composed of a multidisciplinary team (psychologist, psychotherapist, speech and language therapist, psychiatrist, occupational therapist, physiotherapist, etc.) to provide a complete care offer.

One of the developments of the private mental health offer is the employee assistance programs. In the employment sector, employers can make use of an employee assistance program for the mental health of their employees. The latter can benefit from those when they have personal problems and/ or work-related problems that may impact their job performances, health, and their mental and emotional well-being. In some employee assistance programs, the family of the employee also can make use of these services. The information about the funding and/or the statistics of the programs are sparse.

Health care professionals are also being hired in public institutions (postal services, the Belgian railways, police, army, fire brigades …), especially through the internal prevention services, to intervene when workers are being confronted with potentially traumatising situations.

4.3.6.1 Private practices of psychiatrists

Description: A psychiatrist is a physician who has a supplementary specialization in psychiatry besides his training in medicine. A part of the psychiatrists also have an additional training in psychotherapy. Besides their job in (psychiatric) hospitals or community mental health centres, psychiatrists often also have a private practice (https://www.geestelijkgezondvlaanderen.be/psychiater). They provide consultations, set diagnoses, start up or alter (pharmacological) treatment and some of the psychiatrist also provide psychotherapy.

Competent authority and financing: Medical acts as provided by psychiatrists are (partly) payed back based on nomenclature by the National Institute for Sickness and Disability Insurance (RijksInstituut voor Ziekte- en InvaliditeitVerzekering (RIZIV) – Institut National d'Assurance Maladie-Invalidité (INAMI)). All the reimbursed health related acts are entered in the intermutualist agency (InterMutualistisch Agentschap (IMA) – Agence InterMutualiste (AIM)) database (reimbursed medical acts, reimbursed pharmaceutical products, reimbursed acts performed during hospitalization …)

Numbers: In 2015, there were 1930 psychiatrists (and neuropsychiatrists) in Belgium. In 2012 the distribution of the psychiatrists throughout the three Regions of the country amounted to 11,4% in Brussels, 74,8% in Flanders and 13,8% in Wallonia [72]. The total amount of reimbursements performed in 2012 by the RIZIV – INAMI amounts to 67 300 000 euros.

The extra data we gathered concerning psychiatrists is not included in this section because it makes no distinction between possible workplaces (private, in an office, in a hospital etc.). Psychiatrist workplaces cannot be deduced through postal code neither.

4.3.6.2 Practices of clinical psychologists and psychotherapists

Clinical psychologist is an independent health profession, as defined by the law (Loi 10/07/2016 réglementant les professions des soins de santé mentale, last accessed 25/03/19).

In order to practice clinical psychology, the clinical psychologist must possess accreditation which can only be granted to a person who holds a university degree in the field of clinical psychology recognising at least 5 years of study or 300 ECTS credits including a placement in the field of clinical psychology. The Law defines the practice of clinical psychology as the usual performance of independent actions seeking to or presented as seeking to prevent, review, screen or establish a psycho-diagnosis, for an individual and within a scientifically-backed reference framework for clinical psychology, for real or imagined, psychological or psychosomatic suffering and the care or support of that person. [73].

A lot of psychologists work as an employee in several categories of services described in this chapter, often in combination with a private practice. Another group of psychologists is entirely self-employed.

Psychologists' consultations have recently been added to the reimbursed interventions by the National Institute for Sickness and Disability Insurance (RIZIV – INAMI). The refunding will be possible if the person is referred by a general practitioner or a psychiatrist for 4 visits at most [74]. There are 5775 of the 12 000 registered psychologists in Belgium which are active self-employed as main or secondary occupation. There are no specific numbers on the distribution between those two categories. Until now there are no data available concerning the number of consultations of independently working clinical psychologists in Belgium.

The law of 10 July 2016 (Loi 10/07/2016 réglementant les professions des soins de santé mentale, last accessed 25/03/19) defines psychotherapy as a form of MHC and not as a specific health care profession that requires an accreditation. Psychotherapy may exclusively be practised by persons who already have a professional title and who fulfil a series of conditions. According to the law, candidates for a recognised practice of psychotherapy need to have a bachelor diploma in a health profession, psychology, educational sciences or social sciences, of at least 3 years or entailing 180 ECTS. In addition, they must be trained in basic notions of psychology in a university or college university ('hogeschool'– 'haute école') and must have coursed psychotherapy for at least 70 ECTS during 4 years in one of the psychotherapeutic orientations recognised by the law (psychoanalytic or psychodynamic; cognitive-behavioural; systemic and family psychotherapy; humanist person-centred and experiential).

Currently, partly due to the lack of reimbursement, no precise data are available concerning the number of consultations of self-employed psychologist and psychotherapists in Belgium. An estimate of the number of persons that consult a psychologist/psychotherapist has nevertheless been provided during the national health interview survey (HIS) realised by the Scientific Direction Epidemiology and Public Health. This estimate, in 2013, was on average of 5 % of the population (both men and women) [75].

A scarce source of data is the year report in 2016 by the commission des psychologies/ – psychologencommissie who mapped 11 941 licensed psychologists [76]. No data is available in terms of FTE concerning these psychologists, neither about the number of patients followed, or even the total cost of the care. These private practitioners can have their practice in several/various locations: hospital, CGG – SSM, ambulatory mental health centre, private practice, shared practice, self-employed etc.

4.3.7 Suicide services

A large number of services and professionals are confronted in their practice with patients having suicidal ideation. Suicide prevention forms an integral part of the specialised services.

Description: In Wallonia, apart from the objective of training and awareness-raising, the service sets as its goal to quickly intervene in case of suicide risk, proposing psychological talks, to provide psychological support to the entourage, including grief management after suicide. The service offers a social support to the general public to coach them in various administrative procedures and intervenes equally in environments (professional or within schools) where a suicide took place through the stimulation of an adapted forum.

In Brussels, the suicide prevention centre develops various types of activities. It provides free psychosocial support for persons in a suicidal crisis and for their relatives, in collaboration with various public hospitals, general practitioners, medical homes, and other partners of the psycho-socio-medico network. The maximum length of care is two months. After that, a reorientation may be proposed if this seems necessary. The Centre also offers the possibility of meetings, individually or with the family, for mourning persons after the suicide of a loved one. In addition, a team of volunteers provides a sympathetic ear through a phone line accessible 24/7. The Centre has as well developed a Forum, a space of free speech, of sharing, of debates and discussions concerning the topic of suicide and its prevention. Finally, the Centre intervenes in communities to provide some support to persons and organisations confronted with suicide.

In Flanders, the Centrum Preventie van Zelfdoding (CPZ) focuses on the prevention of suicide. They organise the Zelfmoordlijn (1813) that is run by volunteers. People enter through the portal https://zelfmoord1813.be/ where contact can be taken by phone, chat, or mail. There are as well some self-help apps available. Werkgroep Verder is concerned on the bereaved after suicide and offers talk groups, online forum, a remembrance site … (www.werkgroepverder.be), etc. Werkgroep Verder is organised by means and staff of a community mental health centre.

Competent authority and financing: The centres are funded by the regional authorities (in Brussels, the centre is now under the authority of the COCOF).

Numbers: In 2018, there was one service in Wallonia, with 8 places for counselling, one in Brussels, and one prevention centre in Flanders. [77]

4.3.8 Specialised rehabilitation centres with convention

Description: Specific agreements ('conventies' – 'conventions) between National Institute for Sickness and Disability Insurance (RIZIV – INAMI) and specialised rehabilitation centres ('Gespecialiseerde centra en revalidatiecentra – Centres spécialisés et centres de rééducation) provide the framework for the activities of the centres and their funding (https://www.inami.fgov.be/nl/professionals/verzorgingsinstellingen/revalidatiecentra/Paginas/default.aspx). The activities provided in these centres may include residential and ambulatory care. Some of these conventions are situated in MHC, of which only two programs focus on adults (i.e. psycho-social rehabilitation for adults (772) and rehabilitation for addiction problems (773)). Psycho-social rehabilitation for adults ('Inrichtingen voor psychosociale revalidatie van volwassen psychiatrische patiënten / Etablissements de rééducation des troubles mentaux adultes (772)) offers specific programs of limited duration that are complementary to other psychiatric treatment plans. The objective of these programs is adapted to the situation of each person and include to improve their quality of life, (social) skills in order to reintegrate into society as well to regain access to the labour market. In addition, the ambulatory centres for rehabilitation (centra voor ambulante revalidatie (CAR) – les centres de rééducation ambulatoire (CRA) (953965)) are subject to the RIZIV – INAMI conventions and provide ambulatory rehabilitation sessions. These centres mostly target children and adolescents but can provide services to adults as well. Conventions for rehabilitation in case of addiction problems services (773) take care for persons addicted to illegal drugs, medication, alcohol or other psycho-active substances. Some of these centres focus on crisis intervention. Different types of ambulatory or residential treatment are offered focusing on detoxification, elimination of addiction and a better social (re)integration. The duration of care is limited.

The patient's contribution in the cost of care depends on his/her status, family situation and whether or not the care is provided in residential settings.

Competent authority and financing: The 6th institutional state reform transferred the accountability for these centres to the federated entities, but the National Institute for Sickness and Disability Insurance (RIZIV – INAMI) remains temporarily responsible for the recognition and funding of a series of programs for various types of rehabilitation [78]. Until the complete transfer of responsibilities between the entities, National Institute for Sickness and Disability Insurance (RIZIV – INAMI) pays a lump-sum that varies according to the activities that aim at covering the staffing costs. The federated authorities can also provide funds for infrastructure, however, in practice this is rarely the case.

Numbers: In 2017, there were 33 psycho-social rehabilitation centres for adults (772): 8 in Brussel, 11 in Flanders and 14 in Wallonia. There were 34 conventions for rehabilitation for addiction problems (773): 7 in Brussel, 16 in Flanders and 11 in Wallonia. The total funding envelope amounted to 28 000 000 euros for the 772-centres and to 56 000 000 euros for the 773-centres [79].

Table 10 – Number and budget of Specialised (772) rehabilitation centres with convention per Region

Number of 772 centres	Region	Estimated budget for 2017 (€)
8	Brussels	10 353 120
11	Flanders	9 854 653
14	Wallonia	8 676 597

Table 11 – Number and budget of Specialised (773) rehabilitation centres with convention per Region

Number of 773 centres	Region	Estimated budget for 2017 (€)
7	Brussels	9 565 582
16	Flanders	31 503 732
11	Wallonia	15 505 550

More data are available on the specialised rehabilitation centres with convention in Appendix 7 of Chapter 05

4.3.9 Psychiatric wards in general hospitals/specialised hospitals

Description: Psychiatric wards in general hospitals (Psychiatrische Afdeling in een Algemeen Ziekenhuis – PAAZ – service psychiatrique d'hôpital général - SPHG) provide short-term in-hospital treatment for patients with mental health problems. The PAAZ – SPHG aim to provide a response for a mental health problem and a 'liaison' function within the hospital.

In general, psychiatric wards in general hospitals reserve 10% of their beds for psychiatric day care or night care [80] (see Appendix 8 of Chapter 05 for bed description and programming norms). The perceived advantage of PAAZ – SPHG services is the lower threshold for consultation compared to psychiatric hospitals (destigmatising), the immediate accessibility of somatic care in a MHC environment (trend towards liaison psychiatry) and the 'short stay' treatment vision (with focus on ambulatory care).

Some of the general hospitals with a psychiatric ward have a psychiatric emergency intervention unit (Eenheid voor Psychiatrische Spoed Interventie (EPSI) – Unité de Crise et d'Urgences Psychiatriques (UCUP)). This unit is mostly located aside the general emergency unit of the hospital, and is staffed with personnel of the psychiatric ward.

Competent authority and financing: The responsibility and the funding for PAAZ – SPHG as well as patient cost-sharing follow rules similar to those applied to psychiatric hospitals (see 4.4.1 for details). The budget for these services does not depend of the notion of justified activities but rather on historically based parameters (e.g. number of recognised beds) [81].

Numbers: In 2019, there are 104 general hospitals in Belgium: 38 in Wallonia, 14 in Brussels and 52 in Flanders. There are 72 SPHG – PAAZ on the total number of general hospitals in Belgium, 24 in Wallonia, 11 in Brussels and 37 in Flanders (FPS on public health-data of 2019 on demand in 2019). The total budget of the general hospitals in 2016 was 6 187 000 000 euros, for a financial performance of (2015) 23 000 000 000 euros [82].

Table 12 – Number of bed in PAAZ – SPHG per index [83]

Number of beds for the different index in January 2018

Beds types	**Flanders**	**Wallonia**	**Brussels**	**Belgium**	**Repartition of the beds**
A	1032	480	268	1780	67.3%
A1	163	73	80	316	11.9%
A2	2	0	0	2	0.1%
T	0	139	0	139	5.3%
T1	0	17	0	17	0.6%
T2	0	0	0	0	0.0%
IB	0	0	0	0	0.0%
S6	118	221	53	392	14.8%
Total	1315	930	401	2646	100%

See 4.4.1 for the bed type description

More data are available on the PAAZ/SPHG in the Appendix 8 of Chapter 05

4.3.10 Psycho-social services in prisons

Description: The psycho-social services ensure the psycho-social reception of each detainee who enters prison and the follow-up during the detention. The team composed of psychologists and social workers prepares the detainee for his/her psychosocial rehabilitation and evaluates his/her proposals for reclassification. The psycho-social services are organised around a central service and local teams in each penal institution. General practitioners in prisons also play a role with prisoners suffering from mental health problems [84].

Competent authority and financing: The authority for these services is the federal government, more precisely, the general management of penal institution (directoraat-generaal Penitentiaire Inrichtingen (EPI) - direction générale des Etablissements pénitentiaires (EPI)). The 2016 budget for care and expert medical examination amounts to 63 166 302 euros[67].

Numbers: there is one service per penal institution. In 2016, for the whole of the penal institutions, there were 389 psychosocial workers for a total of 324,07 FTE [67].

4.3.11 Initiatives of sheltered living

Description: Sheltered accommodation (Initiatieven Beschut Wonen – IBW – Initiatives Habitation Protégée - IHP) (RIZIV/INAMI, Beschut wonen voor psychiatrische patienten) are residential structures for patients with psychiatric problems who have difficulties to live independently. It is an alternative for or in addition to PZ – HP. They take care of adult patients who have been discharged from psychiatric hospitals and who do not need permanent follow-up but who must be assisted in their living environment to acquire certain social skills. The main aim is to support people with mental health problems by supporting them in living independently. The patients are supported by a multidisciplinary team and suitable day activities are organised. Residents can live in different types of accommodation with a limited number of other patients in ordinary houses (3 to 10 persons). Since 2000, people can also live in individual dwellings; however, their number cannot exceed 20% of the total.

Competent authority and financing: The 6th institutional state reform transferred the competence of programming, recognition and funding of IBW – IHP to the federated entities. Until the complete transfer of responsibilities between the entities is completed, the National Institute for Sickness and Disability Insurance (RIZIV – INAMI) pays a daily lump-sum that covers the staff salary according to the established norms for the minimum personnel availability. The federated authorities can also provide funds for infrastructure. [85] Patient's participation in the cost of boarding and lodging varies between the institutions.

Numbers**:** In May 2017, there were 27 IBW – IHP for 798 places in Wallonia (including 1 IBW – IHP in the German community), 18 IBW – IHP for 560 places in Brussels and 43 IBW – IHP for 2889 places in Flanders [86] [87]. The global budget for the IBW – IHP was amounted to 43 722 000 euros in Belgium in 2013 [87].

A traditional form of sheltered accommodation in Belgium for people with chronic mental health problems is care within a foster family ('gezinsverpleging' – placement familial'). [58, 88, 89] Patients participate in family life and sleep in the family house.

More data are available on the initiatives of sheltered living in the annexe 10.9.

4.3.12 Psychiatric care homes

Description: Psychiatric care homes (psychiatrisch verzorgingstehuis- PVT – Maison de soins psychiatriques - MSP) take care of patients of all ages with a stable psychiatric condition who need permanent care for a long-term mental health problem and for intellectually disabled persons who need permanent supervision. The people who live in this secure collective living facilities do not need intensive in-hospital specialist (neuro-) psychiatric treatment but are unable to live independently in the community or in other living communities (e.g. initiatives for sheltered living, nursing homes for older persons).

Competent authority and financing: The 6th institutional state reform transferred the competence of programming, recognition and funding of PVT – MSP to the Regions. At the moment of the writing of the report and until the end of 2018, the federal authorities remain responsible for the funding of PVT – MSP. The National Institute for Sickness and Disability Insurance (RIZIV – INAMI) pays a lump-sum to cover health care services and help support for the activities of the daily living [90]. Patient's participation in the cost of boarding and lodging is fixed by the Minister of Public health and depends on the patient's status and family situation (RIZIV/INAMI, psychiatrische verzorgingstehuizen). Patients must pay a fixed co-payment for pharmaceuticals delivered in the psychiatric care home (PVT – MSP).

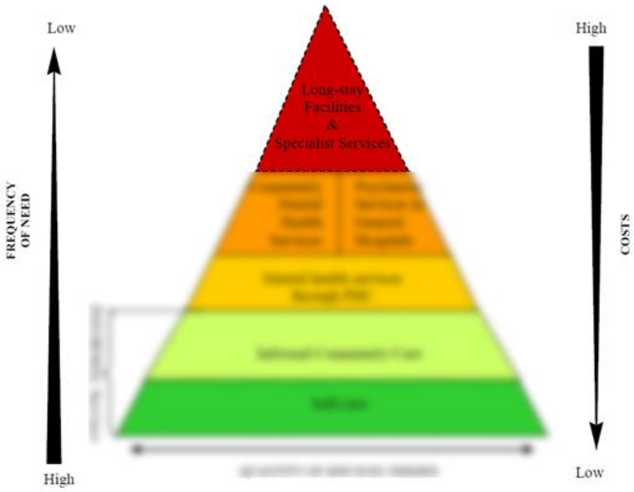
Numbers: In May 2017, there were 40 psychiatric care homes (PVT – MSP) in Belgium, 23 PVT – MSP for 1896 places in Flanders, 14 PVT – MSP for 818 places in Wallonia (including 30 places in the German speaking in 1 PVT – MSP) and 3 PVT – MSP for 229 places in the Brussels Region [86]. The global budget in Belgium for the PVT – MSP was of 98 129 000 euros in 2013 [87].

More data are available on the psychiatric care homes in the annexe 10.10.

The category “community mental health services and psychiatric services in general hospitals” includes a large amount and a wide variety of offers. This category corresponds to the general offer in mental health. It brings together MHC services set up in the living environment. Next to the public services, the private offer in MHC emerges as well. The available data concerning the various categories of services are unfortunately limited and then the description of the MHC offer is unfortunately still confused.

4.4 Long stay facilities & specialist services

The services presented in this section are the most specialised ones of the mental health care system. They have a very high operating cost compared to the other categories. In the pyramid these services should be the smallest category within a community view of care.



4.4.1 Hospitalization units inside psychiatric hospitals

Description: Psychiatric hospitals (Psychiatrisch Ziekenhuis PZ – Hôpital Psychiatrique HP) provide treatment and care for patients with severe psychiatric problems. Besides fulltime hospitalisation for all patients regardless of their age, a psychiatric hospital can also offer day-care (day hospitals) and less often night care [81]. Psychiatric hospitals often offer more than hospitalization units as day care and consultations. Those type of services are described in the sections 3.3.3. and 3.3.6. Within each psychiatric hospitals, one or more specialised services (addiction, psychosis, depression,…) and different types of beds are available.

Neuropsychiatric Observation and Treatment Service, index A: treatment of adult individuals (15 years and older) who are in need of an urgent intervention in case of a crisis, an observation or an active treatment. Service A is to ensure hospitalisation during the day (A1) or at night (A2).

Neuropsychiatric Treatment Service, index T: service for the treatment of adults (15 years and older) focusing on maximal social rehabilitation activities. The T service is to ensure the hospitalisation during the day and at night and may ensure the hospitalisation during merely the day (T1) or during the night (T2).

Intensive treatment of psychiatric patients, index IB: specialised services with beds for intensive treatment of psychiatric young (less than 18 years) and adult patients with a greatly disturbed behaviour and aggressive patients.

Psychogeriatric Service, index SP: specialised service for the treatment and rehabilitation of patients with psycho-geriatric disorders who require a diagnosis and/or a treatment of a psychiatric and somatic kind as well as a multidisciplinary support, in order to ensure the recovery or preservation, as high as possible, of the physical, psychological and social level of the patient.

Psychiatric foster care, index TFB: care for patients whose psychological and social balance can only be maintained if permanent care is provided by a foster family and therapeutic guidance by a multidisciplinary treatment team within the organizational framework of a psychiatric hospital service.

Day and night care for geriatric patients, index Tg: day and night beds for geriatric patients requiring neuro-psychiatric treatment.

The multidisciplinary teams offer the therapy that is most suitable to the problem they encounter. The medical team for services A and T is run by a doctor specialised in (neuro)psychiatric science. The medical-psychological-social team is composed of at least a graduated psychologist and of a social nurse or a social worker (for every 60 patients for the A services, for every 120 patients for the T service). Form also part of the team: nurses (preferably psychiatric nurses), occupational therapists educators, assistants in psychology, physical therapists, or other persons who obtained a licentiate's degree or a degree in higher non-university education that is paramedical-oriented. [91].

Competent authority and financing: Federal authorities (SPF Public health and RIZIV – INAMI) are responsible for funding and programming of psychiatric hospitals. In general, hospitals receive their revenue from various sources. The two primary sources of public funding are a global budget, called the Budget of Financial Means (Budget des Moyens Financiers (BMF) – Budget Financiële Middelen (BFM)) and physician fees. [92] The Budget of Financial Means (BFM) is divided into different sub-budgets and is allocated to individual hospitals according to specific rules for each sub-budget. [81] Since the 6th state reform, the budget for infrastructure and investment from the BFM (part A1 and A3) and recognition norms are the responsibility of the federated authorities. The BFM B budget for psychiatric hospitals and psychiatric wards in general hospitals is allocated individually based on the number of recognised beds (see Appendix 2 of Chapter 05 for beds descriptions and programming norms), the amount of hospitalisation days and the occupancy rate. The latter differs from the funding of general hospitals and other hospital wards that receive a budget based on 'justified activities'. The hospital's 'justified activity' is based on the national average length of stay (LOS) per pathology group (All Patient Refined Diagnosis Groups (APR-DRGs)), which is then applied to the case-mix of each hospital. [92] Patients pay a daily fee for a hospital stay that covers the cost of 'boarding and lodging' and of health care services with the exception of medicines, physician's consultations and technical acts ('technische verstrekkingen' — 'prestations techniques'). The daily fee varies according to the patient's status (e.g. eligibility to increased reimbursement) and the length of stay. For inpatient medicines, hospitalised patients pay a fix sum of € 0.62 euro per day independently of their pharmaceutical consumption. [92, 93]

Numbers: In September 2017 psychiatric hospitals had 13 806 recognised beds for adults (9 401 in Flanders, 3 696 in Wallonia and 709 beds in Brussels). In 2016, there were 60 PZ – HP in Belgium with 32 in Flanders, 19 in Wallonia and 9 in Brussels. A- and T-beds make up the majority of available beds (36.8% and 35.7% respectively) [86].

Table 13 – Budget (global, including bed for children) of the PZ – HP per Region for 2018.

	Flanders	Wallonia	Brussels	Belgium
BFM	739 777 531 €	350 017 602 €	90 518 221 €	1 180 313 354 €
Percentage	63%	30%	8%	100%

Table 14 – Number of beds per index type for each Region in PZ – HP in January 2018 [83]

	Number of beds				
Beds types	**Flanders**	**Wallonia**	**Brussels**	**Belgium**	**%**
A	3 057	1 722	297	5 076	36.8%
A1	534	261	49	844	6.1%
A2	127	7	33	167	1.2%
T	3 322	1 331	274	4 927	35.7%
T1	1 019	109	30	1 158	8.4%
T2	206	31	10	247	1.8%
IB	32	16	16	64	0.5%
SP	504	201	0	705	5.1%
TFB	81	18	0	99	0.7%
Tg	519	0	0	519	3.8%
Total	9 401	3 696	709	13 806	100%
%	68.1%	26.8%	5.1%	100%	

More data are available on the HP in the Appendix 11

4.4.2 Internment

Interment [internering – internement] is defined by the law of May 5th 2014 (Loi relative à l'internement, last accessed 27/03/19), implemented since October 1st 2016 (regarding internment of persons with a psychiatric disorder), as a safety measure to protect society as well as to ensure that care is provided to the interned person as required by his/her mental state in the perspective of his/her reintegration into society [94]. As people who are interned have a mental illness, they need to get treatment in a specialised institution.

Internment or internee concept requires three main elements to be appropriately used: the person has committed a crime needing detention; the person presents mental health problems during the judgement impairing his ability to decide; and there is a risk of recurrence of crimes.(https://wallonie.similes.org/2017/06/22/dossier-la-nouvelle-loi-relative-a-linternement-des-personnes-quest-ce-qui-a-change/

Last access 18-04-2019) The internees have to be distinguished from the high number of detainees and convicts in prisons which present mental health problems or receive anti-psychotics (21%), antidepressants (25%) and anxiolytics (31%). [84]

The usual place for internment is in social defence institute (Etablissement de Défense Sociale-EDS – Inrichting tot Bescherming van de Maatschappij-IBM) or in centre of forensic psychiatry (Forensisch Psychiatrische centrum - centre de psychiatrie légale) or in secured psychiatric hospitals. However, a part of the internees are detained in psychiatric annexes of prisons. (https://wallonie.similes.org/2017/06/22/dossier-la-nouvelle-loi-relative-a-linternement-des-personnes-quest-ce-qui-a-change/, Last access 18-04-2019)

On 18 November 2016, the Council of Ministers approved the Prisons and Internment Masterplan [95] on the proposal of the Minister of Justice, elaborated in collaboration with the Ministers of Public Health and Security and the Interior. With this plan, the Government wants to reduce overcrowding of psychiatric annexes in prisons, renovate the prison infrastructure and make it more suitable for the reintegration of prisoners, and offer alternatives to the application of traditional sanctions. An adapted infrastructure will be put in place for the internees, in which they will benefit from human dignity and personalised care and support. Two new centres of forensic psychiatry of 250 places each will be available in the coming years.

The overall budget for internment amounts to approximately 27 500 000 euros.

4.4.2.1 Centre of forensic psychiatry

Description: The centre of forensic psychiatry (Forensisch Psychiatrische centrum - centre de psychiatrie légale) is responsible for internees care. They are psychiatric hospitals with a high degree of security. The current equivalent in Wallonia are the secured psychiatric hospitals. There exist also a limited number of secured sections in certain hospitals in Brussels and in Flanders, for persons who are interned but released on probation.

Competent authority and financing: The centers depend on the FPS justice and the FPS public health.

Numbers: In 2016, there were 2 centre of forensic psychiatry in Flanders (Ghent since 2014, 270 places and Antwerpen since 2017, 182 places). Two new centres for internees will be also built in Wallonia (Wavre and Paifve, where the existing establishment becomes a prison facility), with 500 places. In Wallonia, there are already two secured psychiatric hospitals. Moreover, the Masterplan also plans 240 additional places to be opened in the future in existing forensic psychiatric or regular care facilities in Flanders and Brussels [95] [96]

In parallel, the internship Masterplan plans to build a “long-stay” establishment with 120 places in Aalst, intended to house internees with a high-risk profile in terms of security and who therefore cannot be maintained in CLP, focused on social reintegration.[95] [96]

Still, quite a number of internees do not have a place in the specialised institutions. In 2016, 784 internees were detained in penal institutions [67], whether in the psychiatric annexes of the prisons or in the social protection institute of Paifves.

Furthermore, some twenty hospitals spread over Belgian territory take in charge internees released on probation (and, in principle, all psychiatric hospitals may take in charge this type of patients).

4.4.2.2 Psychiatric annexes in prisons

Description: In certain prisons, the internees stay in a separated section and live therefore separately from the other prisoners. In these psychiatric annexes, also called social protection sections, a care team has the mission to provide a therapeutic care support to the prisoners. The team groups a psychiatrist, a psychologist, a social worker, an occupational therapist, a psychiatric nurse, a physiotherapist and an educator [97].

Competent authority and financing: The organisation and funding of health care provision within the prisons is primarily a Federal competence (Federal Public Service Justice) whereas RIZIV – INAMI covers the cost of healthcare outside of the prison (secured psychiatric hospitals, extra-muros hospital care and medical treatment). In addition, the federated entities are competent for the organisation of services of well-being, preventive health care, including prevention of addictions, health promotion, social and professional reintegration, education, culture and sports in prisons. [98]

Numbers: According to the 2017 KCE report on MHC in prisons [84], 12 prisons have a psychiatric annex or a social protection section. This number also includes the social protection institute of Paifve. In 2019, around 600 internees were detained in psychiatric annexes of prisons. Even if this type of detention is not allowed regarding international rules, it is an improvement in comparison to 2014 when around 1100 internees were not in care structure. (https://www.rtbf.be/info/societe/detail_les-internes-ne-sont-plus-les-oublies-de-la-justice-et-du-soin-en-belgique-selon-pierre-titeca-psychiatre-a-schaerbeek?id=10113873-Last access 15-04-2019)

4.4.2.3 Social defence institute

Description: As in the psychiatric annexes of the penal institutions, the Social Protection Institution disposes of a care team (psychiatrist, psychologist, social worker, occupational therapist, psychiatric nurse, physiotherapist and educator) who have as their goal to assure therapeutic support.

The goal is to protect society and to provide appropriate health care to these persons with MH problems. The social defence institute consists of male individuals who have been interned as a result of a crime or a delict. The decision of the court to intern a person is a measure and not a conviction [99].

Competent authority and financing: The competence depends of the Federal Department of Justice and is listed as penal institution

Numbers: Currently, only one Social Protection Institution exists on the Belgian soil: the Social Protection Institution in Paifve. With an accommodation capacity of 208 beds the institution detains male patients interned due to a crime or an offence.

The internment Masterplan [95] comprises the construction of a forensic psychiatry in Paifve. The current social protection institution will be transformed into a penal institute. There is no Social Protection Institute in Flanders nor in Brussels.

The category “long stay facilities and specialist services” mainly picks up the psychiatric hospitals and the structures that allow internment. This category remains limited and decreases further but represents an elevated operating cost.

Regarding the psychiatric hospitals, their number is still large but it do not well reflect the changes emerging in this sector and the diversity of the current offer that is being proposed, even if official data is available about their offer.

4.5 E-mental health

This section differs from the categories presented in this report as it does not represent a category of services/institutions, neither does it represent a level of the pyramid of the optimal mix of services. The e-mental health care represents a new form of counselling. Given the evolution in the use of new technologies and the emergence of new ways of care, cross-cutting the categories, it seems appropriate to tackle these new developments here.

Since a number of years e-health has been developed. Particularly, e-mental health can be defined as “the use of information and communication technologies (ICT) to support, enhance or improve the well-being and the care for mental health » [100]. E-mental health may take the form of prevention, diagnosis, advice, treatment, follow-up and long-term assistance. Various on-line tools are being used, in line with different objectives and different target groups. The on-line offer may range from interactive websites to mobile applications, from on-line counselling to self-help programs, etc. The digital tools can also be used in addition to face-to-face therapy. The digital offer is being presented by certain recognized services as a way to deal with specific problems, particularly regarding addictions. The on-line offer facilitate the access to the mental health offer.

In Flanders a coherent policy and a funding framework for on-line MHC is being elaborated, as announced in the Flemish action plan for mental health. The Flemish government currently funds various websites (https://www.geestelijkgezondvlaanderen.be/, http://www.alcoholhulp.be/, http://www.gokhulp.be/ http://www.depressiehulp.be/, www.Drughulp.be, www.Cannabishulp.be) developed and implemented by recognised mental health services, mainly community mental health centres. All the websites have a similar structure, i.e. an information module that offers an on-line auto-diagnosis test, an on-line self-help module the public may use anonymously and for free, and an on-line orientation module.

The site http://www.gokhulp.be/ has its equivalent in French http://www.aide-aux-joueurs.be/ . It has been set up by CAD (Centra voor Alcohol en andere Drugproblemen)-Limburg, La commission des jeux de hasard – Kansspel Commissie, and the Pélican non-profit association).

In French-speaking Belgium, some initiatives are supported by the COCOF and Wallonia. For instance the site www.aide-alcool.be, funded both by the COCOF and Wallonia, offers on-line help for alcohol addiction. Its goal is to enhance the accessibility of information and care related to alcohol use in French-speaking Belgium. Beside its informative objective, this free service offers self-help tools as well as an on-line structured support programme delivered by a psychologist, for a period of 3 months. The therapist provides support for formulation of the objectives set by the user. He guides the user personally and individually, in an anonymous way. The user can contact the therapist, by appointment, by means of a chat session, or by email.

E-mental health is also being developed by private initiatives of psychologists or psychotherapists, who offer on-line consultations. Some of them are grouped on platforms. For instance, the platform MyPsy, set up with the support of the Walloon Region and some private partners, enables video-conference consultations with clinical psychologists, which are all members of the Commission of Belgian Psychologists and registered under their true identity. The fees are determined by each individual psychologist.

Another kind of care than the above is the site www.mijnkwartier.be.This is an online self-care program for persons with stress, burn-out, anxiety, panic, phobia, hyperventilation, rumination and depression. People use it a quarter a day for one month (or longer when necessary/ desired). The program costs 55 euros per month.

5 OVERVIEW OF THE SECTOR

Four tables were designed to provide a summary of an essential part of the available information. The different tables present the different categories of mental health services, the participation in the Psy107 networks, the responsible authorities, the regions where the service delivers the care, and the budget.

The first summary table (Table 15) presents the number of Psy107 networks where the different categories of services are partner. This table was made by analyzing the partners' lists of the 20 Psy107 networks for which we personally received data from each coordinators. A colour code has been added, representing the sectors from which they are derived.

Table 15 – Partnership of the services in the Psy107 networks.

Services	Number of networks (out of 20) where the category of service is a partner
Society	20
User and family association	20
General practitioner	17
Medical homes	13
Family planning centre	5
CAW	12
Health Relays	4
Aid to maltreated elderly persons	-
Helpline for young people	-
Helpline for adults	4
Helpline for marital violence	-
SOS Children's Teams	-
Trust centres for preventing child abuse	-
Shelter for victims of marital violence	-
The help and care services for prostituted person	1

Plural gender non-profit association	-
The support services for partner violence and / or gender-based violence	-
Centre for Sexology and Gender	-
Adults residential services	4
Support services (handicap)	7
Assistance to litigants	3
Housing	3
Community mental health care centres (CGG – SSM)	20
Psychiatric home care teams (PZT – SPAD)	13
Mobile team for adults (Psy107 reform)	11
Mobile team for children	4
Mobile care path for internees	8
Mobile team of intervention	5
Day centre	15
Services for addiction	11
Exile services	-
Private practices of psychiatrists and of clinical psychologists and psychotherapists	3
Suicide prevention and support	4
Specialised rehabilitation centres with convention	17
Psychiatric departments in general hospitals/specialised hospitals	17
Psycho-social services in prisons	-
Initiatives for sheltered accommodation (IBW – IHP)	20
Psychiatric care homes (PVT – MSP)	19
Psychiatric hospitals	20
Forensic psychiatry	-
Psychiatric annexes in prisons	1
Social defence institution	-

Legend

Mental health Sector	Society & Informal Community Care	Health Sector	Handicap Sector	Justice Sector	Social Sector

Table 15 should be read with caution. Indeed, it has not always been possible to identify precisely the services indicated in the annual report. Networks organize their list of partners in their own way, classifying or not according to functions, with a degree of precision that also differs from one network to another. Moreover, the equivalence of services from one Region to another is not easy to clarify.

A majority of the services studied in this chapter are partners in at least one of the Psy107 networks.

Five categories of services are present in all networks: formal mental health services and institutions (Community mental health services, Psychiatric hospitals, Initiatives for sheltered accommodation), and also informal structures (associations of users and relatives, and society as a whole (category which covers a large number of different sectors and services)).

Only certain categories are not partners in any network: teams specialised in the sectors of maltreatment, telephone services, more specific services in gender transition and exile, and services related to penal institutions, with the exception of a psychiatric annex.

More generally, taking all the network partners together, the analysis shows that, all networks and all functions confounded, more than 100 categories of services are partners in Wallonia, 50 in Brussels, 80 in Flanders. Not all are listed in the table because a part of them are under the Society category (see 4.1.2.) The high number of services categories in Wallonia is maybe linked to the structuration of the offer that seems less grouped than in Flanders.

Table 16 presents the function committees within the Psy107 networks where a category of services is involved. A function committee groups together services which aim to fulfil one of the five functions of the Psy107 network. Each committee also includes categories of services implied in collaboration(s) with the services in charge to fulfil the desired function. However, the Table 8 does not present the function fulfilled by each category (information only partially available) but do present their representation in the function committee.

Reminder about the Psy107 network functions:

- Function 1: prevention, promotion of MHC, early detection, screening and diagnosis
- Function 2: intensive outpatient treatment teams (2a and 2b)
- Function 3: rehabilitation teams working at the reintegration and social inclusion
- Function 4: intensive residential treatment units
- Function 5: specific residential formulas allowing provision of care

A colour code has been added, representing the sectors from which the services categories are derived.

Table 16 – Involvement of the category of service in the function committees in networks.

Services	Function(s) committees where the category of service is involved				
	1	2	3	4	5
Society	X	X	X	X	X
User and family association	X	X	X	X	X
General practitioner	X	X	X	X	
Medical homes	X	X	X	X	
Family planning centre	X		X		
CAW	X	X	X	X	X
Health Relays	X	X			
Aid to maltreated elderly persons					
Helpline for young people					
Helpline for adults		X			
Helpline for marital violence					
SOS Children's Teams					
Trust centres for preventing child abuse					
Shelter for victims of marital violence					
The help and care services for prostituted person					X
Plural gender non-profit association					
The support services for partner violence and / or gender-based violence					
Centre for Sexology and Gender					
Adults residential services			X		X
Support services (handicap)	X		X		X
Assistance to litigants	X		X		
Housing					X
Community mental health care centres (CGG – SSM)	X	X	X	X	
Psychiatric home care teams (PZT – SPAD)		X		X	X
Mobile team for adults (Psy107 reform)	X	X	X	X	X
Mobile team for children		X			
Mobile care path for internees		X			
Mobile team of intervention		X	X		
Day centre	X		X	X	
Services for addiction	X	X	X	X	
Exile services					
Private practices of psychiatrists and of clinical psychologists and psychotherapists	X				

Suicide prevention and support	X	X			
Specialised rehabilitation centres with convention	X	X	X	X	X
Psychiatric departments in general hospitals/specialised hospitals	X	X	X		X
Psycho-social services in prisons					
Initiatives for sheltered accommodation (IBW – IHP)	X	X	X	X	X
Psychiatric care homes (PVT – MSP)		X	X	X	X
Psychiatric hospitals	X	X	X	X	X
Forensic psychiatry					
Psychiatric annexes in prisons			X		
Social defence institution					

Legend					
Mental health Sector	Society & Informal Community Care	Health Sector	Handicap Sector	Justice Sector	Social Sector

The data in Table 16 show that, all networks combined, functions 2 and 3 committees gather each one 20 different services categories while functions 4 and 5 a bit less (14). Function 1 committee groups 19 different services categories.

Certain categories of services are present in all the function committees (all networks combined). This is especially the case for the associations of patients and their relatives, the CAW's in Flanders (that, as described above, bring together very varied offers), the Psy107 mobile teams, the government-regulated centres RIZIV – INAMI, the Initiatives of sheltered living and the psychiatric hospitals.

Considering that the category of services "psychiatric hospitals" is involved in all the 5 function committees highlights the different types of services psychiatric hospitals can delivered and not only hospitalization units as described in the last level of the WHO pyramid of the previous section (4.4.1.).

The analysis per function committees, independently from the Regions, shows that the number of different services category partners is higher in function committee 3, followed by function committee 1. Thereafter comes function committee 5 with approximately a third of partners less; function committee 2 follows, with a bit more than 50% of partners less when compared to function committee 1. Function committee 4 counts the least partners.

Table 17 presents various categories of services/institutions regarding the responsible authorities (first column). The services categories are spread in the following columns in function of the Regions where the missions assigned are fulfilled. A colour code has been added, representing the sectors from which they are derived.

Table 17 – Repartition of the offer according to the Regions and the competent authorities

Competent authority(s)	Wallonia	Brussel		Flanders
-	Society			
Federal, federated entity	User and family association			
Federal	General practitioner			
Federated entity	Medical homes	Medical homes	Wijkgezondheidscentra	Wijkgezondheidscentra
Federated entity	Family planning centre		CAW	
Federated entity	Health Relay		CAW	
Federated entity	Aid to maltreated elderly persons		CAW	
Federated entity	Helplines		CAW	
Federated entity	SOS Children's Teams		Trust centres for preventing child abuse	
Federated entity	Shelter		CAW	
Federated entity	The help and care services for prostituted person		CAW	
Federated entity	Plural gender non-profit association		Centre for Sexology and Gender	
Federated entity	The support services for partner violence and / or gender-based violence		CAW	
Federated entity	Adults residential services		Woonondersteuning/Multifuntionele centra	
Federated entity	Support services (handicap)		Individuele begeleiding/Multifunctionele centra	
Federated entity	Assistance to litigants		CAW	
Federal, federated entity	Services of police assistance to victims			
Federated entity	Housing		CAW	
Federated entity	Employment			
Federated entity	Community mental health care centres (CGG – SSM)			
Federal, federated entity	Mobile teams			
Federated entity	Day centre			
Federated entity	Services for addiction	Services for addiction	CAW	
Federated entity	Exile services+ CAW (Flanders)			
Federal	Consultation practice of psychiatrists and of clinical psychologists and psychotherapists			
Federated entity	Suicide prevention and support			
Federated entity (6th reform)	Specialised rehabilitation centres with convention			
Federal, federated entity	Psychiatric wards in general hospitals/specialised hospitals			

Federal	Psycho-social services in prisons
Federated entity(6th reform)	Initiatives for sheltered accommodation (IBW – IHP)
Federated entity(6th reform)	Psychiatric care homes (PVT – MSP)
Federal, federated entity	Psychiatric hospitals
Federal	Forensic psychiatry
Federal	Psychiatric annexes in prisons
Federal	Social defence institution

Legend					
Mental health Sector	Society & Informal Community Care	Health Sector	Handicap Sector	Justice Sector	Social Sector

As shown in Table 17, there is a higher number of service categories in Wallonia that, apart from generalist services, have developed a series of services for specific publics. A significant number of these missions are fulfilled in Flanders by one single service (CAW). We notice as well that the Regions have gained a large part of competences, in accordance with the 6th state reform.

Table 18 offers for each category presented in this report the available data on the budget, the number of services and a quantification of the number of produced interventions. The same colour code as previously is used to precise the sector from which the services are derived. The measure units through the table are variables and depend on the type of available data. Question marks (?) stand for the lack of information. The lack of information may be due to one of the following reasons: the data is not treated, not accessible, not available in the study delay, not gathered, or our requests were not answered.

The data taken up in Table 18 are extracts of the descriptions of the services categories. For more details (especially for the years of reference of the data), see the category service description above in the report (section 4).

Table 18 – Distribution of the offer according to Global budget, number of services and population treated

Categories of services	Mental health budget (€)	Number of services	Quantification of provided MHC
Mental health through PHC and related sectors			
General practitioner	?	15 989 GP	?
Medical homes	?	132 Medical homes in Belgium	?
Centre for general welfare (CAW)	? (total 117 693 987)	11	7 083 appointments
Family planning centre	? (total of 20 600 000)	89 centers	?
Health Relays	?	6	?
Aid to maltreated elderly persons	?	3 services	1000 calls for psychological aspects
Helpline for adults	?	6	30 000 calls related to psychological problems
Helpline for children	?	?	? (20% of the calls are made by adults, around 30% for emotional/relational issues)
Helpline for marital violence	?	1	? (total 3347 calls)
SOS Children's Teams	8 432 509	14 teams,	2053 support
Trust centres for preventing child abuse	?	6	? (6 922 calls in total)
Shelter	?	15 in Wallonia 15 in Brussels	?
The help and care services for prostituted person	? (total 672 000)	3 in Wallonia, 4 in Brussels, 1 in Flanders	?
Plural gendre non-profit association	? (total 115 000 for the center in Wallonia)	1 in Wallonia, 1 centre in a hospital in Ghent	?
The support services for partner violence and / or gender-based violence	? (total 550 000)	13 in Wallonia	?
Adults residential services	? (total 19 000 000)	102 in Wallonia 20 in Brussels, 82 in Flanders	?

Support services (handicap)	?	42 in Wallonia, 24 in Brussels, 26 in Flanders	?
Assistance to litigants	? (total 3 309 000)	29 in Wallonia and Brussels	?
Services of police assistance to victims	30 000/police zone	67 police zones	?
Housing	?	12 projects (housing first),	?
Community mental health services/PAAZ – SPHG			
Community mental health care centres (CGG – SSM)	31 000 000 Wallonia, 16 000 000 COCOF, 70 000 000 Flanders	65 in Wallonia (1 in the German Community), 27 in Brussels (22 COCOF, 5 COCOM), 20 in Flanders (113 total)	Wallonia :27 844 new people helped, COCOF :14 555 people helped, Flanders :57 901 people helped (30 050 new patients)
Mobile teams for adults	?	? (548.54 FTE in total)	2A team 6 738 patients 2B team 6 337patients
Mobile teams for children	?	?	?
Mobile teams care path for internees	?	5 teams	?
Mobile team of intervention	?	7 teams	?
Day Centre	?	?	?
Services for addiction	? (Wallonia), 4 636 000 (COCOF)	47 in Wallonia, 15 in Brussels (COCOF)	
Exile services	?	3 in Wallonia, 1 in Brussels, 1 in Flanders	x
Consultation practices of psychiatrists	67 300 000	1 930 psychiatrists	820 441 acts
Practices of clinical psychologists and psychotherapists	?	11 941 psychologists	?
Suicide prevention and support centre	?	1 service with 8 antennas in Wallonia,	?

		1 service in Brussels	
Specialised rehabilitation centres with convention	? (total 84 000 000)	67 centres in Belgium (33 "7.72" centre and 34 "7.73" centre)	?
Psychiatric wards in general hospitals/specialised hospitals	? (total 6 409 007 890)	104 PAAZ/SPHG (40 in Wallonia (1 in the German Community), 14 in Brussels, 63 in Flanders)	48 261 care periods in 2013
Psycho-social services in prisons	63 166 302	35 services	?
Initiatives for sheltered accommodation (IBW – IHP)	43 722 000	43 facilities (27 in Wallonia (1 in the German Community), 18 in Brussels, 43 in Flanders)	5 280 care periods (2013)
Psychiatric care homes (PVT – MSP)	98 129 000	40 in Belgium (14 in Wallonia (1 in the German Community), 23 in Flanders, 3 in Brussels)	2 462 car periods (2013)
Long stay facilities & specialized services			
Psychiatric hospitals	350 017 602 for Wallonia, 90 518 221 for Brussels, 739 777 531 for Flanders	60 PZ – HP (19 HP in Wallonia, 9 HP in Brussels, 32 HP in Flanders)	care periods: 16 507 in Wallonia, 4 913 in Brussels, 37 576 in Flanders
Internment	27 500000	?	?
Forensic psychiatry	?	4	?
Psychiatric annexes in prisons	?	12 prisons with a psychiatric annex	?
Social defence institute	?	1	?

LEGEND				
Mental health Sector	Health Sector	Handicap Sector	Justice Sector	Social Sector

Table 18 shows the difficulties to obtain a coherent set of data with identical units, due to the absence of a structured data collection. For the service categories of which the main goal is not mental health care, it’s difficult to access to the part of the data concerning mental health care.

About the global budget for MHC in Belgium, considering the data available witch present a degree of certainty (no question mark) (with a mix of years concerned for the different categories of services budget and missing data), it can be assumed that the budget represents at least 1 612 209 165 euros per year. This budget is mainly of public expenses and it represents the lowest estimation as it does not consider the categories of services for which an estimate of the budget allocated to mental health is not available. It also does not count the private practice of psychologists.

6 THE NETWORKS AND ASSOCIATION OF HEALTH/MENTAL HEALTH CARE ACTORS

This section describes the networks and associations in the field of mental health in different ways. Those structures do not provide care to persons with mental health problems but maintain a direct link with services providing MHC. One of their missions is to sustain the collaboration and the organization of the consultation between services of MHC and with services outside the MH sector which participate to mental health.

6.1 The Psy107 networks

The Psy107 networks combine actors from different sectors as MHC, health, social help, justice etc. The actors involved in a network have to organise themselves to meet the demand in mental health care of the population on a defined territory. Together, they provide an answer to the mental health needs, in accordance with the philosophy of the reform defined in the “guide towards better mental healthcare through the realisation of circuits and care networks” [63] This reform was approved during a public health inter-ministerial conference in 2010 by the responsible Ministers of the Federal and the Federated authorities. The developed network alliances are an attempt to respond to the overall and integrated vision supported by this reform focuses on the needs of the patients, on care delivered in the environment of the patient, and on a recovery goal.

To cover the Belgian territory, 23 networks, which were now groups in 20 networks (7 in Wallonia, 1 in Brussels and 12 in Flanders), have been created. All the formal actors in the field of MHC are network partners. To these are added a variety of actors that do not belong to the MHC sector, yet who offer MHC. These actors are mentioned in the description of the MHC offer. Furthermore, an additional set of partners participate in the network. These partners, for example the employment sector, provide reintegration help to persons having (had) mental health problems. In this way, each actor brings in its expertise, skills and work field, serving the patient needs through sharing.

As defined in the reform, all the networks follow a common purpose, common objectives and common functioning, and must fulfil 5 functions:

- Function 1: prevention activities, promotion of MHC, early detection, screening and diagnosis
- Function 2: intensive outpatient treatment teams, both for acute psychological problems (2a) and chronic problems (2b)
- Function 3: rehabilitation teams working on the reintegration and social inclusion
- Function 4: intensive residential treatment units, both for acute and chronic psychological problems, if a hospitalisation is inevitable
- Function 5: specific residential formulas allowing the provision of care when the organisation of the necessary care at home or in a substitute home is impossible

Within each network, a network coordinator is designated. His function is to facilitate the creation and the functioning of the network. The coordinator has strategic, policy, organisational and managerial duties. The coordinators enhance the importance of the reform to a variety of actors i.e. turning them into partners. Amongst other, one of his tasks is to carry out an updated cartography of the offer of the network. The federal government allocates funding to the coordination function of each network.

The precise description of the collaborations within each network go beyond the scope of this chapter and will not be subjected to an analysis. It is important, however, in terms of cooperation, to make a reference to the fact that the networks are developing, in a participatory fashion, joint methodologies for collaboration, and instrument for concertation allowing to coordinate, in an integrated way, the available resources for the client. In this regard, the investigation carried out in 2016 [101] by the CRéSaM concerning the actors in Wallonia shows that this concertation instrument is still only being partially used.

6.2 The consultation platforms in mental health

The consultation platforms are funded by the regions and group the actors from the formal MHC offer, namely the psychiatric hospital, the PAAZ – SPHG, the IBW – IHP, the PVT – MSP, the CGG – SSM and the specialised rehabilitation centres with a convention [102]. There was at least a platform on each province/district in Wallonia and Brussels. However, since January 1st 2019, the 5 provincial platforms in Flanders merged into one. The duties of the platforms are:

- the concertation of their members on the needs in terms of psychiatric equipment on their territory
- the concertation on the task repartition and the complementarity in the services offer, the activities and the target groups, to offer a better response to the needs of the population and to improve the quality of the MHC
- the concertation on the possible collaboration and the distribution of the tasks for integrated MHC
- if needed, the concertation with other association of institutions or of psychiatric services
- to cooperate on the collect of data and their use as part of a national study on the needs in the MHC
- the concertation on the policy of admission, exit and transfer as well as on the coordination of the medical and psycho-social policy
- to dispose of a mediation function

The platforms also have external activities (not dedicated to members). They organise a concertation between the different platforms by Region. The platforms in Wallonia also collaborate with the platform in Brussels. Together, they organise task forces about specific subjects that can lead to recommendations.

The platforms also develop collaborations with other partners such as centres of reference, Psy107 networks, association of patient or family, etc. and attend to board of directors, general meeting, and organise seminars and conferences.

As opposed to the various existing networks, the platforms do not intervene directly in clinical situations. Their action level is situated beside the services and institutions.

6.3 Children and adolescent networks

The children and adolescent networks integrate all partners as health care providers, institutions and services concerned by children, adolescents and their entourage. They were created according to the new mental health policy on children and adolescents encompassing an overall and integrated approach of the various components of care, focussing on the needs of children and adolescents who show signs of psychological problems and of their entourage [65]. It is dealt with in this report about adults for the pivotal age range 16-23.

There are 5 networks in Flanders and 5 in Wallonia, each of them corresponding to the territory of a province, and one in Brussels. The networks develop various activity programs: a program for crisis care, a program for long-term care, a program for the consultation and the concertation between various sectors, and a program for the enhancement of the double diagnosis offer. Certain target groups have equally been defined, such as the 16-23 years' age group, for which the networks have to organise an adapted offer with particular attention for care coordination and case management.

Each network has set up a coordination function supported by one, two or three persons. This coordination makes the task of the network easier and develops actions on the strategical and operational level for the network. An amount of 137 000 euros for every network is foreseen for the funding of the coordination function of the network [65].

The funding by the federal government is done through the B4 conventions with the hospitals that form part of the network. These hospitals serve as letterboxes and transfer the dedicated funds to the network. The communities and the regions fund the partners according to their authorities and missions [65].

For each network, a budget of 100 000 euros a year is foreseen for the means of the functioning, as well as 175.000 euros for the recruitment of a responsible doctor (38 hours). These 275 000 euros can be used completely for the setting up of various programs, in particular for crisis care, long-term care, consultations and linking with different sectors. Besides these budgets, there are additional global funding for the implementation of the main programs [65], for instance 4 680 000 euros for the setting up of long term mobile aids within the framework of the funding of the long-term program [65], 4 680 000 euros for the setting up of mobile crisis care , as well as a yearly complementary investment of 4 332 540 euros for the support of mobile, ambulant and (semi-)residential crisis care» within the framework of the funding of this crisis care program.

Mobile teams on crisis and assertive care have been set up and are operational in all the networks. The mobile teams are made up by personnel provided by the network partners resulting in multidisciplinary teams that combine various sectors. It is not yet possible to have an overview of the implementation of the various programs. Some data can be found on the internet sites of the networks, but not all the networks have of internet sites yet (4/5 in Flanders, 3/5 in Wallonia, 0/1 in Brussels).

6.4 The coordinators of the care path for internees

The multi-year plan of the federal government, with regard to internees, aims to provide adequate care to the internees, in particular by removing them from penitentiary institutions so as to achieve optimal social integration. The multi-year plan fits into the MHC reform[95].

The multi-year plan includes in particular:

- The establishment of the care path for internees' coordinators (in-patient care path, FPS public health) and coordinators of external care circuit for internees (SPF justice)
- The implementation of care path for internees' mobile team by court of appeal

<u>Competent authority and financing</u>: 102.000 euros per year per Court of Appeal (staff costs and running costs) is allocated for coordinators of internal care path for internes, via the BMF of the hospital.

The function of coordinators of external care path for internees (SPF Justice) is a promotion, internally, for justice civil servants. Their wage scale corresponds to the wage scale of prison directors.

6.5 Integrated care services at home

The Integrated care services at home (Services Intégrés de Soins à Domicile (SISD) - Samenwerkingsinitiatieven Eerstelijnsgezondheidszorg (Geïntegreerde dienst voor thuisverzorging)(SEL(GDT)) are institutions working in a delimited area, allowing the reinforcement of the care for patients by the practical organisation and the management of care at home's interventions by the different professionals. They ensure the follow-up and the sharing of information. To enhance the collaboration, they organise information meetings and provide administrative and technical support.

In addition, the integrated care services at home play a crucial role in organising and coordinating the consultation around the psychiatric patient, possibly in conjunction with a Home Care Coordination Centre. The conditions for the funding of these multidisciplinary consultation meetings aroud the psychiatric patient were defined by the Royal Decree of March 27th 2012, itself modified by the Royal Decree of June 18th 2014 (http://www.ejustice.just.fgov.be/eli/arrete/2012/03/27/2012022121/justel) . For adults, the consultation for which it is satisfied with the conditions of the decree is refundable 3 times a year.

The competent authority was the federal government. With the 6th state reform, the competences for these services are transferred to the Federated entities.

6.6 Coordination and addiction networks

6.6.1 Networks of assistance and specialised care on addictions

Only Wallonia accredits and funds 12 addiction networks. Their missions are described in the Walloon Code of Social Action and Health [103] as:

- The identification of the offer and the needs concerning addiction in their zone
- The collaboration with the mental health consultation platforms
- The institutional consultation on the distribution of tasks and their complementarity in order to develop a coherent help and care offer, including the management of crisis and emergency situations, whatever the nature of the addiction;
- The support to the collaboration of specialised services through the setting up of conventions or the development of common tools.
- The initiation or the organisation of intervision at the behest of networks members

6.6.2 Flemish expertise centre on alcohol and other drugs

The Flemish expertise centre on alcohol and other drugs (Vlaams expertisecentrum Alcohol en andere Drugs - VAD) acts as the umbrella organisation for all organisations and departments or sections that are active in the continuum of prevention, early intervention, care, harm reduction and social inclusion concerning addiction.

They develop tools and programs in function of a specific domain (alcohol and drugs; youth care, education, justice and police, wellbeing, sport…), a target group (youngsters, children of users, elderly …), healthcare workers profile (ambulatory prevention workers, local health promotion, provincial coordinators…) etc.

6.6.3 Eurotox

The aim of the Eurotox non-profit association is to improve the knowledge on the use of legal and illegal drugs. In this context, the association can carry out studies and research projects in the field of addictions. It can also coordinate and promote all the synergies between associations which have a similar purpose.

Eurotox promotes and conducts research projects, reflection days, and since the year 2000, it fulfils the function of Alcohol-Drugs socio-epidemiological observatory in Wallonia and Brussels. It also ensures the mission of REITOX Network Sub-Focal Point (European Network for Information on Drugs and Drug Addiction), for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Eurotox non-profit association is also the "drugs" support service of COCOF.

6.7 Regional coordination in MH

6.7.1 The centre of reference for mental health

The non-profit association centre of reference for mental health (Centre de référence en santé mentale - CRéSaM), founded on October 21st 2011, has been recognised since January 1st 2012 in the capacity of « Centre de Référence en Santé Mentale » in Wallonia based upon the decree that regulates the Walloon mental health services [103]. CRéSaM aims to support the actions of MHC professionals and their integration in the MHC sector. It develops support for the actors in MHC, functions as an observatory of the practices and initiatives in mental health, is engaged in research, provides information, and pursues a consultation mission.

CRéSaM functions as a partner to various actors of the mental health sector (users and relatives, first-line stakeholders, mental health services and other professionals, services and institutions), this in concertation with the responsible political and administrative authorities. CRéSaM aims at enhancing the accessibility of MHC, at increasing the general public's awareness of the MHC offer, and at encouraging the concertation with the patients and their relatives.

Its activities are directed at the mental health professionals in Wallonia, primarily at the community mental health services.

It also tries to reach every actor in mental health in Wallonia, every professional confronted with mental health problems, associations and federations actives within the sector, as well as the administrative and political authorities.

6.7.2 Mental Health Focal Point

Since January 2019, the Mental Health Focal Point (Steunpunt Geestelijke Gezondheid) is active.

It brings together several organisations and projects on mental health in Flanders: (i) Vlaamse Vereniging voor Geestelijke Gezondheid (Flemish Association Mental Health), (ii) Te Gek!?, (iii) Federatie van Diensten voor Geestelijke Gezondheidszorg (Federation of Community Mental Health Services), (iv) networks on culture-sensitive care and projects that were carried out by Vlaams expertisecentrum voor Alcohol en andere Drugsproblemen (VAD), and (v) Zorgnet-Icuro. The Mental Health Focal Point has a role in supporting mental health actors in their goals towards a better mental health for the Flemish population. Central values are inclusion and autonomy in and through connectedness in a good understanding between care users, relatives and professionals.

Key points are:

1. the development of methodologies based on scientific research, best practices and innovating practices
2. supporting practices and implementing methodologies
3. the destigmatisation of mental illness.

6.7.3 French-speaking Brussels league for mental health

The Brussels French-speaking League for Mental Health (Ligue Bruxelloise Francophone pour la Santé Mentale - http://www.lbfsm.be/.) is a non-profit association recognised and funded by the French Community Commission of the Brussels-Capital (COCOF). Its objective is the organisation and the coordination of activities related to the promotion and the information of outpatient services in mental health, and it represents them at the public authorities.

The League is made out of 70 services and team members: the 22 Brussels-based French-speaking Community mental health services, the 5 Brussels-based Bilingual Community Mental Health Services, Brussels-based psycho-social-therapeutic structures for children or adults, services active in the matter of drug abuse, the Initiatives of Sheltered Housing, hospital institutions, various psycho-social services of the socio-sanitary, and Brussels-based network and training associations.

The league is a place for reflection and exchange between knowledge and practice. The league reacts to public policies and does not hesitate to take a position. The league informs, documents and organises scientific meetings on clinical and psychosocial issues.

7 TRANSFER OF COMPETENCES (6TH STATE REFORM)

Through the 6th state reform, a significant number of competences concerning care are being transferred towards the federated entities. This may entail a differentiating policy development between the 3 Regions.

The competences transferred or to be transferred are:

- nursing homes, rest and care homes and day care centres;
- the funding of Initiatives of sheltered living (IBW – IHP);
- the funding of psychiatric care homes (PVT – MSP);
- the funding of the consultation around the psychiatric patient at home;
- certain agreements with functional rehabilitation centres; and
- the funding of Integrated Care Services at home (SEL(GDT) - SISD).

In Wallonia

Following the 6th reform of the state, the AViQ (Agence pour une vie de qualité) has been created on January 1st, 2016 to group a large part of the “care and help to persons” competences transferred to Wallonia [104].

The AViQ works with the National Institute for Health and Disability Insurance (RIZIV – INAMI) and the Federal Public Service (FPS) Public Health to prepare these transfers.

The 2017-2022 Management Contract between the AVIQ and the Walloon Government describes the AViQ's missions through 13 strategic objectives. A 5 years Administrative Plan will describe the objectives and commitments of the Management Contract in an operational manner. In this Administrative Plan, a work plan will be set up for each objective, specifying the actions to be taken, the organisational aspects, human resources, IT resources, communication and budget monitoring.

In addition to ensure the continuity of “care and help to persons” services to the public, the Walloon Government wants to implement a number of fundamental reforms to better meet the needs of the Walloon population. These include the policy reform on mental health and addictions based on the homogenisation of the policy that has guided the transfer of competence in long term care, as part of the 6th Reform of the State. This Walloon reform aims to set up a readable service offer, coherent and efficient for professionals, users and patients.

The AViQ will also monitor cross-cutting plans, including the Adult MHC Reform and the New Mental Health Policy for Children and adolescents.

In Brussels

In Brussels, the competences will be transferred and dispatched between the 4 competent federated entities for Brussels Region (VGC, COCOF, COCOM, Brussels Capital Region). As far as the social side and the ambulant health are concerned, the authorities will be primarily transferred, in the first time, towards the COCOF but also towards the COCOM for the services that regard both communities. This concerns all the authorities dealing with elderly persons, the houses of psychiatric care, sheltered housing and merging of authorities that aim at homogenising the policies of help to the disabled, the addicted to drugs, the prevention policies, etc.

The COCOM will be reformed and a new public interest organism, Iriscare, has been created in 2017. It includes a bi-community health office, an office of help to persons and family counselling. This structure is charged of the transfer of the competences from the federal level towards the COCOM.

The three management institutions of this new organism are composed equally of representatives of the union and employer organisations, of assurance associations, of health care providers, of family allowance offices and of family organisations.

Different technical committees give technical advices to the management board of “help and care to the persons”. The committee “mental health” has authority on the following matters:

1. psychiatric care houses(PVT – MSP);
2. initiatives sheltered housing(IBW – IHP);
3. ambulant sector of mental health.

A series of political and administrative tools are set up to enable the activation of Iriscare (a permanent inter-cabinet workgroups, specific coordination according to their authorities, a general coordination, meetings with assurance associations).

Control activities remain under the responsibility of the COCOM services.

In Flanders

The Flemish government is preparing a new decree on mental health. The goal of this decree is to integrate all the authorities that Flanders has on mental health issues, since the 6th constitutional reform.

At the moment of writing, this decree still has to be voted by the Flemish Parliament.

In general the new decree wants to rise mental wellbeing of the Flemish population according to accessibility; integrated services on wellbeing and health; evidence based on scientific knowledge and experts by experience; recovery and quality of life; and participation of users in community life in a society that is free of stigma and discrimination.

Therefore services should be organised in networks wherein all mental health providers in the region are member of.

The offer of individual care is differentiated in five care levels: self-care, informal care, basic mental health care, regional specialised mental health care, supra regional specialised mental health care. The decree accords to the five functions described in the Psy107 networks and adds two more functions: rehabilitation on all life domains towards a comprehensive citizenship, and exchanging expertise between mental health partners and partners in the domain of wellbeing and eventually other domains.

8 DISCUSSION

8.1 Precautions about the collected data

Before discussing the results, it is important to remind the some limitations of the study (see 3.2)

- The definition of mental health as proposed by the WHO refers to different levels of intervention such as care, prevention, reintegration, etc., which implies including a wide range of services and institutions. Although the report focuses on care, it cannot ignore other levels of intervention, while raising the question of the limits and boundaries of MHC. So, how do we situate what is and what is not part of MHC provision and, more broadly, what is "care" in mental health? The definition is not unanimously accepted and the actors themselves are not always clear about their place in the mental health(care) spectrum.
- This study do not intend to investigate the needs of people with mental health problems. Nothing in this part of the study gives any indication whether the offer and its organisation are conform with people's needs. No data are either given on the singularity of the patients’ trajectory of care.
- There is a certain gap between the standards and regulatory texts about formal services categories and the actual real care offer. As it was decided to describe the level of service categories and as it is pretty much impossible to obtain details about each services involved in mental healthcare, the important variations between each services in the field are not illustrated in this chapter.
- At the level of budgets, some uncertainty about the estimations remains. Additional data (indexation, scales, etc.) would have made possible to add nuances to the data presented in this report.

8.2 Multiplicity and diversity of the offer

- Starting from the WHO pyramid, namely the “World Health Organisation Service Organisation Pyramid for an Optimal Mix of Services for Mental Health”, implies taking into account a large number of actors involved in mental health in addition to the mental health care offer. It is consistent with the orientations of the Belgian MHC reform. The actors described in the level of the informal community care are a good example of structures involved in mental health which do not deliver MHC:
    - User and family associations (even if they are becoming more and more formal) that occupy an important place in the mental health sector and are partners in all Psy107 networks.
    - A large number of "society" actors (employment, culture, education, etc.), whose missions are not dedicated to aid or care but which are, to some extent, partners in some networks and play a crucial role in terms of determinants and recovery of mental health.
    - The non-accredited accommodation structure offering accommodation of variable quality to persons generally having trouble with autonomy, addiction or mental health.
- Behind the officially recognized categories of services there is a very large number of services which develop an additional MHC offer to the formal one. They can vary according to the size of the services, the funding, the composition of the teams (due to managerial flexibility in the type of functions required), the population of the territory where each service is located, the institutional environment, the needs of the target public, etc. A good example is the very diverse day care centres which are usually not well registered structures.
- Some of the primary health care are Psy107 networks partners and delivers MHC but are not considered as MHC professionals. The best example is the GPs.
- As well, some services in the justice sector or initiatives relating to housing or employment are also described in the chapter because they employ MHC professionals and provide MHC. They are also partners in the Psy107 networks and are essential for recovery. These are named the "related sectors" in this study.
- Psychiatric and general hospitals mainly described for their residential care offer also includes diverse services categories as day care, consultations of MHC professionals and day hospitals. In this case, the diversity of the offer can sometimes be located in the same place.

The boundaries of the mental health care are difficult to define. While it is important to take into account all the providers that contributes to the MHC offer, it is important to avoid an excessive expansion of the field of mental health care, with a risk to blur the respective fields of intervention of each services category, a risk of confusion of the roles of the professionals and a risk of psychologisation and psychiatrisation of the social interventions.

8.3 Diversity of local and regional realities

The data collection revealed a diversity of local realities.

- The Psy107networks partners vary from a network to another depending on various factors such as the offer available on the territory, the governance of the network, the characteristics of the territory, etc. This is reflected in the composition of steering groups.
- Depending on the region, the health offer is historically not evenly distributed over the territory. Moreover, following successive reforms of the Belgian state and the transfer of competences, regional authorities have developed different policies from one Region to another, making comparisons difficult. One element can be highlighted from this study: if we focus on the offer developed by sectors other than mental healthcare, the organisation of well-being in Flanders appears to be more grouped under a limited number of actors whose missions are broad and generalist, compared to what is observed in Wallonia or Brussels, where, alongside the generalist offer, there are more specific services for targeted populations. In Flanders, the trend is towards

merging or integrating services. In this way, CAWs address a wide range of mental health and wellbeing needs of the population, and community mental health services (CGG) have been merged from 80 services in the late 1990s to 20 today, with broader coverage and larger teams. In Wallonia, for example, the regional authority recognises services for migrant populations, prostitutes, victims of domestic violence, etc. The offer therefore varies from region to region. A critical analysis of these regional differences would require putting them into perspective with the territorial characteristics of each Region, with the distribution of the population over the territory, with the political orientations and budget lines supported by each federated entity.

8.4 Gaps in data

- Firstly, it is possible that some services have not been inventoried in this study, notwithstanding the care with which the data have been gathered. Indeed, all of the partners of the Psy107 networks have been covered, the boards and the administrations involved in MHC have been contacted, and diverse websites such as the social guide have been consulted. Nevertheless, the lack of information and of visibility is a reality and may lead to an incomplete description of some services categories and to some gaps in the inventory of the effective mental health care offer.
- Secondly, data availability and accessibility are not equivalent across service categories. While quantifying MHC is possible (but remains difficult) for the formal mental health care services and institutions recognised and funded from the authorities, it is much more difficult to quantify the part of work devoted to MHC in the services where MHC is not the primary mission. In this case, the specific budget devoted to mental healthcare and the number of full-time equivalents of MHC professional is difficult to collect. Overall budgets can be obtained but they do not give a clear idea of the financial resources and staff dedicated to mental health in these services. It would be interesting to complete the data relating to general hospitals with indications on the budgets allocated to psychologists attached to other services, or to the liaison psychiatrist.
- **It is therefore not currently possible to evaluate the total budget allocated to the MHC, if the total offer is taken into account.**
- **Thirdly, many registers exist but there is no harmonisation**. Data collection differs between Region, province, network, sector, etc. Registers are organised according to different logics with different indicators using different units, which makes comparisons extremely difficult and requires crossing different sources of information. This exercise requires considerable time without any guarantee of the results.
- On the data side about the mental healthcare offer, **the websites of the responsible administrations and the information concerning the categories of services are not always precise, comparable or complete.** Nevertheless, a distinction must be made between the data collected in the mental healthcare sector as such, which is generally more accessible, and those collected for other services where it is difficult to pinpoint what is a matter of mental health.
    - For the mental healthcare sector, more data are available, but the data collected are not identical for the hospital sector and the ambulatory sector. Prospects for revising the Minimum psychiatric summary (Minimale Psychiatrische Gegevens (MPG)- Résumé Psychiatrique Minimum (RPM)) were on the agenda of the Psychiatry working group of the national council of hospitals (Conseil National des Etablissements Hospitaliers - CNEH) in 2015, on the basis of concerted work with the Regions in which CRéSaM has participated, with the aim of harmonising encoding systems, but it has not yet been completed.
    - For services outside of the mental health sector, data collection was more laborious. The deadlines set for the work to be carried out did not allow the persons requested to gather the useful information within a reasonable time for the research, even if the data requested were more limited.

These gaps at all levels do not make possible to offer a complete quantitative assessment of mental health provision or to objectively identify the populations and pathologies covered, their evolution or the impact of reforms on the various services. The multiplicity of gaps will therefore make difficult to make recommendations on the organisation of services.

8.5 Complexity of the offer

The complexity of the offer is at different levels.

- **Complexity of the organisation of the health system in Belgium** linked to the different levels of authority: even if the 6th state reform has as a consequence a regionalisation of most mental healthcare services / institutions, hospitals remain under federal competence for several dimensions of their functioning and funding. Moreover, within the same level of authority, different administrations manage different aspects of health, wellbeing, social action, disability, etc. often in a very fragmented way. The situation in Brussels is particularly complex regarding the distribution of the competences and the number of administrations.
- However, it would be interesting to compare this Belgian structure of health system with the health system as it is organised in other countries, in order to see to what extent this complexity is specific to Belgium and how the articulations between sectors are organized elsewhere.
- The categories in the pyramid do not correspond precisely to services or institutions. Depending on their missions and functioning, some services and institutions may be found in **several places in the pyramid**. For example, some RIZIV/INAMI accredited centres offer daytime reception while others offer residential accommodation. Similarly, hospitals offer residential care but also day hospitalisation and consultations.
- **The collected data does not give a precise idea of the type of interventions** carried out by practitioners, in particular psychologists or general practitioners.
    - Concerning the GPs, there is no information on the proportion of their consultations dedicated to mental healthcare, nor on the type of interventions that they carry out with their patients with mental health problems.
    - Similarly, the study provides an estimate of the number of psychologists hired in each service category. However, the role of these psychologists varies from one category of services to another, and within the same category, from one worker to another. This is particularly true for the offer in related sectors services. Some information is available on this subject but in a very disparate way. It is therefore very difficult to be aware of the type of interventions carried out. Some psychologists support the team, others provide psychosocial support to users, others offer therapeutic follow-up, others provide MHC at home, etc.
    - Some multidisciplinary teams have also chosen to work without any real distinction of function. All members of the team perform the same function, while retaining their basic training, which allows them to take different views on the situations encountered in practice. This is for example the case in some mobile teams.
    - Another barrier to understand the nature of interventions is the diversity and variability of the vocabulary used to describe the type of intervention being carried out. This relates in particular to the existence of multiple frames of reference and approaches in the field of MHC.

The complexity is also linked to the collaboration organisation between the services. Describing the services and institutions that constitute the offer is not enough. It is also important to have an idea of how this offer is organised and how effective the collaborations are. However, collaborations are organised at the local level, according to the actors present on the territory, the characteristics of the population, the consultation structures in place, etc. It is not possible to make generalisations in terms of collaborations from a study on the categories of services. However, various concertation structures exist throughout Belgium. They are briefly described in this study, but there is little indication of how they work in each region/territory. This complexity, however, might testify of the richness of the responses provided to the diversity of needs and backgrounds of people with mental health problems. The complexity, reflected by the number of services, might be an answer to the variety of the demands.

8.6 Overlap

Several elements make possible to highlight the existence of overlap within the offer, in terms of age categories or types of interventions. However, it is difficult to have a clear and precise idea of this overlap, considering the elements relating to the complexity of the system as described above.

Such supposed overlap probably do not promote a good visibility of the offer and interventions of each service and professional. **This makes difficult, for example for a GP, to refer his patient to the most appropriate help** (also taking into account the fact that a patient's referral depends on several criteria, such as the patient's resources, skills, social network, diagnosis/difficulties, existing offer on the territory, etc.). **It also makes difficult for people themselves and their families to seek help**. Moreover, do these overlaps, particularly in terms of age categories, contribute to better continuity of care? Or, do they allow greater accessibility, for people with mental health problems, with several types of entry into the MHC system? Today, it is indeed possible to enter the healthcare system through a multitude of doors whatever the level of service specialisation may be. However, this does not mean that people are in the right place at the right time in their care journey.

The question of overlap also raises the question of the balance or articulation between general mental health care services and specific services intended for a targeted public.

8.7 Accessibility

Describing the offer of MHC implies also looking at the accessibility of this offer. This point is not in itself the subject of this study. But the elements addressed in this framework are raising various accessibility issues.

- To what extent have services overlap an impact (positive or negative) on accessibility?
- What is the accessibility to care for people with multiple problems or diagnoses?
- What is the financial accessibility of services and institutions?
- What is the waiting period to access MHC? Even if the offer seems very extensive, the study does not allow to have indications on the waiting time.

8.8 Residential and outpatient MHC

The descriptive part of this study can be used to question the adequacy of the offer considering the most recent reform in Belgian MHC which emphasises treatment, recovery and reintegration of patients to society, consistent with the impulses given by the WHO. Regarding the offer of MHC as such, the residential offer remains predominant in terms of financial means. It will be necessary to monitor the evolution of the reform in order to situate the evolution of this distribution throughout the country. Because of the caution needed for the interpretation of the data, because of the fact that these data must be put into perspective in relation to other types of data not collected in this framework, and because of the fact that this study is a photograph of the offer, it is not possible to draw conclusions about the balance between outpatient and residential MHC.

8.9 Territorial coverage

This study is not intended to provide an exhaustive inventory of the offer. It is therefore difficult to measure the territorial coverage, since the unit of analysis is the service category.

One indicator in relation to territorial coverage is programming standards. However, they must be compared with the local realities and the needs of the population. A "theoretically" covered territory does not necessarily mean that needs are met.

Moreover, the programming standards established some time ago have not necessarily kept pace with developments in the sector. They would require regular reassessment.

8.10 Partnerships

The analysis of the partner lists of each 107 network revealed a large number of partners. Mental health service categories are partners in all networks. For related sectors, there are differences between networks, but overall, they are very present in each network. This means that, theoretically at least, there is a set of potential partners in each territory covered by the networks. Information is available on the involvement of the services in the working groups and committees organised by the networks, but there is no data on how these services actually collaborate in the field. A survey carried out by CRéSaM [101] on the involvement of Walloon stakeholders in the 107 networks revealed that concertation tools were still used only partially. In addition, certain services that are not signatories of the network agreement on their territory are in active collaborations concerning clinical situations.

8.11 Collaboration between networks according to age groups

The study focuses on the adult population. However, age limits sometimes differ from one service category to another. For example, in hospitals, the adult population begins at age 16. Mobile teams, developed under the new mental health policy for children and adolescents, take care of young people up to 23 years old (one of the target populations of this new youth policy is, in particular, the key age group 16-23 years). This is also the case for other services for young people.

Transitions between services dedicated to young people and those dedicated to adults are often delicate moments. This issue of the concertation between the adult and youth sectors was not addressed in this study. It would be interesting to integrate data relating to the 16-23 age group, but the breakdown is not the same according to the different categories of services, which makes comparisons impossible.

The same reflexion applies to MHC for the elderly. But as reported in the 2018 KCE report on "How to improve the organisation of MHC for older adults in Belgium", the MHC for the elderly should be integrated to the adults MHC offer according to several criteria: the absence of age cut-off but rather an evaluation of the frailty profile when deciding the type of intervention; the development of an expertise in old age psychiatry; the greater involvement of the GPs; and an increased at home MHC offer.

9 CONCLUSIONS

The purpose of this study is to answer the following question: What is the current MHC offer in Belgium and how is it organised?

To present the MHC offer, the work was based on the WHO definition of mental health and was structured by the pyramid of the optimal mix of mental health services, and on the inspired model of the 5 functions of the reform of MHC in Belgium, while sticking as closely as possible to the reality on the work floor.

The WHO recommendations on mental health and the directions opted for in the context of MHC reform, faced to the reality of the work floor, lead us to take into account the fact that MHC includes a large number of actors. This option allows not only the needs in terms of mental health *stricto sensu*, but also **all the needs** of people with mental health problems to be taken into account.

On the base of the pyramid, the different levels were explored and the following key messages emerge:

- Although the informal community care do not offer MHC, they contribute to the mental health sector and are already partially included in Psy107 networks. The category “informal community care” resumes the user and family associations that are well represented, developed and partially formalised in Belgium, as well as the general services offered by the society to the population (social, employment, education, housing, etc.) that are sensitive to the mental health problem. Overall, a lot of services of various sectors are concerned with MH problem and have a role to play in collaboration with the services of the MHC offer.
- The category “mental health through PHC and related categories” corresponds to the first level of the WHO pyramid in which MHC are delivered. Beyond the healthcare sector in general, we find the services of different non health sectors: social, disability, justice, housing and employment. The MHC offer in the related sectors has a high variability and is often directed to a rather special than general public. In this level of the pyramid, MHC services categories usually employ MHC professionals except in the case of the care delivered by GPs.
- The category “community mental health services and psychiatric services in general hospitals” includes a large amount and a wide variety of offers. This category corresponds to the more formal offer in mental healthcare. It brings together official MHC services related to the living environment and the private offer in MHC. The available data concerning the various categories of services are unfortunately limited, in particular for the private sector, and then the description of the MHC offer is unfortunately not precise.
- The category “long stay facilities and specialist services” mainly picks up the psychiatric hospitals as well as the structures that allow internment. This category remains limited and decreases further but represents an elevated operating cost.

Regarding the psychiatric hospitals, their impact is still large but it do not well reflect the changes emerging in some place of the MHC sector neither the diversity of the current offer that is being proposed even if no official data are available about their offer.

The compilation of the available data and the support of various organisations such as the "mental health consultation platforms", the responsible administrations, the service federations, the 107 networks, the coordination of the Psy107 networks and various associations enabled us to provide some answering elements to the initial question. However, despite the numerous steps taken, the **results remain partial** and the information contained in the report is limited, particularly on outpatient services and those offered in related sectors.

Caution should be taken in data interpretation, not only because they are incomplete, but also because they are "macro" data, i.e. data linked to categories of services. **A gap might exist between these collected data and the reality of the field**. Given the heterogeneity of the type of data collected by each sector and the limited accessibility of existing data, it is not currently possible to have precise indications on the use of services, on the offer of mental health services in related sectors, on patient trajectories, on the matching between offer and needs, on the way services are evaluated.

The study found that adult MHC provision is very **diverse, large and complex**. This offer is available in the mental health sector but can also rely on a multitude of other actors from services with support and care goals (who do not necessarily recognise themselves as part of the mental health sector), associations of users and relatives, and society as a whole. If everyone, whatever their psychological difficulties, has access to all goods and services, without discrimination, then society as a whole contributes to what care is.

Although the study is not based on mental health needs, the **richness and diversity** of the offer suggests that there is a real opportunity to address all mental health needs at the national level. Analysis of network partner lists provides insight into the diversity and quantity of mental health and related services available. If, in practice, contractual formalisation is effectively translated into collaboration between partners, it may be thought that the different aspects of the needs of people with mental health problems can be taken into consideration, in addition to psychological care as such.

However, the data collected do not allow conclusions to be drawn on the **adequacy of the offer**, both in terms of needs (not investigated in this context) and in terms of the quantity and diversity of services. It is also not possible on the basis of this part of the study to identify any gaps in the offer, since this is not an offer register and needs are not investigated. The study also highlights **overlap** between services, at different levels (territorial, target public, type of offer proposed, etc.), without being possible at this stage to decide on their advantages and disadvantages: on the one hand, they do not facilitate the visibility of the offer, on the other hand, they are probably useful in terms of continuity of care, accessibility and permeability between services.

This diversity and complexity really contribute to a bad visibility and understanding of the offer, for the users, the professionals or the policy makers in MHC, at the local, regional or federal level.

In order to have a more precise representation of the offer, it is necessary to put this diversity of services coming from various sectors in perspective with the way they organise their **collaboration** and complementary. The study revealed, on the one hand, a large number of concertation bodies and, on the other, information on the composition of the Psy107 networks. But these elements are not sufficient to describe how networking takes shape in the field.

Moreover, **differences** exist at regional and local level, both in terms of available offer and in terms of the organisation of offer and collaboration. Thus, at regional level, there is a tendency in Flanders to merge services, going hand in hand with the enlargement of their objectives, while in Brussels and Wallonia, specific services are created, in particular in the related offer, to meet specific needs. Differences are also marked at the local level, between networks.

The WHO pyramid has guided the structure of this report. The structure of the offer in Belgium does not correspond exactly to the pyramid. However, the lack of data makes it impossible to clearly situate the MHC offer in Belgium in relation to WHO recommendations, in terms of the distribution of care between residential and community care services. What we can say is that an important part of resources are yet allocated to residential.

At present, there is no clear and global vision of the sector (in a broad vision but also restricted to the "basic" actors) of mental health in terms of offer. This is linked to the difficulty of obtaining harmonised data within the mental health sector and more broadly, between the different sectors concerned by mental health. It is also linked to the complexity of the organisation of offer. Information sources have been multiplied to overcome this difficulty, with varying results. Furthermore, the study was not based on a prior needs analysis. This limits the conclusions that can be drawn from this description of the offer.

Nevertheless, at the end of this study we have a basis for work and reflection on the MHC and the organization of standardized data collection across sectors.

10 SUGGESTIONS FOR RECOMMENDATIONS

Based on the results obtained in this chapter showing large gaps and incoherence in qualitative and quantitative data, it is not possible today to formulate recommendations on the organisation, in the broad sense, of the mental health sector for decision-makers.

The following recommendations therefore focus more on the necessary prerequisites before the organisation of mental health services in Belgium can evolve:

- Conduct a study on mental health needs to determine the adequacy of the offer in relation to the needs of the population: Are services used because they correspond to the needs, or are they used because they are the only services available, or because of other reasons?
- Resume work on harmonising the collection of useful and necessary data;
- Give priority, within the services and/or ad hoc administrations, to the processing of data already encoded by the field teams;
- Develop harmonised regional registers, in consultation with mental health networks and consultation platforms;

On this basis:

- Using reliable data on the offer and use of services, situate the offer of MHC in Belgium in relation to the WHO's "ideal" pyramid;
- Take measures to decrease stigmatisation, by widening the base of the pyramid;
- Carry out a study of patients' trajectories through the different services;
- Carry out a study on the real articulation between services, incentives and obstacles to collaboration, beyond the formalisation of networking promoted by the ongoing reform "For better MHC";
- In order to objectivise access to care, conduct a study on waiting periods and care;
- Create a clear presentation of “who is who” in MHC for the mental health professionals;
- Carry out, in concertation with the field, a qualitative and quantitative study, about the functions/ missions fulfilled by the various categories of services in the mental health sector.
- Review service programming standards in light of changes in mental health policy;
- Introduce into the training curricula of professionals elements relating to the offer, its organisation, its evolution, the paradigms of intersectoral collaboration and networking.

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CHAPTER 06 STRENGTHS, WEAKNESSES, GAPS, AND OVERLAPS IN THE CURRENT MENTAL HEALTH CARE SUPPLY: A FOCUS GROUP STUDY

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1 AN EXPLORATION ON HOW MENTAL HEALTH CARE FOR ADULTS IN BELGIUM IS ORGANISED

1.1 Objectives

The first stage of the research aims to identify strengths, weaknesses, gaps, and overlaps in the current development of the local supply of care that either facilitate or hinder the achievement of the five overarching aims of the current reorganisation process of Belgian mental health care for the adult population (i.e. deinstitutionalisation, inclusion, decategorisation, intensification, and consolidation).

1.2 Material and methods

Strengths, weaknesses, gaps, and overlaps were addressed with a qualitative approach using focus group discussion. Ten focus groups gathering health care professionals, managers and service users and family representatives, each representing the local system composition were organised on the basis of organisational vignettes" [1, 2] These organisational vignettes covered empirical dimensions related to the five above mentioned aims. Participants were required to address dimensions relating to the local care system by answering questions and mentioning their preferences and the perceived forces (resources) and weaknesses (gaps) in relation to a concrete case, which they were asked to reflect upon. The same vignettes translated from English to the national languages were used in all focus groups in order to better assess the influence of contextual factors on the care provided at the local level.

This section describes the development of the focus group material, the sampling process, the final focus group composition and the data collection procedure.

1.2.1 Development of focus group material

1.2.1.1 Organisational vignette

Following Barter and Renold (1999) [3], vignettes are used in qualitative research to provide a "less personal and therefore less threatening way of exploring sensitive topics". They relate brief and plausible stories on which the participants are invited to reflect. Vignettes do not intend to limit either the content or the terms of the discussion. Instead, the participants are encouraged to reframe the situation in their own terms, according to their experience, and to discuss other topics relating to this situation. Vignettes thus constitute an adequate method to discuss a particularly sensitive topic with participants from different backgrounds and to uncover opinions, unknown aspects or hidden problems that emerge through reflecting of this topic. Other methods can be used in complement to the vignette, to ensure that the discussion expand beyond the particular situation it relates.

For the purpose of this research, the organisational vignette was designed to elicit common and controversial topics amongst stakeholders, taking into account the five overarching aims of the framework as well as facilitators and barriers for collaboration. It was defined as *organisational* since it aimed to explore different ways to organise and coordinate mental health care, with a view to (better) address a concrete situation. This in mind and based on previous research [1, 2, 4], all team members designed and discussed vignette proposals intended to foster discussion on the gaps and overlaps of the current supply of care. These proposals for the vignette were subsequently synthesized into an intermediary version with the consensus of all members of the consortium.

The vignette accordingly raised the situation of 45 years old man called Ahmed. Ahmed was unemployed and lived in a sheltered housing. He was suffering from a psychotic disorder since the age of 25 and was diagnosed with type 2 diabetes three years before. Ahmed plans to find a job and move to his own apartment. By emphasising this situation, the vignette aimed to draw focus on the adult population, in accordance with the research question. It also drew attention to the central questions of care fragmentation and the relationship between primary and secondary care, while encouraging the participants to express themselves on a particularly complex situation, which combines somatic and mental health problems and raises cultural, ethnic and socio-economic questions. Moreover, it emphasised the objectives of socio-professional insertion and alternative housing, which are central to the 107-reform. The vignette thus highlighted key challenges and questions of the current reorganisation of mental health care in Belgium. It was complemented by two additional methods, which helped to shift the discussion to other types of situations and organisational questions. On the one hand, participants were asked to write down three key words best describing their overall opinions of the organization of mental health care in their area before the start of the group discussion. As explained in the section 1.2.5 (data collection), these key words and the associated topics were presented through an initial tour the table. The moderator then paid a particular attention to refer to these topics through the discussion that unfolded following the presentation of the vignette. On the other hand, as set out in the following section, a topic guide was carefully defined, with a view to raise generic features of the organisation of mental health care systems.

In order to ensure the suitability and the realistic nature of the vignette, its first intermediary English version was translated into French and Dutch and piloted with professionals through two one-on-one interviews in each language. The selected professionals were a psychiatrist and a psychologist, not involved in the research, and active on distinct local areas with extensive experience in clinical and managerial positions, both in inpatient and outpatient services. These professionals were not invited to later participate in the focus groups. Feedback relating to the realistic nature of the vignette emanating from these interviews were discussed within the consortium, and appropriate changes were made.

After the two first focus groups, one in each language, members of the consortium further discussed the appropriateness of the organisational vignettes, which at this point was divided into two parts: one part describing a generic situation prior to a crisis, and a second part describing the same situation later in time, after the occurrence of a crisis situation. After the first focus group, both teams agreed that the second part of the vignette drew excessive focus on clinical aspects in contrast with organisational aspects of the case. Indeed, the second part of the vignette called for precisions on the somatic as well as mental health problems mentioned in the vignette rather than raising questions and ideas as to how to organise and coordinate care provision in order to better address these problems. In other words, this part was too specific to enable the participants to draw relationships between the clinical aspects of the situation and the decision of organisation it might have induced. In addition, the second part did not enrich the discussion or provide any additional information. For this reason, the first part of the vignette was retained for the remaining focus groups. Because of these procedures, the following final version of the organisational vignette was employed:

Ahmed is 45 years old, he is unemployed and lives in a sheltered housing in the city of [City]. He has been suffering from a psychotic disorder since the age of 25 and was diagnosed with type 2 diabetes three years ago. Ahmed is under the care of a psychiatrist, a general practitioner as well the sheltered housing team, which includes a reference educator. He has an older brother whom he has not seen for many years.

With the help of the sheltered housing team, Ahmed plans to find a job and move to his own apartment. He was signed up in an « adapted work enterprise » and will begin his new professional occupation in ten days. Although Ahmed shows enthusiasm with regard to these new life plans, he is somewhat troubled about embarking on these projects which are now materializing.

These past weeks, Ahmed shows unusual behaviours. He did not show up to his last appointment with his psychiatrist and has not been taking part in the sheltered housing activities. Several co-residents have been complaining about Ahmed being intrusive (day and night, he regularly rings his neighbours' doorbells) and his referee at the sheltered housing notices that he seems disoriented.

1.2.1.2 Topic guide

The questions included in the topic guide were structured around three generic topics: care provision, governance (or regulation), and financing. These generic topics are commonly acknowledged as key features for the definition and examination of health care systems (see, for example, [5-7]. Care provision refers to the characteristics of the actors who are in charge of providing and delivering care, i.e. type of institutions and professionals, their role in care provision and delivery, their status, and their relationship with the public authorities and the social insurance scheme. Governance refers to the degree and type of decentralisation of decision-making about care provision and resource allocation, priority setting in decision-making, capacity for care planning and norms for certification, and definition of public health targets. In a broader definition, governance might be extended to decision-making capacity at the level of inter-agency collaboration for specific target-groups of users. Finally, financing refers to three basic dimensions: resource allocation, service purchase (including social insurance coverage), and the mode of payment of professionals.

These themes were selected with the intention to address the research question regarding the gaps and overlaps regarding the current supply of care.

Coordination is not easily defined as a single concept or activity, and is a key step for each topic and between topics, thus coordination functions at different levels were addressed: between different levels of services and around the service user. Besides, overlaps and complementarity between levels of coordination were considered.

The topic guide was developed following the same procedures as the organisational vignettes: opening questions and additional prompts were structured around the three main themes piloted through one-on-one interviews with professionals at the same time as the vignette, and were adapted accordingly. As for the organisational vignette, the topic guide was further adapted after the two first focus groups, one in each language.

The final version of the topic guide resulting from these procedures can be found in Appendix 1 of Chapter 06.

1.2.1.3 Focus group interactions

In addition to the narratives making up the focus group discussions, the discussions host important interactions between participants. This aspect is important for interpretation of the content, particularly as the groups gathered participants from different backgrounds and profiles. Focus groups entail situated and socially embedded interactions, which may influence the content of focus groups' discussion and thus the research results. Therefore, the influence of the political context, different professional and social positions and power relations on the course of the focus groups' discussion has been taken into consideration and will be metioned through the conclusion.

1.2.2 Sampling process

A total of ten focus groups, five in Flanders, four in Wallonia and one in Brussels, were organised in the geographical areas of the participants covered by local mental health networks. Each focus group was composed of 12 purposively selected participants at most, although a number of additional participants showed up spontaneously through word of mouth. Altogether, a total number of 121 participants (55 in Wallonia and Brussels; and 66 in Flanders) took part in this qualitative stage of the study.

Local areas: According to standard practice in qualitative studies, the sampling was not designed with a view to representativeness of stakeholders, but with a view to the highest diversity of situations. End of 2017, the whole country was covered by 23 mental-health service networks, each network being active in a specific catchment area. Due to time and resource constraints, a selection of areas was made. Moreover, as mentioned in the following section on the recruitment methods, the sampling was not limited to the members of the 107-networks but included services providers active in the ten selected areas. In that regard, the research teams paid a particular attention to include not only mental health care providers but also primary care and social services, as well as the representatives of service users and relatives associations.

Based on previous research, four criteria were taken into account for the selection:

1. The <u>geographical characteristics</u> of the region: rural versus urban regions.

   In all regions, we decided to include the main urban areas: Brussels, Ghent, Antwerp, and Liège (Charleroi has only been included in the catchment area of the network "Région du Centre" recently). In addition, we included Luxembourg as a rural area. The remaining areas had to be semi-urban areas.

2. The temporal <u>scope</u> of the networks, that is, the starting date of the networks. Thus, networks created in the first, second and new waves were included.

   For obvious reasons, the effects of the reform policy are supposed to be more intensive in the areas where the reform was implemented first. Networks have been established in different waves: 10 networks were established in 2011, 9 additional networks were established in 2013, and 4 networks have been established since 2016. We decided to include first-wave networks to get knowledge of their longer experience, but to balance with at least one of the latest networks in each linguistic region.

3. The estimated <u>size</u> of the networks, in terms of the number of services they include.

   Research showed that the size of networks, i.e. number of services included, has an influence on organisational mechanisms and governance procedures [8]. In 2015, a cluster analysis identified a group of 5 small networks that included less than 30 services, a group of 11 medium-sized networks with an average of 55 services, and 3 large networks of more than 100 services [9]. Networks of the main urban areas tend to be larger. Hence, we decided to complement the large, urban networks (more than 100 services) with medium-sized networks (between 30 and 100 services, and to include at least 2 small networks (less than 30 services). These small networks were more likely to be found in Flanders.

4. The <u>composition</u> of the networks, understood as the proportions of residential, ambulatory and social services.

   Networks were also very different in composition, i.e. proportion of service types (e.g. community mental health, hospitals, social services…) and centrality of services (e.g. hospital-centred networks, primary care-centred networks, mobile teams-centred networks. [9] We decided to include different composition profiles.

Table 19 – Network characteristics

Date	Area	Size	Wave	Composition*	Urban	Part. Rate (%)
23/11/17	Namur	Large	1	Main group F3	Semi-Urb.	44
24/11/17	Leuven – Tervuren	Medium	1	Main group F1	Semi-Urb.	58
29/11/17	Brussels	Large	1	No social service	Urban	25
05/12/17	Antwerp	Medium	2	Balanced	Urban	71
06/12/17	Liège	Large	1	30% SSM	Urban	69
08/12/17	Gent	Large	1	Main group F4+F5	Urban	65
13/12/17	Hainaut	Medium	1	Main group F3 + F4	Semi-Urb.	42
13/12/17	Roeselare	Small	2	Main group F5	Semi-Urb.	76

15/12/17	Mechelen-Duffel	Small	3	NA	Semi-Urb.	-
20/12/17	Luxembourg	Medium	3	NA	Rural	-

Function 1 to 5 of the mental health care system

1.2.3 Recruitment method

The method of approach for the recruitment aimed to gather participants representing the current local system composition, that is, to include participants active in the local area selected whether part of the 107 network or not. Heterogeneous groups of stakeholders were preferred to homogeneous groups, which facilitates in-depth exploration of precise and specific research questions. Given this research objective to address the general question of mental healthcare organisation by drawing from the various perceptions and experiences of a broad range of stakeholders, the method aimed to increase the focus groups' diversity through the selection participants representing the main categories of actors playing a part in the mental health system. The main advantages and shortcomings of this methodological decision to privilege heterogeneous groups will be highlighted throughout the report.

The method of approach was divided in two stages which will be described into detail below: (1) we reached three strategic contact points to collect lists of services and names of potential participants; (2) on the basis of these lists, we purposively selected participants.

1.2.3.1 Contact points

This first stage of the recruitment process aimed to collect lists of potential participants for the focus group discussions. At this stage, three contact points were first reached via email: (a) each 107 network coordinator for all 23 networks; (b) each representative of the "plateforme de concertation en santé mentale" for all 10 provinces; and (c) the boards of the 107 network promoting hospitals for all 23 networks.

Contact points (a), (b) and (c) each received an email describing the purpose of the study and asking them to each provide a list of participants active in their local area who would be relevant to take part in the ten focus group discussions. More specifically, the contact points were asked to suggest names of participants involved in inpatient and outpatient settings from different backgrounds including clinicians, managers, professionals involved in providing social support for service users, as well as service user representatives and representatives of service users' relatives.

After this first stage of the recruitment process, the consortium collected the obtained lists and examined the response rates from the three contact points in all areas. These response rates, as well as the response rates assessed on the basis of the previous evaluative study conducted by the consortium, were taken into account for the final selection of the local areas.

1.2.3.2 Final selection of participants

After the final selection of the local areas, a second stage of the recruitment process was launched via telephone to provide additional names of participants if necessary. Official invitations were sent out to each heterogeneous group of participants via email.

1.2.4 Description of sample

As a result of the recruitment procedure, the following services were represented across focus groups: Health services, social services, community mental health services, general hospitals, psychiatric hospitals, sheltered housing, mobile teams, functional rehabilitation centres, home care services, and user and family associations. In terms of professions, participants included psychologists, psychiatrists, social workers, nurses, occupational therapists, general practitioners, and economists.

1.2.5 Data collection

1.2.5.1 Setting

Each focus group took place in neutral areas; either in the university or selected with the help of 107 network coordinators or the coordinators of mental health care dialogue platforms. The duration of focus groups lasted between two and two and a half hours, they were recorded with participants' approval and transcribed verbatim.

1.2.5.2 Moderator and observer

One researcher led the focus group and was responsible for explaining the context of the study, launching a collective discussion enabling the participants to elaborate on their position while ensuring that every participant was actively involved. In Wallonia, the moderator holds a PhD in Social and Political Science and the observer holds a Master in Psychology. The moderator's PhD dissertation focused on the 107-reform's implementation. However, it must be emphasised that the moderator's PhD research was a sociological, fundamental research financed by the National Fund of Scientific Research (F.R.S. – FNRS). This research was thus conducted independently from the evaluation research commissioned by public health authorities and the policy objectives promoted through the 107-reform. Moreover, since the moderator's PhD research relied on qualitative methods and entailed extended contacts with field actors over a five-year period (2010-2015), it provided the moderator with the opportunity to build trust relationships with the members of the three 107-networks she had analysed. Some of these actors participated in the focus groups held for the purpose of the present research in the Walloon Region. In these cases, the moderator's background appeared to foster a convivial atmosphere and facilitated the discussion since the participants assumed that the main aspects of the local organisation of mental health care were known by the research team. In general, previous research led by the IRSS' team provided its members with a significant knowledge of the organisation of the mental health system and the developments of the 107-reform. Such knowledge was viewed as a prerequisite to address the complex question of the mental health system organisation in the timeframe of the present research. It oriented the researchers' attention towards challenges and questions that emerged as important aspects of the mental health care reform following previous research. The methods used for the focus group discussions then enabled to deepen these important themes, but also to take some distance from the researchers' assumptions, through the uncovering of different and unknown understandings of the reform's objectives. For Flanders, both the moderator and observer hold a Master in work and organisational psychology. Besides, the moderator holds a PhD in applied economics (about networks, collaboration and technological innovation); the observer holds a PhD in biomedical sciences. These researchers were only indirectly involved in the previous evaluation research on article 107, which allowed them to listen and observe with an open, unprejudiced mind. Yet, the moderator was familiar with mental health research as she has extensively examined vocational rehabilitation for people with severe mental illness and regularly gave training to mental health professionals and students on the recovery vision and communication styles in mental health care.

1.2.5.3 Unfolding

A combination of the structure of focus group topic guide with an inductive approach was used. As described in the topic guide (Appendix 1 of Chapter 06), the focus groups were structured in three main parts:

1. Participants were asked to write down three key words best describing their overall opinions of the organization of mental health care in their area. A first 'tour de table' took place in which participants were asked to introduce themselves, the service or association they represented and to explain their choice of key words. Throughout this first stage, the moderator paid careful attention and noted down key elements, which were most important to participants, in order to further explore these in the ulterior stages of the discussion.
2. The moderator read the vignette out loud to participants and asked the opening questions stated in the topic guide. Prompts were asked to explore key dimensions into more depth. This second part of the discussion drew focus on the first two main topics of care provision and governance/coordination.

3. A final section drew focus on financing mechanisms. A general question was used to open the discussion and prompts were formulated based on the topic guide as well as cues from the previous parts of the discussion using an inductive approach.

1.3 Data analysis

In this paragraph, we make a distinction between the analyses of the content and themes that were discussed during the focus groups (thematic analysis) and the analyses of the behaviours and interactions between the participants (observational analysis). For the latter, we report in the result section the most notable interactions during the focus groups that might be influenced by the political and local context of the study, differences in position of the participants [10] and by forming adjacent pairs to assert a point of view (Dings, 2014).

To analyse the content of the focus groups, we relied on a framework consisting of the following six phases of thematic analysis [11]:

1. Familiarizing yourself with your data: we transcribed all data, read and re-read the data
2. Generating initial codes: we gave initial codes to meaningful phrases (or parts of phrases) in a systematic way
3. Searching for themes: we compared the codes and searched for potential themes.
4. Reviewing themes: we extensively discussed the emerging themes and made a thematic map (i.e. a consistent structure of the themes)
5. Defining and naming themes: we described a definition for each theme.
6. Producing the report: we relied on the final thematic map to write the report.

In this paragraph, we give a summary of the final themes belonging to the thematic map. We define each theme briefly in the result section.

- Provision of mental health care
    - Characteristics of the current provision of mental health care
    - Characteristics of current providers of mental health care
    - Provision needs
- Access of mental health care
    - Types of services and professionals
    - Access for different groups of service users
    - Access in rural versus urban areas
- Integration of mental health care
    - Values and norms related to mental health care
    - Factors influencing a collaborative culture shift
    - Formal tools
- Financing of mental health care
    - A system view on the question of mental healthcare financing
    - Financing mechanisms to resolve the issues of housing facilities
    - Financing at the level of professionals
    - Promising solutions
- Political and societal context of mental health care
    - Political context
    - Societal context

2 RESULTS

The results of the focus groups are structured around five main themes which were selected following the previously described iterative procedures. These five themes correspond to (1) provision of mental health care; (2) access to mental health care; (3) integration of mental health care; (4) financing mechanisms; and (5) political and societal context.

Throughout this section, each theme is previously defined and terms clarified. Some names of institutions and actors purposely remain in the original language in order to limit confusion related to terminology. Note that if participants combine multiple positions, we only describe the most relevant position in order to guarantee anonimity. As regards terminology, we use the uniform concept of ‘service user’ to refer to patients, clients, and people with mental health problems in general. As it is hard to find an appropriate term, we decide to use this term without wanting to attach a certain connotation to it.

On some occasions, themes and subthemes contain specific dimensions which were sometimes context-specific, conflictual, consensual or represented marginal views. These aspects will be explicitly mentioned in reporting the results and important aspects will be further developed in the discussion of the present report.

2.1 Provision of mental health care

This section reports participants’ accounts relating to provision of mental health care. Firstly, participants in most focus group discussions spontaneously and explicitly described their representations of the general structure of the mental health system. These aspects are discussed in the first subtheme on the current provision of mental health care services. Secondly, although many services associated with the five care functions and a number of professionals were mentioned, some of these received particular attention and were recurrently discussed compared to others which were not extensively covered. They are described in the second subtheme on the characteristics of particular providers of mental health care. Finally, particular needs in terms of services or professionals emerged. This final subtheme created a distinction between provision needs and accessibility, the latter of which will be reported into further detail in the following section.

2.1.1 *Characteristics[d] of the current provision of mental health care*

Although representations of the general characteristics of the current provision overlap with the subsequent more specific themes, an interesting finding relates to a great number of participants explicitly referring to the perceived internal complexity and “overstructuring” of the general mental health system. For instance, when participants were asked to recount three key words best describing their views of the current organisation of mental health care in their area, words such as “complicated”, “fragmented”, “maze”, and “lack of visibility” were typically most often mentioned by the participants of all focus groups.

This general characteristic emanates from participants coming from contrasting profiles, managerial positions and clinicians, from inpatient and outpatient settings specialised or not in mental health care, as well as service users and their relatives. Perceived complexity of the care system is strongly related to a lack of knowledge of and between existing services but also to a lack of clarity regarding services’ missions and roles, as the following extract puts forward:

> *[General director of a psychiatric hospital]: « […] pour moi c’est compliqué […] pour le patient qui a du mal à s’y retrouver dans l’exhaustivité des services, c’est compliqué pour le gestionnaire, parce que ses moyens sont insuffisants et […] pourraient être plus focalisés. C’est compliqué aussi dans la façon de manœuvrer l’organisation, parce que la multiplicité des organisations et la disparité et le manque*

[dd] The characteristics mostly apply to urban as opposed to rural areas.

> *de clarté dans qui décide de quoi et qui est responsable de quoi, ça rend extrêmement compliqué de prendre des décisions et de faire avancer les choses parfois. »*

> *[Psychiater algemeen ziekenhuis]: « Oogkleppen [als sleutelwoord]: iedereen kijkt vanuit eigen bril naar de wereld en ziet totaal de samenhang niet, heeft geen helicopterzicht en staart zich blind op bepaalde groepen van patiënten terwijl er heel veel soorten patiënten of cliënten zijn. »*

Furthermore, a 107 network coordinator reported having received phone calls from unknown independent psychologists, asking for support in referring service users to appropriate services or professionals. This example emphasized that experiences of the system's general complexity is particularly increased for private practices. The following extract further illustrates certain consequences of internal complexity in terms of inadequate referrals and time consumption:

> *[Relatives representative] : « [Ce] qui fait qu'il y a une complexité accrue, c'est qu'on passe un temps très important à expliquer aux personnes comment fonctionne une [institution]. Il faut remettre les pièces du puzzle à leur place et voir comment circuler [...] dans ce circuit. […] En tout cas la réforme et ce qui est mis en place maintenant […] ça complexifie très fort les choses et c'est de moins en moins évident pour les personnes.*

> *[Moderator] : Est-ce que ce problème d'information conduit à des orientations mal adaptées ?*

> *[Relatives representative] : […] Oui, ça entraîne des mauvaises orientations […] quand il y a parfois des situations qui relèvent plus de l'ordre d'un accompagnement psychosocial, et pas forcément psychologique, on consacre un temps à ré-aiguiller et accompagner dans ce dédale... C'est complexe. »*

Altogether, the findings suggest that the perceived complexity of the system as a whole has concerning consequences in terms of exclusion of people with mental health problems and burn-out of mental health care professionals. As the following quotes put forward, such concerns are also associated with risks of tight structuring:

> *[Psychologists, Community mental health centre] : « Il y a un risque de rigidification, et de saucissonnage sur un diagnostic, plutôt que de rester dans une approche généraliste […] au plus on est dans des procédures d'admission, au plus il y a des grands exclus. »*

> *[Psychiater en systeemtherapeut]: « We worden opgebrand in een structuur die vaak pseudo-georganiseerd is. We zijn georganiseerd, we hebben deze taak. Daardoor wordt het vaak verengd en branden mensen [hulpverleners] die liefdevol en passievol zijn vaak op. »*

Although the complexity is viewed as a rather negative aspect, the diversity and amount of the care offer is considered positively.

> *[Director sheltered housing initiative]: « Ik vind het wel positief dat er binnen onze regio toch wel een groot GGZ-aanbod is maar dat het ook een valkuil is want niet iedereen weet ervan. Dus er is veel maar waar is het overal. »*

2.1.2 Characteristics of providers of mental health care

Certain providers of mental health care, in terms of services and professionals, were discussed recurrently and into further detail across the focus groups. These reflect the aspects of provision that are most salient in the current system and that received most attention in the political climate in which the focus group took place. The impact of ongoing policy programmes on focus group discussions will be further construed in another section of this report, which is precisely devoted to the political context.

Reporting on the main characteristics of these services and professionals, which were highlighted namely in terms of the missions and roles associated with them, will enable to better grasp the main challenges which arise in discussing how they interact with each other.

Formal network

In this report, the formal network describes the services and the professionals whose formal mission is to provide care for service users suffering from mental health problems. These services and professionals are integrated in formal as well as informal networks of relationships which, according to the focus group discussion, would have contrasting properties. First, the networks 107 are (1) mostly structured around the five functions, (2) partially depend on the integration work performed by the coordinators, and (3) rely on procedural mechanisms of collaboration. Second, the informal networks would depend on inter-organisational and inter-professional relationships that have been developed through concrete practices. These networks mostly rely on informal mechanisms of mutual adjustment. Third, the properties of both types of network would be, in contrast to the network partners, to be present continuously instead of only being switched on when a particular problem occurs. The composition of these latent networks should, however, be reassessed on a regular basis to ensure their adequation to the service users needs. The partial decoupling of formal and informal networks will be deepened in the section on coordination and collaboration.

> *[Medewerker wijkgezondheidscentrum]: « […] Ik denk dat we veel meer moeten gaan naar een stand-by principe i.p.v. een on-off. Een on-off is eigenlijk het ziekenhuis: Ofwel zet je GGZ aan en al de rest [vb. welzijnshulp] niet. […] We moeten zien: 'Hoe kunnen we een stand-by realiseren, waarbij niet iedereen altijd even actief moet zijn?' […] Wat wij nu heel de tijd doen is verwijzen. Iemand heeft zijn verhaal nog niet gedaan en... Eigenlijk moet je toevoegen. Je moet toevoegen en je moet af en toe evalueren en zeggen van 'zitten we met teveel aan tafel, dan moogt gij en gij en gij gaan spelen en iets anders gaan doen'. Maar dat doen we niet. We gaan rond de tafel zitten en we blijven rond de tafel zitten en we evalueren niet meer van 'is dit nu wat nodig is'. Dat is een hele andere manier van denken. Dan maak je u er niet vanaf en dan geef je het door aan de volgende. […] Hoe moeilijker dat het is, hoe rapper dat iemand weggegeven wordt. Je moet zeggen 'blijf'. Ik ben de eerste waar jij bij komt. Ik weet niet wat ik allemaal kan doen maar ik blijf luisteren en zoek bij wat dat nodig is. »*

Service providers

The services which raised critical issues in terms of particular characteristics which will be discussed in this section, mainly concern: Medical centres, Community mental health centres, Mobile teams, Psychiatric and emergency units of general hospitals and Crisis units. Findings relating to particular categories of professionals will be discussed in the following paragraph.

Medical centres were regarded as important in playing a preventive role and ensuring care continuity, as they are in contact with service users before the occurrence of debilitating mental health problems. A director of a Medical centre in one of the focus groups explains they can more easily have a feel for the service users' social environment which contributes to supporting them in this role:

> *[GP working in a Medical centre] : « [N]ous sommes les garants de la continuité, parce que pour nous il y a pas de fin dans la prise en charge. La prise en charge, elle est illimitée, elle est gratuite pour le patient, enfin gratuit c'est jamais gratuit, mais le patient ne doit pas payer, et donc nous on garantit une continuité tant que c'est nécessaire, possible, et tant que le patient est en vie, d'avant la naissance, et jusqu'à la mort. Je dis, d'avant la naissance, parce qu'on travaille aussi avec des familles depuis toujours. On connaît les familles, ça c'est extrêmement précieux, quand on connaît tout le système dans lequel les gens se trouvent. »*

Some characteristics of **Community mental health centres** also received particular attention. While the diversity and the strong specialisation of the services provided were acclaimed, these characteristics were also the source of confusion in terms of provision of care. Accounts of how exactly these characteristics impact on accessibility will be discussed in §1.4.2.

Mobile teams were also often discussed and regarded as playing a key role in care continuity. However, participants raised several obstacles for them to take on this key role effectively. Namely, mobile teams are held responsible for sometimes very large territories with unclear boundaries.

> *[Director mobile team]: « We hebben een zeer grote regio en met het mobiel team worden we daarmee geconfronteerd. We moeten zeer ver in de regio gaan begeleiden waardoor je wel wat tijd in afstand aflegt wat je aan kwaliteit inboet. Dat vind ik een zeer belangrijke. »*

Moreover, they are often short staffed, and financing mechanisms which will be discussed later on, lead to difficulties in ensuring the presence of full-time psychiatrists within these teams. Another obstacle related to the fact that mobile teams include professionals with multiple employers, managed by a coordinator with no real hierarchy. Altogether, these characteristics and a lack of clear guidance on how to use newly created facilities such as mobile teams have certain undesirable consequences. Namely, both service users and health professionals may use them according to their own needs and preferences, which results in creating additional needs and enlarging the system's boundaries.

> *[Psychiatrists, Head doctor of a psychiatric hospital] : « Je vais prendre l'exemple des équipes mobiles […], je crois qu'au départ […] les patients qui sont entrés dans ce système là, venaient essentiellement de l'hôpital psychiatrique, et puis je crois que progressivement ça c'est élargi à des patients […] qui y étaient, chroniques et complexes en gros, et maintenant ça s'adresse à une patientèle qui ne serait probablement jamais arrivée à l'hôpital psychiatrique avant. Et donc il y a un effet d'aubaine […] à partir du moment où il existe un outil, les gens qui n'ont pas des pathologies plus lourdes s'en servent et je crois qu'il y a un effet pervers lié au fait que nous tous, en tant que professionnels, nous préférons travailler bien sûr avec des gens qui ont des ressources potentielles de guérison […]. Donc, tous nos outils glissent vers des patients qui en ont le moins besoin. »*

The characteristics of **psychiatric services of general hospital** and **emergency services/ crisis units** in relation to emergency situations (NL/FR) also received particular attention. In Flanders, participants reported that GPs are increasingly inclined to refer crisis situation to emergency services of general hospital because psychiatric hospitals are full. Besides, participants highlighted the difficulty in dealing with a high number of emergency situations in a very short time scope often leading to involuntary commitment procedures. Both general and psychiatric hospitals put forward the need to improve the management of these situations by increasing the delay for emergency services and crisis units to make an accurate diagnosis, namely, by allowing time for other services, professionals or relatives to be involved. Despite these challenges revolving around emergency situations, participants also stressed that local organizational initiatives in general hospitals, articulating their emergency and psychiatric units could effectively limit the need to resort to involuntary commitment procedures.

Professionals

Throughout the overall focus group discussions, recurrent issues and characteristics related to certain professionals were raised.

The role of psychologist has been extensively discussed in certain focus groups. As it will be explained in the section on the political context, this particular emphasis could be explained by recent political decisions directly impacting this profession. Participants generally mentioned that primary care psychologist could play a valuable role in ensuring care continuity. The role of these psychologists is, however, limited to short term interventions. Therefore, in Flanders, a participant suggested that their role could be complemented by the intervention of primary care nurses, as in the collaborative care model implemented in the United States. On the other hand, the distinction between private psychologists and psychologists working in Community mental health centre has been particularly raised in French-speaking focus groups. In that regard, the participants argued that private psychologists could perform a key role in ensuring care continuity but may lack knowledge of the mental healthcare networks. Given the limited time scope of psychologists' interventions, knowledge of the networks' resources would, yet, be particularly needed. By contrast, psychologists working in Community mental health services would hold an extensive knowledge of the network's resources, but the development of the psychologists' function within community settings would be threatened by recent policy measures:

> *[Psychologist, Community mental health service] : « Si l'INAMI débloque des millions et des millions, pour rembourser des soins psychologiques […] chez des psys privés, ces millions-là pourraient être utilisés pour étoffer des institutions existantes de quartier, de proximité, les institutions pluridisciplinaires, pour justement être encore plus présents dans la cité, parce que un psychologue privé, il n'aura pas le temps de faire de la liaison. »*

The role of the general practitioner in mental health care was a sensitive issue in many focus groups. Important roles associated with GPs were raised, but certain concerns also appeared. Regarding the important roles, the GP was often considered a good point of entry for a public needing mental health care but not willing to seek specialised care. For service users already under specialized care, the GP was regarded as a resource to secure the long-term follow up of stabilized situations, a role which results in eased access to specialized care for those in crisis situations. Despite these potentialities, participants refer to individual differences between GPs in their mental health care competences. They often mention a lack of training, or of inclination for dealing with mental health, as illustrated in the following interaction:

> *[Director psychiatric center]: « De samenwerking is heel fluctuerend. Ik denk dat eigenlijk heeft de samenwerking tussen individuele personen heel vaak te maken met de persoon. Er zijn huisartsen die radicaal antipsychiatrie zijn en er zijn huisartsen die zeer veel psychiatrische patiënten in hun praktijk hebben en dat ter harte nemen. Dus daar zie je ook heel grote individuele verschillen tussen huisartsen. Dus het hangt er al een beetje van af welke huisarts je hebt. »*
>
> *[General practitioner]: « Dat klopt. Onze achterban is zeer versnipperd. »*

Besides, the role of the GP as a reference person was a sensitive topic in many focus groups. In fact, persisting misunderstandings and disagreements regarding the precise role of a reference person and who should fulfil this role were recurrent across focus groups discussions. The term, reference person, had a strong connotation in the 107 Reform context which will be described into more detail further on. Moreover, debates on whether the formal or the informal network should take on the role of reference person raises the issue of the consideration of the informal network's position in the care system. These issues are illustrated in the following extract:

> *[Coordinator of Mental health care dialogue platform] : « Personne de référence, ça dépend comment on le définit, et j'entends plutôt la nécessité de pouvoir... Ça ne se décrète pas comme une fonction, c'est dans le service, en fonction de l'accroche qui a été établie entre la personne et quelqu'un du service. Et donc parfois c'est le médecin, parfois c'est l'AS, parfois la secrétaire, n'importe. Et c'est cette flexibilité là qui est importante à maintenir. »*

In this regard, some representatives of service users described that they only want one 'confidential' person that they can choose themselves. This confidential person is not necessarily a professional, but someone who has strong listening skills and is able to help the person find the care he or she needs. The focus group participants agreed that this reference person has a different profile/function for different people. They claimed that the choice for a reference person needs to be a result of natural selection and not of organisational choices. Furthermore, this reference person should be supported as well. They even mentioned that it might become too hard for one reference person to bear all the problems. Therefore, a professional recommended to create a team of confidential persons around the service user instead of putting all the load on one confidential person. A representative of service users agreed with this approach as long as it stays clear for the service user who belongs to this team of confidential persons.

> *[General practitioner]: « Het probleem waar eigenlijk al jaren naar gezocht wordt is dat ankerpunt zeker als je een MDO organiseert, dan wordt sowieso gevraagd wie is uw vertrouwenspersoon maar ook daarop is niet direct een antwoord te vinden en ook omdat het eigenlijk heel verschillend kan zijn. Je verwoordt het juist: In het geval er iets gebeurt wil ik iemand hebben waar ik in vertrouwen naar toe kan gaan. Die problematiek waarop je aanstuurt, kan heel verschillend zijn, zoals ook de persoon die hij zoekt, verschillend kan zijn. Dus we hebben al ontzettend veel tijd en geld gestoken in een soort aanspreekpunt binnen*

> *de zorg om dat te universaliseren maar dat gaat niet, dat is individueel. Vandaaruit mijn pleidooi om te werken in geïntegreerde zorgteam en in dat zorgteam maken dat er vertrouwenspersonen aanwezig zijn die jullie als patiënt altijd willen bekend maken. Dat is ook iets wat we vragen bij een opname, bij een nieuwe episode. Telkens vragen: wie is er op dit moment de beste persoon om aanspreekbaar te houden. »*

Informal network

The informal network describes actors who are also involved in providing support for service users, but for whom this support is provided informally, in that it is not considered a part of their professional or institutional mission.

Participants highlighted the key roles of relatives of service users for care continuity, and especially so for people not willing to seek care. Professionals highlighted their important role as a source of information, particularly in crisis situations but concerns regarding the professional secret were raised. Generally speaking, representatives of relatives claimed that they are in need of training and support in dealing with crisis situations and that they should be involved in formal mental health care from the start. Even if the client doesn’t want to be in contact with his/her family, professionals need to inform family members about this choice of the client.

Another concern for these participants regarded post-hospitalisation care in the long term, or "after-parent". This expression refers to parents of service users who feared their passing would inevitably provoke recurring hospitalisations as their role in securing care continuity is not effectively replaced.

Apart from family and friends, the neighbourhood can also fulfil a role in detection and prevention of mental health problems:

> *[Directeur psychiatrisch ziekenhuis]: « Dat is wat ik een aantal keren in het buitenland gezien heb en wat we vaak al benoemd hebben. De schakel die we hier bij de implementering van de gemeenschapsgerichte zorg vergeten is wat we in het buitenland Community MH Care noemt. De services daar zijn anders dan de diensten GGZ hier. Daar heb ik gemerkt dat ze zeer proactief rond dat soort cliënten met buren, mantelzorgers, de beenhouwer, de bakker etc. omgaan. Zij zijn contactpersoon voor zo een persoon. Die manier van werken zonder dat ze al zwaar therapeutisch interveniëren zit in die tussenzone. Dat ondersteunt heel erg de eerste lijn maar tegelijkertijd zijn ze de eerste detectiegroep voor wanneer mogelijke… »*

2.1.3 Provision needs

The generic complexity raised by participants in expressing their views of their local mental health system, and confusion and disagreements regarding the missions and roles of each others’ professions and institutions, nevertheless enabled to put forward certain needs in terms of provision which were further expressed.

An important provision need which arised from the focus groups concerned low threshold services with no admission criteria. According to focus group participants, the lack of these types of services is greatly related to overcrowded residential care, but also to the existence of “black lists” in residential care, that is, lists of problematic severe mentally ill service users cumulating complex needs (see access for different types of service users) who previously caused problems in specialized inpatient services, and thus are no longer welcome.

The most important consequence of the existence of these black lists was the shift of these service users towards outpatient primary care services, who claim they do not always have the expertise or resources to provide adequate care for these service users. The findings importantly highlight the difficult position that these “black lists” put primary care services in. For example, medical centres end up having to find costly solutions to provide care for these service users, as the following participant expresses:

> *[General practitioner, director of a medical centre] : « Il arrive assez fréquemment que l'hôpital n'en puisse plus avec des patients, donc ils sortent des patients, ils les mettent dehors, et ces patients arrivent chez nous. Et nous, comment on fait? Il faut savoir que par rapport à ça, nous, on n'a aucune reconnaissance [...] Notre service psycho-social n'est absolument pas financé, [...] il y a quand même plus de la moitié du financement qui se fait sur fonds propres, c'est-à-dire, sur l'argent*

> *qu'on va chercher sur des honoraires des médecins, des kinés, des infirmiers. On espère que notre forfait de va pas être réduit, [...] ça nous inquiète au plus haut point. »*

> *[Employee, Medical centre]: « Een ziekenhuis kan zich op een bepaald moment enorm gaan afschermen. Ze hebben soms een complexe casus gehad, ze staan soms op de zwarte lijst maar eerstelijnsdiensten worden geconfronteerd met die problematiek uiteraard ook en staan uiteindelijk veel kwetsbaarder ook in hun zorg naar die desbetreffende doelgroep. »*

2.2 Access to mental health care

Reporting on the provision of mental health care implied describing some characteristics of services and professionals which stood out during focus group discussions. Before delving into how exactly these services and professionals interact with each other (see integration of mental health care), this section on access to mental health care will make a step further into the situational and temporal context in which existing services and professionals are difficult to access. Firstly, the types of services and professionals which received the most attention will be exposed. Secondly, the characteristics of the public particularly affected by hindered access will be covered. Finally, geographical aspects raised important issues which will conclude this section.

2.2.1 Types of services and professionals

During the round table introductions, participants from diverse outpatient and inpatient institutional backgrounds put forward the rich diversity of the care offer and opposed this characteristic with a general saturation of the network. Community-based (ambulatory care and preventative services) and emergency inpatient services as well as some professionals were targeted in ways which will now be described. By and large, access to housing facilities were considered a central issue for system saturation. Based on the characteristics of such housing facilities that were expressed during the focus groups, these facilities do not necessarily correspond to the typical ones that already exist within the mental health system, such as Psychiatric Nursing Home and Initiatives of Sheltered Housing.

Access to ambulatory care and preventive services

Participants in all areas point to poor accessibility of ambulatory mental health care, particularly of community mental health centres (CMHCs). Although they are required to intervene within three months, CMHCs claim their resources are insufficient to meet this requirement. As a result, many CMHCs no longer employ waiting lists and directly refer service users to other services and professionals.

An important difficulty for these types of referrals concern access to psychotherapy to ensure a regular therapeutic follow-up at affordable prices, namely after inpatient care episodes or after transition from day-care hospitals:

> *[Psychologist, administrative director of CMHS]: « Il n'y a pas assez de thérapeutes cliniciens qui pratiquent à des prix démocratiques, donc pas assez de cliniciens à mon sens, peut-être de plus en plus de coordination, mais il faut des gens sur le terrain. »*

> *[Expert by experience]: « Een veel voorkomende vraag is aandacht voor psychotherapie. Veel cliënten wensen een afbouw van medicatie en over het aanbod moet bekeken worden wat er in de plaats komt. Psychotherapie is nog altijd voor veel mensen niet betaalbaar. »*

Although the focus group discussions suggest that access to affordable psychotherapy is thus an important issue, a key aspect in the French focus groups was that psychologists practicing in the private sector were often overwhelmed by complex situations in which social aspects prevailed. For this reason, as previously mentioned, participants put forward the need for psychologists to be anchored in community facilities to benefit from multidisciplinary work.

In order to effectively compensate long-term inpatient specialized care for stabilized service users suffering from severe mental conditions, participants also highlighted the severe lack of psychiatrists within CMHCs. A psychiatrist working in a mobile team explains that as mobile teams are active on very large territories, they cannot effectively compensate specialized inpatient care and that this is due to a lack of multidisciplinary outpatient services such as CMHCs. As a result, a community-based approach to care for these service users remains a challenge:

> *[Psychiatrist, mobile team] : « Au départ l'hôpital, c'est quand même [...] le lieu de l'accueil de la psychose, et maintenant [...] y a plus de lits T, donc on a vraiment quelque chose autour de la psychose [...] dont on sait plus très bien que faire. Est-ce qu'elle va que à l'hôpital, où elle passe quelques semaines et puis les gens sont mis dans la rue, et je trouve qu'il y a vraiment un déficit du côté ambulatoire [...] ces gens ont quand même besoin de prise en charge multidisciplinaire [...] où on peut [...] mettre des relais vraiment implantés sur le territoire local pour penser ces choses-là. On a bien des équipes mobiles, mais [...] ça reste des territoires qui sont quand même relativement grands, [...] donc on connaît pas la réalité locale du quartier [...] On est en déficit de structures comme des services de santé mentale. Par exemple, dans la psychose, il faut un relais psychiatrique, la question de la médication est quand même importante, et les psychiatres restent quand même fort centrés autour de l'hôpital, les psychiatres privés on en a quelques-uns, mais d'abord ils sont assez inaccessibles financièrement, et puis dans les SSM on n'a quasi pas de psychiatres, ils meurent. »*

> *[Employee community mental health center]: « Hulpverleners zijn zo geëngageerd en betrokken maar bij ons in het CGG is er zoveel vraag – het is Sophie's choice'. Je moet kiezen en mensen weigeren. Dat is […] eigenlijk is dat echt niet haalbaar. Die therapeuten willen dat ook anders. Er zal een andere organisatie voor instaan maar je moet die overgang ook maken. »*

Difficult access to CMHCs which provide specialized care, with sufficient numbers of psychologists and psychiatrists, further emphasize the confusion regarding whether these outpatient services provide frontline or specialized care addressing complex and severe psychosocial needs – a characteristic which was reported in the previous section. Although this was not expressed in all focus groups, the following extract suggest that medical centers, in addition to dealing with service users on inpatient services' black lists, also face an excessive number of severe mentally ill service users compared to their capacities:

> *[General practitioner, director of a medical centre] : « Les maisons médicales sont un peu les poubelles du système. [...] On a fait lors de la recherche qui a été menée par l'UCL, la KUL, dans le cadre du 107, y a quelques années, on avait essayé d'analyser un peu notre population, donc sur 3000 patients inscrits, on a identifié 200 patients présentant des troubles psychiatriques graves sur base d'une échelle d'évaluation fonctionnelle [...]. On a constaté que sur ces 200 patients y en avait plus de la moitié, qui n'avaient jamais été suivis par le secteur spécialisé [...] Pourquoi c'est comme ça ? Parce que nous avons une grande accessibilité, on n'est pas stigmatisant, chez nous les gens ne paient pas, on a un système du forfait, et on n'a aucune discrimination à l'inscription, […] on accepte toutes les demandes et ils arrivent en masse chez nous, ça c'est assez clair. »*

Access to emergency crisis care

In addition to problems of accessibility in community-based services, access to crisis care, as previously described, was a recurring issue across focus group discussions. On the one hand, outpatient services, particularly those not specialised in mental health care, are faced with acute situations which feeds through to crowded community mental health services, not always but often leading to involuntary commitment procedures as the following exchange conveys:

> *[107 network coordinator] : « Parfois, quand on fait appel à des équipes de crise, où il y a des délais d'attente, ils ne savent pas […] faire face à la demande. Et donc, c'est les relais santé, les maisons d'accueil social, qui subissent en fait les crises de santé mentale des personnes, et ils viennent de plus en plus vers les services de santé mentale en disant, mais qu'est-ce qu'on fait ? Nous on n'est pas spécialisés, et on ne sait pas gérer ça. Ça c'est vraiment un gros problème. »*

> *[General director of a psychiatric hospital]: […] Et donc nous, on reçoit tout ce public-là, qu'on ne sait pas réorienter puisque les équipes en aval sont full et qu'il y a pas de place, donc on fait tampon, mais le*

> *tampon du tampon, donc pour finir, nous on ne saura plus faire notre mission, et [les urgences] se rempli[ssen]t petit à petit.*
>
> *[Coordinator of a mobile team supporting professionals]* **:** *Et les conséquences de ça c'est qu'on n'a jamais vu autant de mesures de protection, puisque la mesure de protection, c'est la porte d'entrée en urgence...*
>
> *[Employee public centre of societal wellbeing]: « Als we bellen naar de huisarts is het vaak van: stuur ze naar de spoed. Mensen gaan naar de spoed maar willen daar niet echt zijn of we moeten een ambulance bellen als het zeer ernstig is. Ze komen op de spoed terecht en worden even opgenomen en gaan tegen advies in weer naar huis en een week later is het weer hetzelfde verhaal. »*

Access to housing facilities

Difficult access to housing facilities was a recurrent issue across focus groups, especially in Wallonia. Along with the perceived general complexity of the mental health care system, difficult access to housing was also a dominant choice of key words amongst participants during the introductory round table discussions. Unanimously, the "freezing" of psychiatric beds causes a lack of alternative housing facilities, particularly so for service users with severe and complex conditions who cannot live autonomously, as the following quote states:

> *[Psychologist, administrative director of CMHS]: « [Il n'y a] pas assez de logements supervisés pour les personnes qui ne sont pas capables d'être dans un logement seul et d'être autonomes. Ça c'est sûr et certain. »*

Access to housing facilities was particularly problematic for certain groups of service users, a finding which will be shortly reported.

2.2.2 Access for different groups of service users

Access to supervised housing facilities, and to the broader mental health care was particularly salient for certain types of public. The focus group participants stress that not every person has equal access to mental health care. They describe the most precarious populations are often those who do not have access to appropriate mental health care during emergencies or for follow-up. Participants highlight that the most socially precarious populations, cumulating severe mental conditions, are often those for whom access to mental health care is the most difficult:

> *[Psychologist, representative of a relatives association]: « Je pense qu'il y a beaucoup de pleins mais il y a aussi des trous, il y a des gens qui peuvent pousser des portes et trouver un interlocuteur mais aussi des gens qui […] se retrouvent malheureusement dans certains trous ou 'no man's land' du réseau. […] quand on cumule des problématiques complexes avec plusieurs axes, que ce soit assuétudes, santé mentale, ou encore précarité sociale, c'est des interactions complexes qui font que parfois ces personnes-là ont du mal à être accueillies. »*

A recurrent concern expressed throughout the focus groups regarded the fact that access is facilitated for service users who are willing to seek help. Persons who do not seek help and do not accept it are often those who are in the most need for mental health care:

> *[Directeur ziekenhuis]: « Bijna overal verwacht men een minimum aan motivatie van de cliënt. Dat is een verwachting die men eigenlijk bijna overal heeft. Als je bij een CGG op intake gaat en je bent niet gemotiveerd, dan zal het CGG zeggen: 'dat is niet voor hier'. Als je in een ziekenhuis niet gemotiveerd bent, word je op een bepaald moment ook de deur gewezen. Dus ik denk dat dat een uitdaging is van wat met mensen die niet gemotiveerd zijn. »*
>
> *[General practitioner, director of a medical centre]: « Les populations qui le plus besoin de psychothérapie, c'est des gens qui font pas ce type de demande. »*

In addition to these types of public, other populations are reported as being excluded from the system, such as the elderly, or mothers with their children, addictions and people suffering from mental disabilities. In Flanders, undocumented migrants are also cited. For this latter group, involuntary commitment procedures are the only way to get access to mental health care.

2.2.3 Access in rural versus urban areas

Focus group participants highlight the strong disparity between urban and rural areas, the latter of which were faced with difficult access to mental health care.

> *[Psychologist, director of a CMHC] : « Ce que j'observe plus dans le milieu rural c'est le manque d'accessibilité aux soins, donc des services de proximité proposant vraiment des consultations de médecins psychiatres, ou d'autres structures ambulatoires. En milieu urbain au contraire il y a un réseau qui se développe assez bien. »*

> *[Psychiatrist, mobile team]: Ça serait quand même vachement important [de] penser la place des psychiatres […] On a des territoires très reculés, alors tous les psychiatres sont centrés sur les territoires urbains.*

Although some participants emphasize several functions of mental health care should be close to the civilian, they also mention that the implementation of strongly specialized mental health care services in every village is not feasible nor recommendable. They conclude that one needs to aim at a good balance between the rural and urban care offer although tensions will always exist.

> *[Directeur psychiatrisch centrum]: « Het kan niet de bedoeling zijn om hyperspecialisatie in elk dorp te gaan organiseren maar bepaalde functies moeten toch echt wel dicht bij de burger gehouden worden denk ik en dat vraagt een goed evenwicht. Dat is nooit helemaal af, daar zullen altijd spanningsvelden zijn maar ik vind dat toch een belangrijke oefening omdat je toch wel ziet dat als een regio georganiseerd is rond een grote stad en dat die stad ook een bepaald aanzuigeffect heeft, een bepaalde concentratie. Er moet over gewaakt worden dat dat nog in accordantie is met de noden in het veld die in ons geval letterlijk van de Nederlandse tot de Waalse taalgrens lopen. Wat niet evident is. »*

Although participants highlighted that specialized care should not be implemented in all areas, focus group participants involved in rural areas emphasized that social isolation in these areas, and poor access to occupational activities was a major problem for chronic mental health service users, and also an important source of relapse. For instance, day-care centres are scarce in these areas and sufficient access to transportation services was a major related issue reported by these participants.

2.3 Collaboration and coordination of mental health care

Reporting on the issue of access to mental health care has introduced certain aspects relating to inter-professional and inter-organisational relationships. The aim of this section is to describe into further detail the main patterns of relationships within the local care system which emerged from the focus group discussions. A careful description of these patterns will enable to better grasp the current complexities of collaboration and coordination within the Belgian mental health system, which will be further analysed in the discussion of this report.

This section will first provide a synthesis of the critical values and norms related to mental health care that most influence inter-professional and inter-organisational relationships, in a way that either hinders or facilitates the recovery of service users. A description of the formal and informal means of communicating within the health system will conclude this section.

2.3.1 Values and norms related to mental health care

Relationships between individuals and institutions are strongly influenced by shared or differing values, considered as deeply rooted representations of mental health which according the findings, remain difficult to define and often cause important relational disruptions within the mental health system. The two following quotes highlight the difficulty in defining mental health, and the deep impact this has on relations within the mental health system, namely among professionals specialized in mental health care such as psychologists and psychiatrists:

> *[Psychiatrist, mobile team]: « Alors la première chose c'est la question de la santé mentale. Pour moi c'est quelque chose d'extrêmement large, et je trouve d'assez mal défini. Et on ne sait pas très bien où ça commence et où ça s'arrête la santé mentale alors […] on met dans ce gros paquet aussi bien des grosses questions de schizophrénie que des questions de gens qui ont des difficultés professionnelles à un moment donné et viennent consulter […] Donc je trouve que là il y a un processus maintenant qui vise à ouvrir, à gommer les frontières, mais aussi avec une difficulté de définir de savoir de quoi on parle exactement. »*

> *[Psychiatrist, medical director of a psychiatric hospital]: « Il y a […] des éléments théoriques qu'il ne faut pas sous-estimer, que les soins de santé mentale, de psychiatrie, il faut déjà s'entendre sur ça, sont encore traversés par des dimensions théoriques ou cliniques parfois profondément contradictoires et qui ne se fondent pas l'une dans l'autre si facilement […] Et qui sont d'énormes obstacles, pas des petits, des énormes obstacles à la coordination. » The same psychiatrist further adds : « Quand on parle de la disparité, on ne parle pas d'une petite disparité […] si on reprend des modèles d'organisation de soins dans d'autres spécialités, […] c'est peut-être un peu grossier comme exemple, mais quand on a un infarctus, on n'a pas vingt traitements différents en fonction du cardiologue que vous [consultez]. »*

In addition to the controversy in defining mental health, another value identified as an important source of disagreement relates to participants' understanding of the very notion of 'community mental health', and their expectations as to how mental health needs should be met. A community-based approach to addressing all service users' needs did not reach consensus amongst participants, importantly altering relationships within the mental health system, as the following quote conveys:

> *[Director of a psychiatric hospital]: « Ik ben het nu 20 jaar aan het doen en is het elke dag bloed, zweet en geen tranen om uiteindelijk elke dag... Want ik merk dat ons ziekenhuis, hoe goed het ook draait en hoe goed de afdelingen georganiseerd zijn en hoe goed behandelingsgericht te zijn... om het dan wat cru uit te drukken: ze lopen wel een aantal versnellingen achter op onze vermaatschappelijken werking. Ja, soms is het ook zo. En onze systeemtherapeut merkt het nu ook. Hij werkt in onze afdeling en in het mobiel team en komt in conflict met de afdeling [van het ziekenhuis]. Daar waar het mobiele team uiteindelijk vanuit een open dialogue met familie aan de slag gaat als op een gegeven moment toch even kort een opname nodig is. En de therapeut begint met het behandelteam [van het ziekenhuis] in onderhandeling te gaan en ze botst op een muur. En dan denk je hoe is het in godsnaam mogelijk dat dit zich manifesteert in een dualiteit van in de twee organisaties te werken waarin je in conflict komt met hoe het eigenlijk niet zou mogen. »*

The findings suggest that diverging perspectives regarding a community-based approach to mental health care is at least partially associated with concerns over excessive normalization, and the fact that gearing service users towards the job market for example is not realistic for all types of people in specific situations and on a specific moment of time:

> *[Psychologist, administrative director of CMHS]: « On est dans une période où il y a une idéologie du rétablissement, de la guérison, de la remise au travail, on est un peu comme ça dans une ère de normalisation, il faut que l'homme redevienne normal. […] Il y a une certaine vision de l'homme et de l'humain qui devrait être sans symptômes, avec une logique de projet, il faut retourner sur les rails. »*

Difficulties in defining mental health, diversity of approaches in addressing service users' needs, combined with concerns over excessive normalization for people who may not be fit enough to live up to collectively agreed expectations, lead to another important aspect affecting relationships according to participants: acknowledging each other's expertise in addressing mental health needs between professions and institutions. Indeed, a recurrent issue throughout focus groups regarded the fact that a culture shift still needs to operate to recognize each other's expertise and function as a network. The following quote emphasizes the impact this has on care continuity:

> *[107 network coordinator]: « Tout le monde n'est pas encore peut-être arrivé à une culture de réseau […] ça entraîne certains freins par rapport à la continuité des soins […] où là il me semble qu'il n'y a pas une place réellement faite, en tout cas d'expertise des travailleurs qui ne sont pas de la santé mentale. »*

In Flanders, there were, however, clear signs of professionals acknowledging each other's expertise. This was especially the case in a small, rural and relative new network but also prevalent in two older networks.

> *[Employee medical centre]: « Je leert dus soms heel veel van die expertise. Ik zou jaren willen meelopen om dat te leren. Dat is knap als je dat ziet gebeuren want je kan dat zelf niet maar je ziet wel het effect van wat mensen doen. En dan denk ik: 'geef ons zo een equipe die komt en die mij leert wat mijn blinde vlek is waardoor ik die mens slechter maak in plaats van beter maar die ook al eens een vorming komt geven bij ons over de problematieken en daar gaat het over. »*

The most recurrent issue across focus groups in this respect concerned addressing service users to specialised care, especially in acute situations as described in the previous section. Although this was not addressed in all focus groups, one of the barriers hindering relationships between specialized and non-specialized services such as home-care services, was the medical professional secret. In one French-speaking focus group, a representative of home-care services (services d'aide à domicile) claimed it was difficult for non-specialized professionals of her institution to play a preventative role as they do not have access to basic information from specialized services. This participant particularly insisted on the fears of non-specialized professionals in dealing with certain service users and the perceived lack of support from specialized services.

2.3.2 Factors influencing a collaborative culture shift

Although important differences in values related to mental health care were identified amongst individuals and between institutions, participants highlighted the need to preserve creativity and autonomy within their practices in order to foster mutual collaboration and an integrated model of mental health care. Important prerequisites for creativity according to participants are sufficient levels of autonomy and flexibility within professional activities. Namely, participants sometimes stressed that excessive 'overstructuring' by the government, and excessive rules undermine professionals' autonomy and flexibility:

> *[Psychiater algemeen ziekenhuis]: « Ik denk dat het heel juist is dat de cliënt centraal staat. En dat het essentieel is -wat je alleen mondeling of over de telefoon kunt doen- te overleggen tussen hulpverleners op een creatieve manier van 'hoe kunnen we in die casus iets op maat organiseren'. Ik moet eerlijk zeggen hoe meer volk ik ken, hoe meer instellingen, hoe meer dat ik creatief daar mee kan schakelen en kan spreken over een behandelvisie ten voordele van de specifieke casus. […] En dat zijn de casussen denk ik waarvan ik content ben dat we toch een oplossing gevonden hebben gewoon doordat we kort op de bal het gehad hebben over een specifieke behandelvisie. Nog niet zozeer over facts en figures. Natuurlijk, die moet je eruit halen, ook de visie van de patiënt moet je eruit halen en dan moet je komen tot een gedeelde behandelvisie. En dan moet je een behandelplan fabriceren maar het behandelplan vaak spreekt men dan van 'wat is de neerslag' en dat is dan ondertekend door de patiënt maar het denkwerk en de communicatie gaan vooraf. »*

> *[Familie ervaringsdeskundige]: « Als je geen verbinding hebt met je cliënt kun je niks doen. »*

> *[Psychiater algemeen ziekenhuis]: « Dan kun je zeker niets doen. »*

Professional autonomy should not mean, however, insufficient common grounds and objectives, which are viewed as resolutely helping individual practitioners to articulate their respective and specialized roles to one another, but also to the global objectives of services' integration and service users' rehabilitation promoted through the 107 Reform. In that regard, adjustments of professional training was seen an important aspect, as the following quote puts forward:

> *[107 network coordinator]: « Toutes les structures, qu'elles soient au niveau fédéral hospitalier ou au niveau même des structures ambulatoires, on est quand même en train de voir opérer de nouveaux métiers […] Les durées de séjour se raccourcissent et donc il y a plus de turnover, les usagers demandent d'avoir plus de procédures personnalisées, et donc il faut connaître chaque situation de chaque usager, plutôt que d'établir des procédures standardisées, mine de rien c'est un métier qui se change radicalement. […] et c'est vrai pour toutes les professions. […] Ne fut-ce que sur les notions de rétablissement, de réhabilitation psychosociale, qu'on n'est plus dans un processus de guérison 'on-off' que de rétablissement sur un parcours de soins, un parcours de rétablissement avec des hauts et des bas, sur une autre santé mentale qui n'est plus une psychiatrie très cloisonnée. »*

In addition to adjustments in training programs, participants in the Flemish-speaking focus groups highlighted the potential for internships within each other's organizations to facilitate relationships and a culture shift:

> *[Directeur psychiatrisch centrum]: « Als je dat allemaal hoort, dan denk ik wel aan iets wat de coördinator arbeidszorg in het lijstje [met sleutelwoorden] had van zo dat, we kunnen als beleidsmensen daar mee bezig zijn en proberen een bepaalde visie mee te dragen maar we moeten de basis mee hebben. Als de basis het ook niet aanvoelt en als het niet merkbaar en voelbaar is voor de patiënt dan betekent het eigenlijk ook niks. En dat vind ik ook wel een grote bekommernis. Binnen elke voorziening en organisatie heb je kernen van medewerkers die echt wel mee zijn, je hebt anderen die zich bewust zijn maar je hebt ook kernen van mensen die met hun hoofd nog een paar jaar geleden bezig zijn. Dat vind ik wel een grote bekommernis. Want grote theorieën à la bonheur maar ... »*
>
> *[Moderator]: « Wat kan daaraan gebeuren? »*
>
> *[Directeur psychiatrisch centrum]: « Een oplossing zie ik niet. Je kunt praten en blijven doorpraten. Je kunt investeren in opleiding en vorming. Dat moet allemaal gebeuren maar het zal niet voldoende zijn.»*
>
> *[Psychiater algemeen ziekenhuis]: « Je moet stages doen in elkaars organisatie. Nog meer dan dat het nu is. »*
>
> *[Directeur psychiatrisch centrum]: « Het gaan veel dingen samen moeten zijn want anders gaat dat niet lukken denk ik. »*
>
> *[Coördinator mobiel team]: « Het is ook niet altijd een kwestie van niet weten. Je hebt personeel die wil vasthouden aan hoe het vroeger was.»*

[…]

> *[Functie 3 voorzitter]: « […] Dat is echt een gemengde groep de basiswerkers. En ik denk dat dat echt een grote uitdaging is om dat te doen keren. Contacten kunnen daar heel grote verschillen in maken, bezoeken, stages..."*

A strong willingness to collaborate and to learn from each other's expertise was variable across focus group discussions, but particularly stood out in Flanders:

> *[Directie CAW]: « Als jij nu zou denken aan ons opvangcentrum [CAW] voor je volwassenen waarbij die cliënt bij jou [in een CGG] een keer komt en de tweede keer niet en de derde keer geven jullie iemand anders een plaats 'want die cliënt is niet therapietrouw'. Ik zeg het nu te cru maar het komt er wat op neer. Moesten wij nu kunnen zeggen van 'we kunnen samen aan zet zijn en wij [CAW] zullen de tijdelijke opvang en begeleiding bieden en jullie [CGG] komen een keer per week naar ons en zien dat je dat kan opbouwen'. Dan zouden we verder kunnen geraken en op een bepaald moment kunnen afronden bij jullie.»*
>
> *[…]*

> *[Medewerker wijkgezondheidscentrum]: « Ik denk… je zegt dat je [in het CGG] veel therapeutische expertise hebt. Ik zou daar zo graag wat meer van zien! En dan denk ik: 'laat ons schakels maken'. Wat ik mis is… er is een heel zware sociale component aan de GGZ en mensen zijn dikwijls niet gewoon maar in nood of in behandeling, er zit heel veel tussen. Ik merk dat dat welzijnsstuk mee moet want anders ga je niet vooruit. En dan denk ik: 'geef mij een equipe met mensen van het CGG, een psychiater, een psycholoog, een goeie sociaal werker. En laat die tot bij mij komen of bij de arts. […] Dikwijls weten wij onvoldoende over hoe we met een bepaald gedrag moeten omgaan. Je kent de medicatie en het ziektebeeld maar hoe ga je ermee om […] »*

> *[Psychiater en psychotherapeut]: « Andersom ook eigenlijk. Ik zou ook graag als psychotherapeut horen wat mijn blinde vlekken zijn. Je hebt de twee nodig.»*

Nevertheless, willingness to collaborate remained somewhat dependent upon how valuable collaboration is perceived by the different organisations:

> *[Netwerkcoördinator]: « Samenwerking is een onderdeel van een goede job. […] Samenwerken… dat wordt dikwijls gezegd maar dat wordt niet altijd systematisch gevraagd maar verondersteld. Als je het gevoel hebt van 'dat is iets wat ik er moet bijdoen' maar dat is niet het belangrijkste onderdeel van de job, dan is dat een andere ingesteldheid dan als je denkt: 'als de psychiater en huisarts niet samenzitten kan ik mijn werk niet doen. Dus dat is een hele andere manier van kijken. »*

All things considered, trust was considered as a key aspect in fostering inter-organisational and inter-professional collaboration. But trust is a problem before constituting a solution. To put it the other way around: trust must be collectively built-up before effectively supporting collaboration. Moreover, the only mean to build trust would be concrete collaboration growing out from professionals' perception of their interdependencies in addressing services users' needs. In that regard, it must be mentioned that participants indicated, in Flanders, that an increase in trust among partners is perceptible in both old and new networks.

> *[Afdelingshoofd psychiatrisch centrum]: « Vertrouwen zal er in het begin niet zijn. En één van de lastige dingen waar ik me altijd tegen verzet, is dat men zegt dat men goed kan samenwerken als er vertrouwen is. Vertrouwen is het resultaat van niet gestuurde verwachtingen. […] Doordat multipartij samenwerking en doordat politiek erbij zit, vind ik het juist één van de gemakkelijke dingen om eigenlijk te kunnen spreken van 'we vertrouwen elkaar niet allemaal' en dit als thema op tafel te kunnen leggen. Niet interpersoonlijk maar gewoon van 'de belangen zijn verschillend en kunnen we het daarover hebben'. Het kunnen hebben over waar we last van hebben, maakt dat het vertrouwen op termijn misschien kan groeien. Als je aan mij vraagt om in een groep te komen die ik niet ken om daar met vertrouwen te komen ? Ik weet niet wat dat gaat betekenen. »*

2.3.3 Formal tools

The participants refer to several formal tools that might enhance collaboration and integration of mental health care as well such as the multidisciplinary dialogue, electronic patient centred files, crisis plans, network maps, individual care plans and video conferences. These tools were sometimes unknown to professionals, were embraced or raised important controversies.

Multidisciplinary dialogue

A multidisciplinary dialogue is a dialogue in which information is shared between the service user and several members (with different backgrounds/disciplines) of the -in most cases formal- network around the service user. This dialogue not only supports professionals in searching together with the service user for a common solution but also serves to improve the follow-up of the care for the service user. This dialogue is viewed as particularly relevant for complex situations in which several services are involved. A positive side effect of this kind of dialogue is that it creates trusts and feelings of involvement between partners.

Although many focus group participants emphasize the benefits of such a multidisciplinary dialogue, they also describe some drawbacks such as the fact that such dialogues are time consuming, practically difficult to organize (because of several agendas that need to be aligned with each other) and sometimes inefficient when too many partners participate. Videoconferences were scarcely mentioned to bypass these problems, but logistical issues remained. Furthermore, fee-for-service payments may cause certain professionals to be less encouraged to participate in such a dialogue, as the following exchange puts forward:

> *[Psychiatrist psychiatric ward of a general hospital]: « Dat heeft ook veel met financiering te maken. Ik zit vaak als psychiater alleen in overleg en ik vind dat heel belangrijk en ik probeer dat ook te doen maar ik krijg mijn collega's niet overtuigd want eerlijk gezegd er staat niets tegenover. »*

This exchange emphasizes the impact of financing mechanisms on professionals' inclination towards collaborating through the use of procedures and tools, an aspect which will be further developed in the subsequent part of this report.

In addition to logistical and time consumption issues, an important controversy regarding the multidisciplinary dialogue regarded service users' participation within this dialogue. The following exchange illustrates this type of controversy:

> *[Service user 1]: […] Il y a juste une chose qui m'a gêné que j'ai entendue, c'est quand on parlait de concertation sans le patient. Ça, ça me gêne très fort, personnellement je ne trouve pas ça normal.*
>
> *[107 network coordinator]: C'est un grand débat qu'on entend dans plein de groupes différents et c'est pas tranché.*
>
> *[General practitioner, director of a medical centre]: Ça ce n'est pas nécessairement pour discuter du patient ou pour décider pour le patient, c'est parce qu'on a des difficultés entre nous qu'on doit régler entre nous et que le patient il n'a pas nécessairement à voir avec ça.*
>
> *[Service user 1]: Je ne suis pas d'accord, parce que si vous avez des difficultés entre vous, c'est vis-à-vis du cas du patient.*
>
> *[General practitioner, director of a medical centre]: Pas nécessairement, ça peut être des difficultés institutionnelles, de mode de fonctionnement entre nous.*
>
> *[107 network coordinator]: Mais alors là on ne parle plus d'une concertation patient, c'est autre chose. Mais une concertation sur le cas d'un patient, pour moi le patient doit être mis dans la concertation.*
>
> *[General practitioner, director of a medical centre]: Oui, on est bien d'accord, c'est deux choses très différentes.*
>
> *[Psychiatrist, mobile team]: Moi je voudrais différencier coordination et concertation.*
>
> *[Service user 2]: Est-ce que vous pourriez expliciter cette différence ?*
>
> *[Psychiatrist, mobile team]: La concertation est un processus qui part du patient où le patient réunit autour de lui des intervenants qui sont importants, et donc s'il y a vraiment un réseau qui est en difficulté, on part de la part du patient et on dit, j'aimerais rencontrer telle ou telle personne.*

This interaction further emphasises that the instrument and concept central to the past and ongoing reforms of mental health care organisation are still interpreted differently by the system's stakeholders. It highlights, in turn, the strength of heterogeneous group discussion to derive common understanding from individual and contrasted experiences of mental healthcare.

(Electronic) patient centered-file

Another tool which was recurrently discussed across focus groups was the electronic patient centered file. While some participants highlight the need to have access to a system working with such files to improve connections and communication between different partners, others expressed strong concerns. The main advantage which is reported concerned avoidance of unnecessary disruptions between services and improved care continuity between inpatient and outpatient care.

However, some participants in Flanders fear that files including reports on mental illness could hinder the somatic care offer as somatic complaints of people with mental illness are not always taken seriously (in somatic care). Other participants insist that electronically shared information would never replace face-to-face interactions:

> *[Employee medical centre]: Amai, dat gaat deuren dicht doen. Hoeveel dossiers dat deuren dicht doen. Dossiers die voorafgaan aan een patiënt. Waarbij ze [vanuit de somatische zorg] zeggen 'we hebben het dossier bekeken, we pakken die niet binnen'.*

> *[Psychiatrist, mobile team]: Il suffit pas de mettre une note quelque part. C'est ça le problème aussi, c'est que moi je vois bien l'hôpital, on a un gros système informatique alors on peut s'envoyer des informations actuelles, mais il ne faut pas que, effectivement ce média-là remplace la communication où on cause avec nos collègues, ça ne va jamais remplacer...*

> *[General practitioner, director of a medical centre]: Ça va jamais le remplacer.*

> *[Psychiatrist, mobile team]: Mais le problème, c'est que si, ça le remplace parfois, j'ai un patient qui rate ma consult', et j'ai mon collègue qui m'a pas téléphoné, et il me dit mais oui, j'ai mis une note dans l'ordinateur. Mais ça ne fonctionne pas évidemment. Quand on adresse quelqu'un en SSM, y a tout un travail, y a une prise de contact, il y a un entretien commun à un moment donné, d'organiser un relais, un tuilage, ou un transfert, je ne sais pas comment on peut dire, mais donc là y a quelque chose qui cloche.*

Furthermore, several participants emphasize that the service user should be the owner of the file and should be able to choose who can have a look in it in order to avoid privacy issues. Other participants also mention the benefit of enclosing a network map and crisis card (see below) in such a file.

> *[Afdelingshoofd psychiatrisch centrum]: « De vraag is hoe we tot een organisatie [van de geestelijke gezondheidszorg] komen met mensen die niet ondanks maar dankzij de verschillende perspectieven op één of andere manier toch geconnecteerd blijven rond die patiënt. En een belangrijke is inderdaad een EPD, een elektronisch patiëntendossier zou daar inderdaad een medium in kunnen zijn - je moet dat ook een beetje relativeren - maar hoe gaan we de zorg organiseren? Hoe meer aparte kotjes je organiseert, hoe meer plooien waarin patiënten zullen in vallen. En is dat ook niet een voorbeeld van dat we moeten naar - ik weet ook niet hoe dat allemaal operationeel wordt maar van een aantal dingen heb ik wel ideeën - moeten we niet meer naar een integratieve zorg gaan? »*

Preventive tools

In addition to multidisciplinary dialogue, videoconferences and electronic patient files, other tools oriented towards prevention for people suffering from chronic conditions are raised. Namely, participants refer to the use of (1) network maps that service users carry and that show all the key actors involved in the person's formal and informal network and (2) crisis plans, such as Wellness Recovery Action Plan (WRAP) that professionals develop together with their service user to anticipate and to know how to manage a crisis, and who to contact. During one focus group, participants discussed whether these network maps and crisis plans need to be uniform. A psychiatrist mentioned that customized plans (e.g. with pictograms) are necessary for people who not only have a psychiatric but also a mental disability. The participants concluded that it might not be feasible to standardize the crisis plans but that one could try to standardize at least the format of (brief) network maps.

Despite the development of a variety of similar tools, knowledge of these tools was variable between focus groups. An important issue which was raised by a 107 network coordinator was the fact that although these tools exist, it remains an important challenge to convince clinicians to use them in practice:

> *[107 Network coordinator]: Je trouve qu'on est dans un paradigme très réactionnel dans l'analyse de la situation [vignette organisationnelle]. […] Je peux pas m'empêcher de reprendre le mot prévention […] Je pense qu'à un moment donné, […] on développe des outils […] Mais une difficulté, est […] qu'entre les développements qu'un réseau peut avoir, et la percolation sur le terrain […] on invente des choses, mais les moyens sont tellement restreints en termes de communication que pour que ça percute sur le terrain...*

2.4 Financing of mental health care

The focus group discussions raised issues related to the financing of mental health care. This section highlights the notable financial aspects, which were recurrently raised amongst participants. As the objective of the focus groups was to gather participants from diverse profiles and backgrounds within the same area, expertise regarding mental healthcare financing was highly variable between participants within the same focus groups. Nevertheless, this research has enabled to identify dominant divides on the field regarding financial-related aspects to mental health care organisation.

This section will first report on participants' spontaneous perceptions of the distribution of public health expenditures among subsectors of the healthcare system in general, as well as subsectors of the mental health system itself. In that regard, it will also describe the focus groups participants' perception of the mechanisms for financing the 107 networks. Third, the specific case of financing alternative housing facilities will be covered since it raised significant disagreements among the participants in the French focus groups. Fourth, the advantages and disadvantages that focus group participants associated to different payment methods for health professionals will be presented. To end with, this section will outline promising solutions or suggestions for improving budget's allocation emphasised across the focus group discussions.

2.4.1 Allocation of financing across systems, sectors, services and networks

The focus group discussions evidenced that the need for rethinking the allocation of financial means was largely acknowledged by the participants. This reallocation should not only concern the residential and ambulatory sectors but also the secondary and primary care in general. In that regard, the only limit appeared to be, for part of the focus group participants, to keep the available resources within the healthcare system. This limit will be highlighted by further discussing the case of alternative housing facilities.

When requested to address the question of mental healthcare financing, the focus group participants firstly and spontaneously mentioned a lack of financial resources. This general lack of resources allocated to mental health was also, but not systematically, opposed to somatic care.

It must be noted, however, that some focus group participants acknowledged that complaining about the lack of financing was helpless and committed themselves to reflect on ways to improve the current distribution of resources – for example:

> *[The representative of the relai social urbain]: "Je pense qu'effectivement il y a une question de financement qui reste présente mais il y a aussi une question de synergie et de partage".*

Moreover, although the participants have variable expertise as to how the distribution of financing resources could be optimized without undermining their institutional interests, the findings put forward a desire to think collaboratively. In fact, the participants were aware that a service-centred approach to the financing question involved important risks, such as simply broadening the demand to a wider variety of service users and pathologies.

The following extract conveys the position regarding the need to think collaboratively. It also emphasises, interestingly, that "thinking locally" rather than on an institutional basis has been viewed as an appropriate strategy throughout the focus groups discussions. This local strategy should, in the view expressed below, be supported through improving the assessment of services' performance.

> *[Representative of the relai social urbain] : C'est sûr que tous dans nos services respectifs on manque d'argent, mais qu'à partir du moment où il y a […] des tensions […], on n'arrivera pas non plus à convaincre les décideurs politiques. Donc je pense que ça doit aller de pair, et si on arrive à avoir une stratégie globale et partagée d'un point de vue local, je pense qu'on aura beaucoup plus de légitimité pour obtenir les financements suffisants […] je pense que c'est important aussi de montrer tous les résultats qu'on engrange chacun respectivement et comment ça peut marcher de financer de manière plus adéquate la santé mentale ou le secteur social demain et repartager.*

> *[Social housing]: Je wilt samenwerken maar de systemen waartussen samengewerkt moet worden moeten eigenlijk hun eigen kaders al serieus achter laten vooraleer je dat kan doen. Terwijl die bovenlokale kaders dat juist zouden moeten faciliteren dat je lokaal kan samenwerken. En nu moet je daar tegenin werken. En als je dan lokale spelers hebt die dat willen doen, dan gaat dat nog niet maar ça va dan weet je. Dat klopt gewoon niet. Cru gezegd als ze bovenlokaal niets afstemmen maar ze geven ons heel veel geld om het allemaal lokaal te compenseren, ok. Maar die combo is gewoon bizar.*

Sectors and Networks

Regarding the distribution of financing within the mental healthcare system itself, the focus group discussions pointed more specifically at disparities between subsectors and the need to rethink the allocation of financial means between inpatient and outpatient services, and between primary and specialized care. Flemish-speaking focus groups particularly emphasized, in addition, that there is still much work to do be done in order to prioritise funds for primary care. By referring to the WHO recommendations, the participants put forward the pyramid of financing care in which basic care receives the most finances and specialized care less.

> *[Director community mental health center]: Je moet als je te weinig middelen hebt - en dat sluit aan bij de visie van de WereldGezondheidsOrganisatie -, dan moet je vooral zoveel mogelijk middelen reserveren in die basiszorg. […] Want je verdient dat in zekere zin terug doordat je heel veel duurdere zorg : elke opname die je kunt voorkomen is een besparing eigenlijk. Elke dag dat er een mens in orde is en goed kan functioneren, kan die gaan werken. Kan die iets doen.*

Finally, the issue of additional financing provided in the framework of mental healthcare reform has been frequently raised across both Walloon and Flemish focus groups. In that regard, participants expressed their feeling that resources allocation was largely arbitrary. The expression "tombola" was used by Flemish participant to denote the financing mechanisms prevailing to the 107 networks. They argue against the vital competition which project financing creates between networks, which does not benefit service users in their view.

> *[Director community mental health center]: Hoeveel werkuren gaan daaraan verloren. Je stelt het nogal simpel met forfaitaire of prestatiefinanciering maar dit is een tombolafinanciering. Er gaat ongelooflijk veel tijd in verloren en het resultaat is opnieuw niet regio dekkend. Je hebt enkele winnaars en veel gefrustreerden.*

Financing and governance mechanisms prevailing to the 107 programme were equally described as arbitrary on the Walloon and Brussels' side. Moreover, focus group discussion emphasized a discrepancy between the 107 programme's general and specific objectives and its financing:

> *[Coordinator of a mental health care dialogue platform] : « On […] fait la promotion des soins communautaires, soins dans le milieu de vie. Dans n'importe quel autre système, pays européen, ça a nécessité, en tout cas dans un premier temps, des moyens supplémentaires […] Ces moyens n'y sont pas. S'il y a une des missions […] que les services de santé mentale ont, c'est effectivement cette mission de mobilité. Certains ont continué à le faire, d'autres pas, et il n'y a jamais un moment donné où on s'est posé la question, « pourquoi ils ne le font plus ? » C'est quand même, il y a un manque de moyens. […] Si on prend d'autres expériences en termes de mobilité à Birmingham […] il y a un case-load bien précis de patients qui permettent une intensivité des soins, quand on voit le staff des équipes mobiles, ... Donc on peut discuter longuement et mettre des outils en place, la concertation autour du patient […] certains ne viennent pas parce que, notamment*

> *le médecin généraliste, « je peux pas perdre deux heures dans ce type de concertation », et donc ça pose aussi la question pas que du financement. »*

Services

As discussed previously, the housing facilities are identified as a major obstacle, especially during the focus groups in Wallonia, and how to reorganize its financing raised important controversies. On the one hand, some participants considered it is crucial to transfer funds from psychiatric hospitals towards housing facilities. On the other hand, participants strongly disagreed with this and consider that this strategy would remove care from the health sector and displace service users to the community without the sufficient supervision in order to remain in the community, and that this strategy could potentially lead to the problem of revolving doors, and repeated hospitalizations. This position indicates the fact that participants do not trust the current system to provide sufficient resources in ambulatory care which could effectively replace inpatient care and effectively stabilize, for instance, the severe chronically ill. Thus, they stressed that funding needs to stay within the health sector.

The following interaction between a general director of a psychiatric hospital and a general practitioner, on the board of a medical centre, clearly highlights this controversy regarding the transfer of resources from residential care to housing facilities. It further highlights that participants are divided on the issue of limiting, or not, the rethinking of financial means' allocation to services included within the mental health system.

> *[General practitioner, director of a medical centre] : 30% de nos patients vont chez les assistants sociaux, et 9% chez la psychologue, ils ne veulent pas aller chez le psychologue, ça ne les intéresse pas […] Il faut qu'il y ait un transfert de moyens de l'hôpital vers l'ambulatoire [mais aussi …] On l'a dit, vers le logement […].*

> *[General director, psychiatric hospital]: Je pense que le logement et le financement des hôpitaux c'est deux choses différentes […] Je ne sais pas si l'hôpital […] sait bien collaborer avec les agences immobilières sociales.*

> *[General practitioner, director of a medical centre]: […] A partir du moment où on ferme un lit d'hôpital, on doit créer un logement pour compenser, c'est un minimum. On a fermé des lits T ici […] tous ces patients se sont retrouvés, il y en a qui se sont retrouvés à la rue […] où est-ce qu'on va ? C'est de la folie.*

> *[Psychiatrist, mobile team] : Moi je trouve quand même très problématique de retirer de l'argent aux soins pour le donner au social qui est le logement […] Par pitié, gardons l'argent qu'on a du côté des soins pour penser les soins !*

> *[General practitioner, director of a medical centre]: Je ne suis pas d'accord. […] Ca a été démontré scientifiquement, la santé c'est 25% dépendant des soins, et 50% dépendant des conditions sociales. Le problème de notre société c'est qu'elle investit énormément de moyens dans le secteur de la santé, comme toutes les sociétés industrialisées. Mais […] c'est beaucoup plus rentable d'investir dans un logement de qualité pour les gens parce que, tant que vous n'avez pas de logement de qualité, la santé est ingérable […] Donc il faut réfléchir globalement à une vision de la santé au sens large.*

This interaction emphasizes that the question of transferring financial resources from the healthcare system to the social system is not only highly controversial but deeply rooted into the participants' professional culture and conception of health. This controversy nevertheless raised creative suggestions for addressing the problem of alternative housing solutions.

2.4.2 Payment methods for professionals

The focus group participants were particularly inclined to discuss the question of financing at the level of professionals. The discussions raised financing mechanisms viewed as hindering or improving collaboration between professionals involved in care, in a way that affects service users' experiences of receiving care.

Focus group discussions first raised the issue that fee-for-service method of payment for GPs and psychiatrists hinder inter-professional relationships and thus quality of care. Fee-for-service payments do not allow incentives to take time out to communicate between professions and institutions. Moreover, it implies institutional workplaces to be more attractive than community ones.

> *[Head of the department of a psychiatric centre]: «Artsen aanwezig mogen me niet misbegrijpen maar de subsidietechniek van artsen en honoraria zorgt heel vaak voor onmogelijkheden en complexiteiten om zaken te regelen. De manier waarop. Niet dat die mensen niet verdienen wat ze verdienen, dat is zeer goed gegund. Maar dat is een lastige. »*

> *[Representative of Provincial authorities]: « Pour nous ce qui est un vrai handicap, c'est que par exemple, trouver un psychiatre qui veut venir travailler en ambulatoire, c'est la croix et la bannière. Pourquoi ? Parce qu'il y a une trop grande différence entre les barèmes hospitaliers et les barèmes ambulatoires. »*

The problem of workplace attractiveness was considered to have worsened with mobile teams which provide psychiatrists with the possibility of developing alternative and mobile professional practices while being attached to residential care.

In contrast to fee-for-service financing of physicians, bundle payment was regarded as a promising solution to facilitate collaborative practices to resolve the problem of workplace attractiveness. It must be noted, however, that this observation was mainly raised by participants coming from services applying the bundle payment method.

> *[GP, Medical centre] : « Il y a des systèmes de financement qui favorisent la coordination […] avec le système du forfait, ça change considérablement les choses […] parce que nous on n'a plus du tout intérêt à faire tourner la planche à billets, on a intérêt à ce que les patients aillent bien, et donc on a intérêt à se coordonner. »*

Another intervention emanating from a psychiatrist argued against the bundle payment, and regarded that an alternative solution would be to keep the fee-for-service payment system but rather finance time spent for inter-professional communication.

> *[A psychiatrist] : « Soit on décide de payer les médecins […] sur un barème horaire, avec quelque chose de forfaitaire, avec quelque chose dans le contrôle du travail, soit on reste dans un système à l'acte, et on crée des nouvelles nomenclatures […] avec des actes qui sont pas simplement des contacts patients : on crée des nomenclatures avec des contacts avec nos collègues. »*

Finally, the performance based financing method was straightforwardly discussed throughout the Flemish-speaking focus groups. In that regard, a psychiatrist stated that the freedom to be creative and thus also collaborative was an important advantage of performance based financing. His statement brought about reactions from other participants claiming that performance could equally encourage health professionals, among which psychiatrists, to concentrate on receiving financial incentives rather than the services users' interest. During another focus group, a discussion took place on the benefits of a mixed financing system, consisting of performance based and fixed payment:

> *[Psychiater mobiel team]: « Datgene wat je beschrijft, is een stuk een forfaitair systeem en daar denk ik, ik zou dan eerder pleiten voor een gemengd systeem [bestaande uit een forfaitair systeem met prestatie gebonden incentives]. Want het forfaitaire, […] zeker nu, in een overgang, zijn het gepassioneerde en gemotiveerde mensen die mee aan de kar trekken maar het systeem moet ook blijven draaien in de toekomst en dan denk ik dat er wel een incentive moet inzitten voor het prestatiegerichte. Dus basisfinanciering, een hele goede laag en misschien de sterkste laag maar daarboven toch iets wat het systeem in gang houdt en wat ervoor zorgt dat we niet moeten hervallen in een gecontroleerd systeem vanuit overheidswege waarin je lijstjes moet gaan aanvinken en criteria moet gaan bewijzen. »*

> *[Psychiater en systeemtherapeut]: « Jij bent daar al veel mee bezig geweest. Ik vind dat ook wel maar ik vind het heel moeilijk om te zeggen waar leg je de incentive. Ik weet niet of daar al ideeën zijn. […] Want dat is de grote valkuil geweest in de klassieke psychiatrie dat turnover werd beloond en je kreeg heel veel diensten die vooral met gemakkelijke pathologie werkten, korte opnames deden... De diensten*

> *die met heel zieke mensen bezig waren hadden weinig financiering. […]»*

> *[Psychiater mobiel team]: « Daar moeten we als psychiaters dan hand in eigen boezem durven steken. Want turnover wordt beloond niet voor ziekenhuizen maar voor psychiaters. […] Het zijn vooral psychiaters die nu aangemoedigd worden om toch een zekere turnover te creëren en je ziet daar dan de gemiddelde liguren die evolueren bij elke hervorming van het systeem naar de meest optimale verhouding tussen inspanning en verloning. »*

2.4.3 Resources' allocation and decision-making power

As previously mentioned, the focus group participants' knowledge of alternative means of financing the mental health care system were partially variable depending on their professional position and their linguistic community, which provide them with different opportunities to experience, and thus to know about, the available financing methods. The focus group discussions nevertheless raised interesting considerations on solidarity, the pooling of resources, the outcome-based financing, the client-centered budget system, and the financing of psychiatric hospitals.

The resource to solidarity economy was evoked only one time by a psychiatrist in Wallonia who specified not being skilled to find out how to resolve the financing problems but insisted that fostering solidarity initiatives could constitute a solution to the issue of housing:

> *[A psychiatrist] : « Je ne suis pas, ni au SPF, ni à l'AViQ, je ne connais pas les moyens financiers […], tout ce que je peux comprendre c'est qu'ils n'en ont pas, point barre. Et donc je suis […] issue de la fonction publique et donc je vais avoir un discours qui peut peut-être heurter mais je trouve quand même qu'il y a des initiatives solidaires de type société coopérative d'immobilière qui pourraient voir le jour […] en matière d'hébergement […]. »*

The pooling of resources was described as consistent with ongoing transformation of mental healthcare organization. It raised, however, the tricky question of who should be entrusted with the power of deciding of resources' allocation.

> *[Psychiatrist and psychotherapist]: Iedereen wil met elkaar verbonden zijn. Maar ik denk budgettair is er een soort structuur waar je toch niet onderuit kan denk ik. Het ziekenhuis heeft heel veel geld. Ik denk dat je daar niet onderuit kunt.*

> *[Employee community mental health centre]: Ik zie heel veel projecten die ook door partners met geld ondersteund worden die aankomen op de eerste lijn.*

> *[Psychiatrist and psychotherapist]: Dat gebeurt, maar dat gebeurt vanuit de passie van die mensen maar de structuur waarvan het budget komt, die houdt dat tegen.*

To that question, the participants in the French focus groups answered that institutional autonomy should absolutely be preserved while ensuring that the head of local mental healthcare services and institutions remain transparent and accountable to their networks.

> *[Director of a psychiatric hospital A] : « La question, c'est une logique d'enveloppe globale, dont on pourrait affecter les moyens de manière différenciée, en fonction des besoins locaux, sauf que la question est de savoir où on place la limite de l'enveloppe. Est-ce que c'est au niveau de l'institution ? Est-ce que c'est au niveau d'un réseau ? »*

> *[Director of a psychiatric hospital B] : « On peut rêver qu'un jour, il y ait plus de pilier chrétien, libéral, socialiste, qu'il n'y ait de public, de privé et que ils arrivent à dire... En attendant, pour moi la seule chose qui serait effectivement abordable, serait comme disait Docteur X, de rassurer les opérateurs en place, de rester maîtres des moyens qu'ils ont, et qu'ils aient à rendre compte aux réseaux de ce qu'ils gèrent. Et qu'ils soient amenés à développer en fonction des besoins qui sont validés par les uns par les autres. »*

Concerning the question of the guiding principle of resources allocations, which the head of local services and institutions should committed themselves to follow, a participant firmly claims the need for clear rules, based on epidemiological data. Getting an accurate picture of the local population needs would, indeed, be a precondition to prioritize local investments.

> *[Psychiatrist, head doctor of a psychiatric hospital] : « On a besoin d'un budget stabilisé, on a besoin de règles du jeu, on a besoin de projet. Qu'on nous dise on va arriver à telle solution, à tel résultat. Qu'il n'y ait plus un patient schizophrène qui soit dans la rue, une diminution des tentatives de suicide. Voilà ce qu'on pourrait nous dire. Et dans le trust, on fait ce qu'on veut, à partir de ce qu'on a. »*

Next, although this was seldom evoked, the personal care budget received attention in Flanders, where it has recently been implemented to finance care for people with disabilities. In this client-centered budget system, the service users decide themselves how to spend their care budget. Some participants are concerned whether care refusers with mental health problems will use their budget in the right way. Moreover, they describe that the instrument used to determine the budget is focusing on deficits instead of strengths, which is not in line with a recovery-oriented vision.

Finally, Flemish-speaking focus groups raised two suggestions relating to the financing of hospital care. On the one hand, day- and full hospitalization should be replaced by care programs (e.g. half days or modules) to avoid that hospitals are encouraged to keep service users in the hospital instead of sending them home. On the other, the participants suggested that financing empty beds in psychiatric hospitals would be a solution for improving the management of crisis situations.

> *[Medewerker CGG]: « Wat zou er dan anders nodig zijn dan de zorg van nu? »*

> *Medewerker wijkgezondheidscentrum: « Lege bedden en teams aan die bedden. Je zegt van 'Ik heb hier een crisis en een bed nodig en ik kom mee de zorg hier rond dat bed organiseren vanuit het mobiel team, de psychiater, de eerstelijn...' »*

> *[Psychiater mobiel team]: « Dat zou je wel kunnen bedenken in 107, als er een tweede golf komt. […] Je zou ze [de bedden] officieel moeten kunnen sluiten om ze dan toch te kunnen openhouden. Om ze leeg te zetten en er enkel de 'hotelfunctie' in te bewaren en de middelen die je verder hebt via BFM [budget van financiële middelen] om die meer in teams te investeren die outreachend werken en polyklinisch werk doen. […] »*

> *[Coördinator psychiatrisch ziekenhuis]: « Iets van rooming-in in maar dan veel uitgebreider denk ik. Rooming-in waarbij bij ons in de organisatie vooral de familie 24/24 naast de patiënt aanwezig mag zijn en het behandelteam van de afdeling. Je zou dat ook kunnen uitbreiden. Dat je niet enkel het behandelteam van de afdeling maar dat je daar het aanwezige netwerk ook extramuraal mee betrekt maar dat is een heel uitdagend project denk ik. »*

> *Medewerker wijkgezondheidscentrum: « Het zou wel kloppen denk ik want als je ziet de opnames zijn niet veel minder vaak maar de opnames zijn veel minder lang. Dat is heel opvallend. »*

All things considered, how the participants positioned themselves in relation to financing issues appears to be partially dependent on their position within the healthcare system as well as knowledge of the available financing methods, both at the professional and system level. It must nevertheless be stressed that the participants generally displayed their openness to hearing to each other and to sometimes conflicting opinions. This indicates the added value of using the focus group's method, and privileging heterogeneous groups, for fostering debate on tricky issues as that of the financing of mental health care.

2.5 Political and societal context of mental health care

2.5.1 Political context

The present research on the organisation of mental healthcare has not occurred in a social vacuum. Instead, it unfolded in a social and political context whose key aspects impacted on participants interventions, and thus the data collected through focus group discussions. This section emphasizes political choices and features of both the political structure and the design of mental health policies which participants described as factors facilitating or hindering collaboration.

The federal state: thinking globally but acting separately

We noticed a widespread agreement across the focus groups on the need for overcoming political divisions. Participants particularly insisted that federal and regional government representatives' participation in the inter-ministerial conference must be accompanied by their respective engagement to take the necessary actions to implement the Conference's decision in their sphere of competencies.

> *[Director of a psychiatric hospital]: Chaque autorité qui participe à une conférence interministérielle, si elle participe à une conférence interministérielle, va quand même prévoir que ça va coûter […] incitons les ministres qui signent des textes en conférence interministérielle à prévoir que c'est une signature qui les engage sur des textes législatifs et sur des financements.*

Given this decoupling between federal and regional entities participation in the Conference and the concrete policy measures through which they support, to a variable extent, the implementation of the Conference's decisions, the sharing of responsibilities between different power levels would remain a significant obstacle to integrated care. In that regard, professionals both in Wallonia and Flanders strongly claimed a strong political framework providing them with stable and common grounds for building an effective integrated care model.

> *[Director of a psychiatric hospital]: « Dans l'organisation des soins de santé, c'est cette difficulté à bouger en même temps, on a différents niveaux de pouvoir […] On sent que ce qui est décidé d'un côté et pas forcément ce qui est désiré de l'autre […] et donc penser ensemble des questions aussi importantes que celles de ces grandes précarités […] est très compliqué puisqu'on a des niveaux de pouvoir où on n'arrive pas à se mettre ensemble. Le jour où on arrivera à […] à réfléchir à un dispositif de soins ensemble, à faire passer des budgets d'un côté à l'autre […] Là on pourra réfléchir à une politique de soins de santé cohérente, constructive. »*

> *« De overheid, federaal en Vlaanderen, zit ook niet zo verbindend te werken. En dat maakt het niet gemakkelijk. Dan denk ik naar de overheid toe, dat vragen wij al lang. van a.u.b. kijk zelf eens waar je kunt verbinden. Als je vindt dat welzijn, gezondheid en nog veel meer het samen moet doen, begin dan zelf eens ermee. »*

The present sharing of competencies between different power levels would, in addition, combine with the flexible and adjusting frame prevailing to ongoing policy change to bring about inconsistent political and administrative requirements. These inconsistencies would cause, in turn, great difficulties in effectively articulating care facilities as well as professional discouragement.

When related to professional concrete work and vision of their role, the sharing of competencies would thus appear to be "artificial" and unappropriated.

> *[Psychiatrist general hospital]: "De dwaasheid is natuurlijk dat je preventie in Vlaanderen steekt en behandeling in België. Alsof ik als psychiater niet elke dag bezig ben met herval preventie."*

Overall, this problematic sharing of competencies between federal and federated entities would lead professionals to conceive of creative articulations between mental healthcare facilities, which are blossoming at the margin of legal framework but helping them to work collaboratively.

> *[Coordinator mobile team]: "En dan de overgang, dat is enorm zoeken hoe zorg en welzijn op elkaar kunnen aansluiten maar dat is dus een*

> *heel moeilijke oefening. Dan merken we met heel veel goede wil maar dan botsten we op onze eigen kaders en visies en we zitten daar toch geregeld op een stuk dat we niet overbrugd krijgen."*

Such local adaptations of the political framework are described as functional while the sharing of competencies is viewed as dysfunctional, meaning that it hinders effective collaboration. Therefore, according to the focus group participants, not only the political and legal framework pertaining to the mental healthcare system should be improved in terms of consistency and clarity but professional autonomy should be promoted, rather than constrained through an increased standardization of their work.

Belgian mental health policies: ambiguous exploratory frameworks

The focus groups participants overwhelmingly deplore a lack of political courage and long-term political perspective on the organisation of mental health care. The experimental and flexible devices supporting policy change in the mental healthcare systems is described a Kafkaïen and associated to a global mistreatment of professionals. This mistreatment of professionals refers to the fact that, since the turn of this century, they have been increasingly requested to work collaboratively while the institutional frame has not been adjusted, and thus continues embodying an institutional and competitive rationale.

> *[Director of a psychiatric hospital] : J'ai dit kafkaïen […] dans la mesure où on nous demande, acteur de terrain, d'être créatif dans l'organisation, d'une transformation des soins et nous sommes nombreux à considérer qu'elle est bien utile cette transformation, et qu'on nous met dans un cadre, moi j'appelle ça l'injonction paradoxale, celle qui rend fou parce qu'on ne demande d'avoir une créativité qui doit se réaliser mais que quand on veut la réaliser, on nous rappelle constamment des cadres contraignants belges, qui sont liés aux niveaux de compétences, aux territoires, au niveau des uns et des autres et qui nous empêche d'avoir cette réelle créativité.*

The very political logic underlying the exploratory projects was to stimulate professional creativity and innovation while allowing for local adaptation of the political frame which should remain, accordingly, global and flexible. This logic of innovation and local adaptation had been significantly emphasized through political discourses since the very beginning of Reform 107. This logic would collide, however, with a political and legal framework which remains fundamentally segmented and institutional on the one hand, and with political requirements for increased standardisation of their work on the other.

> *[Coordinator of a network 107] : On passe son temps à essayer de s'articuler, et donc ce serait bien de renvoyer aux politiques que ce serait bien de, à son niveau, s'articuler un tout petit peu parce que ça ne facilite pas le travail d'organisation du secteur, et cette transversalité.*

Finally, this decoupling between the development of collaborative practices, in an experimental frame, and an institutional rigid and segmented framework would combine with the general uncertainty prevailing to the experimental frame to increase the discouragement of professionals. In that regard, we must emphasize a general request for clarifying the rules of the game, stabilizing the new practices developed through the network 107 as well as improving the consistency and formalizing the frame in which these network will pursue their development over the coming years.

> *[Director community mental health service]: Ik denk dat het stilletjesaan tijd wordt dat de overheid zou moeten denken om deze experimenten 107 structureel te maken. Daar is heel veel vraag naar. Ik kan me inbeelden dat een overheid wacht op zo een studies om daar beslissingen in te kunnen nemen. Maar het zou in de volgende legislatuur stilletjesaan mogen landen.*

> *[Coordinator of a network 107] : On est dans un système qui dépend de bonne volonté et […] on doit quelque part, sur base de créativité locale faire fi de contraintes qui existent et qui perdurent et quand on disait qu'effectivement les règles du jeu ne sont pas tout à fait explicites et […] on se rend compte qu'à un moment donné, elles sont variables.*

> *[A psychiatrist] : On a besoin d'un budget stabilisé, on a besoin de règles du jeu, on a besoin de projet. Qu'on nous dise on va arriver à telle solution, à tel résultat.*

2.5.2 Societal context

This section highlights a persisting stigmatisation of mentally-ill persons across the society, which would prevent services users from finding appropriate answers to their mental healthcare needs, but also professionals to develop innovative and alternative solution.

Generally speaking, focus group's discussions first evidenced that professionals themselves have contrasting views on the possibility of considering mentally-ill persons as other citizens. The following quote illustrates the recognition of the urgent need to give mentally-ill persons a place as a full citizen within the society:

> *[A representative of the Provincial Authority] : « Si on veut que la société survive, il faut que tout le monde ait sa place. Qu'on n'ait pas une classification entre : toi t'as un problème de santé mentale et toi t'en as pas. C'est pas possible, on peut pas séparer les choses comme ça.»*

During another focus group, however, one participant suggested that, although nowadays societies are more open to mental health, the society would never adapt itself to mental disorders. This participant suggested, accordingly, that psychiatric hospitals remained an absolute necessity. How professionals themselves consider service users is thus very difficult to disentangle from their discourse on the global society's readiness to stop considering mental illness as a stigma. This entanglement of professional attitude toward services users and their perception of the society openness to mental illness is further illustrated by another discussion between a leisure organisation employee, who is visiting the neighbours together with the client to tackle stigma, and another participant fearing that not all neighbours react positively to this type of visit.

> *[Psychiatrist general hospital]: Het is toch wel een beetje stigmatiserend om ergens bij de buren met een psychiatrische patiënt te komen en te zeggen: als ze ziek is, bel dan even*
>
> *[Expert by experience]: Neen maar als je ergens woont, wordt dat: 'ik woon daar'.*

Moreover, the fact that not all professionals unequivocally destigmatize mental illness is reverberated through people's attitude towards professionals, which incorporate the fact their mental illness is still, in fact, viewed as a stigma. In that regard, one expert by experience stated that not all services users accept to tell their GP they are suffering from mental illness. In such situation, the services users' subjective perception of health professionals' stigmatisation of mental illness thus turns into a very objective obstacle to care.

Second, the focus group' discussions evidences two particular situations in which the stigmatisation of mental illness hinder services users' access to adequate facilities. The first situation relates to the stereotypes about mentally ill persons displayed by housing companies, which would prevent services users from getting an appropriate and affordable housing. In that regard, one recommendation could be to encourage increased communication and dialogue between the mental health care system's stakeholders and holders of social housing. The second situation relates to the presence of mentally ill people in the GPs' waiting room, which would upset their other patients and would thus be a concrete obstacle against entrusting GPs with the role of reference person.

> *[A Psychiatrist, Head Doctor of a Psychiatric hospital] : « [Au sujet du généraliste comme personne de référence] je pense qu'il [le patient] va faire fuir les autres, ne fut-ce que ça, la présence dans la salle de garde, il ne tient pas de trop, etc. Donc il faut quand même être cohérent, la disponibilité du médecin généraliste comme référent, euh... »*

Third, professional rhetoric regarding medical professional secret as well the poor development of the sharing of information and collaborative relationships with not only services users but their relatives would participate, in a diverted way, to increase mental illness stigmatisation across the society. This observation emerged through an informal, off-record discussion between one researcher and a representative of service users' relatives. This person emphasized that, by referring to the medical professional secrecy to refuse to collaborate with non-medical professionals as well as lay people, the psychiatrists would increase the halo of oddity surrounding mental illness. The fact that this participant had not feel free or able to communicate this observation in the presence of the other focus group's participants must finally be emphasized. Indeed, it tends to demonstrate that, apparently, service users and their relatives still do not always feel legitimate stakeholders as compared to professionals.

3 CONCLUSION

This research addresses the question of the gaps and overlaps in the Belgian mental healthcare system in order to support policy decision-making on the organisation of mental health care for adults in Belgium. It examined, by a qualitative approach, five aspects of the Belgian mental healthcare system, namely, mental health care provision, accessibility, coordination, financing mechanisms and the political context. This conclusion starts by presenting the research findings along each of these five aspects. Then, it frames the results with three controversies regarding the system' priorities, the organisational design, and the coordination and funding mechanisms. Limitations related to the research process are finally exposed.

3.1 Main findings

3.1.1 Provision

The stakeholders generally describe the organisation of mental healthcare as complicated or complex. Both terms mainly refer to a lack of clarity of service' missions and roles that leads to inappropriate referrals on the side of professionals, and increases the problem of identifying the existing care providers on the side of service users and their relatives. The complexity of the system would thus denote a lack of transparency in service provision, which brings about significant loss of time for professionals and exclusion for services' users, particularly when it combines with strict admission criteria. The system' complexity alternatively relates to its diversity that is, by contrast, considered as a strength of the system.

Key service providers – improving care continuity

The following types of service providers received particular attention during the focus groups. In the primary care sector, medical centres play an important preventive role and ensure long-term care continuity for service users. Yet, they have trouble collaborating effectively with the mental health sector. In the secondary care sector, community mental health centres are viewed as effective means to compensate for long stay in psychiatric hospitals. Their role in mental health care is nevertheless unclear as it can include both the provision of specialised care such as psychotherapies and prevention or early detection of psychological problems. Furthermore, according to the participants, a lack of financial and human resources prevents the centres from performing their role properly. Finally, the mobile teams resolutely seem to contribute to ensuring the continuity of care. However, as new services in the Belgian mental healthcare system, they face difficulties regarding their caseload, their missions and their geographical reach.

Gaps and overlaps in care provision

Overlaps in care provision are generally described as necessary on both side of the country. According to the stakeholders, overlaps ease the transitions between services, particularly in urban areas where service provision is both dense and diverse. While they perceive overlaps as a strength of the system, the stakeholders describe gaps in services provision as a weakness, which has concerning consequences for the most vulnerable groups of population. In that regard, they first point out a significant lack of low threshold services without admission criteria, which are likely to result in excluding precarious groups with complex mental health problems and a low motivation for seeking help. Second, they indicate a lack of care for people with comorbidities (addictions, mental disabilities). Third, the inadequacy and insufficiency of housing solutions for service users discharged from long-term inpatient facilities also stood out from the research, particularly in Brussels and Wallonia.

3.1.2 Access to mental healthcare

This research emphasises a low access to ambulatory mental health care and affordable psychotherapy. This problem results in inappropriate referrals leading other providers, for instance the mobile teams, to play a role for which they are not prepared and trained.

Two other types of services providers facing access problems are housing facilities and crisis services. Since the problem of access to housing concerns services users with chronic and complex conditions who cannot live autonomously, it is often associated to the freezing of psychiatric hospital beds. Crisis services and psychiatric residential services at large are also having access problems, which may explain the increasing resort to involuntary commitment procedures, and imply that outpatient, social and primary care services are recurrently compelled to deal with crisis episodes.

Finally, the problem of access to mental healthcare is particularly emphasised in rural areas as well as for specific subgroups, particularly the most precarious population, people with comorbidities, and undocumented migrants.

3.1.3 Mental healthcare coordination and collaboration

Deeply rooted and differing representations of mental health and psychiatry strongly influence relationships between the stakeholders. They bring about concerns over excessive normalisation for people who do not meet collectively agreed about expectations such as labour integration of patients with a psychiatric disorder. They also cause difficulties, on the part of health professionals, in acknowledging social workers’ and lay people’ expertise.

Also, contrasting understandings of the 107-reform’ key notions and instruments reflect the stakeholders’ differing representations of mental health. In that regard, the patient-centred file and the multidisciplinary dialogue are the most commonly used coordination instruments. They are nevertheless defined differently and sometimes unknown to mental healthcare professionals. In contrast to these controversial coordination instruments, participants perceive soft integration mechanisms, such as inter-organisational learning and adjustments in professional training, as prompting trust among the stakeholders.

3.1.4 Financing mechanisms

Professionals acknowledge that the ongoing shift toward community mental health requires rethinking resources' allocations across the system, but also models of payment for professionals. The question of rethinking resources' allocation, either within the limits of the current healthcare funding or beyond, nevertheless remains highly controversial.

Regarding financial mechanisms, mental health professionals do admit that pooling resources at the network level would be more consistent with the ongoing transformations of the mental health care organisation. They raise the question of who should have the decision-making power in relation to resources' allocation. In Wallonia and Brussels, they mostly argue for preserving the autonomy of mental health care organisations, which should commit themselves, however, to remain accountable to their network's partners.

Regarding the types of financing for professionals, the advantages and disadvantages associated to the fee-for-services, bundle payment and performance-based financing methods remain controversial and vary across the system, depending on the stakeholders' professional and institutional position. In Flanders, several participants are in favour of bundle payment.

3.1.5 Political context

This research emphasises a widespread agreement among the stakeholders on the need for overcoming political divisions across the many layers of executive and legislative powers in the country. In addition, the exploratory model prevailing to the 107-reform implementation bring about political and administrative requirements, which do not fit in the current legal and administrative framework. These discrepancies would induce great difficulties in effectively implementing the 107-reform locally as well as professional discouragement. The stakeholders now overwhelmingly associate this exploratory strategy to a lack of political courage and long-term political perspective, and urge policy makers to adapt the legal, budgetary and administrative framework to the 107-reform's objectives. In Flanders, participants were asking for a consolidation of the 107-reform projects.

3.2 Recurring controversies

3.2.1 Priorities of the system

The Belgian mental healthcare system is undergoing rapid transformations which can be associated to a "paradigm shift" [12], that is, a shift in (1) the dominant orientations prevailing to mental health care provision (2) the organisation of work, roles and stakeholders' relationships, and (3) the legal, budgetary and administrative framework.

This research emphasises persisting disagreements on the very meaning of mental health and the priorities of the system, in terms of both goals and target groups. The diversity of the stakeholders' reactions to the vignette, embodying the goals of individual autonomy and social integration, clearly demonstrated that the extent to which the 107-reform' objectives are shared and understood importantly vary across the ten selected areas. The focus group vignette nevertheless triggered discussions emphasizing the need for rethinking the priorities in terms of target groups and services provision. In that regard, the most deprived, homeless and migrant populations with complex mental health problem appear to be the first priority. The second priority is resulting from the freezing of psychiatric beds and concerns people with chronic and complex problem who are not able to live autonomously. In terms of service provision, the priority is thus to support the development of (1) 'no' or low-threshold services accessible to people who do not necessarily seek help, (2) services addressing the needs of people with complex mental health problems, and (3) affordable and long-term housing facilities (especially in Wallonia).

3.2.2 Designing and building bridges in the mental healthcare system

The division of work and the definition of roles and relationships between the stakeholders also remain controversial. This research highlights debates revolving around two organisational models which can be defined as organic and mechanistic [13]. While mechanistic organisations combine a high degree of formalisation, specialisation and centralisation with a low degree of integration; organic organisations are less formalised, specialised and centralised but more integrated and, importantly, more inclined to learn.

The formalisation of work first refers to the use of formalised tools to perform professional functions. Patient-centred files and multidisciplinary dialogue are the main tools mentioned by professionals. The extent to which they know about or use these tools greatly differs across the networks and regions. Their positive aspects are to help professionals to “think out of their box” and to force them to know each other, thus improving trust between them. The most debated aspects of these tools are their degree of standardisation *versus* customization [14] to specific professionals and service users’ needs. Indeed, while mental health professionals using the above-mentioned tools argue that more standardised tools mean an increased care efficiency and continuity, they also insist on the need to be able to customize the tool to service users’ specific needs.

Second, according to organisational literature, work is viewed as specialised insofar as each category of professionals performs only a limited number of well-defined functions. By contrast, this research draws attention to the diversity and lack of clarity of the roles performed by mental health care providers, particularly community mental health centres and mobile teams. This finding indicates the existence of overlapping missions and functions which are, however, described as useful for care continuity. Roles and functions diversity is thus viewed as positive but would require better articulations between existing services providers and at the patient levels. The reference person, or a fixed reference team appointed by the patient, would be central to this articulation work.

Third, centralisation refers to the concentration of decision-making power and resources by a central committee, organisation, or the political elite. It thus concerns the scope of authority of the government as well as professional and institutional autonomy. This research emphasises that professionals are urging policy makers to clarify the rules of the games, that is, to adapt funding mechanisms to the ongoing transformations of the organisation of mental health care. The government authority, according to some stakeholders, should however be focused on the legal, budgetary and administrative framework rather than interfering in the professionals work.

Fourth, integration refers to processes and structures enhancing collaboration and coordination across health, mental health and social services. Regarding collaboration mechanisms, which relates to horizontal relationships between mental healthcare providers and professionals, the stakeholders insisted on the importance of mutual adjustments allowing them to make the most of the system diversity, in a way consistent with service users’ needs. Regarding coordination, which relates to vertical integration, this research evidences that the sharing and understanding of the 107-reform’ recovery oriented-vision importantly vary across the ten selected regions. Moreover, professionals generally display their preference for coordination mechanisms relying on qualification rather than formalisation and standardisation. Formalisation and standardisation are often associated to the ongoing reform and viewed as threatening not only individual creativity but also inter-organisational learning. By contrast, the mechanism of standardisation by qualification, achieved by adapting professional training and enhanced inter-organisational learning, is viewed as particularly relevant given the system internal complexity and the changing nature of service users’ needs.

3.2.3 Paradigm shift and power divisions: policy-makers, professionals and the public

The last step for changing the dominant paradigm consists of adapting the prevailing governance and financing mechanisms. This research indicates, interestingly, that the stakeholders acknowledge the need for completing this shift and even urge policy-makers to make the required political decisions. Completing a paradigm shift entails, however, rethinking the power relationships between the stakeholders.

In that regard, this research raises three interesting questions. First, the question arises of rethinking resources' allocation within health care *versus* expanding this reallocation to parts of social care. This question directly relates to the definition of mental health as a medical, psychological, or social problem and draws attention to the professionals' tendency to claim for exclusive rights over their jurisdiction, which belongs, from the end of 1960' onwards, to health care. That topic was particularly salient when addressing psychiatric beds *versus* improving long-term housing facilities.

Second, this research raises the question of prioritizing resources investment within the mental healthcare system, where outpatient and primary care claim to lack resources to meet service users' needs. Moreover, the question of the financial balance between the outpatient and residential sector appears to overlap that of the distribution of psychiatrists and psychologists between residential and community settings, as well as the private and public sectors. Mental health professionals point to a lack of psychiatrists and psychologists in community settings and state that this situation is currently worsening. In this respect, this research indicates that a recent political decision concerning the financing of private psychologists, leads psychologists working in community settings and the public or non-profit sector to make a division of the psychological work explicit. According to this division, psychologists working in community settings would distinguish themselves by their ability to work in multidisciplinary teams and their knowledge of the local services' provision.

Third, this research highlights that pooling financial resources at the local or regional level is consistent with ongoing transformations of mental health care. However, this shift immediately raises the issue of decision-making power in resources allocation. In that regard, mental health professionals in Wallonia insist that the autonomy of mental health services in deciding of how to use their human and financial resources must be preserved. They nevertheless suggest that this autonomy should be counterbalanced by two mechanisms. On the one hand, the stakeholders entrusted with decision-making power should be transparent and accountable to their networks partners. On the other hand, scientific evidence regarding the mental health needs of the local population, or good epidemiological data, should guide decision-making regarding local resources allocation. Local networks could then be assessed according to their effectiveness in achieving well-defined outcomes in terms of specific population mental health care needs (e.g. via quality indicators).

Finally, this research highlights enduring controversies concerning the adequate methods of payment for professionals. Professionals working in community settings or in the primary care sector generally claim that the fee-for service method hinders inter-professional collaboration. Moreover, professionals are sometimes (especially in Wallonia) divided on the question of the respective advantages and disadvantages of fixed payment as well as performance-based method of payment. While fixed payment is viewed as potentially decreasing the quality of care, the risk of performance-based payment would be, both at the professional and organisational level, to encourage professionals and services to behave according to their financial interests. In this respect, mental health professionals globally insist that service users' needs should be the driving principle. A complete reversal of the logic prevailing the mental healthcare financing, which would consist in moving toward a patient-centred system had, however, only be discussed in Flanders, where professionals fear that care refusers do not use this budget in the right way.

3.3 Reflection on the research process, main limitations and next steps

3.3.1 *Social embeddedness*

The present research on the organisation of mental health care is unfolding in a social and political context whose key aspects influenced participants' interventions, and thus the data collected.

First, recent policy choices punctually but straightforwardly influenced focus group discussions. These choices concern specific aspects of mental health care provision, for example the financing of private psychologists. Some focus group participants, especially in Wallonia, brought such decisions into the meeting room and took advantage of the discussion to express their concerns regarding the possible impacts of these decisions on mental health care provision. This instrumental or expressive use of focus group discussions can be considered as a limit of this research. It raised, however, interesting discussions that evidenced jurisdictional conflicts brought about by policy choices, but also alternative choices that could be considered in the future.

Second, policy choices embodied in the policy programme underlying the 107-reform, as well as recent decisions regarding the reform's continuation and possible extension, implicitly but constantly influenced the research process. The relationship between the present research and the 107-reform had never been made explicit neither by the KCE nor by the members of the present research consortium. However, the organisational vignette used in conducting the focus groups embodied a recovery-oriented vision that lead some focus group participants to draw association between the research and the political agenda.

The concerns expressed by participants regarding that political agenda, particularly in Wallonia and Brussels, eventually appears to constitute interesting findings. Indeed, they draw attention to persistent disagreements on the fundamental options lying at the core of 107-reform, misunderstanding or ignorance of key notions conveyed by this reform, and a profound feeling of mistrust between field actors and government representatives.

Third, the focus group participants' position in the mental healthcare system influenced their interventions and interactions. In that regard, the moderator and observer first noticed the punctual use, mainly by psychiatrists, of a professional language in interpreting the situation described in the vignette. The side effect of using this professional language through the focus group discussions was to disqualify other participants' previous interventions, and thus to discourage them from remaining involved in the discussion. When faced with this type of situation, the moderator encouraged the participants to keep discussing the issue at stake.

Fourth, given the research team's methodological decision to privilege heterogeneous focus groups, the discussions led to confront lay and professional stakeholders' perspectives on the mental healthcare system's organisation. The moderators and observer noticed that this confrontation constituted an interesting "occasions for sense-making" [15], where participants build on one another's perception to yield a common representation of the issue under discussion.

3.3.2 *Limitations of this research*

First, given the timeframe of this research, only ten focus groups were organized over a short period of time, between November and December 2017. These focus groups enabled the research teams to explore the characteristics of mental health care provision and organization in different regions, linguistic communities and urban/rural areas, but they did not provide the ground for a proper comparison between all the mental health care networks developing in Belgium.

The organization of the focus groups over a short period also limited the research teams' capacity to optimize the recruitment of the focus groups participants, through ensuring the equal representation of corresponding categories of stakeholders in all the ten focus groups.

Moreover, the research teams lack time to schedule complementary interviews with some stakeholders, either to discuss the reasons of their refusal to participate in a focus group, or to deepen some topics mentioned through focus groups discussions.

Finally, given the number of focus groups and their composition, the possibilities for generalizing this research results are *a priori* limited. This research nevertheless aimed to overcome these limits through scheduling a second, quantitative study designed to examine how the stakeholders position themselves in relation to different alternatives for the organization of mental health care, which were derived from the results of the focus groups (see "The Next Steps" below).

Second, this research intended to include the representatives of services users and their relatives in the focus groups. However, given the time frame of the research and the recruitment methods, only the members of services users and relatives associations have been included in the focus groups. A more inclusive representation of the service users' perspective on the organization of mental health care would have implied to reach different categories of people, including those who are currently undergoing mental health treatment but are not involved in associations, and those who have an history of contacts with mental health care but are currently excluded from the mental health care system. This second category could have been reached through low threshold services, or alternative spaces, which are oriented towards integrating people with mental health problems within the society. It must be emphasized, however, that contacting and mobilizing those two categories of people is a long process, entailing pre- and post-focus groups meetings and interviews. It would thus be relevant to complement this research by another study concentrating on the service users' perspective, and involving a preparatory phase aimed to recruit a representative panel of service users and their relatives.

Third, subjectivity is inherent to qualitative and indeed to any type of study carried out by humans and raising the question of social systems' organization. Subjectivity/objectivity is a permanent debate in social science research, not a question of methods. More specifically, subjectivity cannot and should not be eliminated from qualitative research. Instead, qualitative research aims to engage with human beings' subjectivity. An ethic position thus entails the recognition, by the researcher, of his or her subjectivity in making methodological decisions and conducting the research, and his or her engagement to grasp and deal with the resulting ambiguity – that is to say: his or her commitment to explain how different perspectives on a research question and the collected data have been brought together and incorporated into the research design and results.

The research teams therefore committed themselves to express and confront their views at different stages of the research process. As set out through the methodological section of this report, decisions concerning the sampling, vignette and topic guide were made through meetings gathering researchers with different backgrounds (in sociology, economy, psychology, political science and public health), different levels of seniority (academics, young and senior researchers), and complementary experiences in studying mental health care organization. Focus groups were organized, moderated and observed by two researchers with different levels of seniority and from different backgrounds in both linguistic communities. And, finally, the coding and interpretation of the collected data were also discussed through three meetings which involved the researchers who conducted the focus groups as well as the other members of both teams.

3.3.3 The next steps

This qualitative stage of the research assessed the perception of stakeholders regarding the organization of mental health care delivery in Belgium. Stakeholders have highlighted features and mechanisms that, in their view, might facilitate or hinder the appropriate mental health care delivery. However, in practice, stakeholders are involved in multiple, complex sources of constraint, interest, and values, and features or mechanisms may have different effects that those perceived and expected [16]. In addition, stakeholders may have contradictory views and expectations. Thus, preferences and barriers expressed by stakeholders need to be consolidated in order to elaborate realistic scenarios that are likely to meet the expectations of most stakeholders and result in the expected outcomes. Such consolidation is the main objective of the following part of the research, i.e. a confirmatory analysis, using a Conjoint Analysis approach (Chapter 07). Stakeholders' expectations will be elicited from the first stage results, and recomposed into a limited set of organizational, multi-attribute scenarios in order to inform final recommendations.

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CHAPTER 07 VALUES AND SETS OF POSSIBLE ORGANISATIONAL SOLUTIONS: A CHOICE-BASED STAKEHOLDER ANALYSIS SURVEY

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1 INTRODUCTION: A TRANSITION TO MENTAL HEALTH CARE FOCUSED ON COMMUNITY CARE AND SOCIAL INTEGRATION

The preceding research phase, as described in Chapter 06, aimed to identify the strengths, weaknesses, gaps, and overlaps perceived by stakeholders in the current supply of mental health care in Belgium. Those qualitative results highlighted features that either facilitate or hinder the achievement of the mental health care reform in Belgium. Yet, coming up with concrete ways to improve our mental health care system requires to consolidate the qualitative information with a broader sample.

In addition, in the real world, stakeholders face choices that involve a trade-off between different values. It is thus difficult to identify gaps and overlaps without considering how different values jointly interact with each other. For example, the qualitative analyses in Chapter 06 confirm the need of stakeholders for more collaboration between clinicians, but wanted to preserve their extensive autonomy of practice at the same time. Secondly, the desirability of a solution is not always consistent with its feasibility [1]. A desirable solution in terms of effectiveness that is not supported by the stakeholders who have to implement it is likely to fail or to deviate. Finally, there may be different sets of solutions to improve a key objective such as community care or, in the opposite, a solution may be resisted because it is perceived as conflicting with another key expectation.

In the second stage of this research, the objective is to consolidate the main qualitative findings of Chapter 06 with stakeholders, in order to elaborate concrete and global scenarios, that is set of solutions and values that aimed to achieve community care and/or patients' social integration and are supported by most stakeholders. Building on the results of the first stage, the second phase performs a choice-based stakeholder analysis to identify values and sets of possible organisational solutions, across stakeholder groups.

2 OBJECTIVES

The main objectives of this chapter are:

1. To elicit the values that underlie the expectations expressed by the stakeholders on the organisation of mental health care in the transition towards a community-based model of care favouring social integration (recovery and rehabilitation) of people with mental health needs;
2. To assess the preferences of stakeholders on organisational interventions[e] that combine the values identified.

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[e] The organisational interventions are sets of interventions that aims to improve the two overarching goals of community care and social integration and cover provision of services, funding (including shift in funding), governance and coordination.

3 DESIGN

The objectives mentioned above was studied using a stakeholder survey. The main part of the survey was performed using a variant of the conjoint analysis (CA) method. *“Conjoint analysis is an innovative multivariate statistical method that identifies, during an actual decision, the relative “importance” of the factors in a decision and the ways individual decision makers combine the factors in making their decisions”* [2]. CA helps elucidating choices among priorities. It has been frequently applied in health and mental health service research [3-5].

The variant that was suggested was the Self-Explicated Method (SEM). In marketing research, SEM is a robust and valid method used to determine the importance of different characteristics of a product in the consumer's choice [6]. While traditional CA methods are de-composing the attributes that underlie a choice, SEM is a compositional method, proposing solutions that combine the preferred attributes [7].

The advantages of both methods are presented in Table 1. A study comparing the two approaches concluded that *“Our comprehensive analysis of empirical studies comparing these two approaches fail to confirm the superiority of conjoint measurement. Instead, the majority of empirical comparisons found either non-significant differences between methods or even higher predictive validity or reliability for self-explicated approaches.”*[7].

Table 20 – Advantages of conjoint measurement and self-explicated approaches (Gustaffson, 2007)

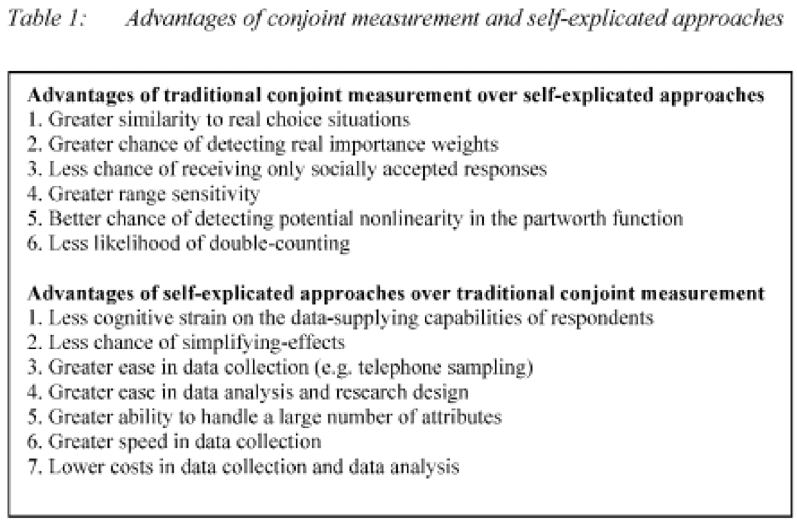


Table 1: Advantages of conjoint measurement and self-explicated approaches

Advantages of traditional conjoint measurement over self-explicated approaches
1. Greater similarity to real choice situations
2. Greater chance of detecting real importance weights
3. Less chance of receiving only socially accepted responses
4. Greater range sensitivity
5. Better chance of detecting potential nonlinearity in the partworth function
6. Less likelihood of double-counting

Advantages of self-explicated approaches over traditional conjoint measurement
1. Less cognitive strain on the data-supplying capabilities of respondents
2. Less chance of simplifying-effects
3. Greater ease in data collection (e.g. telephone sampling)
4. Greater ease in data analysis and research design
5. Greater ability to handle a large number of attributes
6. Greater speed in data collection
7. Lower costs in data collection and data analysis

In addition, the SEM method is the most suitable for present survey because (1) it allows including a larger number of attributes, (2) the response process is simpler and faster for respondents and (3) the attributes are presented one by one and not in a complete scenario which corresponds better to the study design.

3.1 Definitions

For the sake of clarity, several terms from this specific methodology need to be defined:

Attributes and attribute levels are part of the conjoint analysis, these are sets of criteria for organising mental health care applicable to all interventions/solutions in order to realize the conjoint analysis.

- **Attributes**: are the attributes of a solution, for example in the case of the purchase of a phone, the attributes are its colour, its weight, the battery life, etc.
- **Attribute levels**: each attribute has different levels, for example the colour of the phone can be blue, red or black.

Organisational interventions were identified and developed via the results of the qualitative part and confirmed by the literature. These organisational interventions have been proposed to stakeholders in the third part of the survey.

3.2 Material and methods

The survey questionnaire comprised **seven sections**. Respondents had to answer to the different stages of the survey according to one objective that was randomly assigned to them:

Objective 1: You are asked to reflect on the organisation of mental health services in Belgium in order to support **the social integration** (support people in their life goals and help them connect with their community) of people with mental health needs (See Appendix 1 and Appendix 2 of chapter 07).

Objective 2: You are asked to reflect on the organisation of mental health services in Belgium in order to support **community-based care model** for people with mental health needs (See Appendix 1 and Appendix 2 of chapter 07).

These two goals were selected based on the objectives of the reform in mental health care in Belgium: “The objective of the mental health care reform is to further orient mental health care towards a reduction of residential hospital care in favour of patients’ social integration and treatment in the community.”[8]. The goal of community care aims at closing psychiatric hospitals and moving resources to community based-services, whereas the second one aims at fostering social integration, community living, avoiding stigmatization and supporting people in their life goal (obtain or retain employment, etc.) [9]. Therefore, these two goals are supported by the implementation of different evidence-based interventions that require a different organisation of care. For example, the goal of community care and deinstitutionalization is pursued by interventions such as acute in-patient care, early intervention teams or assertive community treatment interventions, while the goal of social integration is pursued by interventions such as peer support workers, wellness recovery action planning or individual placement and support interventions [10, 11].

3.2.1 *First part of the survey*

In the first part of the survey, respondents had to rank the objectives of the reform of mental health care in Belgium (see Table 21) in order to identify the level of importance for each objective.

These selected objectives were the five objectives of the reform of mental health care in Belgium [8]. The objective of "consolidation" has been omitted, as it is considered to be an administrative goal which is already included in the objective of “care in the community”.

The objective of social integration/recovery is a broad objective that covers several dimensions. Therefore, to measure the different dimensions of social integration and recovery, a scale of recovery-oriented practices was used (Questionnaire Recovery Self-Assessment – RSA – Provider Version) [12]. Based on a factor analysis carried out in previous research on the RSA, items with the highest factor analysis score were selected in each of the tree main dimensions of the scale (life goals, involvement, social support) and converted them into objectives [13].

Table 21 – Objectives

Source		Objectives
Objective of the reform in Belgium		Treating users in their community (de-institutionalisation)
Objective of the reform in Belgium		Provide short hospitalisations (intensification)
Objective of the reform in Belgium		Ensure continuity between the social and care sectors (de-categorisation)
Objective of the reform: social integration/recovery	RSA – Involvement	Involve users in developing and offering new services
	RSA – Social Support	Support users to connect with their neighbourhood and community
	RSA – Life Goal	Support users to develop life goals

3.2.2 Second part of the survey

This section is based on the CA method, in which attributes and attribute levels that underlie organisational interventions in mental health care were proposed to respondents (see Table 22). Respondents had to answer to the different stages of the CA according to the objective (social integration or care in the community) that was randomly assigned to them.

The selection of attributes and levels has been has been based on [14]:

- previous research addressing organisational interventions related to mental health and patient care were reviewed [1, 3, 5, 15-18];
- attributes and levels that came out frequently from the qualitative results (Chapter 06) were extracted;
- third previous typologies of mental health care reform were considered [11, 19].

Because of the overall goal of this research, these attributes needed to differentiate solutions aiming to deliver community care or social integration. After three rounds of discussion within the research team, the list in Table 3 was elaborated. The attributes and levels needed to fulfil three properties: the fewer the better, understandable for a Belgian stakeholder, consistent with the literature.

Table 22 – Conjoint Analysis: attributes and attributes levels

	Attributes	Levels	Literature	Issue from the qualitative survey
PROVISION	Target group of the intervention	- Whole population with mental health needs - Severe mentally ill population (SMI) - Socially deprived population with mental health needs	[20, 21]	- Lack of low-threshold services - Gaps in care for most vulnerable groups
	Geographical organisation of care	- Care is organised on a local area basis - Care is not organised on a local area basis	[22, 23]	- Difficulties to network/collaborate over a wide area
	Provision of care by:	- Generic services - Specific services	[11]	- Organisation of care with a high degree of formalization and specialization or not
COORDINATION	Formalization of care pathway:	- No referral guideline - Formal referral guideline	[24, 25]	- Patients' lack of knowledge of services and their function - Inappropriate referrals / use of services
	Type of coordination	- Integrated services - Coordination between stand-alone services - Linkage / Patient coordinator	[19]	- Difficulties in collaboration / coordination between services and sectors
FUNDING	Payment of providers with an:	- Activity-based funding - Episode-based funding	[26]	- Lack of appropriate payment mechanism of provider and services
	Resource pooling level	- Resources are pooled at the service/provider level - Resources are pooled at the network level	[27, 28]	- Rethinking resource allocation across sectors and services - Pooling resources at the network level would be more consistent with the ongoing reform

The different terms used in this table have been clearly defined in French and Dutch in the questionnaires.

3.2.3 Third part of the survey

In the third section of the questionnaire, a list of organisational interventions was suggested to respondents. The interventions (see Table 23) were developed based on the different attributes of the first part of the survey (target audience, funding mechanism, etc.). These interventions were also based on the proposals extracted from the qualitative study (Chapter 06) and have been confirmed with the literature. This literature encompasses:

- Studies on collaborative care and mental health interventions [10, 11, 19, 29-53];
- Evaluation of mental health network [51, 52, 54-61].

Two interventions of a same theme (e.g. increase the supply of housing facilities) were proposed in pairs (see Table 23), respondents had to choose the most appropriate intervention to achieve the objective they received at the beginning of the questionnaire (social integration or care in the community). In each pair, intervention differed on one or two attributes of the organisation of care and both interventions had to be realistic and controversial. The objective was to analyse through the selected interventions the attributes that weigh in their choice.

Table 23 – Organisational intervention

Issue from the qualitative survey	Attributes	Levels	Interventions
Lack of housing facilities	1. Target group of the intervention 2. Resource pooling level	1. SMI 2. Network level	Increase the supply of accommodation for people with severe mental illness. Funded on a lump sum basis for a set services of the network.
		1. Whole population 2. Service level	Increase the supply of accommodation for people with a need for accommodation. Funded on a lump sum basis for each service.
Lack of low-threshold services	1. Target group of the intervention 2. Geographical organisation of care	1. Whole population 2. Yes	Increase the supply of low-threshold services targeting the population with mental health needs in a given territory.
		1. SMI 2. No	Increase the supply of low-threshold services targeting people with severe mental illness, throughout the territory.
Lack of support to employment	1. Provision of care by 2. Type of coordination	1. Specific services 2. Integration	Integrate employment support for people with a psychiatric disorder into specialised services that provide mental health care.
		1. Generic services 2. Coordination	Implement employment support for people with a psychiatric disorder in existing generic social services, coordinated with the mental health sector.
Lack of psychotherapy services	1. Formalization of care pathway: 2. Resources pooling level	1. Formal referral guidelines 2. Service/provider level	Increase the supply of psychotherapy services, accessible by reference from other services of the network. Each service is individually funded.
		1. Informal 2. Network level	Increase the supply of psychotherapy services, accessible without reference. The activity is funded for a set services of the network.
Lack of personalised care planning	1. Geographical organisation of care 2. Type of coordination	1. Yes 2. Patient coordinator	Implement an individualised care plan per patient, shared with services of a given territory. The plan is self-managed by the patient.
		1. No 2. Integration	Implement an individualised care plan per patient. The plan is managed by a case manager in collaboration with the patient.
Lack of inpatient-outpatient integration	1. Type of coordination 2. Resources pooling level	1. Integration 2. Network level	Implement a data sharing and recording system between mental health services. The system is funded for a set of services of the network.
		1. Coordination 2. Service/provider level	Implement a data sharing and recording system for mental health services that want to record and share data. The system is funded by a contribution from each participating service.
Lack of professional attractiveness in	1. Payment of providers with an	1. Episode-based funding 2. Whole population	Provide a lump sum financial incentive per patient for outpatient medical professionals working with patients with mental health needs.

Issue from the qualitative survey	Attributes	Levels	Interventions
outpatient services	2. Target group of the intervention	1. Activity-based funding 2. SMI	Provide a financial incentive by act of care for outpatient medical professionals working with severe mental illness patients.
Lack of appropriate payment mechanism	1. Payment with an:	1. Activity-based funding	Finance psychiatric hospitalisation taking into account the length of stay, with a financial incentive when the patient is referred to an outpatient service of the network at discharge.
		1. Episode-based funding	Finance psychiatric hospitalisation with a flexible budget based on the characteristics of the episode of care.
Lack of local governance	1. Type of coordination	1. Coordination	Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory. Mental health care services are financed individually by the public authorities.
		1. Integration	Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory and to allocate the corresponding financial resources.

3.2.4 Part four to seven of the survey

In the **fourth section**, respondents were asked for names of people to contact for the survey (snowballing sample) with the aim of validating and improving the initial list of stakeholders.

In **section five and six**, sociodemographic information about respondents were collected as well as their position in their institution. The position within their institution allowed us to have an idea of their capacity to influence as stakeholders. This method and questions were also previous KCE research (KCE reports 90B, 2008).

In the **last section** respondents were given the opportunity to freely give their opinion on the survey and on the study.

3.2.5 Validation of the content

The questionnaire was pre-tested face-to-face with stakeholders with different profiles (2 French and 1 Dutch speakers). Face validity tests were performed to validate the content, the formulation, the clarity of the instructions and to calculate the necessary response time. As a first step of the face validity testing, the stakeholders had to respond to the survey online without interaction with the surveyor. Then, respondents could report their main remarks about the survey. Finally, each question was examined one by one to test the accuracy of the terms used, the understanding of the question, the decision processes and the response processes [62, 63].

On the basis of the face validity test, several terms were clarified as well as the statements of some questions. The questionnaire on the online platform was also tested in French and Dutch.

3.2.5.1 Questionnaire - testing and modifications

The following elements of the questionnaire have been modified on the basis of (1) the results of the face validity tests and (2) comments received from the KCE and from the UCL and KUL teams:

Informed consent: Informed consent has been modified to take into account the new legislation on the protection of personal data of the European Parliament of 27 April 2016. The average duration of the online survey was also specified in the text and the objective of the study was reformulated.

Questionnaire part 1: The ranking of the objectives of the reform of mental health care in Belgium was moved in the first part of the survey (the survey initially began with the part based on the CA method). Indeed, the ranking of objectives is a more general question with a less complex design, this part was therefore more adequate to start the questionnaire. An instruction has been added to the question to clarify the task.

Questionnaire part 2: As previously explained, respondents were randomized into one of the two objectives. After the testing of the questionnaire, the objective of "social integration" was defined in the text to ensure its understanding by respondents. In all three parts of the CA, the instructions were reworded based on the results of the face validity test. Some attributes and levels have also been reformulated to simplify their understanding and differentiation.

Questionnaire part 3: A list of organisational interventions were suggested to respondents. Based on the face validity test, the instructions were reworded to clarify the task. In the proposed interventions, some elements of language have also been adapted.

Questionnaire part 4: Respondents were asked for names of people to contact for the survey (snowballing sample). This part was not commented during the validity test, the instructions and the task were clear. An expert proposed to directly request a contact email. This proposal was rejected to avoid asking respondents to search for email addresses at the same time as responding to the survey.

Questionnaire part 5: Sociodemographic information about respondents were collected. This part was not commented during the validity test. The category "researcher / expert" has been added to the types of professions.

Questionnaire part six and seven: These sections were not commented during the face validity test and were not modified.

3.2.6 Sampling

3.2.6.1 Description of sample:

We defined a stakeholder is a person or an organisation having an important stake in or influence on the solutions being considered [64-69]. As part of this research, these include: public authorities, managers involved in inter-organisational activities and organisational mechanisms, clinicians (mental health and social care) and representatives of users and family associations.

The stakeholders were selected from the contact list used in Chapter 06, from the contact database of the Institute of Health and Society (UCLouvain) and LUCAS (KULeuven) and the KCE contact list.

The aim was to have a representative sample of the diversity of the different mental health care functions, the different stakeholder profiles, in the different regions (see Table 24).

Table 24 – Contacted stakeholders: n = 1174

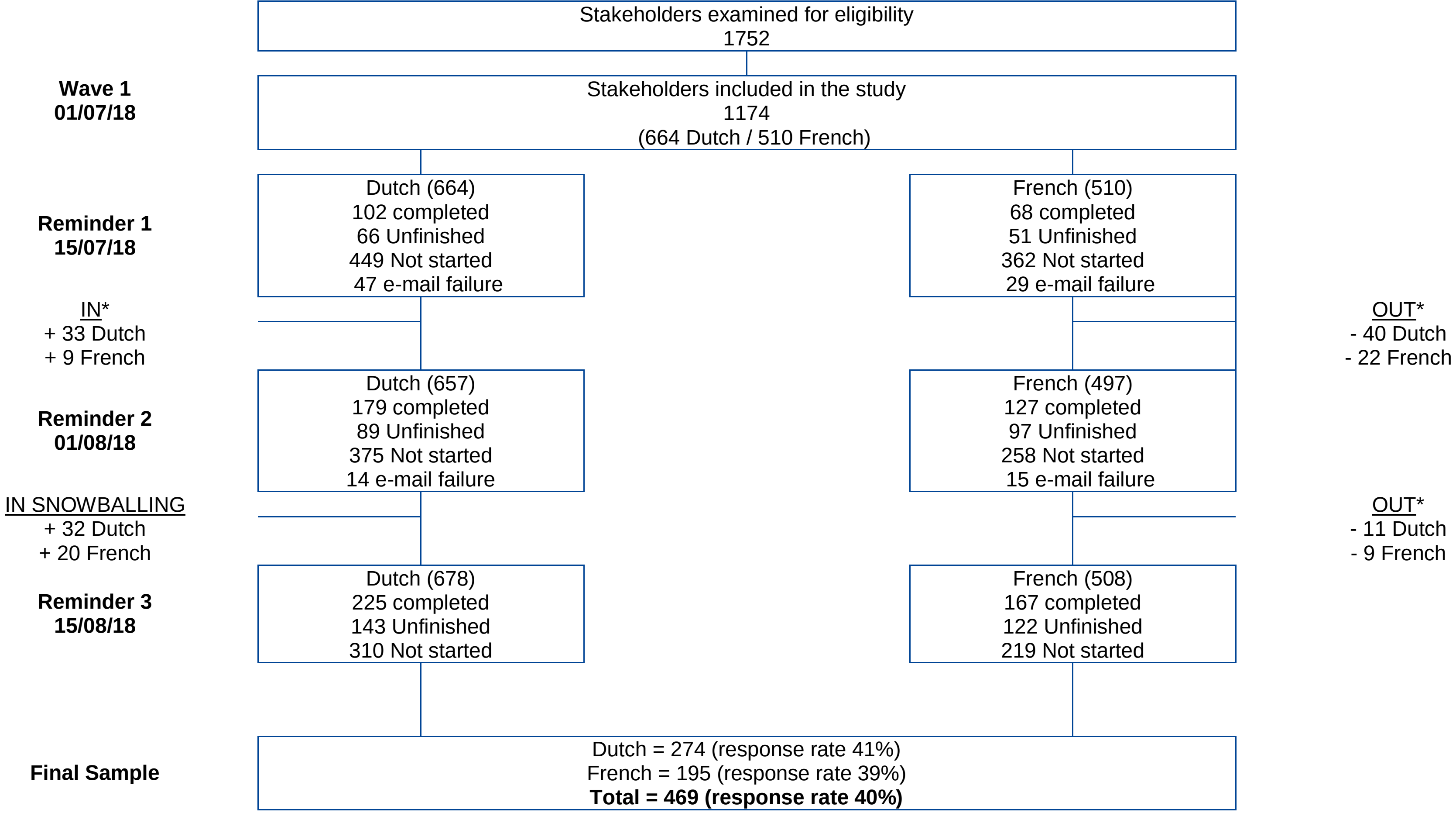
Characteristics	N (%)	
Linguistic community		
• **Dutch**	653 (55%)	
- **Flanders**		- 626 (53%)
- **Brussels**		- 27 (2%)
• **French**	508 (44%)	
- **Wallonia**		- 339 (29%)
- **Brussels**		- 169 (15%)
• **German**	13 (1%)	
Geographic area		
• **Flanders**	627 (53%)	
• **Brussels**	197 (17%)	
• **Wallonia**	340 (30%)	
Function in the mental health system	223 (19%)	
• **F1: Prevention**	92 (8%)	
• **F2: Mobile outreach team**	144 (12%)	
• **F3: Rehabilitation**	183 (15%)	
• **F4: Intensive residential care**	131 (11%)	
• **F5: Housing**		
Other specific type of services	92 (8%)	
• **Addiction services**	79 (7%)	
• **Coordination services**		
• **Self-help**	80 (7%)	
• **Other / information missing**	150 (13%)	
Stakeholders profile:	66 (6%)	
• **Policymakers**	27 (2%)	
• **Experts**	858 (73%)	
• **Health and social service: managers - clinicians**	92 (8%)	
• **User representatives and family associations**	124 (10.5%)	
• **Coordinators (professional association, network, etc.)**	7 (0.5%)	
• **Health insurance representatives**		

3.2.6.2 *Sample size:*

On the basis of the inclusion criteria of the stakeholders and after examination of the eligibility, the size of the sample contacted was 1174 stakeholders (see Table 24). With a confidence level of 95% and a population proportion of 50%, the sample to be reached was at least 290 people (finite population).

A response rate of minimum 30% was expected according to the literature and on previous online surveys [70, 71]. The final sample size was 469 people with a response rate of 40% (see Table 25). This response rate was different between regions (Wallonia = 27%, Brussels = 64%, Flanders = 37%).

Table 25 – Flowchart of sampling process



** From e-mail failure, pensioner, resignation, contact person, etc.*

3.2.6.3 Snowballing sample

At the beginning of August, the names of the contact persons proposed by the stakeholders were exported from the database. In total, 643 nominations of 391 different persons were made by 306 stakeholders. After comparing these people with our initial list of stakeholders, 295 (75%) had already been contacted and 96 (25%) were not in the starting list of stakeholders. The eligibility of the 96 people was evaluated and a contact email was sought. A total of 52 people were added to the study (32 Dutch speakers and 20 French speakers) (see Table 25).

3.2.7 Data collection procedure

The majority of respondents were asked to answer the survey online via the Qualtrics platform. The Qualtrics platform allows secure and anonymous access to a questionnaire. A subsample of elite stakeholders (± 10 per region) were interviewed face-to-face and by phone with the same questionnaire (computer assisted) to make sure of their participation in the survey, and to give them the opportunity to clarify their responses. Indeed, "*Health policy interviews tend to be undertaken with senior decision makers and representatives of powerful interest groups and are, therefore, of a special nature. These are sometimes called elite interviews.*" [66].

To increase the response rate, an email was sent by the KCE before the start of the survey to inform respondents that a survey would be sent to them shortly. The link of the online questionnaire was sent by email at the beginning of July 2018, the online survey was open until the end of August 2018. In total, three reminders were sent only to people who had not yet completed the survey (see Table 25).

3.2.8 Selection bias related to non-respondents

To ensure that non-respondents did not induce selection bias, several analyses were conducted. First, a comparison between early and late respondents (see Appendix 3 of Chapter 07). Indeed, late respondents can be considered as proxy of non-respondents [72]. The results of the comparisons of responses between early and late respondents showed that there was no significant difference between the two groups (see Appendix 3 of Chapter 07).

In addition, after analysing the preliminary results, some questions with the largest variance of responses were selected and were sent by email to a sample of non-respondents. By comparing the responses of a small sample of non-respondents with respondents' responses on these few questions, we can analyse whether there was a participation bias in this study (see Appendix 4 of Chapter 07).

Again, comparisons of responses between respondents and non-respondents did not show significant differences, so we can conclude there is no evidence of participation bias in this study (no selection bias related to non-random participation in the study).

3.3 Data analysis

Subgroup analyses by regions and by stakeholder profiles were performed to address the research questions previoulsy mentioned. One-way ANOVA tests were computed to assess differences between the regions and stakeholders' profiles in each individual scores.

In addition, we ran multilevel multivariate regressions for testing simultaneously for both stakeholders profile and region and across all scores. In these multilevel analyses, the unit is one score-dimension and an individual has n observations (for the n dimensions). In these multilevel analyses, the score is the level 1 and the individual is the level 2 (thus a random intercept coefficient). Obviously, stakeholder profiles and regions were fixed-effect estimates.

Respondents had to answer to the different stages of the survey according to the objective of social integration or care in the community that was randomly assigned to them. T-tests were performed to assess whether the organisational interventions considered as priorities were significantly different depending on the objective to be achieved (social integration or care in the community).

The following explanations apply to the data of the conjoint analysis. For each level of the different dimensions of the mental health care organisation[f] a utility score (U) was calculated (ranging from 0 to 10). The calculation of utility scores was realised in the following way. Stakeholders assigned an importance score from 0 to 10 to each level of each dimension. Then they distributed a total of 100 points across all dimensions. A simple multiplication of both produces utility scores for each level of each dimension (divided by 100 to reduce to a score ranging from 0 to 10). Therefore, levels that are desirable and occur in important dimensions will have higher utility scores, while those that occur in less important dimension will have lower scores. An importance score (I) was also calculated for each dimension of the care organisation. The importance of the dimension in the organisation of mental health care is expressed as a percentage, a higher percentage indicates a greater importance of this dimension, regardless of the levels in this dimension. Finally, for each level of the different dimensions, a Z score (Z) was calculated. Z scores were calculated based on utility scores ($Z = U / SE$). A high Z score indicates that this level is favoured by stakeholders and that this choice is more unanimous among them.

One-way ANOVA tests were performed to assess differences in utility scores of different levels of the organisation of mental health care between the three regions (Flanders, Brussels, and Wallonia) and between stakeholders’ profiles (clinicians and managers, users’ representatives, policymakers and experts). Stakeholders had the possibility to choose between three target groups of the organisation of mental health care (the whole population with mental health needs, the severe mentally ill population, and the socially deprived population with mental health needs). Multiple logistic regressions were performed for each target group (stratification) to analyse whether stakeholders favoured different levels of organisation of care according to the target group.

Summary statistics were calculated to identify which are the preferred organisational interventions and which are the priority interventions according to the stakeholders. One-way ANOVA tests were performed to assess differences in priority interventions between the three regions (Flanders, Brussels, and Wallonia) and between stakeholders’ profiles (clinicians and managers, users’ representatives, policymakers and experts). Chi-square tests were performed to assess differences in preferred organisational interventions between the three regions and between stakeholders’ profiles. A cluster analysis was conducted to highlight which organisational interventions were favoured together by stakeholders.

Organisational interventions were proposed in pairs to stakeholders and each intervention differed on one or two attributes of the organisation of care (e.g. a different target group, a different coordination mechanism, etc.). This analysis allows the respondents to choose one or the other intervention and to analyse through the selected interventions the attributes that weigh in their choice. Nine pairs of two interventions were proposed to stakeholders for a total of 18 interventions. The analysis being on the attributes of the selected interventions ($n = 469 * 18 = 8442$), conditional logistic regressions with a stratification according to participant's identifier were performed to quantify the probability that an organisational intervention will be chosen according to its attributes of the organisation of care.

All the statistical analyses were performed using SAS 9.3.

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[f] For example, the "target group" dimension has three levels (the whole population with mental health needs, severe mental ill patients and socially deprived patients).

4 RESULTS

4.1 Sampling and stakeholders' characteristics

Stakeholders' characteristics are shown in Table 26. The total sample was composed of 469 stakeholders, 41.6% were French speakers and 58.4% were Dutch speakers, 51.9% from Flanders, 20% from Wallonia and 28.1% from the Brussels-capital region. The average seniority in the sector of health or mental health of stakeholders was 19 years (SD = 11.5). Stakeholders rated their perceived influence on the organisation of mental health care at an average of 14.1/20 (SD = 3.6), with 1 having no influence and 20 having a very strong influence on the organisation of care.

Since the types of professional activities and types of services are not exclusive, the sum may be greater than 469. For example, many stakeholders were both service managers / coordinators and clinicians. Among stakeholders, 34.8% were clinicians, 24.2% were service managers or coordinators (network coordinator, professional association coordinator), 9.9% were policymakers, 7.3% were users' and carers' representatives, 5.5% were experts and 4.1% were heads of administration (federal and regional administrations, political institution, INAMI – RIZIV, etc.).

Table 26 – Stakeholders' characteristics (n = 469)

	n	%
Seniority (mean, SD)	19.1	11.5
Perceived influence on mental health care organisation / 1 = low, 20 = high (mean, SD)	14.1	3.6
Language		
• French-speaking	195	41.6
• Dutch-speaking	274	58.4
Professional activity (non-exclusive)		
• Clinicians	223	34.8
• Users' and carers' representatives	47	7.3
• Heads of administration	26	4.1
• Policymakers	64	9.9
• Experts	35	5.5
• Service managers / coordinators	155	24.2
• Other	91	14.2
Type of services (non-exclusive)		
• Administration / political institution	40	7.4
• INAMI/RIZIV / Sickness fund	15	2.8
• University / Research institute	24	4.5
• Federation / coordination service	51	9.5
• Professional association	30	5.6
• Hospital / health and social services	239	44.4
• Other	139	25.8
Geographical distribution		
• Flanders	234	49.9
• Brussels	127	27.1
• Wallonia	90	19.2
• Missing value	18	3.8

4.2 Priority objectives of the reform in mental health care in Belgium

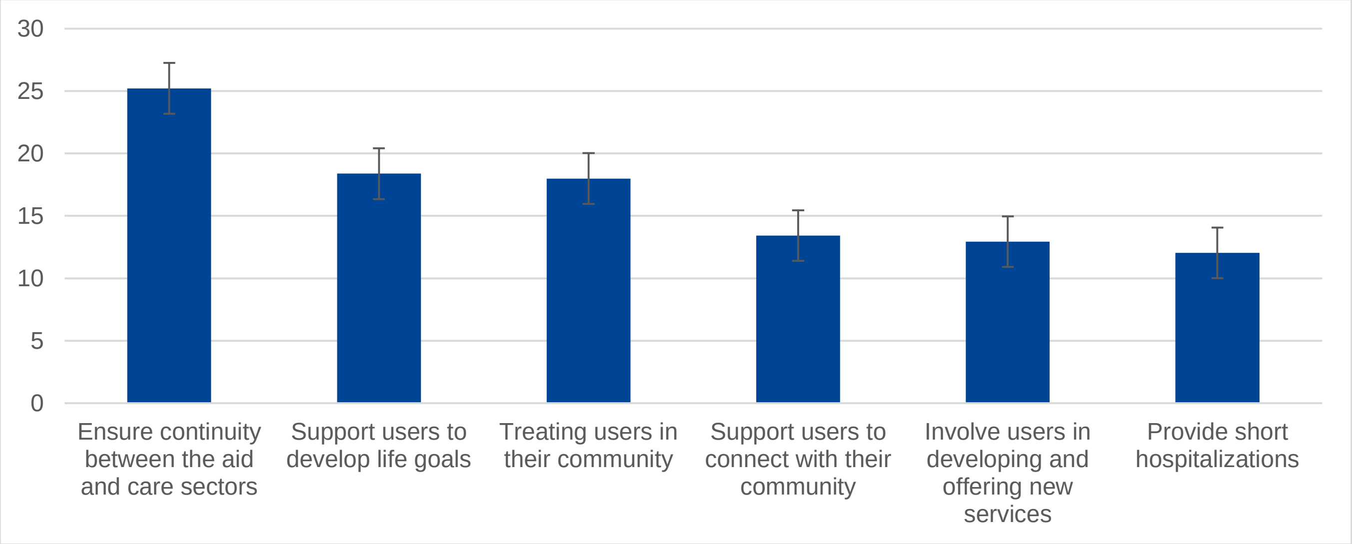
In this chapter, we present the objectives of the reform in mental health care in Belgium that were considered as priority or not by stakeholders and if these considerations were different between the three regions or between stakeholders' profile. The ranking of priority objectives of the reform in mental health care in Belgium is shown in Table 27 and Figure 23. The stakeholders had to distribute a total of 100 points on all the objectives, this method which forces to make choices on a set of possibilities explains the fact that the scores are quite low for all the objectives. Indeed, the objectives were rarely scored at 0 and rarely scored higher than 50, so the respondents distributed the points on all objectives rather than prioritizing one or the other (Table 27).

Figure 23 shows that the 6 objectives were distributed in 3 groups of priorities. In the first group, the priority objective (25.2 / 100) was to "ensure continuity between the social and care sectors", this objective was ranked first by more than half of the sample and ranked last by 9.8%. In the second group, the objectives of "supporting users to develop their life goals" and "treatment of users in the community" were ranked with equivalent priority. The third and last group includes the 3 objectives classified as lower priority; "support users to connect with their community", "involve users in developing and offering new services" and "provide short hospitalisations". The reduction in hospital stays was considered the least priority objective (12.1 / 100), 60% of stakeholders ranked last and 24% gave it a score of 0/100.

Table 27 – Priority objectives of the reform in mental health care

Reform objectives	Mean (0 = low priority, 100 = high priority)	SD	Ranked first (non-exclusive) N (%)	Ranked last (non-exclusive) N (%)	Scored at 0 N (%)	Scored > 50 N (%)
Ensure continuity between the social and care sectors	25.2	14.6	226 (50.4)	45 (9.8)	13 (2.8)	45 (9.8)
Support users to develop life goals	18.4	13.2	151 (33.1)	103 (22.5)	52 (11.4)	16 (3.5)
Treating users in their community	18	11.1	124 (27.2)	126 (27.6)	41 (8.9)	10 (2.2)
Support users to connect with their community	13.4	8.6	65 (14.2)	169 (37.1)	62 (13.6)	0 (0)
Involve users in developing and offering new services	12.9	9.7	68 (14.1)	206 (45.1)	69 (15.1)	4 (0.8)
Provide short hospitalisations	12.1	12.1	63 (13.8)	274 (60.1)	111 (24.3)	11 (2.4)

Figure 23 – Priority objectives of the reform in mental health care



Note: mean 95% CI displayed on each bar.

4.3 Differences between regions and stakeholders in priority objectives of the reform in mental health care

The comparisons of the priority objectives between the three regions and between stakeholders' profiles are respectively presented in Table 29 and Table 30. Table 28 shows the association between all given scores and objectives as well as the interaction of stakeholder profiles and regions with objectives. This analysis being on the set of the scores across all objectives (n = 469 * 6 = 2814), a multivariate multilevel linear regression was performed with the participants' identifier as random intercept.

Results in Table 28 shows that on the set of priority scores, the scores were significantly different between objectives (F = 26.4, df = 5, p < 0.0001). The interactions between the objectives and the three regions and the three stakeholder profiles were also significant. Therefore, there were significant differences in priority objectives between regions and between stakeholders' profiles as shown in Table 29 and Table 30. These differences were larger between stakeholder profiles (F = 3.3, df = 10, p < 0.001) than between regions (F = 2.4, df = 10, p < 0.01).

Table 28 – Fixed effect tests on priority scores*

	F	p-value
Objectives of the reform (df = 5)	26.4	**<0.0001**
Interaction between objectives * regions (df = 10)	2.4	**<0.01**
Interaction between objectives * stakeholder profiles (df = 10)	3.3	**<0.001**

** Results from multivariate multilevel linear regression with stakeholder regions and profiles as fixed effects and participants ID as a random intercept*

There was no significant difference in the objectives considered as priorities between the 3 regions, except for the objective of "supporting users to develop their life goals" (see Table 29). This objective was ranked second in Flanders and Wallonia and third in Brussels. The second objective in Brussels was the treatment of users in the community.

Table 29 – Priority objectives of the reform in mental health care, differences between regions

Reform objectives	Mean (SD) [rank] (0 = low priority, 100 = high priority)			F (p-value)
	Flanders	Brussels	Wallonia	
Ensure continuity between the social and care sectors	24.1 (12.4) [1]	27.0 (17.8) [1]	25.3 (14.8) [1]	1.62 (0.19)
Support users to develop life goals	19.5 (11.8) [2]	15.5 (13.5) [3]	19.6 (14.9) [2]	**4.31 (0.01)**
Treating users in their community	18.6 (10.8) [3]	16.3 (11.1) [2]	18.4 (11.8) [3]	1.87 (0.15)
Support users to connect with their community	14.0 (8.2) [4]	13.6 (9.0) [5]	12.3 (8.8) [5]	1.31 (0.27)
Involve users in developing and offering new services	12.1 (8.8) [5]	14.1 (10.4) [4]	14.1 (10.5) [4]	2.71 (0.06)
Provide short hospitalisations	11.8 (10.4) [6]	13.3 (14.8) [6]	10.2 (10.8) [6]	1.86 (0.15)

There were several significant differences in the objectives considered as priorities according to the profile of the stakeholders (see Table 30). The largest significant difference in the priorities between stakeholders' profiles was for the objective of "supporting users to develop their life goals". This objective was ranked second for clinicians and third for user representatives and policymakers (F = 6.1, p < 0.01). Although the objective of continuity of care was ranked first for the three stakeholder profiles, it had a significantly higher priority score for policymakers and experts than for user representatives and clinicians (F = 4.1, p < 0.01). The objective of "involving users in developing and offering new services" was ranked fourth for user representatives, fifth for clinicians and sixth (last) for policymakers (F = 4.2, p = 0.01). The reduction in hospital stays was in sixth (last) position for clinicians and user representatives but in fourth position for policymakers (F = 4.1, p = 0.01). For policymakers, the objective considered as the least priority was "involving users in developing and offering new services".

Table 30 – Priority objectives of the reform in mental health care, differences between stakeholders

Reform objectives	Mean (SD) [rank] (0 = low priority, 100 = high priority)			F (p-value)
	Clinicians and managers	Users' representatives	Policymakers and experts	
Ensure continuity between the social and care sectors	24.9 (13.7) [1]	19.5 (14.6) [1]	27.5 (16.3) [1]	**4.1 (0.01)**
Support users to develop life goals	19.7 (13.8) [2]	18.6 (13.3) [3]	14.8 (10.8) [3]	**6.1 (<0.01)**
Treating users in their community	17.9 (11.1) [3]	19.1 (13.5) [2]	17.7 (10.5) [2]	0.2 (0.8)
Support users to connect with their community	13.4 (8.3) [4]	14.4 (9.1) [5]	13.3 (9.2) [5]	0.2 (0.8)
Involve users in developing and offering new services	12.9 (9.5) [5]	17.5 (12.9) [4]	11.9 (8.9) [6]	**4.2 (0.01)**
Provide short hospitalisations	11.1 (11.4) [6]	11.4 (9.5) [6]	14.7 (14.1) [4]	**4.1 (0.01)**

4.4 Comparisons between goals, social integration or care in the community

As previously explained, stakeholders had to answer to the different stages of the survey according to the objective of social integration (n = 237) or care in the community (n = 219) that was randomly assigned to them. In this section, we highlight if stakeholders' answers were different depending on the objective received.

The table in Appendix 5 of Chapter 07 presents the profile and region of the stakeholders assigned to both objectives. As expected, the profile of the stakeholders and their region was not significantly different between the two objectives because these objectives were randomized between stakeholders.

4.4.1 Differences in priority organisational interventions according to the objective to be achieved

The differences in the organisational interventions perceived as priorities by the stakeholders according to the objective of social integration and care in the community are shown in the Table 31.

Priority scores given to the "implementation of low-threshold services" and "implementation of employment support" were significantly different between the two objectives. Implementing low-threshold services had a higher priority score for the objective of care in the community and implementing employment support a higher score for the objective of social integration. However, these differences of priority do not change the ranking; these two interventions remain respectively first and last in the ranking for the two objectives. There was no other significant difference between the two objectives, even though the ranking of interventions had changed somewhat.

Table 31 – Differences in priority organisational interventions according to the goals of social integration and care in the community

	Priority of organisational interventions Mean (SD) [rank] 1=high, 3=low		
	Goal is : Social Integration	Goal is : Community Care	T-test (p-value)
Implement low-threshold services	1.71 (0.76) [1]	1.55 (0.66) [1]	**2.44 (0.01)**
Implement personalised care planning	1.73 (0.70) [2]	1.78 (0.70) [4]	-0.71 (0.47)
Implement psychological support	1.75 (1.65) [3]	1.73 (0.82) [2]	0.31 (0.75)
Implement housing facilities	1.77 (0.75) [4]	1.75 (0.71) [3]	0.25 (0.80)
Increase professional attractiveness in outpatient services	1.90 (0.80) [5]	1.83 (0.76) [5]	0.98 (0.32)
Change the payment of psychiatric hospitalisations	1.94 (0.77) [6]	2.04 (0.80) [6]	-1.42 (0.15)
Implement a local governance structure	2.15 (0.85) [7]	2.12 (0.86) [7]	0.41 (0.85)
Implement data sharing system	2.50 (0.64) [8]	2.47 (0.69) [8]	0.36 (0.72)
Implement employment support	2.51 (0.68) [9]	2.68 (0.57) [9]	**-3.06 (< 0.01)**

4.4.2 *Differences in levels of the organisation of mental health care implicitly preferred according to the objective to be achieved*

As previously explained, organisational interventions were proposed in pairs to stakeholders and each intervention differed on one or two attributes of the organisation of care (e.g. a different target group, a different coordination mechanism, etc.). This allows the respondent to choose one or the other intervention and to analyse through the selected interventions the attributes that weigh in their choice. The analysis being on the attributes of the selected interventions (n = 469 * 18 = 8442), conditional logistic regressions with a stratification according to participant's identifier were performed. Table 32 shows the probability that an organisational intervention will be chosen according to its attributes of the organisation of care. The results are stratified according to the objective that the stakeholders have randomly received in order to identify if the same attributes influence their choice between the two objectives of social integration and care in the community.

There were some differences between the two objectives. Respondents allocated to the goal of “social integration”, were more likely to select an organisational intervention with a provision of generic services rather than specific services (OR = 1.39, p < 0.001) and a pooling of financial resources for a set of services at the level of a network rather than a funding per service (OR = 0.80, p < 0.01).The other significant results were identical between the two objectives and will be discussed later in this report.

Table 32 – Levels of the organisation of mental health care preferred by stakeholders according to the goal of social integration vs care in the community

	Social integration	Community care
	OR	OR
Target group		
- Whole population with mental health needs	0.91	1.22
- Severe mentally ill population	0.97	1.09
- Socially deprived population with mental health needs	REF	REF
Care is organised on a local area basis (yes, ref = no)	1.15	0.96
Provision of care by generic (ref = specific services)	**1.39*****	1.08
Care pathway with formal referral guideline (yes, ref = no)	**0.56*****	**0.79****
Type of coordination:		
- Linkage / Patient coordinator	2.05	1.40
- Coordination between services	**3.56*****	**2.01*****
- Integrated services	REF	REF
Payment of providers with an episode-based (ref = activity-based funding)	**1.32*****	**1.40*****
Resources are pooled at the service/provider level (ref = at the network level)	**0.80****	1.1

** p-value < 0.05, ** p-value < 0.01, *** p-value < 0.001*

4.5 Conjoint Analysis: Explicit values that underlie the expectations on the organisation of mental health care in Belgium

In this section, we discuss the different dimensions and levels of the organisation of mental health care that have been explicitly considered as more important by stakeholders. We look at whether these considerations are different between regions and between stakeholder profiles. Finally, we look at whether stakeholders proposed a different organisation of mental health care according to the target group.

4.5.1 Utility and importance of dimensions and levels of the organisation of mental health care

The results of the conjoint analysis are shown in Table 33. As previously explained, a high utility score (U) indicates that a level is of greater importance in the organisation of care aimed at patients' social integration and care in the community. The importance (I) of the dimensions in the organisation of mental health care is expressed as a percentage, a higher percentage indicates a greater importance, regardless of the levels in this dimension. Finally, a high Z score indicates that a level is favoured by stakeholders and that this choice is more unanimous among them.

The results of the conjoint analysis show that the most important dimension of the organisation of care to be considered was the target group of interventions (23.3%), followed by the type of coordination (15.7%) and the type of service provided (15.1%). The dimensions of the organisation of care considered to be the least important were the funding dimensions (payment method of providers and resource pooling level).

Regarding the target group of intervention, the three target groups had a high utility score (U) compared to the scores in the other dimensions. The socially deprived population with mental health needs had a higher utility score (U = 1.61) than the whole population with mental health needs (U = 1.21) and the severe mentally ill population (U = 1.17). The consensus score (Z score) for the socially deprived population was also higher, meaning that the stakeholders considered this target group as a priority in a relatively consensual way.

Stakeholders also favoured (U), by consensus (Z), a geographical organisation of care (U = 1.03, Z = 1.01) and a coordination between providers (U = 1.13, A = 1.12) rather than letting the patient coordinate his or her own care (U = 0.50, Z = 0.61) or than integrating the different providers in the same structure (U = 0.76, Z = 0.65).

In the other dimensions of the organisation of care, stakeholders favoured the establishment of specific services rather than generic services (U = 1.01 vs. U = 0.50) and an informal organisation of the patient's care pathway rather than setting referral guidelines (U = 0.81 vs. U = 0.40).

Finally, although the funding dimensions were considered by the stakeholders as less important in the organisation of care, they favoured an episode-based payment of providers rather than an activity-based payment (U = 0.74 vs. U = 0.28) and a pooling of financial resources for a set of services at the level of a network rather than a funding per service (U = 0.61 vs. U = 0.43).

Table 33 – Conjoint analysis on the dimensions and levels of the organisation of mental health care

Dimensions	Levels	Utilities (U) Mean (SD)	Importance (I) %	Z score (Z)*
Target group of the intervention	Whole population with mental health needs	1.21 (1.57)	23.3 %	0.77
	Severe mentally ill population (SMI)	1.17 (1.32)		0.88
	Socially deprived population with mental health needs	1.61 (1.46)		1.10
Geographical organisation of care	Care is organised on a local area basis	1.03 (1.02)	13.2 %	1.01
	Care is not organised on a local area basis	0.27 (0.66)		0.41
Provision of care by:	Generic services	0.50 (0.85)	15.1 %	0.59
	Specific services	1.01 (1.14)		0.88
Formalization of care pathway:	Formal referral guideline	0.40 (0.94)	11.8 %	0.42
	No referral guideline	0.81 (0.91)		0.89
Type of coordination	Linkage / Patient coordinator	0.50 (0.82)	15.7 %	0.61
	Coordination between stand-alone services	1.13 (1.01)		1.12
	Integrated services	0.76 (1.16)		0.65
Payment of providers with an:	Episode-based funding	0.74 (0.94)	10.4 %	0.79
	Activity-based funding	0.28 (0.61)		0.46
Resource pooling level	Resources are pooled at the service/provider level	0.43 (0.80)	10.5 %	0.53
	Resources are pooled at the network level	0.61 (0.83)		0.73

** Z scores were calculated based on utility scores (Z = U / SE). A high Z score indicates that this level is favoured by stakeholders and that this choice is more unanimous among them.*

4.5.2 Differences between regions and stakeholders in priority levels of the organisation of mental health care

The comparisons of the priority levels of the organisation of mental health care between the three regions and between stakeholders' profiles are respectively presented in Table 35 and Table 36. Table 34 shows the association between all utility scores and the levels of the organisation of mental health care as well as the interaction of stakeholder profiles and regions with these levels. The analysis being on the set of utility scores across all levels of the organisation of mental health care (n = 465 * 16 = 7504), a multivariate multilevel linear regression was performed with the participants' identifier as random intercept.

The results presented in Table 15 show that across all utility scores, the scores were significantly different between levels of organisation of mental health care (F = 30.1, p < 0.0001). The interaction between the levels of organisation of care and the three regions was also significant, across all utility scores (F = 3.58, df = 15, p < 0.001). The interaction between the levels of organisation of care and stakeholders' profile was not significant. Differences in the utility scores of the levels of the organisation of care were therefore greater between regions (see details in Table 35) than between stakeholders' profile (See details in Table 36).

Table 34 – Fixed effect tests on utility scores (U)*

	F	p-value
Levels of the organisation of mental health care (df = 15)	30.1	**<0.0001**
Interaction between levels * regions (df = 30)	3.58	**<0.001**
Interaction between levels * stakeholder profiles (df = 30)	1.06	0.37

** Results from multivariate multilevel linear regression with stakeholder regions and profiles as fixed effects participants ID as a random intercept*

The results in Table 35 show several significant differences between the three regions in the utility scores of the levels of the organisation of care. As previously explained, the socially deprived population with mental health needs was the priority target group, however this importance was different between the three regions (F = 5.04, p < 0.01). The utility score of this group was significantly higher in Flanders and Brussels than in Wallonia, with stakeholders in Wallonia giving a higher utility score to the severe mentally ill population.

The coordination between providers is also a level previously indicated as important in the organisation of care, the utility score of this level was also significantly different between the three regions (F = 9.94, p < 0.01). The utility score to the coordination between stand-alone providers was significantly higher in Brussels and Wallonia than in Flanders. In Flanders, stakeholders gave a relatively equivalent score to the coordination between providers and to the integration of different services within the same structure.

The importance of the type of service provided was also significantly different between regions. Although the provision of specific services had a higher utility score than the provision of generic services in the three regions, this difference is significantly greater in Flanders than in Brussels and Wallonia.

As previously explained, stakeholders favoured an episode-based payment of providers rather than an activity-based payment. However, the utility score of the episode-based payment was significantly higher in Brussels and Flanders than in Wallonia. In Wallonia, both types of payment had quite similar utility scores (episode-based payment U = 0.50, activity-based payment U = 0.34).

Finally, there was significant regional differences in the resource pooling level (F = 4.54, p = 0.01). The pooling of financial resources at the network level (for a set of services) was favoured in Flanders and Brussels, stakeholders in Wallonia favoured individual funding per service.

Table 35 – Levels of the organisation of mental health care, differences between regions

Dimensions	Levels	Utilities (U) Mean (SD)			F (p-value)
		Flanders	Brussels	Wallonia	
Target group of the intervention	Whole population with mental health needs	1.20 (1.54)	1.30 (1.81)	1.10 (1.24)	0.62 (0.54)
	Severe mentally ill population (SMI)	1.26 (1.37)	1.10 (1.19)	1.21 (1.38)	1.59 (0.20)
	Socially deprived population with mental health needs	1.79 (1.57)	1.58 (1.40)	1.21 (1.17)	**5.04 (<0.01)**
Geographical organisation of care	Care is organised on a local area basis	1.06 (0.99)	0.99 (1.05)	1.06 (1.12)	0.23 (0.79)
	Care is not organised on a local area basis	0.23 (0.58)	0.31 (0.67)	0.35 (0.83)	1.25 (0.28)
Provision of care by:	Generic services	0.36 (0.71)	0.63 (0.90)	0.68 (1.06)	**6.56 (<0.01)**
	Specific services	1.10 (1.11)	0.76 (1.03)	0.99 (1.25)	**3.64 (0.02)**
Formalization of care pathway:	Formal referral guideline	0.36 (0.91)	0.47 (1.09)	0.38 (0.76)	0.59 (0.55)
	No referral guideline	0.79 (0.86)	0.89 (1.1)	0.77 (0.93)	0.57 (0.56)
Type of coordination	Linkage / Patient coordinator	0.48 0.90)	0.55 (0.75)	0.47 (0.73)	0.32 (0.72)
	Coordination between stand-alone services	0.93 (0.97)	1.39 (0.99)	1.26 (1.06)	**9.94 (<0.01)**
	Integrated services	0.87 (1.28)	0.64 (1.11)	0.68 (1.04)	1.96 (0.14)
Payment of providers with an:	Episode-based funding	0.78 (0.92)	0.81 (1.12)	0.50 (0.63)	**3.52 (0.03)**

	Activity-based funding	0.25 (0.54)	0.26 (0.54)	0.43 (0.83)	2.92 (0.06)
Resource pooling level	Resources are pooled at the service/provider level	0.39 (0.76)	0.29 (0.62)	0.66 (0.95)	**6.01 (<0.01)**
	Resources are pooled at the network level	0.72 (0.87)	0.55 (0.76)	0.43 (0.80)	**4.54 (0.01)**

The results in Table 36 show significant differences between stakeholder profiles in utility scores of three levels of the organisation of care. A geographical organisation of care was favoured for the different stakeholder profiles, but the utility score was significantly greater for policymakers than for clinicians and user representatives (F = 3.23, p = 0.04).

The provision of specific services had a significantly higher utility score for user representatives than for clinicians and policymakers (F = 3.64, p = 0.02).

Finally, although all stakeholders favoured an informal organisation of patient's care pathways, the utility scores of the implementation of referral guidelines was significantly higher for policymakers than for clinicians and user representatives (F = 4.45, p = 0.01).

Table 36 – Levels of the organisation of mental health care, differences between stakeholders

Dimensions	Levels	Utilities (U) Mean (SD)			F (p-value)
		Clinicians and managers	**Users' representatives**	**Policymakers and experts**	
Target group of the intervention	Whole population with mental health needs	1.23 (1.50)	1.17 (1.56)	1.15 (1.75)	0.13 (0.88)
	Severe mentally ill population (SMI)	1.19 (1.36)	1.58 (1.54)	1.01 (1.12)	2.53 (0.08)
	Socially deprived population with mental health needs	1.59 (1.35)	1.82 (1.24)	1.59 (1.78)	0.37 (0.68)
Geographical organisation of care	Care is organised on a local area basis	0.97 (1.1)	0.93 (0.85)	1.24 (1.11)	**3.23** **(0.04)**
	Care is not organised on a local area basis	0.31 (0.72)	0.26 (0.60)	0.18 (0.49)	1.57 (0.20)
Provision of care by:	Generic services	0.47 (0.81)	0.40 (0.76)	0.61 (0.96)	1.43 (0.23)
	Specific services	1.02 (1.11)	1.12 (1.14)	0.89 (1.22)	**3.64** **(0.02)**
Formalization of care pathway:	Formal referral guideline	0.33 (0.66)	0.21 (0.50)	0.61 (1.47)	**4.45** **(0.01)**
	No referral guideline	0.79 (0.89)	1.07 (1.02)	0.80 (0.93)	1.45 (0.23)
Type of coordination	Linkage / Patient coordinator	0.48 (0.79)	0.60 (0.78)	0.53 (0.93)	0.43 (0.65)
	Coordination between stand-alone services	1.17 (1.04)	1.00 (0.82)	1.06 (0.99)	0.80 (0.45)
	Integrated services	0.78 (1.13)	0.80 (0.98)	0.71 (1.28)	0.16 (0.85)
	Episode-based funding	0.78	0.58	0.69	0.89

Payment of providers with an:		(0.97)	(0.70)	(0.92)	(0.41)
	Activity-based funding	0.28 (0.62)	0.31 (0.68)	0.29 (0.57)	0.03 (0.96)
Resource pooling level	Resources are pooled at the service/provider level	0.43 (0.83)	0.37 (0.75)	0.44 (0.74)	0.10 (0.90)
	Resources are pooled at the network level	0.63 (0.83)	0.53 (0.68)	0.59 (0.87)	0.28 (0.75)

4.5.3 A different organisation of mental health care according to the target group?

The results of the conjoint analysis presented previously in Table 33 highlight that the target group is the dimension that has the most importance in the organisation of care, but also that the different target groups are important (high utility scores). We therefore decided to stratify the sample in three groups according to the target group with the highest utility. The purpose of this analysis was to highlight whether the stakeholders favoured different levels of organisation of care according to the target group. Results are presented in Table 37.

If the two target groups of the organisation of mental health care were the severe mentally ill population and the socially deprived population with mental health needs, stakeholders had a significantly higher probability of choosing a geographical organisation of care but not if the target group was the whole population with mental health needs.

The probability that stakeholders choose a provision of generic services rather than specific services was significantly higher (OR 1.701, $p < 0.01$) if the target group was the whole population with mental health needs. In contrast, this probability was significantly lower (OR = 0.53, $p < 0.01$) if the target group was the severe mentally ill population.

When the organisation of care targeted the whole population with mental health needs, there was a significant higher probability (OR = 1.51, $p < 0.05$) that stakeholders choose to implement referral guideline rather than an informal organisation of patient's care pathways, but not if the organisation of care targeted the other two groups.

Finally, the probability that stakeholders choose an episode-based payment of providers rather than an activity-based payment was significantly higher (OR = 2.12, $p < 0.001$) if the target group of the organisation of care was the socially deprived population with mental health needs.

Table 37 – Multiple logistic regression models on levels of the organisation of mental health care preferred by stakeholders stratified by target group with the highest utility.

	Target group with the highest utility		
Levels of the organisation of mental health care	**Whole population with mental health needs**	**Severe mentally ill population**	**Socially deprived population with mental health needs**
	OR	OR	OR
Care is organised on a local area basis (yes, ref = no)	0.78	**1.37***	**1.62***
Provision of care by generic (ref = specific services)	**1.70****	**0.53****	1.08
Care pathway with formal referral guideline (yes, ref = no)	**1.51***	0.81	0.88
Type of coordination:			
- Linkage / Patient coordinator (yes, ref = no)	0.75	1.12	1.43
- Coordination between services (yes, ref = no)	1.38	0.97	0.91
- Integrated services (yes, ref = no)	1.02	1.13	1.04
Payment of providers with an episode-based (ref = activity-based funding)	0.79	0.95	**2.12*****
Resources are pooled at the service/provider level (ref = at the network level)	1.08	0.86	1.35

** p-value < 0.05, ** p-value < 0.01, *** p-value < 0.001*

4.6 Organisational interventions: priorities and preferences

In this chapter, we present the organisational interventions that were preferred and prioritized by stakeholders and whether these considerations differ between the three regions and between stakeholders' profile. Finally, we performed a cluster analysis to identify groups of stakeholders holding similar preferences in terms of organisational intervention and we describe these groups.

4.6.1 *Stakeholders' prioritized organisational interventions, for the overall sample, by region and by stakeholders' profile*

Stakeholders' priority organisational interventions are presented for the overall sample, by region and by stakeholder profiles in Table 39 and Figure 24. Table 38 shows the association between all priority scores and the different organisational interventions as well as the interaction of stakeholder profiles and regions with these interventions. The analysis being on the set of priority scores across all interventions (n = 469 * 9 = 4221), a multivariate multilevel linear regression was performed with the participants' identifier as random intercept.

The results presented in Table 38 show that on the set of priority scores, the scores were significantly different between organisational interventions (F = 42.73, df = 8, p < 0.0001). The interaction between organisational interventions and stakeholder profiles was significant (F = 2.66, df = 16, p < 0.001). The interaction between organisational interventions and the three regions was not significant (F = 1.03, df = 16, p = 0.41). Differences in priority scores for organisational interventions are therefore greater between stakeholder profiles than between regions (See details in Table 39).

Table 38 – Fixed effect tests on priority scores *

	F	p-value
Organisational interventions (df = 8)	42.73	**<0.0001**
Interaction between interventions * regions (df = 16)	1.03	0.41
Interaction between interventions * stakeholders (df = 16)	2.66	**<0.001**

** Results from multivariate multilevel linear regression with stakeholder regions and profiles as fixed effects participants ID as a random intercept*

For the overall sample (see Figure 24), the highest priority was the implementation of low-threshold interventions, then the implementation of psychotherapy services, housing facilities, and personalised care planning. The implementation of a data sharing and recording system and the implementation of employment support were deemed of lower priority.

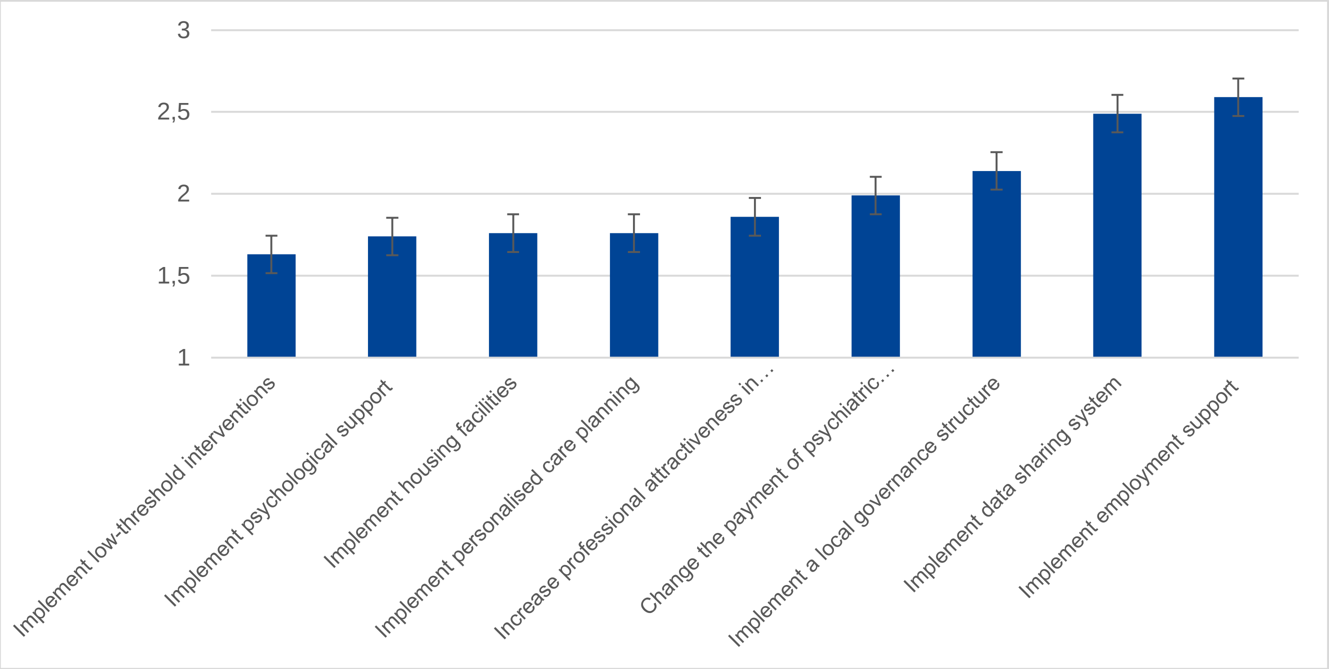
The implementation of low-threshold services was considered a priority in Flanders and Wallonia but came third in Brussels (Table 39, F = 3.53, p = 0.03). In Brussels, the implementation of psychological support came as the first priority. The implementation of housing facilities came second in Brussels, third in Wallonia and fourth in Flanders.

Regarding stakeholder profiles, the priority given to the implementation of housing facilities was significantly different between stakeholders (F = 8.5, p < 0.01). The implementation of housing facilities was in first place for users' representative, third for clinicians and managers and fifth for policymakers and experts. For clinicians, managers and policymakers, the intervention considered as a priority was the implementation of low-threshold services. The priority given to the implementation of employment support was also significantly different between stakeholders (F = 11.4, p < 0.01). This intervention was the least priority for clinicians, managers and users' representative but was in second last position for policymakers.

Table 39 – Priority organisational interventions

	Overall sample	Priority by region Mean (SD) [rank], 1=high - 3=low				Priority by stakeholders' profile Mean (SD) [rank], 1=high - 3=low			
		Flanders	Brussels	Wallonia	F (p-value)	Clinicians - Managers	Users' representatives	Policymakers – Experts	F (p-value)
Implement low-threshold services	1.63 (0.71) [1]	1.56 (0.67) [1]	1.76 (0.76) [3]	1.63 (0.74) [1]	**3.53 (0.03)**	1.64 (0.69) [1]	1.59 (0.50) [2]	1.62 (0.76) [1]	0.09 (0.91)
Implement psychological support	1.74 (0.83) [2]	1.73 (0.80) [2]	1.73 (0.88) [1]	1.76 (0.82) [4]	0.05 (0.95)	1.69 (0.82) [2]	1.90 (0.73) [5]	1.84 (0.87) [3]	1.93 (0.14)
Implement housing facilities	1.75 (0.73) [3]	1.80 (0.74) [4]	1.74 (0.76) [2]	1.71 (0.67) [3]	0.60 (0.55)	1.70 (0.72) [3]	1.53 (0.50) [1]	1.99 (0.76) [5]	**8.5 (<0.01)**
Implement personalised care planning	1.76 (0.70) [4]	1.77 (0.75) [3]	1.80 (0.66) [4]	1.66 (0.61) [2]	1.10 (0.33)	1.79 (0.69) [4]	1.60 (0.93) [3]	1.72 (0.67) [2]	1.41 (0.24)
Increase professional attractiveness in outpatient services	1.86 (0.78) [5]	1.88 (0.76) [5]	1.90 (0.79) [5]	1.81 (0.84) [5]	0.40 (0.67)	1.84 (0.79) [5]	2.00 (0.80) [6]	1.89 (0.75) [4]	0.71 (0.49)
Change the payment of psychiatric hospitalisations	1.99 (0.78) [6]	1.98 (0.80) [6]	1.95 (0.80) [6]	2.05 (0.72) [6]	0.45 (0.63)	2.01 (0.77) [6]	1.75 (0.80) [4]	2.01 (0.81) [6]	1.63 (0.19)
Implement a local governance structure	2.14 (0.85) [7]	2.13 (0.86) [7]	2.14 (0.84) [7]	2.13 (0.85) [7]	0.01 (0.99)	2.14 (0.85) [7]	2.25 (0.80) [7]	2.10 (0.87) [7]	0.39 (0.67)
Implement data sharing system	2.49 (0.67) [8]	2.48 (0.66) [8]	2.46 (0.67) [8]	2.56 (0.68) [8]	0.68 (0.50)	2.51 (0.66) [8]	2.50 (0.62) [8]	2.43 (0.70) [9]	0.53 (0.59)
Implement employment support	2.59 (0.63) [9]	2.63 (0.58) [9]	2.48 (0.72) [9]	2.65 (0.60) [9]	2.87 (0.06)	2.64 (0.60) [9]	2.87 (0.33) [9]	2.38 (0.72) [8]	**11.4 (<0.01)**

Figure 24 – Priority organisational interventions, 1 = high priority, 3 = low priority



Note: mean 95% CI displayed on each bar.

4.6.2 Stakeholders' preferred organisational interventions

The organisational interventions preferred by stakeholders are presented in Table 40. Full tables and preferred organisational interventions by region and by stakeholders' profile are presented in Appendix 6 of Chapter 07.

As a reminder, the interventions were proposed in pairs and differed by one or two attributes of the organisation of mental health care. This analysis technique was intended to allow the respondents to choose one or the other intervention and to analyse through the chosen interventions the attributes that weigh in their choice. Therefore, the descriptive results on the selected interventions and the differences between regions and stakeholder profiles are less interesting. Some results are nevertheless important to highlight.

First, 71.1% of stakeholders preferred to implement employment support for people with a psychiatric disorder in existing generic social services that coordinate with the mental health sector rather than integrating this type of intervention in specialised mental health services. This result was the same regardless of the region and stakeholder profile.

There were also significant differences between regions in the choice of two pairs of interventions, the implementation of a data sharing and recording system and the establishment of local governance. In the first pair of interventions, stakeholders had to choose between "implementing a data sharing and recording system between mental health services. The system is funded for a set of services of the network" and "implementing a data sharing and recording system for mental health services that want to record and share data. The system is funded by a contribution from each participating service". In the whole sample, 68.4% of stakeholders favoured the first intervention, but this choice was significantly different between the three regions ($\chi 2 = 35.5$, $p < 0.01$). The implementation of a data sharing and recording system between mental health services and funded for a set of services of the network was more favoured in Flanders (79.9%) than in Wallonia (65.6%) and Brussels (49.6%).

In the second pair of interventions, stakeholders had to choose between "establishing a local governance structure that has the power to coordinate the provision of mental health services in a given territory. Mental health care services are financed individually by the public authorities" and "establishing a local governance structure that has the power to coordinate the provision of mental health services in a given territory and to allocate the corresponding financial resources". In Flanders, 60.3% of stakeholders have chosen to have local governance which also has the power to allocate financial resources to services against 55.9% in Brussels and 43.3% in Wallonia ($\chi 2 = 7.5$, $p = 0.02$).

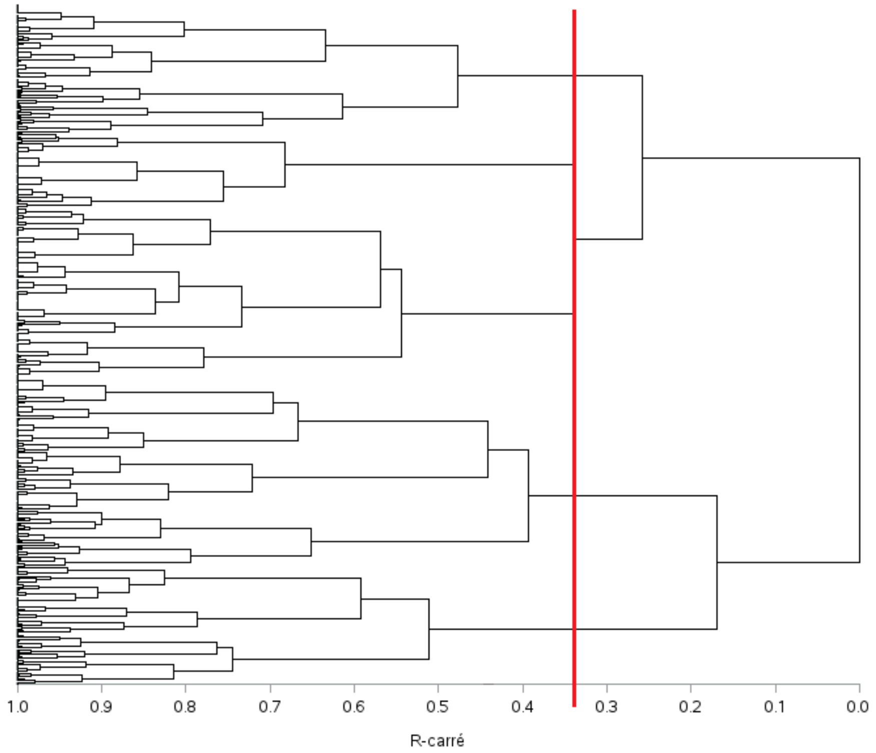
Table 40 – Preferences in couples of organisational interventions

Increase the supply of accommodation for people with severe mental illness. Funded on a lump sum basis for a set services of the network.	Increase the supply of accommodation for people with a need for accommodation. Funded on a lump sum basis for each service.
45.6 %	54.4 %
Increase the supply of low-threshold services targeting the population with mental health needs in a given territory.	Increase the supply of low-threshold services targeting people with severe mental illness, throughout the territory.
70.2 %	29.8 %
Integrate employment support for people with a psychiatric disorder into specialised services that provide mental health care.	Implement employment support for people with a psychiatric disorder in existing generic social services, coordinated with the mental health sector.
28.9 %	71.1 %
Increase the supply of psychotherapy services, accessible by reference from other services of the network. Each service is individually funded.	Increase the supply of psychotherapy services, accessible without reference. The activity is funded for a set services of the network.
37.1 %	62.9 %
Implement an individualised care plan per patient, shared with services of a given territory. The plan is self-managed by the patient.	Implement an individualised care plan per patient. The plan is managed by a case manager in collaboration with the patient.
31.4 %	68.6 %
Implement a data sharing and recording system between mental health services. The system is funded for a set of services of the network.	Implement a data sharing and recording system for mental health services that want to record and share data. The system is funded by a contribution from each participating service.
68.4 %	31.6 %
Provide a lump sum financial incentive per patient for outpatient medical professionals working with patients with mental health needs.	Provide a financial incentive by act of care for outpatient medical professionals working with severe mental illness patients.
63.4 %	36.6 %
Finance psychiatric hospitalisation taking into account the length of stay, with a financial incentive when the patient is referred to an outpatient service of the network at discharge.	Finance psychiatric hospitalisation with a flexible budget based on the characteristics of the episode of care.
54.2 %	45.8 %
Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory. Mental health care services are financed individually by the public authorities.	Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory and to allocate the corresponding financial resources.
44.5 %	55.5 %

4.6.3 Clustering of organisational interventions

The cluster analysis shows how stakeholders who have chosen the same organisational interventions can be grouped together. In this chapter, we highlight existing coalitions of stakeholders according to their organisational choices and identify the organisational dimensions of care that differentiate these coalitions. A cluster analysis is defined by the distance matrix, the clustering method and the dendrogram cut-off point. We performed a non-metric cluster analysis to identify the groups of stakeholders. First a distance matrix was computed across the n*n respondent with the Gower dissimilarity for nominal variable. Then clusters are formed with the Ward minimum variance method. Figure 25 describes the dendrogram, with a solution cut-off for four clusters. Each stakeholder or cluster of stakeholder is merged with the closer cluster on the basis of a non-metric distance, accounting for 34% of the variance. The results of the cluster analysis shown in Table 41 present the different organisational interventions favoured in the 4 groups of stakeholders (4 clusters). The results in Table 41 are ranked in descending order according to the difference in intervention choices between groups (chi-square tests), so a larger difference between groups is at the top of the table.

Figure 25 – Clustering dendrogram (n clusters = 4, R2 = 34%)



The first cluster is the largest and includes 249 stakeholders. This group favoured organisational interventions where the funding of services was pooled for a set of services at the level of the network. It is also the only group that favoured the implementation of a local governance that also has the power to allocate financial resources to the services it coordinates. Hereafter, we label this group as the “pro-catchment area”.

In the second cluster (n = 63), stakeholders favoured organisational interventions targeted one specific group; the severe mentally ill (SMI) population. We label this group as “target group SMI”.

In the third cluster (n = 75), the preferred organisational interventions targeted the whole population with mental health needs and funding was pooled at the level of each service and not at the level of a set of service (network). We label this group as “target group whole population”.

In the fourth cluster (n = 82) the preferred organisational interventions were those where service funding was pooled at the level of each service, with no specific target group. Hereafter we label this groups has “service-autonomy”.

Two interventions were favoured in the four clusters; the implementation of employment support for people with a psychiatric disorder in existing generic social services that coordinate with the mental health sector, and the implementation of an individualized patient care plan, managed by a case manager in collaboration with the patient.

Table 41 – Clustering of organisational interventions

	Clusters	**1** **N = 249**	**2** **N = 63**	**3** **N=75**	**4** **N = 82**	**χ2** **(p-value)**
		%	**%**	**%**	**%**	
Increase professional attractiveness	Provide a lump sum financial incentive per patient for outpatient medical professionals working with patients with mental health needs.	**64.7**	36.0	**84.0**	57.3	268.1 (< 0.001)
	Provide a financial incentive by act of care for outpatient medical professionals working with severe mental illness patients.	35.3	**64.0**	16.0	42.7	
Implement data sharing and recording system	Implement a data sharing and recording system between mental health services. The system is funded for a set of services of the network.	**93.6**	38.0	12.0	37.8	206.2 (< 0.001)
	Implement a data sharing system for mental health services that want to record and share data. The system is funded by a contribution from each participating service.	6.4	**62.0**	**88.0**	**62.2**	
Implement a local governance structure	Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory. Mental health care services are financed individually by the public authorities.	19.3	**88.0**	46.7	**92.7**	179.6 (< 0.001)
	Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory and to allocate the corresponding financial resources.	**80.7**	12.0	53.3	7.3	
Implement psychological support interventions	Increase the supply of psychotherapy services, accessible by reference from other services of the network. Each service is individually funded.	23.7	18.0	**72.0**	**97.5**	158.1 (< 0.001)
	Increase the supply of psychotherapy services, accessible without reference. The activity is funded for a set services of the network.	**76.3**	**82.0**	28.0	2.4	
Implement employment	Integrate employment support for people with a psychiatric disorder into specialised services that provide mental health care.	30.1	26.0	37.3	19.5	109.2

support interventions	Implement employment support for people with a psychiatric disorder in existing generic social services, coordinated with the mental health sector.	**69.9**	**74.0**	**62.7**	**80.5**	(< 0.001)
Implement low-threshold services	Increase the supply of low-threshold services targeting the population with mental health needs in a given territory.	**76.7**	16.0	**82.7**	**72.0**	80.9 (< 0.001)
	Increase the supply of low-threshold services targeting people with severe mental illness, throughout the territory.	23.3	**84.0**	17.3	28.0	
Implement housing facilities	Increase the supply of accommodation for people with severe mental illness. Funded on a lump sum basis for a set services of the network.	45.0	**86.0**	17.3	48.8	57.4 (< 0.01)
	Increase the supply of accommodation for people with a need for accommodation. Funded on a lump sum basis for each service.	55.0	14.0	**82.7**	51.2	
Change the payment of psychiatric hospitalisations	Finance psychiatric hospitalisation taking into account the length of stay, with a financial incentive when the patient is referred to an outpatient service of the network at discharge.	**61.8**	16.0	41.3	**65.9**	44.7 (< 0.01)
	Finance psychiatric hospitalisation with a flexible budget based on the characteristics of the episode of care.	38.2	**84.0**	**58.7**	34.1	
Implement personalised care planning	Implement an individualised care plan per patient, shared with services of a given territory. The plan is self-managed by the patient.	34.1	20.0	40.0	22.0	9.8 (0.01)
	Implement an individualised care plan per patient. The plan is managed by a case manager in collaboration with the patient.	**65.9**	**80.0**	**60.0**	**78.0**	

The differences in the composition of the four clusters in terms of stakeholder profiles and regions are presented in Table 42. The clusters were significantly different in terms of regions ($\chi2 = 41.38$, $p < 0.001$) but not in terms of stakeholder profiles ($\chi2 = 0.67$, $p = 0.67$). The cluster “Pro-catchment area” was more composed of stakeholders from the Flemish region (61.1%) than the other clusters. The clusters “Target group SMI” and “Target group whole population” were mainly composed of stakeholders from the Brussels-Capital region. The cluster “service-autonomy” had the highest percentage of stakeholders from the Walloon region.

Table 42 – Composition of the four clusters

	Cluster 1: Pro-catchment area	Cluster 2: Target group SMI	Cluster 3: Target group whole population	Cluster 4: Service-autonomy	χ2 (p-value)
Stakeholders’ profile (n, %)					4.01
• Policymakers	63 (25.3)	20 (32)	15 (20)	25 (30.4)	(0.67)
• Professional	168 (67.4)	39 (62)	53 (70.6)	53 (64.6)	
• Users	18 (7.2)	4 (6)	7 (9.4)	4 (4.8)	
Regions (n, %)					**41.38**
• Brussels	57 (23.1)	28 (44.9)	35 (47.3)	13 (16)	**(<0.001)**
• Flanders	151 (61.1)	22 (34.7)	24 (32.4)	26 (32.2)	
• Wallonia	39 (15.8)	13 (20.4)	15 (20.3)	42 (51.8)	

4.7 Implicit values of the organisation of mental health care behind selected organisational interventions

In this chapter, we analyse the attributes of the organisation of care that influence stakeholders' decision when they have to choose between different organisational interventions.

As previously explained, the organisational interventions were proposed in pairs and differed by one or two attributes of the organisation of mental health care. This analysis technique was intended to allow the respondents to choose one or the other intervention and to analyse through the chosen interventions the attributes that weigh in their choice. The analysis being on the interventions and their attributes (n = 469 * 18 = 8442), conditional logistic regressions with a stratification according to participant's identifier were performed. Results in Table 43 show the probability that an organisational intervention will be chosen according to its attributes. The results are presented for the whole sample and stratified by regions and stakeholder profiles.

For the whole sample, an organisational intervention was significantly more likely to be chosen if it implied the establishment of generic rather than specific services (OR = 1.2, p < 0.001), a coordination between different services rather than the integration of these services in the same structure (OR = 2.7, p < 0.001), an episode-based payment of providers rather than an activity-based payment (OR = 1.4, p < 0.001) and if this intervention did not involve the implementation of referral guideline, but rather an informal organisation of patient's care pathways (OR = 0.7, p < 0.001).

The stratification shows some differences between regions and between stakeholder profiles. An organisational intervention was significantly more likely to be chosen if it implied a geographical organisation of care (OR = 1.2, p < 0.01), the provision of generic services (OR = 1.4, p < 0.001) and an episode-based payment of providers (OR = 1.5, p < 0.01) in Flanders but not for the other two regions. In Wallonia, an intervention was more likely to be chosen if it implied an individual funding per service rather than a pooling of funding for a set of services at the network level (OR = 1.3, p < 0.05).

Regarding differences between stakeholders’ profile, an intervention was significantly more likely to be chosen if it implied the provision of generic services (OR = 1.3, p < 0.01) and an informal organisation of patients’ care pathways (OR = 0.7, p < 0.001) for clinicians but not for user representatives and policymakers. For clinicians and policymakers, an episode-based payment of providers rather than an activity-based payment influenced the choice of an intervention but not for user representatives.

Table 43 – Conditional logistic regression on the levels of the organisation of mental health care implicitly preferred by stakeholders

		Regions			Stakeholders' profile		
	Whole Sample	Flanders	Brussels	Wallonia	Clinicians - Managers	Users' representatives	Policymakers - Experts
	OR	OR	OR	OR	OR	OR	OR
Target group							
- Whole population with mental health needs	1.1	1.1	1.3	0.8	1.1	0.6	1.1
- Severe mentally ill population	1.1	1.1	1.1	0.7	1.0	0.5	1.2
- Socially deprived population with mental health needs	REF	REF	REF	REF	REF	REF	REF
Care is organised on a local area basis (yes, ref = no)	1.1	**1.2****	0.8	0.9	1.1	1.1	1.1
Provision of care by generic (ref = specific services)	**1.2****	**1.4*****	1.2	0.9	**1.3****	1.1	1.2
Care pathway with formal referral guideline (yes, ref = no)	**0.7*****	**0.7*****	**0.6****	**0.8***	**0.7*****	0.7	0.9
Type of coordination:							
- Linkage / Patient coordinator	1.7	1.8	1.4	1.8	1.7	1.5	1.7
- Coordination between services	**2.7*****	**3.2*****	**1.9****	**2.7*****	**2.7*****	**2.4***	**2.6****
- Integrated services	REF	REF	REF	REF	REF	REF	REF
Payment of providers with an episode-based (ref = activity-based funding)	**1.4*****	**1.5****	1.2	1.1	**1.4*****	1.1	**1.3***
Resources are pooled at the service/provider level (ref = at the network level)	0.9	0.7	0.8	**1.3***	0.9	0.8	0.9

** p-value < 0.05, ** p-value < 0.01, *** p-value < 0.001*

4.8 Interviews with stakeholders

A subsample of elite stakeholders were interviewed face-to-face or by phone with the same questionnaire (computer assisted) to make sure of their participation in the survey, and to give them the opportunity to clarify their responses. Indeed, *“Health policy interviews tend to be undertaken with senior decision makers and representatives of powerful interest groups and are, therefore, of a special nature. These are sometimes called elite interviews.”* [66].

The elite stakeholders have been selected by the UCLouvain and KU Leuven research teams on the basis of their knowledge of the field of mental health and previous research on the evaluation of mental health care in Belgium [56, 58, 59, 73-75]. Among the selected stakeholders were policymakers at the federal and regional level, experts, presidents of federations and associations of service and professionals, and presidents of user and family associations. A total of 34 stakeholders were interviewed (9 from the Flemish region, 14 from the Brussels-Capital region and 11 from the Walloon region). Stakeholders responded to the online survey and had the opportunity to comment on their response. Their responses to the online survey were aggregated in previous quantitative analyses. Notes were taken by the interviewers on the additional qualitative information given. A summary of this additional information is presented in this chapter.

4.8.1 Priority objectives of the reform in mental health care

Continuity between social and care sectors was mentioned by most stakeholders as a big issue in Belgium and thus as a priority objective. To ensure continuity across sectors, stakeholders explained that it is necessary to work with a shared vision of treatment and recovery among providers. They emphasized fragmentation between health and social systems and many barriers to continuity. For example, the fact that each service and organisation have its own philosophy and vision (e.g. intake procedure, inclusion/exclusion rules), the multitude of local services and initiatives as well as the large number of public authorities involved. This fragmentation was particularly emphasized by stakeholders in the Brussels-Capital region because of the density and diversity of services, but also because many different public authorities are competent for this territory.

Regarding the objective of supporting users in the development of their life goals, it was noted that this goal is in line with the vision on recovery and patient participation. Stakeholders explained that professionals sometimes tend to claim to know what is best for the patient. Yet, the patient must be considered equal and must have control over his or her own process. Other stakeholders mentioned that in the ideal world, achieving life goals should have the highest score as this is the final goal of all other objectives of the reform. However, some explained that this is not an achievable goal for all patients. One policymaker explained that policies are not evaluated on the extent to which patients reach their life goals (nor on the social integration of patients), but on more tangible, visible and manageable elements (e.g. shorter hospitalisations). Finally, one stakeholder pointed out that reaching life goals does not only depend on the mental health sector but on all sectors such as employment, housing, education, and so on.

Stakeholders further highlighted the importance of care in the community and integration of patients in the society. Stigma in society (e.g. the idea that people with mental health problems are responsible themselves for their illness; the idea that they are dangerous or that they cannot work) is still an issue in Belgium according to them. Stakeholders explained that to take care of patients in the community, we must put a wide range of services available which is not necessarily the case currently. By reducing the number of beds in hospitals without creating alternatives in the community, the risk is that some patients find themselves in more precarious situations such as living on the street or no longer having access to health and social services.

Stakeholders explained that the goal of helping patients to connect with their neighbourhood is also important. According to them, mental health problems cannot be seen separately from social problems. A stakeholder mentioned that there is often too much focus on medical or mental health problems.

According to stakeholders, the involvement of users and families in policies and service delivery has become increasingly important. Yet opinions are sometimes a little divided on this subject. While some stakeholders mentioned that user participation should be the priority in mental health care and that it is a prerequisite to ensure the adequacy of the care offer and patients' social integration, other mentioned that it is sometimes difficult to give decision-making power to people with mental health problems. Another stakeholder explained that involving users is important, but care should be taken not to put too much burden on them.

Although short hospitalisation was also considered by several stakeholders as important, many explained that this is not a result but rather a means to achieve other goals such as community care and social integration. Several stakeholders agreed that psychiatric hospitalisations are too long in Belgium. Others pointed out the relevance of having care based on the needs of patients, and that this could sometimes mean shorter, or longer hospitalisations. Others explained that the length of hospital stays is long because of lack of alternatives in the community and that it is therefore necessary to focus on developing local initiatives before decreasing hospital stay. Some stakeholders mentioned that hospitals retain a central role in the provision of care despite a desire to provide care in the community.

When we asked which important objectives were not mentioned in the list, some stakeholders referred to:

- Involving patients' family
- Accessibility (waiting lists, availability of services)
- Involving other partners such as housing, employment or sociocultural partners
- Estimate care needs and how to respond to these needs at the regional level
- Matched care (instead of obliging 'stepped care'). Whereas stepped care refers people from primary care to more specialised care, a stakeholder mentioned that matched care immediately refers people to the correct instance.
- Balanced care: care that is a balance between hospital and community-based care

Comments

Stakeholders evaluated the question on priority objectives of the reform in a positive way. Some stakeholders found it interesting to be instructed to make choices by spreading the points across the set of objectives. Other stakeholders found that the assumptions of the question were correct.

4.8.2 Conjoint analysis on the dimensions and levels of the organisation of mental health care

- Target group of the intervention

Many stakeholders explained that the target group is the main element of the care organisation. We need to know who we are aiming for, their care needs, and controlled that we have reach the target group. On the one hand, some stakeholders chose the whole population with mental health needs as everyone can deal with mental health problems. They also explained that national reform must target the whole population. In addition, they mentioned that distinguishing subgroups (people with severe mental illness or socially deprived people with mental health needs) from the general population can lead to discrimination and stigmatization. However, other stakeholders insisted on the importance of focusing on specific subgroups because they are more likely to be forgotten, especially if the reform targets the whole population. Someone concluded that stepped care is important, specialised mental health care should focus on specific "complex" subgroups and generic services on the whole population.

- Geographical organisation of care

Most stakeholders were convinced that care should be geographically organised. According to several stakeholders, working with geographical areas is a political choice, about which it is necessary to remain consistent. Stakeholders explained that the geographical organisation allows a better vision of the supply of care and therefore of its adequacy but also a better coordination between providers of the same territory. They also emphasised that it is important (1) to work close to the patient (in the area where he/she lives) and (2) that each region is responsible for its inhabitants.

Other stakeholders mentioned that the choice should be free for the patient to choose in which area he or she want to go. Finally, one family representative did not agree with the majority. According to this person, there is a huge fragmentation as networks have a lot autonomy which causes differences in their approaches and makes it more difficult for patients to find their way.

- Provision of care

Several stakeholders mentioned that generic services (e.g. general practitioners, social services) are very important because they are often the first contact, they reach a wide group including more complex or insecure target groups who have little or no access to more specialised services. According to one stakeholder, generic services are important for care continuity, but should interact of course with specialised services. Besides, clinical reports of patients with mental health problems should be given to the general practitioner as well. In addition, some stakeholders explained that generic services are often more oriented outside the scope of mental health, which decreases stigma and promote patients' social integration.

Other stakeholders argued that specialised services can offer more qualitative mental health or psychiatric care. They also stated that there should be more complementarity and alignment in the provision of mental health care.

- Formalization of patients' care pathway

Many stakeholders highlighted the importance of informal ways of working (according to the needs of the patient) as relationships are an important instrument in care. They explained that formal care can lead to automatic trajectories that do not match the needs of the patient. Nevertheless, they explained that informal care requires coordination and dialogue between professionals, the client and the context. Most of them mentioned that rules and guidelines are important as well, but informal collaboration is even more important. Other stakeholders explained that having no guideline can lead to patients "shopping", overconsumption and misuse of services. They explained that guidelines make it possible to ensure the proper use of the various services according to the needs of the patients, and thus to prevent some services from being on waiting list because of misused. For example by avoiding hospitalisations that are not necessary because the patient could be cared for in the community, or avoiding the use of psychotherapy or community mental health services for needs that do not correspond to this care offer. Some stakeholders were convinced that an organisation of care with rules and guidelines ensures better continuity of care and therefore better patient care. However, they also mentioned the importance of flexibility and informal contact.

- Type of coordination between providers

Regarding the type of coordination, stakeholders favoured coordination between the different providers to respond to the problem of fragmentation and to the lack of continuity of care. They generally did not favour the integration of different services within the same structure. They explained that a "mega" structure would have too much power over a territory and that the various services must maintain a certain autonomy. Some stakeholders were convinced that people with severe mental illness can coordinate their care themselves. Others were hesitant as to whether these patients have difficulty coordinating their care themselves and therefore need a care coordinator. One policymaker emphasized the importance of not treating the patient in a paternalistic way and to empower patients to coordinate care themselves. According to this person, e-health is a tool for somatic care and should also be a tool for mental health care. Giving full autonomy in using e-health in the somatic care only would be stigmatizing.

Other suggestions were (1) a trialogue coordination of services (patient, family and professional) with a clear structure and (2) give patients the tools to coordinate their care (e.g. via a case manager for people with more severe or complex problems).

- Payment of providers

The choice of stakeholders between episode-based and activity-based payment of providers was often complicated. Some stakeholders explained that both modes of payment have advantages and disadvantages. Other stakeholders expressed that the key to healthcare reform is funding, but that this dimension is rarely questioned or analysed in detail. Most of the stakeholders favoured an episode-based payment of providers. They explained that this mechanism makes it possible to follow the patient between his various cares, in the mental health but also in the general health sector. Others explained that activity-based payment has negative effects on the coordination between providers and leads to fragmentation of care. One stakeholder explained that activity-based payment can be a barrier to access to care for the most vulnerable and socially deprived patients.

Advantages and disadvantages of fixed payment and payment by performance have also been discussed. Some stakeholders mentioned that payment by performance is not a good idea as it results in an overshooting of performances (this is already the case for somatic care according to one stakeholder) whereas fixed payment implies a risk of being payed fully while fewer care are needed.

Some stakeholders preferred mixed payment mechanism (e.g. incentives for performance and a fixed budget). Another stakeholder preferred a personal care budget that allowed patients to spend money on the institution they chose, especially for initiatives such as sheltered housing and psychiatric nursing homes as care is more demand driven.

- Resource pooling level

Several stakeholders mentioned that currently, it is mainly the hospitals that have weight in the budget allocation decisions. Several stakeholders explained that funding at the network level would allow a better distribution of funding between services as well as better coordination at the network level. Other explained that services must be financed individually to maintain a certain autonomy in their management to guarantee a diversity of care offer.

Comments

Most stakeholders did not have any comments on this part of the survey. Several stakeholders indicated that it was difficult to focus only on the goal of social integration or care in the community to answer the question. Others explained that these choices required thinking of many elements at different levels of the organisation of care. Some stakeholders found these questions more difficult, e.g. someone felt not sufficiently informed to make choice about funding (episode/activity based), another one reported that choices were difficult to make as the answer options were sometimes equally important.

4.8.3 Organisational interventions

- Implement low-threshold services

Accessibility has often been mentioned as a top priority and a prerequisite for mental health care, particularly for prevention and care of more serious or complex subgroups. Stakeholders stated that the supply of mental health care must be accessible (the minimum exclusion criterion) and varied. Several stakeholders explained that currently, people with high care needs (with a severe mental health problem or a complex health and social situation) tend to have less access to care.

One stakeholder emphasized the importance of extending the primary care psychological function (without referral by a medical certificate) to increase accessibility.

- Implement housing facilities

It was difficult for stakeholders to choose between housing and employment interventions. Both, housing and employment were considered as important dimensions of patients' social integration. Most stakeholders decided to prioritise housing before employment because of the housing first principle: Housing is a prerequisite for having a job.

- Implement employment support interventions

Some stakeholders have prioritised employment interventions, as employment affects health, mental health and social dimensions. According to them, (1) employment would have the most important effect on patients' social integration and (2) there are more people with mental health problems who lose their job than their house. Other stakeholders suggested implementing interventions for employers to maintain people with mental health needs in the workplace. Others explained that there is a need to increase collaboration between generic social services (CPAS / OCMW), employment services (Forem, Actiris, VDAB) and the mental health sector.

- Implement psychological support

Some stakeholders stated that the main problem is the lack of psychotherapy services, especially for people with substance abuse problems and complex mental and social issues. They explained that sufficient treatment options would improve the social integration of patients.

Other stakeholders were less convinced that this is a priority. One stakeholder explained that the extension of psychosocial services is already underway and is therefore not a priority.

- Implement personalised care planning

Many stakeholders were convinced that implementing an individual care plan is important because it allows for better quality of care, empowers patients and improves coordination between providers. Yet, according to some stakeholders too few attentions is paid to individual care plans.

Other stakeholders pointed out that individual care plans need to be continually updated, which they consider unfeasible. Some stakeholders stated that case managers can be helpful but that it is an expensive intervention and sometimes not necessary. According to them, a case manager and a personalised care plan is very important and necessary for patients with complex, chronic care needs. In other cases, patients can manage their own care plans.

- Implement a data sharing and recording system

Almost all stakeholders were convinced of the relevance of a system to register and share data to enhance collaboration and continuity of care and to have a better vision of mental health care needs.

One stakeholder stated that every region needs its own system. Other emphasized that safety in exchanging data is important and that issues of medical secrecy and data protection are complex. Several stakeholders also mentioned that such systems are expensive and that currently services are funded individually to develop their own data recording system. The multitude of different systems makes data sharing and global data collection very complicated.

One stakeholder mentioned that data sharing is likely to be practiced and is therefore not a priority.

- Increase professional attractiveness in outpatient services

Stakeholders stressed the importance of supporting outpatient services as they enhance patients’ social integration. Some considered incentives for these services as important, others mentioned that outpatient services need to be more invested in. They explained that outpatient services should receive a budget that is adequate for their work, but not necessarily with an incentive-based funding mechanism. Another stakeholder stated that incentives should be given to services and not to professionals.

- Change the payment of psychiatric hospitalisations

Although most stakeholders considered a change as complicated, they were convinced that the hospital funding system should change. According to them, hospital funding is complex, and it is therefore difficult to propose concrete changes.

They mentioned that there should be guidelines for networks on how to finance their services and they would change the financing system in care programs and modules. Although many stakeholders mentioned that the length of stay in psychiatric hospitals was too long, others mentioned that it was important not to put funding pressure on the length of stay. If a patient needs hospitalisation for a long period, he/she should stay hospitalised. According to them, duration of hospitalisation should be tailored to the need of the patient.

One stakeholder felt it was unwise to provide incentives for referrals to outpatient services because people with severe mental illness could be referred quickly without an appropriate treatment plan.

- Implement a local governance structure

Some stakeholders explained that there is a need to establish a local governance structure for coordination and provision of care (including funding), although this will require a total change in the current organisation. A change that will be difficult to achieve according to them. Therefore, they explained that it might be too early to coordinate care locally and to give financing power to the local governance structure. Others explained that this structure should not be a separate organisation and that this governance structure could be an existing organisation such as networks. Some stakeholders feared that an additional local structure would become another non-profit organisation, making the organisation of mental health care more complex by raising the level of formalization. One stakeholder perceived a local governance structure as dangerous if the institutions who are currently having the power, keep on having most power in this local structure.

Other interventions

Stakeholders were asked to mention some interventions that might also be relevant but were not in the questionnaire. Here are their answers:

- Supporting general hospitals to work in a holistic way
- Implement a central coordinating instance at the network level who has medical responsibility (e.g. National Health Service in the UK) [76]
- Promote and support financially self-help groups
- Implement fixed payment for full care trajectories
- Financial incentives for informal care givers
- Support patients to build networks, facilitate social contact
- Facilitate access to employment (child care, public transport, flexible work)
- Promote leisure time and cultural activities
- Implement family support services
- Involve family in the care planning
- Interventions that focus on reducing stigmatisation of mental illness
- The buddy systems (in which the patient is accompanied by a buddy) to enhance patients’ social integration
- Extra training for professionals and exchange between them
- Implement quality monitoring

Comments

A stakeholder considered these questions as interesting, another one said it was not easy to focus only on social integration when answering the questions. According to one stakeholder, the word 'medical' should be deleted in the intervention “Provide a lump sum financial incentive per patient for outpatient medical professionals working with patients with mental health needs”. Another stakeholder would use the term 'regional' instead of 'local' (governance structure).

4.8.4 Final comment

Most stakeholders positively evaluated the questionnaire and stated that it was not pushing in a certain direction. Some stakeholders have found interesting to be exposed to exclusive choices because these choices have highlighted certain contradictions in their decisions. Several stakeholders stated that the questionnaire covered the different dimensions of the organisation of care. Some of them also mentioned that the interview was useful to express nuances in their responses. One stakeholder mentioned that the method implies the risk that current powerful stakeholders keep on deciding about the organisation of mental health care without using an innovative approach. One stakeholder pointed out the lack of questions about education of caregivers and involvement of family and partners. Finally, another stakeholder mentioned that there were too few questions about involvement of users in care and policymaking.

4.9 Stakeholder comments in the online survey

Stakeholders had the opportunity to leave a comment at the end of the web survey. A summary of these comments is presented in this chapter. Of the 469 stakeholders who completed the survey, 12% left a comment (15% of the 195 French-speaking stakeholders and 10% of the 274 Dutch-speaking stakeholders).

Some stakeholders emphasized the complexity but also the interest of having to choose only one intervention in the pairs of organisational interventions.

> *« Intéressant d'être confronté à des choix exclusifs qui ont parfois mis en évidence des contradictions internes. ».*

> *« Soms is het **moeilijk** om een keuze te maken tussen de antwoorden. Vaak zou ik liever genuanceerd antwoorden in plaats van of het ene of het andere.»*

Some stakeholders agreed that networking, corporate social responsibility and innovation are necessary.

> *« Ik werk ruim 30 jaar als leidinggevende/directie in de social profit (VAPH, Welzijn, GGZ). Ik zie mooie dingen gebeuren in en tussen sectoren waar mensen elkaar vinden in patiënt-cliëntgericht werken, maar stel helaas ook nog veel protectionistische, aanbodgerichte reacties vast die **innovatie, netwerkgericht en maatschappelijk verantwoord ondernemen** in de weg staan. »*

Other stakeholders highlighted the problem of medical secrecy in networking and information-sharing interventions.

> *« (…) Le **secret professionnel partagé** ne peut être remis en cause par un système (…) au sein d'un réseau de soins. La vie privée du patient est essentielle, elle lui appartient (…) ».*

Some controversies have emerged on the question of the geographical organisation of care and the potential conflict with patients' free choice of care providers.

> *« Il me semble également essentiel de continuer à garantir au patient sa **liberté** de **choix** du thérapeute, ou du service auquel il peut faire appel, sa possibilité de s'inscrire en dehors d'un réseau géographique, ainsi que sa liberté de partager ce qu'il souhaite avec chaque professionnel (…) Priver les personnes de ce droit fondamental serait préjudiciable à tous les métiers de soins (…) ».*

Some stakeholders supported the « bottom-up » approach of the reform but they emphasized the need for a framework and guidelines.

> *« Il est nécessaire **d'éviter le top-down** et d'avoir une impulsion qui vient du terrain. A cet égard, il conviendrait de définir les **lignes directrices** et règles du jeu valables (…). ».*

Several stakeholders supported the importance of adapting some dimensions of the organisation of care according to the patient profile and needs.

> *« (…) il me semble que le dispositif de soins et de concertation doit être sensiblement différent suivant qu'on s'adresse à des personnes ayant des troubles psychiatriques sévères chroniques ou des problèmes de santé mentale. ».*

Many stakeholders underline the underfunding of the outpatient sector compared to the hospital sector and the paradox in the context of deinstitutionalization.

> *« Ce n'est quand même pas le moindre des **paradoxes** que de voir la **concertation financée pour les patients hospitalisés mais pas pour les patients ambulatoires**, alors qu'on essaye de favoriser les soins dans le milieu de vie ! ».*

> « *Meer inzetten op ambulante zorg en ziekenhuizen belonen bij specifieke behandelingen en kortdurende behandelingen.* »

Furthermore, someone argued for more prevention, more time to communicate and for an extension of the primary psychological care function.

> *« Ik wil graag het belang benadrukken om maatschappelijke aandacht te besteden aan de algemene geestelijke gezondheid van de bevolking en mensen met psychische problemen.* ***Preventief*** *moet er nog meer worden geïnvesteerd. De druk in onze samenleving is te hoog met alle gevolgen van dien. Het zou al helpen als maatschappelijk aanvaard wordt dat mensen/zorgverleners opnieuw de* ***tijd*** *krijgen om met een persoon/cliënt gewoon een babbel te kunnen doen bij een tas koffie over hoe hij/zij zich voelt. Daarnaast moet ook het aanbod voor toegankelijke* ***eerstelijnspsychologische hulp*** *serieus worden uitgebreid (meer nog dan wat men van plan is). Dank u wel voor de aandacht. »*

Another stakeholder emphasized the importance of volunteers in mental health care.

> « *Bij de laatste vraag is geen rekening gehouden met* ***vrijwilligerswerk****, hoewel vrijwilligers toch een belangrijke rol hebben binnen de GGZ.* »

Many stakeholders have asked for the follow-up and conclusions of the study.

> *« Ik kijk alvast uit naar de resultaten en vooral naar de beleidsimplicaties ervan .»*

5 CONCLUSION

The results of the present study give a global picture of stakeholders' perception of the organisation of mental health care for the Belgian adult population and the organisational interventions they support. The conclusion presents a detailed interpretation of the results as well as a comparison with the existing literature. A summary of the main findings is available at the end of each section. Strengths and limitations of the study are finally exposed.

5.1 Interpretation of findings and comparison with previous literature

5.1.1 Objectives of the mental health care system

As previously explained, the objectives of the reform of the organisation of mental health care were all considered relatively important by stakeholders. This result seems to indicate that according to stakeholders, an objective should not be a priority over the others, but the mental health care system should pursue all these objectives together. The objective considered as a priority was to ensure continuity between the health and social sectors. As explained in the interviews with elite stakeholders and in the preceding qualitative study, stakeholders perceived the lack of continuity of care and the fragmentation between the health and social systems as one of the main problems of the organisation of mental health care in Belgium. This goal of continuity of care was already mentioned as important by stakeholders during the evaluation of the mental health care reform in 2010 [56].

The objective considered as the least priority in the three regions was the shortening of hospital stay, which was also the case during the evaluation in 2010 [56]. During the interviews, several stakeholders explained that they did not consider this objective as a result to be achieved but rather as a means to achieve other objectives such as community care and patients' social integration. Several stakeholders also mentioned that before reducing the length of hospital stay, it was necessary to ensure that patients' care needs could be met in the community in terms of provision of services, which, according them, is not always the case. However, policymakers attached greater importance to this objective than clinicians, service managers and representatives of users and relatives. It therefore seems that if the objective of reducing the length of hospital stay remains a priority, it should no longer be presented as a goal but rather as a means of achieving the other objectives considered as priorities by stakeholders.

The goals of patients' social integration and community care (deinstitutionalization) are often concomitant in mental health systems. For example, in Belgium, the objective of the mental health care reform is to "further orient mental health care towards a **reduction of residential hospital care** in favour of **patients' social integration** and **treatment in the community**." [8]. Indeed, social integration is partially supported by deinstitutionalization movements with a transition of resources from institutional psychiatric care to community care [9]. These two goals, although concomitant, are not necessarily met together. The goal of community care aims at closing psychiatric hospitals and moving resources to community based-services, whereas the second one aims at fostering social integration, avoiding stigmatization and helping patients to obtain or retain employment. Therefore, these two goals are supported by the implementation of different evidence-based interventions that require a different organisation of care. For example, the goal of community care and deinstitutionalization is pursued by interventions such as acute in-patient care, early intervention teams or assertive community treatment interventions, while the goal of social integration is pursued by interventions such as peer support workers, wellness recovery action planning or individual placement and support interventions [10, 11]. Therefore, one hypothesis of this study was that stakeholders would favour different interventions and a different organisation of care to support these interventions between the two goals.

This hypothesis was not confirmed because there was no real difference in stakeholders' choices between these two goals, except for a few elements that will be discussed later. A first explanation of this result is that when stakeholders make choices of healthcare organisation, other concerns related to their own perspectives take the lead over the objective to be formally achieved. The second explanation is more conceptual and resides in the fact that stakeholders may not see these two goals as different concepts demanding different interventions. The third explanation is that this lack of difference may be related to problems of linguistics and terminology in the questionnaire. This last explanation seems less likely because the questionnaire and its content was pre-tested with stakeholders before launching the survey. Face validity tests were performed to examine the content of the questionnaire, the formulation and the understanding of the questions and terms. The other two explanations seem more likely for different reasons. First, the results of the interviews show that some stakeholders explained having difficulty keeping the goals of social integration or community care in mind when answering questions because some choices required thinking about different elements at different levels of the organisation of care. This result support the first explanation. Some results of the preceding qualitative study support the second explanation. Indeed, the qualitative study highlighted persistent disagreements on the basic objectives of the 107-reform as well as misunderstanding or ignorance of the key concepts conveyed by the reform.

Finally, the fact that some differences between the two objectives have been highlighted reinforces the first explanation rather than the second. Employment support interventions, provision of generic rather than specific services and pooling of funding for a set of services at the network level have been favoured to achieve the goal of social integration. Employment is highlighted in the scientific literature as one of the main dimensions of patients' social integration [77-80]. The results of the interviews also show that stakeholders tended to favour generic services because they could be outside the mental health scope and therefore consider other dimensions of patients' social integration. According to the stakeholders, these services contribute to reducing the stigma related to mental health problems and care in specialised mental health services and to improving the social integration of patients. Finally, the goal of social integration requires collaboration between different services from different sectors (treatment services, employment and housing services, services with occupational activities, etc.) [77, 81]. However, because of the multitude of services and public authorities involved in the management and financing of these services, patients' pathway in and between these different services is often fragmented [82-84]. Stakeholders may therefore prefer a common funding for these different services to better share a common goal such as social integration.

Main findings: Objectives of the mental health care system

The stakeholders considered all the objectives of the reform of the organisation of mental health care as relatively important, which could mean that these objectives must be pursued together. Continuity between the health and social sectors stood out with the highest priority in the three regions and for all stakeholders, whereas reduction of hospital length of stay got the lowest priority in the three regions. The reduction of hospital stay was not perceived by stakeholders as a result to be achieve but rather as a means to achieve the other objectives of the reform. These results are consistent with the results of the preceding qualitative study and the results of the previous evaluation of the mental health care reform in 2010. Indeed, the lack of continuity of care and the fragmentation between services was and remains the main problem of the organisation of mental health care according to stakeholders.

There were few differences in organisational choices between the stakeholders allocated to the goal of “social integration” versus those allocated to the goal of “care in the community”. The interviews and the results of the preceding qualitative study support two hypotheses. The first hypothesis is that when stakeholders make choices of healthcare organisation, other concerns related to their own perspectives take the lead over the objective to be formally achieved. The second hypothesis is that stakeholders may not see these two goals as different concepts requiring different interventions and organisation of care. Nevertheless, employment support interventions, provision of generic rather than specific services and pooling of funding for a set of services at the network level were favoured by stakeholders allocated to the goal of “social integration”.

5.1.2 A different mental health care organisation according to the target group?

The dimension of the organisation of mental health care considered the most important by stakeholders was the definition of the target group. The literature also emphasizes that a clear definition of the target group is a key element of effective care organisation [85]. The current reform targets mainly the whole population with mental health needs and does not propose different organisational mechanisms according to the target group, except for age groups (child psychiatry, adult psychiatry and psychogeriatric) or for specific audiences such as mentally ill offenders [8, 57]. As previously explained, the target group is the dimension of the organisation of mental health care regarded as the most important by stakeholders, however, they favoured a relatively different organisation of care depending on the target group. This result can be illustrated by Leutz's theory of integration, the integration of care in this theory being a mechanism among others of the organisation of care: « *you can integrate all of the services for some people, some of the services for all of the people, but you can’t integrate all the services for all of the people.* » [19, 50]. According to this theory, a way of organising care can be adapted to a small number of services for the whole population, to all services for a specific target group, but not to all services for the whole population. This result is also consistent with the interviews with stakeholders. Indeed, some stakeholders insisted on the importance of focusing on specific subgroups (severe mentally ill population, socially deprived population with mental health needs) because they are more likely to be forgotten, especially if the reform targets the whole population with mental health needs. A study conducted with data from the first evaluation of the reform in 2010 had already shown that patients with the lowest level of social integration were not targeted for care within networks by clinicians [75]. This study also concluded that “*the targeting process has to be clarified within the reform process. In particular, more specific networking and collaborative mechanisms should be tailored to address different target groups and to involve services more in line with their usual user profiles.*”.

Overall, stakeholders favoured a geographical organisation of mental health care. During the interviews, several stakeholders explained that the geographical organisation of mental health care in Belgium was, in their opinion, a political choice about which it is necessary to remain consistent. The results of the interviews also show that stakeholders see the geographical organisation of care as a tool for community care, coordination between providers of the same area and continuity of care. The results of the present study also show that stakeholders focused more on a geographic organisation of care for specific groups such as the severe mentally ill population and socially deprived population with mental health needs. As previously explained, these publics are more likely to suffer from a lack of continuity of care and fragmentation between health and social services. Stakeholders may prefer a geographical organisation of care, as it is a way to address fragmentation and improve continuity of care for these specific groups.

Stakeholders also favoured an episode-based payment of providers for the socially deprived population with mental health needs and a provision of specific services for the severe mentally ill population. The choice of an episode-based payment mechanism for socially deprived groups may be related to the fact that this payment method minimises direct costs for patients at the time of delivery and reduces the financial barriers to accessing care [86, 87]. The choice of a provision of specific rather than generic services for patients with severe mental illness can be explained by the results of the interviews. Indeed, some stakeholders argued during interviews that specialised services can offer more qualitative mental health and psychiatric care.

Finally, if the organisation of care targets the whole population with mental health needs, stakeholders favoured the provision of generic services and the implementation of referral guidelines. During the interviews, several stakeholders mentioned that generic services (e.g. general practitioners, social services) are very important because they are often the first contact. Moreover, in a logic of stepped care, it seems appropriate to first offer generic services to the whole population with mental health needs. The target group is therefore a determining factor in stakeholders' choices regarding the type of service provided. The choice to implement referral guideline for the whole population and not for specific groups may seem contradictory because such mechanisms are usually favoured in the literature for more severe patients with complex needs [50, 88]. Again, the results of the interviews can provide an explanation for this result. Some stakeholders explained that having no referral guideline can lead to patients "shopping", overconsumption and misuse of services. According to them, guidelines could allow a better use of the various services and thus prevent some services from being on waiting list because of misused. Negative effects such as over-consumption or misuse of services have a lower impact if they are linked to minority groups with low prevalence in the general population but a considerable impact if they are linked to the whole of the population with mental health needs. In this logic, the implementation of guideline is therefore more important for the whole population than for specific minority groups.

Main findings: A different mental health care organisation according to the target group?

Stakeholders considered the definition of the target group as the most important dimension of the organisation of mental health care. The current reform targets mainly the entire population with mental health needs and does not propose different organisational mechanisms depending on the target group. However, stakeholders supported a relatively different organisation of care depending on the target group and this result is consistent with a study conducted following the first evaluation of the reform in 2010 [75]. In the present study, stakeholders focused more on a geographical organisation of care for specific groups such as the severe mentally ill population and socially deprived population with mental health needs. They also favoured an episode-based payment of providers for the socially deprived population with mental health needs and a provision of specific services for the severe mentally ill population. Finally, if the organisation of care targeted the whole population with mental health needs, stakeholders favoured the provision of generic services and the implementation of referral guidelines. During interviews, stakeholders emphasised the importance of focusing and having different organisational mechanisms for target groups with more severe and complex issues because they are more likely to be forgotten, especially if the reform targets the whole population with mental health needs.

5.1.3 Coordination between providers and formalization of patients' care pathways

The second dimension of the organisation of care considered the most important by the stakeholders was the type of coordination between providers. This choice is probably in line with the previous results which highlighted that according to stakeholders, the main problem in the organisation of mental health care was the lack of continuity and the fragmentation of services. In this study, the three types of coordination described in the Leutz theory were proposed to stakeholders; linkage, coordination and integration [19, 50] (see Table 22). In the linkage model, the patient ensures the continuity of his care between his various health, mental health and social providers. In the coordination model, care is provided by different providers who coordinate with each other. In the integration model, care is delivered by the different providers within the same structure.

The type of coordination favoured by stakeholders is the coordination between different providers, followed by integration and then linkage as a last choice. The current organisation of care relies on the linkage model in which patients coordinate their care. However, some stakeholders explained during the interviews that this type of coordination may not be suitable for patients with a more severe or chronic problem, which is consistent with the literature. Indeed, these patients are more likely to experience fragmentation and lack of continuity of care as highlighted in the literature [50, 88, 89]. However, according to the quantitative results, there was no association between the target group prioritised and the type of coordination. The target group and the type of coordination were the two most important dimension of the organisation of mental health care according to stakeholders (23.3%, 15.7%). Yet, it could be that stakeholders do not associated target group and type of coordination. This could be the result of the current implementation of the reform that avoid matching coordination procedures with specific taget groups. Also, different coordination procedures imply different clinical practices (information exchange, referral practices, etc.) and providers may not be ready to consider the clinical implications of a change in the type of coordination.

Stakeholders also favoured an informal organisation of patient's care pathway. These two results may seem contradictory because stakeholders want to strengthen the organisation of coordination while avoiding formalizing this coordination. During interviews, some stakeholders explained that formal care could lead to automatic trajectories that do not match the needs of the patient. Nevertheless, they explained that informal care requires coordination and dialogue between professionals.

Moreover, as explained in the previous section, the choices of the stakeholders in terms of formalization of patients' care pathways were different between target groups. Stakeholders favoured the implementation of referral guideline for the whole population with mental health needs but not for specific target groups. Different hypotheses are provided in the previous section to explain the choice of stakeholders to implement referral guidelines for the whole population. It seems that for the more severe and chronic groups, stakeholders do not favour the implementation of referral guideline because the complex needs of these groups can not be met with guidelines.

Main findings: Coordination between providers and formalization of patients' care pathways

The type of coordination between providers was considered by stakeholders as the second most important dimension of the organisation of mental health care. In the current organisation of mental health care, the main type of coordination is the linkage model in which the patient is the coordinator of his care between the different providers. However, stakeholders favoured the coordination model in which care is provided by different providers who coordinate with each other, while the linkage model was their last choice. During interviews, stakeholders explained that the linkage model may not be suitable for patients with more severe and complex issues and that these patients suffer more from fragmentation in and between mental health and social care.

Although stakeholders want to strengthen the coordination between providers, they do not want to formalize the patient care pathway between providers. The stakeholders favoured an informal organisation of the patient care pathway, especially for patients with more severe and chronic conditions because the complex needs of these patients can not be met with guidelines. However, stakeholders favoured the implementation of referral guidelines for the whole population with mental health needs because, according to them, it allows a better use of the various services and thus prevent some services from being on waiting list because of misused at the population level.

5.1.4 *Funding of mental health care*

The dimensions of the organisation of mental health care considered as the least important by the stakeholders in the quantitative results were the funding dimensions. However, during interviews several stakeholders explained that the key to healthcare reform is funding and that this dimension is rarely questioned or analysed in detail. It is possible that the low importance given to funding dimensions is related to the complexity of these dimensions. For example, during the interviews, stakeholders were convinced that the hospital funding system should be changed but it was difficult for them to make a choice because the funding system is currently complex. Choices between episode-based and activity-based funding of providers were also difficult for stakeholders. The stakeholders explained that on the one hand, the two funding mechanisms have advantages and disadvantages and, on the other hand, the repercussions of a change in the funding mechanism of providers are multiple and relatively unknown by stakeholders.

Overall, stakeholders favoured an episode-based payment of providers and a pooling of financial resources for a set of services at the network level, which are two novelties in the Belgian context. The scientific literature emphasises that an activity-based payment of providers does not favour continuity within the network (patient retention) [90, 91]. During interviews, some stakeholders explained that an episode-based payment of providers make it possible to follow the patient between his various cares (across health, mental health and social sectors) and that activity-based payment has negative effects on the coordination between providers. Regarding the resource pooling level, several stakeholders explained during the interviews that currently, it is mainly the hospitals that have weight in the budget allocation decisions and that a pooling of financial resources at the network level would allow a better distribution of funding between services, including community mental health services, as well as better coordination at the network level. However, preferences for funding mental health care were different between regions.

Main findings: Funding of mental health care

The funding dimensions were considered by stakeholders as the least important dimension of the organisation of mental health care. The stakeholders explained that the funding of care is complex and that it was therefore difficult for them to make choices. However, stakeholders explained that funding is often the key to organisational reform.

Overall, stakeholders favoured an episode-based payment of providers and a pooling of financial resources for a set of services at the network level. Preferences that are different from the current situation in Belgium. However, these preferences were different between the three regions.

5.1.5 *Organisational interventions focused on access to care*

As previously explained, the organisational interventions prioritized by stakeholders were the development of low-threshold service, the development of housing facilities and increased access to psychotherapy services. It is the dimension of access to care that is transversal through these organisational interventions. In Belgium, in the areas of low threshold, housing and psychotherapy services, it is the difficulty of finding places in reasonable time and for more severe and complex groups that was already put forward during the preceding qualitative study. Indeed, the results of the qualitative study already highlighted that stakeholders emphasized the lack of low-threshold services without admission criteria and the inadequacy and insufficiency of housing facilities, especially for the most vulnerable and complex groups. It should be noted that the implementation of housing facilities was even more important for representatives of users and relatives.

The organisational intervention considered as the least priority was the implementation of employment support interventions. This result is in contradiction with the scientific literature because employment is considered as one of the main determinant of patients' social integration [9, 77]. In addition, many studies have highlighted the difficulty of accessing or maintaining employment for people with mental health problems. In OECD countries, people with severe mental illness are six to seven times more likely to be unemployed than the general population [92]. Across different countries the rate of employment of patients with severe mental illness is between 10 to 25% while 55 to 75% of them express an interest in having a job [93]. This result can be related to the fact that some stakeholders explained in the qualitative study that the reintegration of patients into the job market is not realistic or desirable for all patients in specific situations and at a specific time. During interviews; some stakeholders also explained that employment comes later in the process of social integration and recovery of the patient, so the priority first goes for example to housing which is one of the first steps. Many stakeholders also see employment as a competence and responsibility of the social sector, so it is not a priority in the organisation of mental health care. Indeed, it should be noted that most stakeholders supported the implementation of employment support interventions for people with a psychiatric disorder in existing social services and in coordination with the mental health sector rather than integrate this type of intervention in mental health services. Several stakeholders also explained during the interviews that there was a need to intensify collaboration between generic social services (CPAS / OCMW), employment services (Forem, Actiris, VDAB) and the mental health sector.

Main findings: Organisational interventions focused on access to care

The organisational intervention considered as a priority by stakeholders was the implementation of low-threshold services, with some differences between regions and stakeholder profiles. The representatives of users and relatives favoured the implementation of housing facilities and stakeholders from the Brussels-Capital region favoured the implementation of psychotherapy services. It is the dimension of access to care that is transversal through these three organisational interventions.

The intervention considered as the least priority was the implementation of employment support interventions. This last result is in contradiction with the literature because employment is considered as one of the main determinant of patients' social integration, particularly for patients with severe mental illness [9, 77, 93]. It is important to note that most stakeholders supported the implementation of employment support interventions for people with a psychiatric disorder in existing social services and in coordination with the mental health sector rather than integrate this type of intervention in mental health services.

5.1.6 Differences between stakeholders

Differences in priority objectives of the reform were greater between stakeholder profiles than between the three regions. Policymakers attached greater importance to the objective of reducing the length of hospital stay and less importance to the objective of involving users in the development and offer of new services than clinicians, service managers and representatives of users and relatives. Policymakers also place greater importance on the geographical organisation of care and the formalization of the patient care pathway. They also place a higher priority on the implementation of employment support interventions and a lower priority on the implementation of housing facilities than clinicians, service managers and representatives of users and relatives. These results are consistent with the analysis of stakeholders' preferences during the reform in 2010 which concluded that "*goals heterogeneity and discrepancies between stakeholders' perspectives and policy priorities are likely to produce an* *uneven implementation of the reform process and, hence, reduce its capacity to achieve the social rehabilitation of users.* " [56].

Nevertheless, across the other results of the study, differences between the three regions are more present than differences between stakeholders.

Main findings: Differences between stakeholders

Differences between stakeholders were mainly present between the group composed of policymakers and experts and the two groups composed of clinicians, managers and representatives of users and relatives. Regarding the objectives of the reforms, policymakers attached greater importance to the objective of reducing the length of hospital stay and less importance to the objective of involving users in the development and offer of new services than the other two groups. Policymakers also placed greater emphasis on the geographical organisation of care, the formalization of patients' care pathways, the implementation of employment support interventions and less emphasis on the implementation of housing facilities. As already concluded in 2010, discrepancies between stakeholder views and political priorities may hinder changes in the organisation of mental health care and thus the effective implementation of the reform [56]

5.1.7 Differences between regions

Stakeholders in the three regions favoured different dimensions of the organisation of mental health care. The integration of different services within the same structure and the pooling of financial resources for a set of services at the network level were more favoured in Flanders. In Wallonia, stakeholders gave more importance to an activity-based payment mechanism of providers and to the pooling of financial resources at the level of each service.

Similar results appeared in the choices of stakeholders in terms of organisational interventions. Indeed, choices in terms of organisational interventions highlighted groups within stakeholders. A first group mainly composed of stakeholders from the Flemish region favoured organisational interventions in which funding was pooled for a set of services at the network level and where the local governance structure could allocate financial resources to providers. Other groups mainly composed of stakeholders from the Brussels-Capital Region and Wallonia favoured interventions in which funding was allocated to each service individually.

One possible interpretation is that stakeholders in Flanders favour an integration both in terms of provision, coordination and funding of services, while stakeholders in Wallonia prefer to maintain the autonomy of each provider with individual funding per provider and an activity-based payment. The Brussels-Capital region was often between the other two regions in terms of organisational preferences.

These results are consistent with the results of the qualitative study. Indeed, the participants in the focus groups in Flanders had already mentioned being in favour of the bundle payment. Regarding the pooling of financial resources, the results of the qualitative study also showed that stakeholders in Wallonia insisted that the autonomy of mental health services in deciding of how to use their human and financial resources should be preserved.

These results may favour a model of organisation that is sufficiently flexible to allow local providers (e.g. networks) to choose and implement different mechanisms in the context of their own regional policy.

Main findings: Differences between regions

Regional differences in organisational choices were more frequent in the present study. Stakeholders in Flanders gave more importance to the integration of different services within the same structure and to the pooling of financial resources for a set of services at the network level than stakeholders in Brussels and Wallonia. In Wallonia, stakeholders gave more importance to an activity-based payment mechanism of providers and to the pooling of financial resources at the level of each service. Choices in terms of organisational interventions also highlighted similar regional differences. Overall, stakeholders in Flanders favoured an integration at the network level both in terms of provision, coordination and funding of services, while stakeholders in Wallonia favoured to maintain the autonomy of each provider with an individual funding per provider and an activity-based payment. The Brussel-Capital region was often between the two other regions in terms of organisational preferences. These results may favour an organisational model that allows local flexibility in the organisation of mental health care.

5.2 Strengths and limitations

The first strength of this stakeholder survey is the quality of the sample. Starting from a database of 1752 people, their eligibility as stakeholders of the organisation of mental health care in Belgium was evaluated to start with contact sample 1174 stakeholders. This contact sample was representative of the diversity of the different mental health care functions, the different stakeholder profiles, in the different regions. As part of the survey, stakeholders had the opportunity to nominate five people to contact to complete the survey (snowballing sample), an analysis of the nominees showed that 75% were already in our starting sample. This result confirms the quality of our initial sample. The remaining 25% were contacted after checking their eligibility. The second strength of this online survey is the 40% response rate obtained, while a response rate of 30% was estimated based on the literature [70, 71].

Another strength of this study is the design based on conjoint analysis method. Indeed, studies on the choices and preferences of stakeholders mainly investigates the individual factors that influence their choices [94, 95]. However, in the real world, stakeholders face choices that involve a trade-off between the different factors that influence the implementation of health care reforms and policies [1]. Therefore, “there is a need for methods that study the implementation decisions in the context of the trade-offs that influence real-world planning”, methods such as conjoint analysis [15].

The main limitation of the present study is that we cannot exclude that some terms of the questionnaire have been understood differently by stakeholders (eg. Episode-based or activity-based payment mechanism). This limitation is partially overcome because the questionnaire was pre-tested with stakeholders with different profiles then adapted before launching the survey. Face validity tests were performed to examine the content of the questionnaire, the formulation, the understanding of the questions and terms, the decision and response processes and the clarity of the instructions [62, 63]. Another limitation related to the design of the online quantitative survey is that the stakeholders did not have the opportunity to comment freely and provide nuances to their answers. Finally, the design of the conjoint analysis implies the presentation of a limited number of attributes and levels. It was therefore not possible, for example, to present an exhaustive list of different payment mechanisms of providers. We have therefore selected broad and realistic categories in the Belgian context.

5.3 Final recommendations based on the qualitative and quantitative findings

Hereafter we suggested recommendations flowing from the qualitative survey and the quantitative stakeholder analysis. We briefly emphasise the main findings supporting the recommendations, putting also these findings in relation with the broader context of the literature; the recommendations include a general orientation, it identifies the targeted audience and then provide more operational avenues for action.

Key concepts and objectives of the reform

The results of the qualitative survey and the stakeholder analysis highlighted persisting disagreement and misunderstanding of the objectives and underlying concepts of the reform in the organisation of mental health care for adults in Belgium. The intensification of inpatient care (short hospitalisation) has remained a controversial objective since the beginning of the reform in 2010 [56] and, currently, many stakeholders do not perceive it as an objective to be achieved but rather as means to achieve the other objectives of the reform (community care, patients’ social integration and recovery, continuity of care). In addition, the objective of social integration and recovery often has a different meaning for different stakeholders. It was previously noticed that the reform objectives were considered too broad and ambitious [96]. The stakeholder analysis also highlighted that all the objectives of the reform should be pursued together but that the priority objective, according to the stakeholders of the three regions, is to ensure continuity of care between the different sectors and services (health, mental health, social). The objective of continuity of care was already mentioned as a priority during the evaluation of the reform program in 2010 [56].

Recommendation 1: The objectives and underlying concepts of an integrated, comprehensive mental-health policy should be better defined, clarified, and endorsed by all the authority levels with responsibilities in mental health care in order to decrease system fragmentation

Targeted audiences: Taskforce mental health, federal and federated health authorities

Avenues for action: (a) Whilst it seems impossible to reconsider the division of health-policy responsibilities between the federal state and the federated entities, an integrated mental-health policy plan, developed at the level of the inter-ministerial health conference, should determine priority public-health objectives for the entire country, leaving room to the different entities as how to operationalise these objectives (See recommendation 8). (b) Each authority with responsibilities in mental-health care (mainly the federal authority and the regions) should develop its own mental-health policy plan that is integrated (all care levels and all target-groups) and that should include public mental-health objectives, financial governance mechanisms to reach the objectives of the reform, and an evaluation framework. In 2017 in Flanders, the Policy Research Center Well-Being, Public Health and Family developed, in cooperation with the Agentschap Zorg & Gezondheid, an integrated mental health policy that resulted in several policy regulations that are included in a draft decree concerning mental health .

Recommendation 2: Continuity of care between sectors and services (health, mental health, social) should be considered as the main priority in the organisation of mental health care for adults in Belgium

Targeted audiences: Mental health services networks, (mental) health and social care services

Avenues for action: (a) In order to strengthen continuity of care across multiple services and providers, authorities should consider the devolution of responsibilities and entitlements to local-level stakeholders, in particular the established networks of services, in terms of provision, planning, and resource allocation within a common framework and an objective-oriented, evaluated policy [97]. (b) Continuity of care across different services and sectors is more effective when it is supported by organisational mechanisms at the local level. For example, having the provision of services under the responsibility of one single provider (e.g. supplying primary and specialised care, inpatient and outpatient care, health and social care), having clear rules regulating referrals between services and a clear information about these rules provided to the patient, having tools to share patient information between services, having a resource allocation that support the care pathway of the patient across different services, and having a local care provider responsible for deciding which services are required. Such features are likely to reduce the time delay in contacts between services (e.g. between the discharge from the hospital and the subsequent outpatient contact) and to improve the variety of the different services and professionals, including non-medical services, that are available to the patient. The service networks that were established by the Belgian reform offer an opportunity to strengthen the capacity for such regulation at the local level. (c) Local networks should include the whole range of (health and social) services that are likely to be involved in the care pathway of patients. Particularly, primary care and social care services should not be left aloof. In addition, the responsible health authorities should support all types of services to fully participate in local networks and in an integrated mental-health policy. However, this is not realistic if there is no clear target-group defined for particular actions and policies. Indeed, it is not possible to include all service types for all types of patients (within a network) [98]. Therefore, this recommendation is linked to recommendation 3.

Targeting process of the reform

The results of the qualitative survey highlighted the need for rethinking the priorities in terms of target groups. The current reform targets mainly the whole population with mental health needs and does not propose different organisational mechanisms according to target groups, except for age groups (child and adolescent psychiatry, adult psychiatry, and elderly psychiatry) or for specific audiences such as mentally ill offenders. The results of the qualitative survey and stakeholder analysis highlighted that target groups with complex mental health and social issues are more likely to be "forgotten", have less access to care and inadequate provision of services (employment support, low threshold services, affordable long-term housing facilities, and psychotherapy services). Employment is often highlighted in the literature as the most important dimension of rehabilitation and social integration of patients. It is also important to underline that the indirect costs of mental health problems on the labour market represent 2.30% of Belgium's gross domestic product (GDP), the highest percentage of OECD countries [97]. Although the current reform does not propose different organisational mechanisms depending on the target groups, the results of the stakeholder analysis highlighted that stakeholders supported a different organisation of care depending on the target group, as in the first evaluation of the reform in 2010 [75]. For example, stakeholders favoured an episode-based payment[g] of providers for the socially deprived population with mental health needs and a provision of specific services for the severe mentally ill population. Quoting the well-known laws of care integration, "you can integrate all of the services for some of the people, some of the services for all the people, but you can't integrate all of the services for all of the people" [98], there is no organisational mechanism fitting with all the individual patient's situations [88]. In addition, care integration for a small group of people with high needs is carried out at the cost of care organisation for the larger group of people with lower needs. This corresponds to another law of care integration: "your integration is my fragmentation" [98].

Recommendation 3: Different target groups with specific care mechanisms should be defined and entitled to an explicit care circuit.

Targeted audiences: Taskforce mental health, federal and federated health authorities

Avenues for action: (a) Organisational care mechanisms have to be tailored for specific target groups who are the most likely to benefit from these mechanisms. For example, a case-manager may be of interest for someone without sufficient capacity for navigating the care system, whereas it is a costly and counterproductive intervention for a patient able to navigate the health care system on his own. (b) The mental-health reform policy is based on two main organisational tools; the establishment of service networks and care circuits. The latter mechanism has been disregarded so far, mainly because it has been broadly understood as a kind of formalised , compulsory care pathway for specific groups of patients. A majority of stakeholders does not endorse such an iron cage and it suggests that the concept of care circuit is not properly understood. A care circuit is as a specific organisational package available for a defined target-group of patients. It may include specific access criteria, information exchange tools, and specific mechanisms for allocating resources and financing interventions and services. For example, well-known severe mentally ill (SMI) patients might register voluntarily to a specific care circuit in which they might get priority access to specific services (voluntarily included in the care circuit), i.e. accommodation or crisis management services, benefit from a particular information system, i.e. including a shared, individualised treatment plan, and within a specific funding mechanism, i.e. episode-based.

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[g] An episode payment is a single price for all of the services needed by a patient for an entire episode of care

Recommendation 4: The provision of community services and the access conditions to care for people with more severe and complex (mental) health and social issues should be strengthened

Targeted audiences: Federal and federated health authorities, mental health services networks, (mental) health and social care services

Avenues for action: (a) There is a need of community primary health and social care services that are easily identifiable and accessible to the whole population, and where any type of need (medical, psychological, social) can be formulated. These primary health and social care services would have the task to orient patients towards the most appropriate service within the local supply. (b) Rehabilitation services and interventions for people with more severe and complex (mental) health and social issues should be supported, e.g. peer support, employment support (Individual Placement and Support - IPS), housing support (Housing First), and low threshold services. It is important to underline that gearing service users towards the job market is not realistic for all types of people in specific situations and on a specific moment of time. Furthermore, insertion and reinsertion into employment can take different forms depending on the demand, needs and abilities of users (regular job or voluntary ⁄ protected ⁄ sheltered work). (c) This research emphasised a low access to affordable psychotherapy that supports the recovery process of the patient. One of the causes put forward is that psychologists practicing in the private sector are often overwhelmed by complex situations in which social aspects prevailed. Therefore, there is a need (1) to increase access and provision of affordable psychotherapy and (2) to anchor psychologists in community facilities to benefit from multidisciplinary work.

Roles, missions and collaboration between providers

The results of the qualitative survey highlighted the lack of clarity of the roles and missions of mental health providers, particularly community mental health centres and mobile teams. This lack of clarity leads, on the side of services users, to a difficulty of identification of the adequate providers according to their needs providers and, on the side of providers, to inappropriate referrals and problems of collaboration. However, the results of the stakeholder analysis showed that the collaboration between providers was considered by stakeholders as one of the most important dimensions of the organisation of mental health care. Although stakeholders want to strengthen collaboration among providers, many of them do not want to formalise and standardize their practice and collaboration. The results of the qualitative survey and the stakeholder analysis highlighted that formalisation and standardisation are sometimes associated to the ongoing reforms and viewed as threatening individual creativity, inter-organisational learning and may lead to automatic trajectories that do not match the needs of the patient. As explained in recommendation 3, such representations of formalisation and standardisation are not shared by all stakeholders but these tools and their impact on practice and collaboration between providers need to be clarified. Moreover, the results of the qualitative survey specifically emphasised that collaborative relationships between mental health professionals and services are strongly influenced by shared or differing values referring to professional and organisational culture and deeply rooted representations of mental health.

Recommendation 5: The roles and missions of mental health providers, particularly community mental health centres and mobile teams, should be clarified

Targeted audiences: Mental health services network, federal and federated health authorities

Avenues for action: a) Health services networks are characterised by a decentralised decision making structure, which importantly rely on trust and mutual acquaintance between stakeholders [100]. In this type of mandated network, a combination of bureaucratic, market and network-based mechanisms should be preferred to formalisation alone [101]. Bureaucratic mechanisms include the formalisation of missions, roles and relationships within the network. Continuing efforts should be made to clarify the missions and roles of services, particularly community mental health centres and mobile teams. Formalisation is required to improve the visibility of the care supply at the network level. b) Market-based mechanisms of "accreditation" should be considered as a tool to reach this objective as well as public mental-health objectives set by the authorities. Accreditation means that additional means (e.g. financial incentives) can be allocated to the providers and services that develop specific actions as to reach the objectives set. In 2016, the Superior Council of Health published a report on quality indicators in mental health care in Belgium that can be used to set and evaluate objectives to be achieved .

Recommendation 6: Collaboration tools to strengthen coordination between providers should be funded and implemented

Targeted audiences: Federal and federated health authorities, mental health services networks, (mental) health and social care services

Avenues for action: (a) Collaboration is a form of network integration referring to horizontal relationships between services that do not belong to the same hierarchical structure. With a view to strengthen collaboration and coordination between providers and avoid that “formalisation leads to exclusion”, bureaucratic mechanisms should be supplemented by network-based mechanisms fostering trust, mutual knowledge and culture shift across the networks. These mechanisms include inter-services immersion, multidisciplinary dialogue and intervision between professionals. Authorities should provide incentives supporting the generalisation of such inter-organisational learning mechanisms. (b) Federated entities, which are responsible for education, should consider the development of coordination-collaboration roles and tools into the framework of education programmes and training, e.g. in universities, high schools, and permanent training programmes, in particular in medicine and psychiatry, psychology, nursing, and social working teaching programmes. (c) One of the main tools and prerequisite of collaboration-coordination between providers is the exchange of information. Previous research in Belgium has highlighted the willingness of stakeholders to set up a system for sharing information between (mental) health and social services as well as to work on existing procedures to standardise and simplify them [102]. However, issues of preserving the anonymity and confidentiality of user information and sharing care information between (mental) health care services and the patient should be discussed beforehand. An example among others of a system for recording and sharing clinical information between health and social services is the interRAI system and the Belgian version BelRAI .

Funding of mental health care

The funding scheme is a key dimension of any (mental) health care system as it determines not only the available resources but also how these resources are allocated across settings and services and how this allocation facilitates or hinders the achievement of goals pursued by the Health Authorities. The funding dimensions of mental health care and the question of resource allocation were described by stakeholders as highly complex and controversial. However, the results of the qualitative survey showed that stakeholders acknowledge that the ongoing shift toward community mental health care requires rethinking resources' allocations across the system and mechanisms of payment of providers. The results of the stakeholder analysis also highlighted that stakeholders are ready to consider an episode-based payment of providers and a pooling of financial resources for a set of services at the network level. These results indicate a major change in the Belgian context. Stakeholders explained, in the qualitative survey, that the pooling of financial resources at the local (network) or regional level would be more consistent with the ongoing transformation of the mental health care organisation, but raised the issue of decision-making power in resources allocation. Furthermore, stakeholders often raised the question of prioritizing resources investment within the mental health care system and the lack of resources of outpatient services and primary care providers compared to the inpatient sector. A paradox highlighted by stakeholders in a context of reform towards care in the community and illustrated by the funding of mobile teams that remains in the hands of the inpatient sector. This paradox was already highlighted during the first evaluation of the reform program in 2010 [96]. The results of the qualitative survey also highlighted that the lack of psychiatrists and psychologists in outpatient services is worsening because of the disparities in the payment, related to differences in payment mechanisms, of these professionals compared to the inpatient sector.

Recommendation 7: The funding and payment mechanism of mental health care providers should be reviewed in order to align the providers' financial incentives with the goals of the reform in the organisation of mental health care

Targeted audiences: Federal and federated health authorities

Avenues for action: (a) The funding of providers for the appropriate target groups should rely more on an episode-based system which should be tailored to cover the effective costs. Such system may rely on a classification, which is not only based on patient diagnosis, but consider a wider range of features (e.g. patient' severity, complexity of treatment, etc.). The experience of several OECD countries on that respect is worth considering. (b) The overall funding mechanism to pay for inpatient care has not changed that much since the 107 reform and remains, basically, a per diem system for inpatient services. Per diem system may lead to over-utilisation and long lengths of stay, beyond what is necessary. As mentioned by the OECD, there is need to move towards a provider payment system that is independent of the care setting and that foster integrated care [92]. (c) The funding of mental health care could be funnelled to a local agency (a Network administrative Organisation, NAO) which would commission health care from the different mental and health services from an area.

Local contexts

The gaps and overlaps in mental health care supply may be quite different across areas, according to the area deprivation level or the population density, just to quote two dimensions. In addition, the 2010 reform has also been implemented with a bottom-up approach, giving each network the autonomy to implement a network of services that consider the resources/services available in the area and their needs. Finally, the recent and sixth reform of the Belgian state led to a significant shift of competences to federated authorities, particularly in the domain of mental health care. Thus, local autonomy is a key stake. The results of the qualitative survey and the stakeholder analysis highlighted clear local differences regarding expectations and needs in the organisation of mental health care. For example, the results of the stakeholder analysis showed that stakeholders in Flanders favoured an integration at the network level both in term of provision, coordination and funding of services, while stakeholders in Wallonia wished to uphold providers' autonomy and their proper funding. The reform process and the funding of the psychiatric inpatient facilities remain a federal competence whereas outpatient mental health services and social services are now reporting to regional authorities. Thus, it should be possible to support local autonomy considering and within the current distribution of competences across federal and regional authorities. Yet, the current governance of network is possibly too weak to allow for an effective local implementation of the 2010 reform, as evidenced in the previous results of the 107 evaluation [96, 99].

Recommendation 8: An organisational model allowing local flexibility in the organisation of mental health care should be favoured

Targeted audiences: Federal and federated health authorities, mental health services networks

Avenues for action: The current governance of network should be strengthened to allow local autonomy. Networks could become Network Administrative Organisation (NAO), with its own legal personality and be in charge of helping care coordination, funnelling the federal funding to the network, helping into the development of local information system and local evaluation procedures.

Monitoring and evaluation

The participation rate of stakeholders in the qualitative survey and in the stakeholder analysis was quite high. Several stakeholders explained that these surveys provided an opportunity for them to express themselves and report problems encountered in the organisation of mental health care. They explained that health policies and interventions should be developed in a bottom-up approach to take into account local needs and particularities. Routine monitoring and evaluation surveys are an opportunity to collect quality data, enable stakeholders to express themselves and develop relevant health policies and interventions.

Recommendation 9: Routine evaluations and monitoring of the mental health care system, services and policies should be supported

Targeted audiences: Federal and federated health authorities

Avenues for action: (a) Strengthen collaboration between authorities and federal centres of expertise (KCE, Sciensano), regional centres of expertise (CRESAM, VVGG - Vlaamse Vereniging voor Geestelijke Gezondheid, Observatoire de la Santé et du Social), and universities and research institutes. (b) Having a comprehensive framework for evaluating and monitoring health services would provide an integrated framework linking service data collection with national data sets, identify key evaluation indicators that are relevant and practical, meet the need for a rigorous evaluation framework for monitoring service performance and quality improvement in the delivery of services, and provide a framework for evaluating the performance and sustainability of small comprehensive primary health care services [104].

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CHAPTER 08 ACCEPTABILITY OF POSSIBLE RECOMMENDATIONS FOR FUTURE MENTAL HEALTH CARE ORGANISATION IN BELGIUM: A STAKEHOLDER SURVEY

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1 INTRODUCTION

We aimed to receive suggestions from all stakeholders (people who work in or are related to the mental health care sector) to improve the organization of the mental health care in Belgium. In order to obtain this goal, we decided to construct a survey based on statements and recommendations gathered from previous chapters of the report and adjusted to a Belgian context, and asked the respondents' opinion towards acceptability and feasibility of these statements.

2 METHOD

2.1 Construction of the survey

Origin and source of the survey statements

The statements submitted to the opinion of the respondents were retrieved from different sources and merged information in the previous chapters of the report. Such as the recommendations from chapter 04, in which an overview of international frameworks and accompanying recommendations on mental health service organization (including reports from the World Health Organisation (WHO), the European Union (EU), the Organization for Economic Cooperation and Development (OECD), etc.) was given.[1-4] Also, a recent scientific publication[5] was used as source to retrieve recommendations from, as well as a consensus paper of the European Community based Mental Health Service providers (EUCOMS) network.[6] Finally, the researchers' background knowledge of the field was applied to select, formulate or reformulate the statements as well as to categorize them into themes.

Selection process of the survey statements

First, the 416 identified recommendations were classified into themes by using keywords. Initially, 39 themes were chosen.

Secondly, within each theme, a deduplication was done of the recommendations, and the recommendations were merged if possible, by two KCE researchers during a meeting. This way unique recommendations per theme were described. This process step resulted in more than 200 recommendations.

Thirdly, four KCE researchers rated independently the (plausible) 'usefulness and applicability' of the recommendations according to the Belgian context. The rating was discussed during a meeting and a selection of applicable recommendations was made, leading to 67 recommendations.

Finally, the recommendations were rephrased towards 67 statements (formulated, if possible, in accordance with SMART (Specific, Measurable, Acceptable, Realistic, Time)-criteria) and adjusted towards the Belgian context. They were categorized into 13 themes.

The stakeholders were also asked their opinion in the following open question: '*If you could change one thing in the organization of the mental health care in Belgium, what would it be?*'

Construction of the survey and implementation

The statements (often phrased in English) were translated in French and Dutch (two of the three official national languages of Belgium) by two researchers and discussed during a meeting with another 3 researchers to fine-tune them. We used the LimeSurvey® program (https://www.limesurvey.org/) to construct and provide the online survey. Before launching the survey, two other KCE researchers (independent from the research team) verified the feasibility and technical aspects of the survey. An overview of the full survey is given in the Appendix. At the beginning of the survey, administrative and demographic data of the respondent were collected. Thereafter, the respondents were asked to give their agreement on the 67 statements (categorized into 13 themes) by selecting one out of four answering options (i.e. completely disagree, rather disagree, rather agree, or completely agree). At last, an open question was asked.

Targeted respondents and acquisition of the responses

The fragmentation and lack of data about the mental health care offer impaired the calculation of a representative sample of respondents. Therefore, a non-exhaustive list with more than 7 500 email addresses of mental health care workers, stakeholders, and associations was constructed. We targeted everyone who considered him-/herself as 'involved in mental health care'. As we aimed to receive as much answers as possible from the mental health sector, we choose to get the most possible opinions from the field through an open recruitment of respondents. This means that an invitation mail to participate with the survey was sent to each email address on the list. The mail contained an open link to the survey website and was therefore generally accessible (without personal identification). Moreover, the mail stipulated that the recipient could transfer the invitation to anyone else involved in mental health care, thus evoking a snow-balling effect. The survey was available to answer during one month (from the 24th of January 2019 until the 24th of February 2019). No reminder was send, however, the 15th of February, we obtained to increase the response rate by sharing the open access link through social media and the (broader) KCE mailing list with stakeholders from previous and current projects. In case of technical errors or the need of support, the respondents could raise their questions or concerns by email or telephone. We will discuss these suggestions in the limitations section of this chapter.

2.2 Statistical analysis of the answers

Descriptive statistics were calculated using R version 3.5.2 (with aside from the standard included packages, the tidyverse packages, ggplot2, and rio)[7]. A description of the sample is provided separately in the results section. For each theme, proportions of responses per question were calculated and appropriate 95% confidence intervals were provided (Wilson[8] for single proportions, Sison & Glanz[9] for simultaneous confidence intervals for multiple proportions).

Subgroup analyses were performed by region of the organisation and by care organisation.

3 RESULTS

3.1 Description of the sample

A total of 2418 persons visited the survey website. Only respondents that at least filled out the first topic “Policy” of the survey (n=1564; 64.7%) were used for further analysis. The survey was fully completed by 1210 (77.4%) respondents. Consequently, across all themes, participation rate was descending ranging from 0.2% to 4.6% per topic. The highest drop-out rate was seen for the “Access” theme, followed by “Registration” (3.5%) and “Intervention” (2.6%) (Figure 43). The majority of the respondents (87.2%) were between 30 and 65 years of age (30-45y (44.4%); 46-65y (42.8%); 18-29y (8.3%); >65y (4.2%); <18y (0.3%)). Among them, 58.1% were Dutch speaking. Most of the respondents indicated to be involved in the mental health sector (83.6%) whether or not in combination with involvement in another sector. 62.7% were solely involved in the mental health sector, followed by the social or welfare sector (8.2%) and a combination of both sectors (7.7%). 13.5% indicated to be involved in the somatic health sector and 8.8% indicated (a combination with) another sector. They were working mainly as health care professional solely (39.1%) or in combination with another profession (60.8%), followed by manager/coordinator (16.1% and 30.8% respectively) (Figure 44). There was a large variation concerning the organization they were working for (Figure 45). In 55.6% of the cases, the organization was located in the Flemish region, 29.5% in the Wallonia region and 14.9% in the Brussels region.

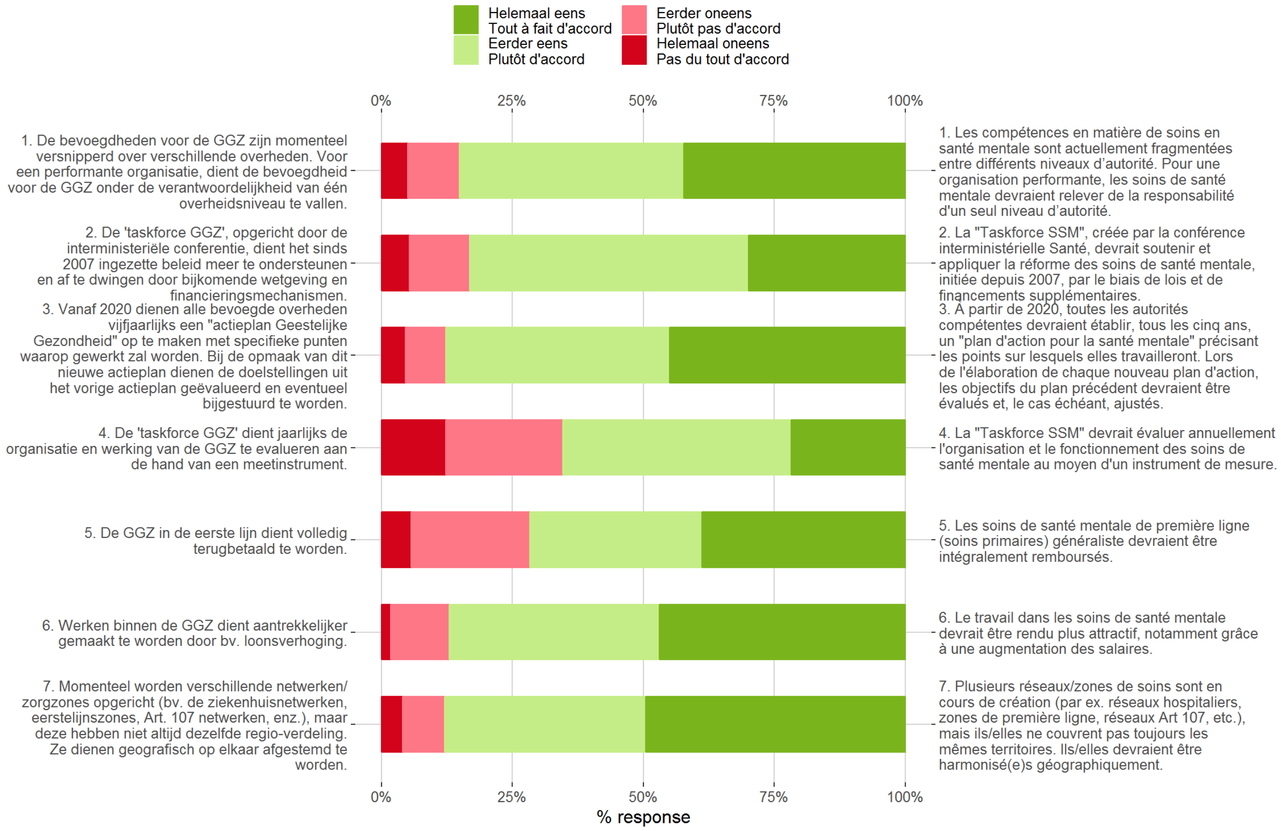
3.2 Results of the main themes

We will discuss for each of the 13 themes separately the number of respondents (n) who filled out the theme, followed by to what extent i.e. proportion given in percentage (%) with the accompanying 95% confidence interval (95% CI) respondents (dis)agree with the statements. In order to improve readability, throughout the results section, it was decided (i) to state ‘agree’ or ‘disagree’ instead of ‘rather/completely’ (dis)agree (however, the complete results can be consulted in the Figures 19-24, 27-30, 32, 34-36, 38), (ii) to not report the accompanying 95%CIs (however, they can be consulted in the Figures 19-24, 27-32, 34-36, 38), and (iii) to only report in this section the more ‘notable’ results. If a result was ‘important or notable’ to report, was decided during a team meeting, based on visual inspection and discussion.

3.2.1 Policy

The policy theme was filled out by 1564 respondents. As seen in Figure 26, more than 75% of the respondents agreed with five statements (1-3, 6, and 7) indicating that MHC should be under the competence of one policy level, the taskforce ‘Mental Health Care’ should support and endorse the policy more, all competent policy levels should construct an action plan for the MHC, working within the MHC should be made more attractive, and that the networks should be more in geographical congruence with each other. It can be observed that statements 4 and 5 evoked some controversy. As such, 34.6% of the respondents disagreed with the need to evaluate the organisation and operation of the mental health sector annually by the taskforce ‘Mental Health Care’ using a measuring instrument (statement 4). While 28.3% of the respondents disagreed with the statement that first-line mental health care should be fully reimbursed (statement 5).

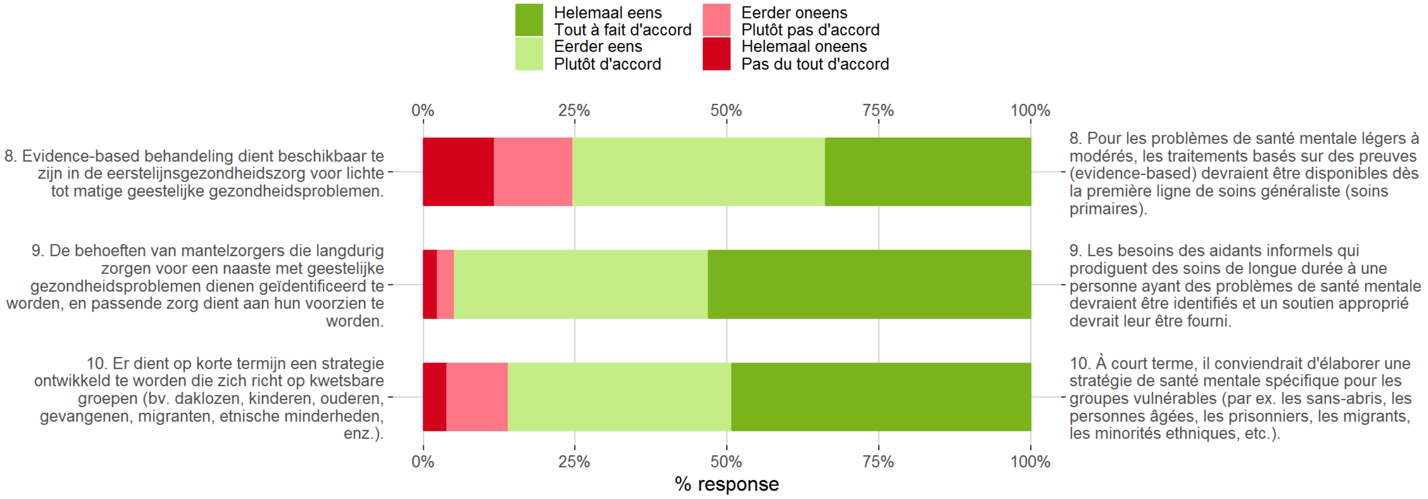
Figure 26 – Visualization of the agreement on policy theme statements.



3.2.2 *Intervention*

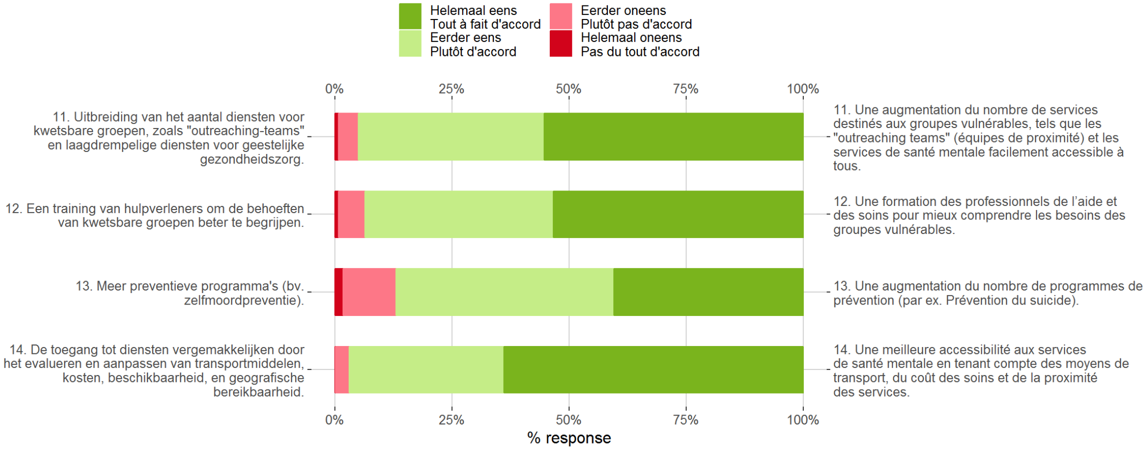
The intervention theme was filled out by 1524 respondents. Figure 27 illustrates that 75.3% to 94.8% of respondents agreed on the statements 8 to 10 of the intervention theme indicating that i.e. evidence-based treatment in the first line should be available for people with light to moderate mental health problems, the needs of the informal caregivers who take care of a relative with mental health problems should be identified and suitable care should be provided, and that a strategy focussing vulnerable groups should be developed.

Figure 27 – Visualization of the agreement on intervention theme statements.



The respondents that agreed with statement 10 (n=1310) on the elaboration of a mental health strategy specifically for vulnerable groups, were asked for their preferred short-time strategy for those groups. Nearly all respondents 86.9% to 97.0% agreed to all proposed strategies (statement 11-14, Figure 28) i.e. increasing the number of services targeting vulnerable people, training of caregivers to be more comprehensive towards vulnerable people, increasing the number of prevention plans and improving the access to mental health services.

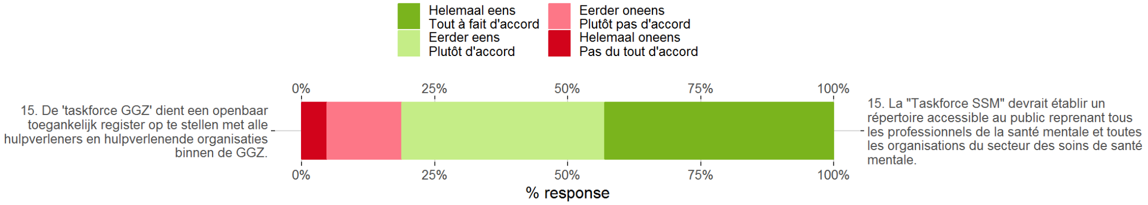
Figure 28 – Visualization of the agreement on intervention theme ‘strategy’ statements.



3.2.3 *Registry*

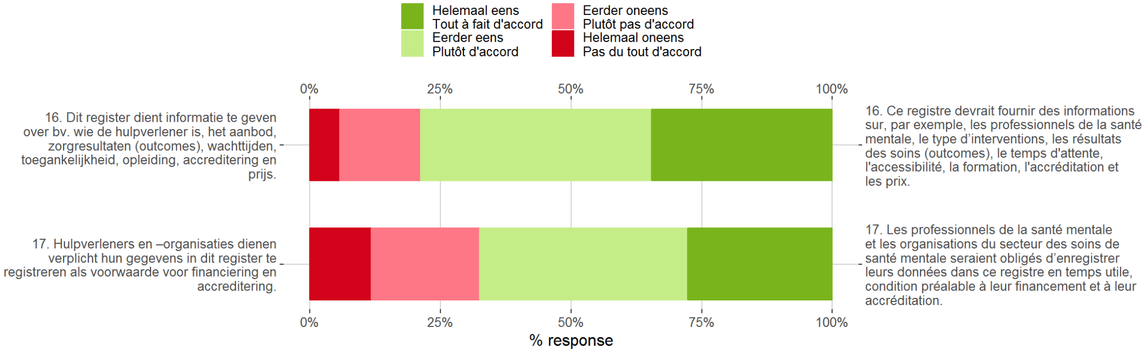
The registry theme was filled out by 1507 respondents. A large 81.2% majority of the respondents agreed that the ‘taskforce mental health care’ should construct a publicly accessible registry containing all caregivers and -organisations within the MHC (Figure 29).

Figure 29 – Visualization of the agreement on registry theme statement.



The respondents who agreed with statement 15 (n=1223) could indicate their agreement on the operationalization of the registry (Figure 30). Nearly 78.8% agreed that the registry should contain information on the caregiver, the care offer, outcomes, waiting time, accessibility, education, accreditation and cost. However, less people (67.4%) agreed that the caregivers and care organisations are obligated to register their data as a condition for financial resources and/or accreditations.

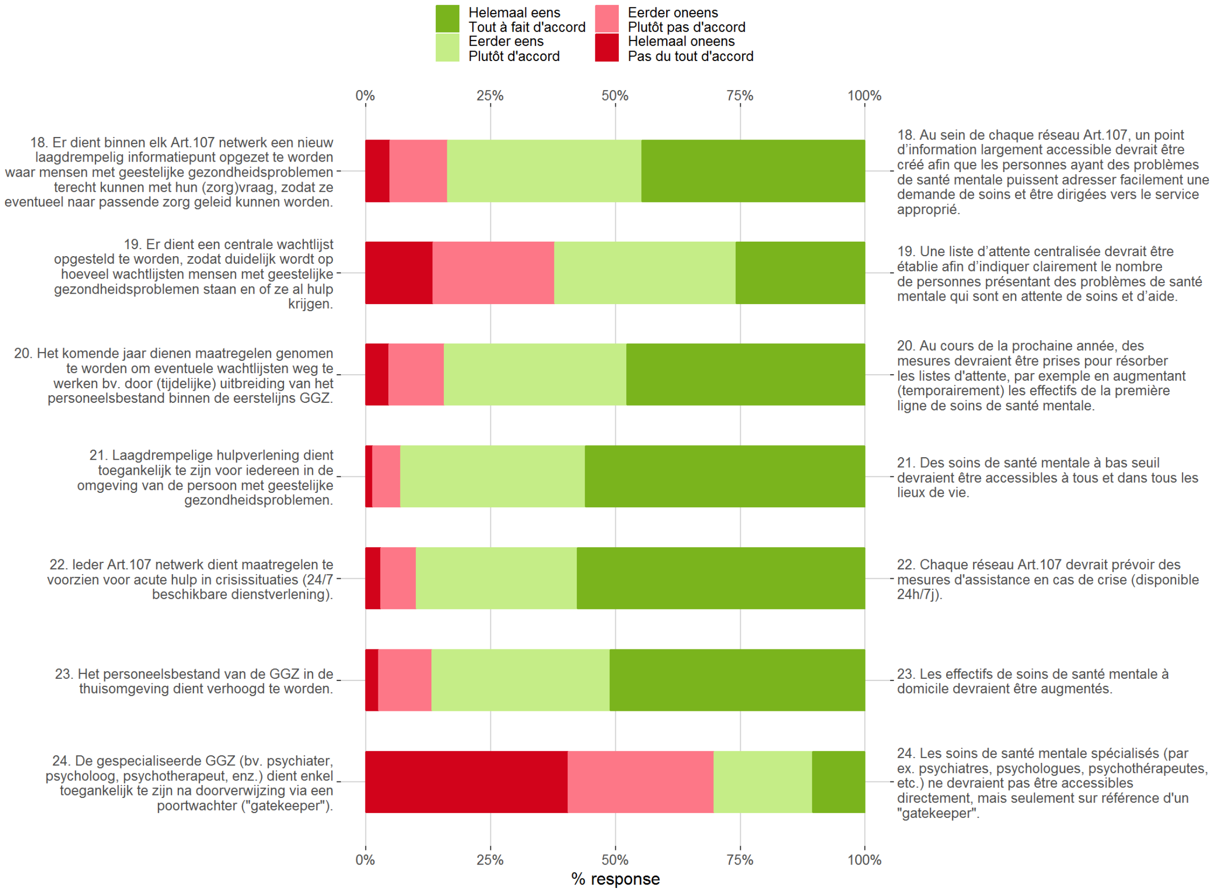
Figure 30 – Visualization of the agreement on registry theme ‘operationalization’ statements



3.2.4 Access

The access theme was filled out by 1436 respondents which generally agreed with five statements (statement 18, 20-23; Figure 31) indicating that a new low-threshold information point should be available within each art. 107 network for people with mental health problems, measures should be taken to reduce and eliminate the waiting lists, low threshold care should be available for everyone related to the person with mental health problems, each art. 107 network should provide 24/7 access to crisis care, and the amount of staff working in MHC focussing at a home-based environment should be enlarged. But, 39.8% of the respondents disagreed with statement 19 concerning the creation of a central waiting list, and a large 69.8% of the respondents disagreed with the implementation of a gatekeeper to access specialized MHC (statement 24). To the respondents agreeing with statement 24, the question was raised who could take up the role of gatekeeper. Nearly 75% selected the GP whether or not in combination with other possible gatekeepers as preferred gatekeeper (Figure 52) of which nearly 15% solely selected the GP as preferred gatekeeper (Figure 53).

Figure 31 – Visualization of the agreement on access theme statements.



18. Er dient binnen elk Art.107 netwerk een nieuw laagdrempelig informatiepunt opgezet te worden waar mensen met geestelijke gezondheidsproblemen terecht kunnen met hun (zorg)vraag, zodat ze eventueel naar passende zorg geleid kunnen worden.

18. Au sein de chaque réseau Art.107, un point d'information largement accessible devrait être créé afin que les personnes ayant des problèmes de santé mentale puissent adresser facilement une demande de soins et être dirigées vers le service approprié.

19. Er dient een centrale wachtlijst opgesteld te worden, zodat duidelijk wordt op hoeveel wachtlijsten mensen met geestelijke gezondheidsproblemen staan en of ze al hulp krijgen.

19. Une liste d'attente centralisée devrait être établie afin d'indiquer clairement le nombre de personnes présentant des problèmes de santé mentale qui sont en attente de soins et d'aide.

20. Het komende jaar dienen maatregelen genomen te worden om eventuele wachtlijsten weg te werken bv. door (tijdelijke) uitbreiding van het personeelsbestand binnen de eerstelijns GGZ.

20. Au cours de la prochaine année, des mesures devraient être prises pour résorber les listes d'attente, par exemple en augmentant (temporairement) les effectifs de la première ligne de soins de santé mentale.

21. Laagdrempelige hulpverlening dient toegankelijk te zijn voor iedereen in de omgeving van de persoon met geestelijke gezondheidsproblemen.

21. Des soins de santé mentale à bas seuil devraient être accessibles à tous et dans tous les lieux de vie.

22. Ieder Art.107 netwerk dient maatregelen te voorzien voor acute hulp in crisissituaties (24/7 beschikbare dienstverlening).

22. Chaque réseau Art.107 devrait prévoir des mesures d'assistance en cas de crise (disponible 24h/7j).

23. Het personeelsbestand van de GGZ in de thuisomgeving dient verhoogd te worden.

23. Les effectifs de soins de santé mentale à domicile devraient être augmentés.

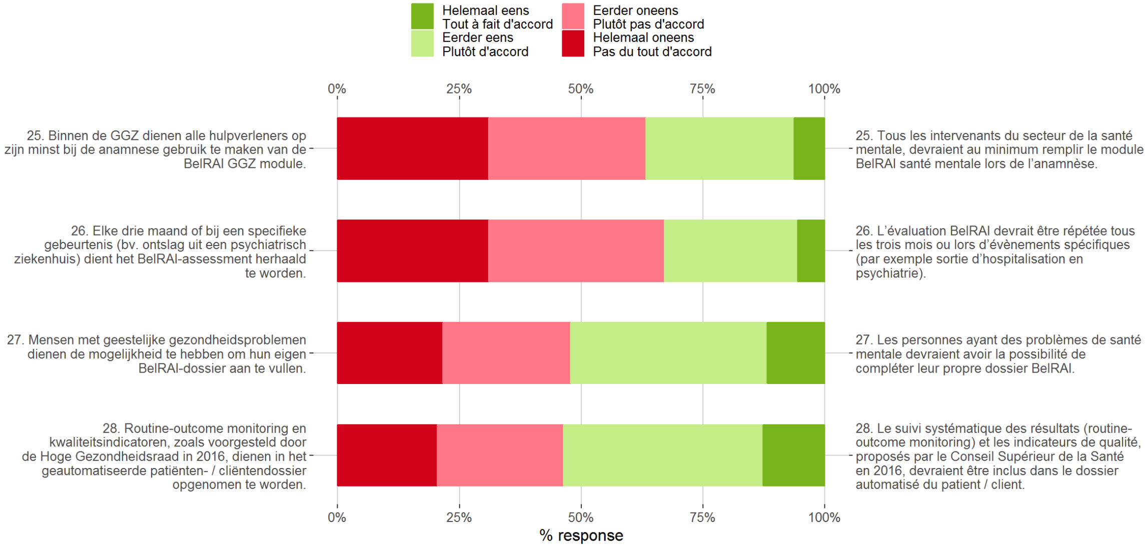
24. De gespecialiseerde GGZ (bv. psychiater, psycholoog, psychotherapeut, enz.) dient enkel toegankelijk te zijn na doorverwijzing via een poortwachter ("gatekeeper").

24. Les soins de santé mentale spécialisés (par ex. psychiatres, psychologues, psychothérapeutes, etc.) ne devraient pas être accessibles directement, mais seulement sur référence d'un "gatekeeper".

3.2.5 Registration

The registration theme was filled out by 1381 respondents. Between the respondents, there was overall controversy concerning the statements 25-28 (Figure 32) i.e. all caregivers within the MHC should use the BelRAI MHC module (at least for the anamnesis), each three months or at a specific occasion the BelRai assessment should be repeated, people with mental health problems should be given the opportunity to fill out their own BelRai profile, and routine-outcome monitoring and quality indicators need to be integrated in the file of the person with mental health problems.

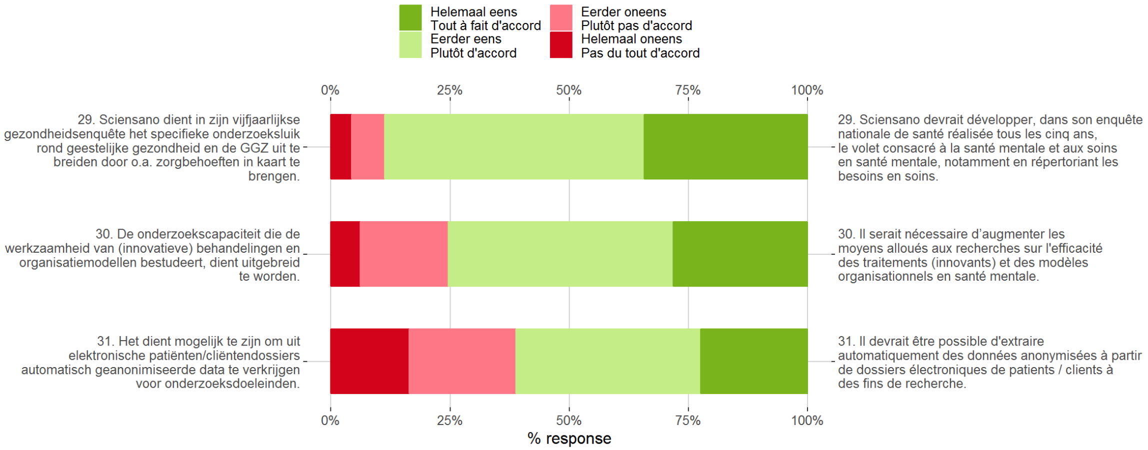
Figure 32 – Visualization of the agreement on registration theme statements.



3.2.6 Research

The research theme was filled out by 1351 respondents. Figure 33 shows that more than 75% of the respondents agreed with the research topic statements 29 (the section on mental health and the MHC should be expanded in the 5 yearly Health Interview Survey) and 30 (the research capacity investigating the effectiveness of (innovative) therapies and organisation models should be expanded). However, 38.8% of the respondents disagreed with the possibility to automatically retrieve anonymised data from patient files for research (statement 31).

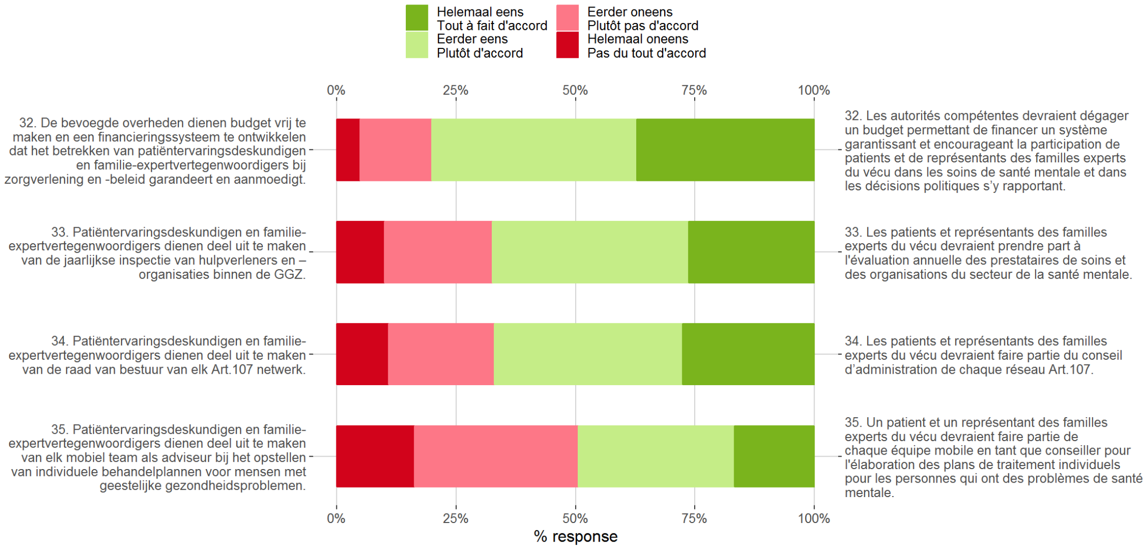
Figure 33 – Visualization of the agreement on research theme statements.



3.2.7 Participation

The participation theme was filled out by 1325 respondents. Figure 34 shows a general controversy across the statements. Although 67% to 80% of the respondents agreed that patient representatives and family-expert representatives should be involved and financed (statement 32, 33 and 34), more than half of the respondents i.e. 50.6% disagreed with them being part of the mobile teams in order to advise on individual treatment plans for persons with a mental health problem (statement 35).

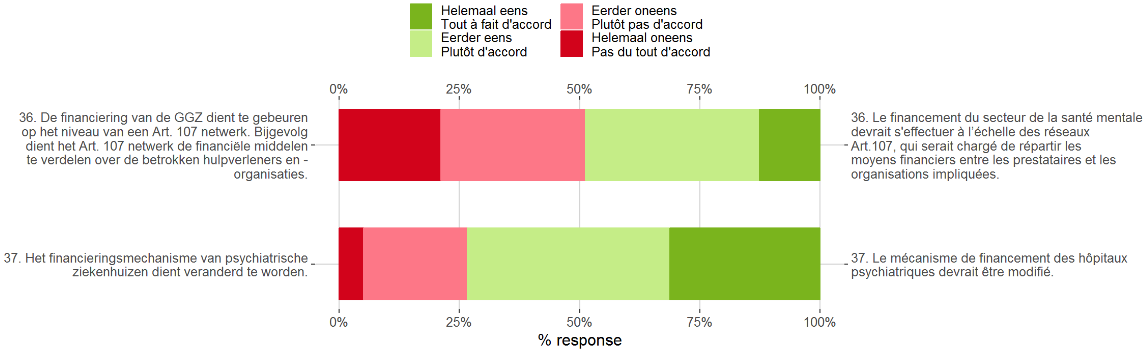
Figure 34 – Visualization of the agreement on participation theme statements.



3.2.8 Financing

The financing theme was filled out by 1311 respondents. Figure 35 illustrates a general controversy across the statements in this theme. More than half of the respondents i.e. 51.2% disagreed with financing at the level of the Psy107 networks (statement 36), while 73.4% agreed that financing mechanisms at the level of the psychiatric hospitals should be changed (statement 37). These last respondents (n=963) were asked on the modalities for the new financing system. The preferred financing choice was based on ‘quality indicators’ 66.1% followed by ‘care paths’ 62.7% (Figure 58).

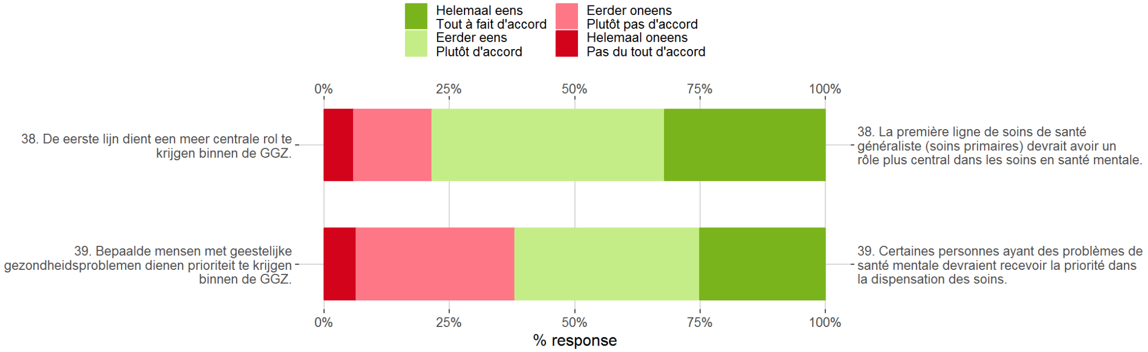
Figure 35 – Visualization of the agreement on financing theme statements.



3.2.9 *Priority*

The priority theme was filled out by 1275 respondents. A 78.6% majority of the respondents agreed that the first line of care should receive a more central role within the mental health care (statement 38) (Figure 36). There was controversy on whether certain people with specific mental health problems should receive priority, as 38% disagreed with statement 39. However, in case the respondents agreed with the statement, people with acute mental health problems were pointed out to receive priority followed by people with severe mental health problems, while priority for vulnerable people and people with chronical mental health problems were rated to be of less priority (Figure 60).

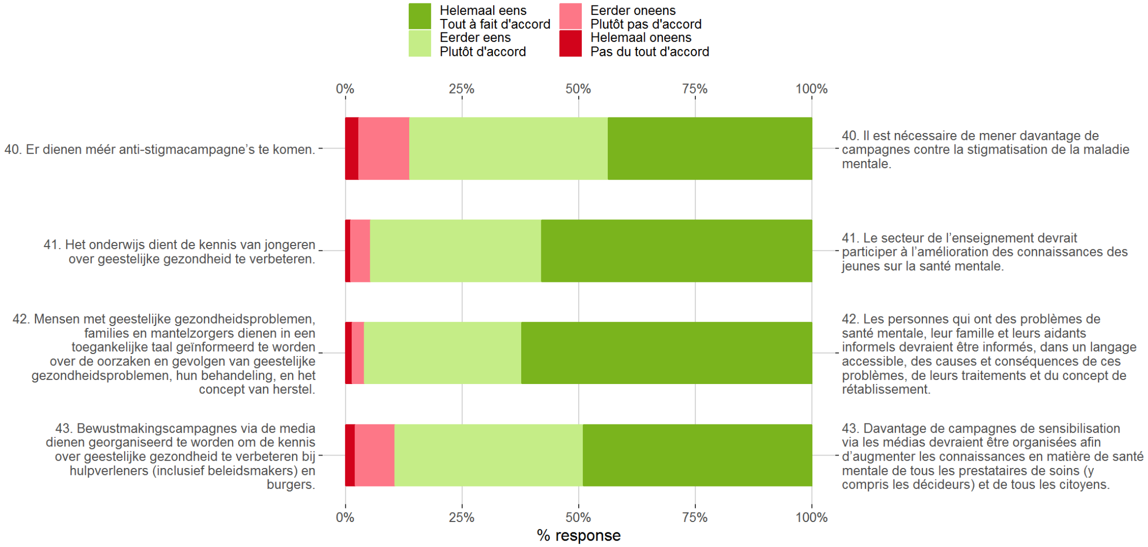
Figure 36 – Visualization of the agreement on priority theme statements.



3.2.10 Stigmatizing or health literacy

The stigmatizing or health literacy theme was filled out by 1269 respondents. Overall agreement with the statements in this theme can be observed (statement 40-43, Figure 37) as the majority of the respondents indicated that (i) more anti-stigma campaigns should be created, (ii) young people should be educated more about mental health at school, (iii) people with mental health problems, their families and informal caregivers should be informed clearly and concise on the causes and consequences of mental health problems, the treatment, and the concept of recovery, and (iv) that awareness should be raised with campaigns organised through the media to improve the knowledge of caregivers and citizens concerning mental health.

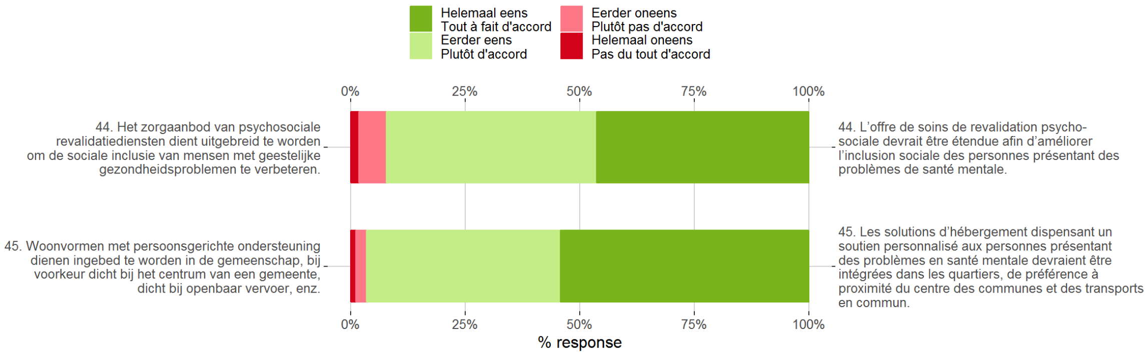
Figure 37 – Visualization of the agreement on stigmatizing and health literacy theme statements.



3.2.11 Inclusion

The inclusion theme was filled out by 1265 respondents. The majority of the respondents agreed with statements 44 (the care offer of psychosocial rehabilitation services should be expanded to improve the social inclusion of people with mental health problems) and 45 (housing with personal support should be embedded in the community, preferably close to the city centre, public transport, etc.) of the inclusion theme (Figure 38).

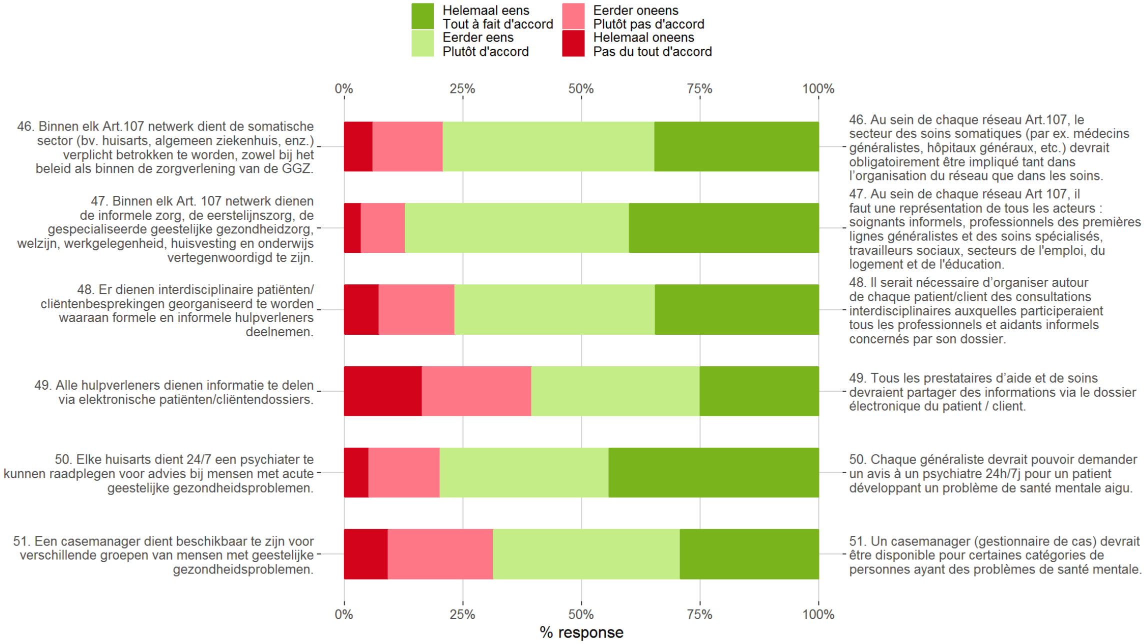
Figure 38 – Visualization of the agreement on inclusion theme statements



3.2.12 Cooperation

The cooperation theme was filled out by 1241 respondents. As seen in Figure 39**Error! Reference source not found.**, more than 75% of the respondents agreed with statements 46-48 and 50 stating that within each art. 107 network (i) the somatic sector should be involve in the policy as well as in the care provision of the MHC, and (ii) the informal care, the first line care, the specialised MHC, well-being, employment, housing, and education should be represented. Moreover, interdisciplinary patient/client discussions should be organised in which (in)formal caregivers should participate, and each GP should be able to consult a psychiatrist 24/7 (in case of people with acute mental health problems). However, 39.5% disagreed that caregivers need to share information through electronic patient files (statement 49) and 31.4% disagreed that a case manager needs to be available for several groups of persons with mental health problems (statement 51). However, in case the respondents agreed with statement 51, people with complex mental health problems were pointed out to receive priority followed by people with acute mental health problems, while priority for vulnerable people and people with chronical mental health problems was rated to be of less priority (Figure 39).

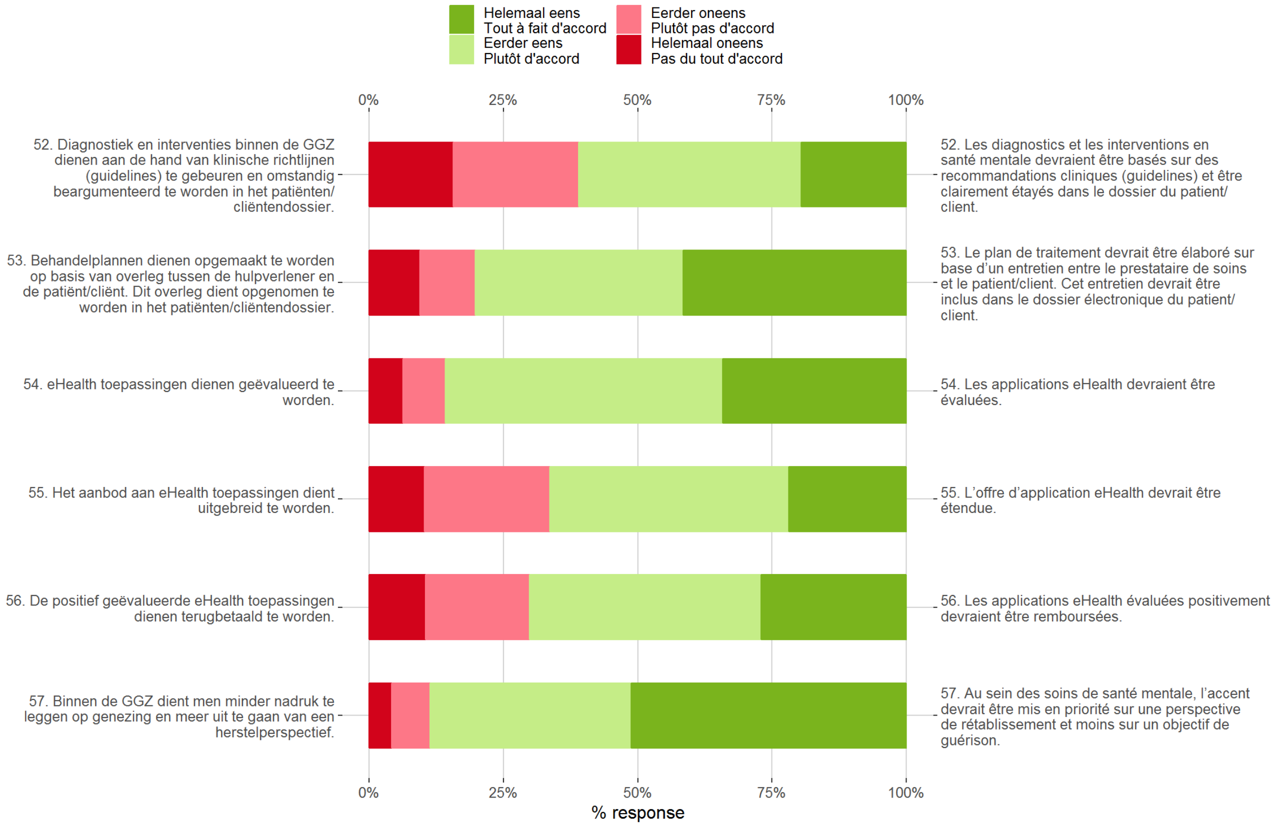
Figure 39 – Visualization of the agreement on cooperation theme statements.



3.2.13 Quality

The quality theme was filled out by 1223 respondents. There was an overall agreement among respondents that quality should be improved (Figure 40). More than 75% of the respondents agreed that care plans should be constructed based on communication between the caregiver and the patient/client which should be recorded in the patient/clients' personal file (statement 53) and that they should emphasize less 'healing' but rather focus on 'recovery' (statement 57). However, there was more controversy between the respondents on three statements i.e. 52, 55, and 56. Statement 52 shows that 61% agreed that diagnostics and interventions within the mental health care should be conducted based on guidelines. Moreover, deviations from these guidelines should be argued extensively in the patient/client file. While 85.9% of the respondents agreed that eHealth should be evaluated (statement 54), less respondents seems to agree i.e. 70.2% that in case eHealth is positively evaluated it should be reimbursed (statement 56). Even less people seem to agree i.e. 67.4% that eHealth applications need to expand (statement 55).

Figure 40 – Visualization of the agreement on quality theme statements.



3.2.14 Respondent opinion on what to change

The question received 941 entrees (575 responded in Dutch and 366 responded in French). Some respondents indicated more than one important thing to improve. We made general categorizations and provide hereunder an impression of the remarks. We received also some feedback on the survey which we added in the limitations section.

In both languages was indicated that the most important thing to change concerned *financing and resources*. Multiple examples were given on which financial measures should be increased: towards prevention (many respondents indicated there should be more (attention for) prevention programmes), to improve the general organisation of the MHC, to make the MHC more attractive (more staff, more innovative, higher salary, etc.), to extend the MHC offer (not referring to the amount of offer but rather as a way to increase access and enhance continuity of care), to eliminate waiting lists, to expand mobile teams and ambulant MHC offer, etc.

The MHC offer was a separate category and it was the second most quoted one. As said above, it does not specifically refers to the amount of available care (as there is 'too much') but rather to the access to the MHC, the fragmentation, the continuity of care and collaboration. Many respondents indicated that they embrace the idea of the government to shift from residential towards community care (however, some respondents argued residential beds are also needed, and financing of these psychiatric beds should be revised). The respondents even indicated and asked that the policy should be reinforced ('stop creating new institutions or organisations and reinforce the existing once, especially towards ambulant care'). It is suggested that ambulant MHC, mobile teams (for acute mental health problems (outreaching teams) but also for chronic mental health problems (continuity of care)), first line MHC, 'herstelacademie', etc. should be even more enhanced and reduction of residential beds should be continued. However, they criticized the fragmentation of the federal and federated competences (e.g. it is suggested that residential care and ambulant care should be the competence of the same entity). They argued the need for simplification of the mental health care organisation as respondents criticized there is 'so much' that even the caregivers do not know all the offer. Therefore someone quoted 'to blow down the house of cards and to start again from scratch'. They also accentuated that organisations within the government and the different layers of the MHC offer should collaborate and communicate more with each other. Furthermore, caregivers themselves should follow a more multidisciplinary patient-centred approach (creating (autonomous) multidisciplinary teams (for each art 107 network), respondents argued that institutions often don't collaborate with 'extra-mural' caregivers or care giving organisations, etc.). Some respondents refer to the organisation of the somatic sector, i.e. towards financing multidisciplinary team meetings and towards their reimbursement strategies.

The topics 'access' and 'waiting lists' were also frequently quoted (together). A general low-threshold access point was multiple times stated and requested. Moreover, in support of the current policy the respondents requested a reinforcement of the 'community' based care i.e. in the community, in the neighbourhood access points (e.g. entrance houses with a short path of diagnosing and referral), through e-communities, improved organisation of the social map, creating inclusion cities, coordinator for each first line care region, 'geïntegreerd breed onthaal' (GP, local community centre, etc.). For more chronic mental health problems, an important task was laid by the home-care nurses, the mobile teams, and it was suggested to install an 'alarm button' at home which alarms the crisis team. When people with mental health problems enter a point of access to the mental health care, respondents indicated a case-manager would be useful (from the multidisciplinary team of the Art 107 networks, GP, mobile team, psychologist, etc.). Often, waiting lists were stated as a major problem in order to provide adequate help once a person with mental health problems decides to seek for help. However, the respondents offer little 'plausible solutions' (often pointing towards more resources) and only a few suggested to create a central waiting list. It was often stated that more attention should be given to support 'vulnerable' groups of people (i.e. children, youth, poor people, etc.) as well as to complex groups and people who 'refuse' care.

From our survey we noticed that many respondents were reserved towards enhancing evidence-based care. However, several respondents indicated that the quality of care should be improved and they referred to the fact that non-evidence based practices should be stopped and appropriate patient-centred care should be pursued, with the recognition (through reimbursement) of caregivers who deliver evidence-based care. This could be related on two things, firstly because they associate evidence-based practice with more registration and administrative task, something that was very often criticized. This could also explain why the respondents were not eager to use BelRai. They indicated they want to focus and listen to the patient. And secondly, because they assume that registration would lead towards changing the financing procedures.

3.3 Results of the sub-analyses

Two sub-analyses were conducted in which we discussed to what extent respondents (dis)agreed with the statements depending on the region in which the organisation was located, and the care organisation itself. We will provide a general conclusion of the results, however the figures presenting the objective proportions with accompanying 95%CIs are added in Appendix 1.15 (Figures 67-96).

3.3.1 *Sub-analysis by region of the organisation*

Across the themes there was little difference in agreement between the regions as for most of the statements, a similar pattern was observed. The respondents from the Brussels region tended to disagree more on the statements, followed by Wallonia and finally Flanders (Figures 39-53).

3.3.2 *Sub-analysis by care organisation*

Across the themes there was general controversy in agreement between the care organisations. However, due to the variability in subgroup size, it was impossible to draw any conclusion (Figure 81 - Figure 95).

4 DISCUSSION

By constructing this survey based on statements and recommendations adjusted to a Belgian context, we aimed to receive suggestions and opinions from stakeholders in order to improve the organization of mental health care in Belgium. After retrieving the international recommendations and adjusting them towards the Belgian situation, the statements were categorized into 13 themes. In the results section we described the more notable results or statements in detail. In the discussion, we obtain to provide a general impression.

The respondents indicated to simplify the organisation of the mental health care by making it the competence of only one policy level. They indicated ‘more financing and resources’ (at multiple levels) as the most important thing to change in the organisation of the MHC. While nearly 73% indicated that financing psychiatric hospitals needed to change, most respondents did not agree with the suggested strategies such as to conduct financing at the level of the Art 107 networks. The majority of the respondents agreed that the MHC should be made more attractive (higher salary, more innovative, etc.) and consequently more staff should be hired. The indicated preferred financing strategy was based on ‘quality indicators’ followed by ‘care paths’. This was confirmed by the last question in which several respondents stated that quality of care should be improved (e.g. more evidence-base work, by improved collaboration throughout multidisciplinary teams, etc.) as indicator for reimbursement and financing (not solely full reimbursement of the first line).

Overall controversy was seen on the ‘registration’ theme. This could be due to the specific term “BelRai”, and the registration of routine-outcome measures for which respondents could assume these measures will be automatically used for financing procedures or would evoke more administration. The latter is often criticized as it would be inhibit to take the time to listen to the patient/client and to offer patient-centred care. Also most respondents agreed to construct a public registry containing all care givers and care giving organisations within MHC, including who is the caregiver, the offer, the outcomes, the waiting time, etc. However, the respondents agreed less that this should be used as prerequisite for financing and accreditation.

The respondents were more redundant about the 'cooperation' and 'participation' themes. In the latter, controversy existed on the participation and role of patient representatives and family expert representatives. This is somehow surprising since most caregivers in MHC place the patient central, and they also indicated that more support should be given to informal care and family. Moreover, it seems that the care givers are not eager to share patient information through electronic patient files with other care givers, within networks, or for research goals. This could be a misunderstanding of the statements because this wouldn't mean that patient data would not be protected (as they might fear that their professional secrecy is endangered). Also, respondents seemed to be more reserved towards eHealth applications. Similar, most respondents agreed that research is important, however, they indicated to be careful with automated access to electronic patient files. Moreover, evidence based treatment is indicated to be less important. Also, many respondents do not agree to use clinical guidelines to establish diagnostics and interventions.

Throughout the survey, most respondents did not feel the need to prioritize certain groups, however, in case they did agree with the prioritization they agreed that vulnerable people (e.g. children, youth, people in poverty, etc.) and people with acute mental health problems should receive priority. Most respondents also agreed on the proposed 'strategies' i.e. expanding the services for vulnerable people, increasing the training for caregivers, more preventive programs and facilitate access. This was conform to the 'access' theme, in which most respondents indicated that a new low threshold information office within each art 107 network would be useful to guide a person (and his/her family) to the suitable care together with a 24/7 crisis service. From the open question was often stated that a case-manager, present at these low threshold access points, would be useful to conduct the first intake and refer to the correct caregiver. Although most respondents agreed on the fact that measures needed to be taken to illuminate the waiting lists, controversy existed on the construction of a central waiting list. Most respondents did not agree to implement a gatekeeper in order to access the specialized mental health care. However, in case they did agree, the GP was stated to be the more suitable person.

The respondents generally agreed and indicated the importance to enhance health literacy and to decrease stigmatization by several measures. As well as they agreed to enhance the inclusion of people with mental health problems in the community, supporting the current policy. In the open question, the respondents often asked for a reinforcement of the current policy towards more community care and several examples were given.

Limitations of the survey

Many (landmark) reports were consulted and available, but we decided to retrieve the recommendations from the largest, more comprehensive reports. The recommendations on which the statements in the survey were based, were gathered among other sources from international frameworks (i.e. WHO, WHO/Europe, UN, etc.) on the organisation of mental health care. Thus, this collection was not exhaustive, however, it was observed that several sources addressed the same (categories of) recommendations. Therefore, we assume that most recommendations from different sources were covered in a comparable way by our survey.

During the period that the survey could be filled out, we received some remarks from the respondents through telephone or email. Some also gave feedback through the last open question of the survey. One respondent indicated the German community (and German language) could not be selected. Some practical remarks were made (e.g. less user friendly to fill out the survey on a tablet or smartphone). Especially the two questions on ranking of the patient groups were stated to be less user friendly to fill out. Some participants indicated they forgot to save their answers to the survey before finishing and submitting it, and dropped therefore out. Few self-employed psychologist, working in a private practise, did not understand why they received the request to fill out the survey. Some respondents identified certain sector specific terms (BelRai, Art.107, IKW, outcome, etc.) as “unknown”, despite mentioning a short description or link. For the same reason, some organisations or teams requested a pdf file in order to fill out together. Thus, it is plausible that more people participated on the survey (as they fill it out by team). Linked to this, some respondents did not feel competent enough to express their opinion on certain topics. Thus, it was indicated that they would have felt more comfortable if not all questions were mandatory to answer or if there would have been a “no answer” or “I don’t know” option. This led to the fact that some respondents expressed their concerns on the applied methodology of the survey (e.g. formulation of the questions) and its validation. We noticed that some respondents would have liked more information on how we would interpret their answers or would made our recommendations (e.g. “how to centralize a waiting list: where? For who? How?”). Some organisations requested therefore a personal meeting.

5 KEY MESSAGES

- **Current competences for the organisation of MHC are too fragmented and more centralization is needed to attain a performant MHC organization.**
- **The interministeriel task force MHC should (en)force the already ongoing reform.**
- **Mental health care should be easily accessible for everyone in need of it and the current offer should be enlarged to cover all MHC needs.**
- **Multiple near-by entry points to MHC should be available and low threshold information points should be created.**
- **There was disagreement that the entry to specialized MHC should be protected by a gate keeper.**
- **Mental Health Care should be based on care needs and more research should be done to investigate care needs.**
- **Financing should be more based on quality indicators and patient trajectories.**

6 REFERENCES

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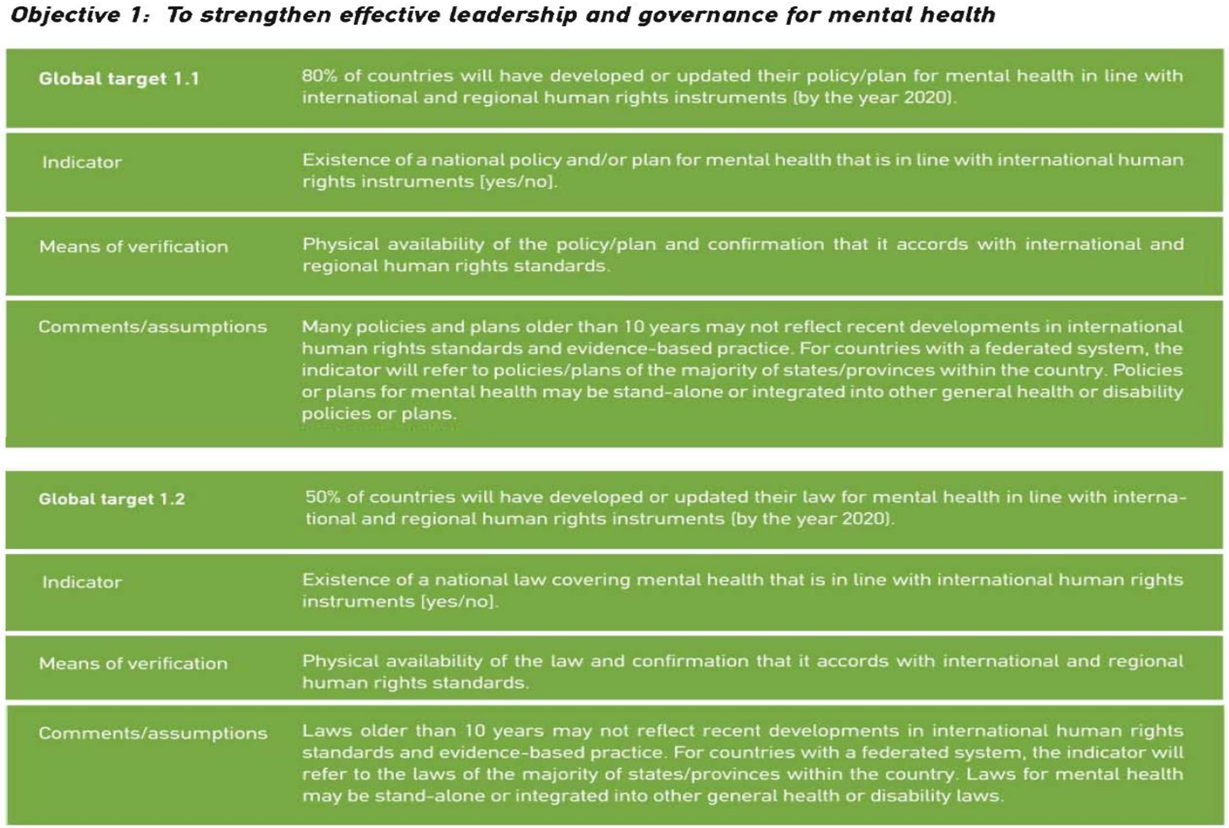
APPENDICES

APPENDICES CHAPTER 4

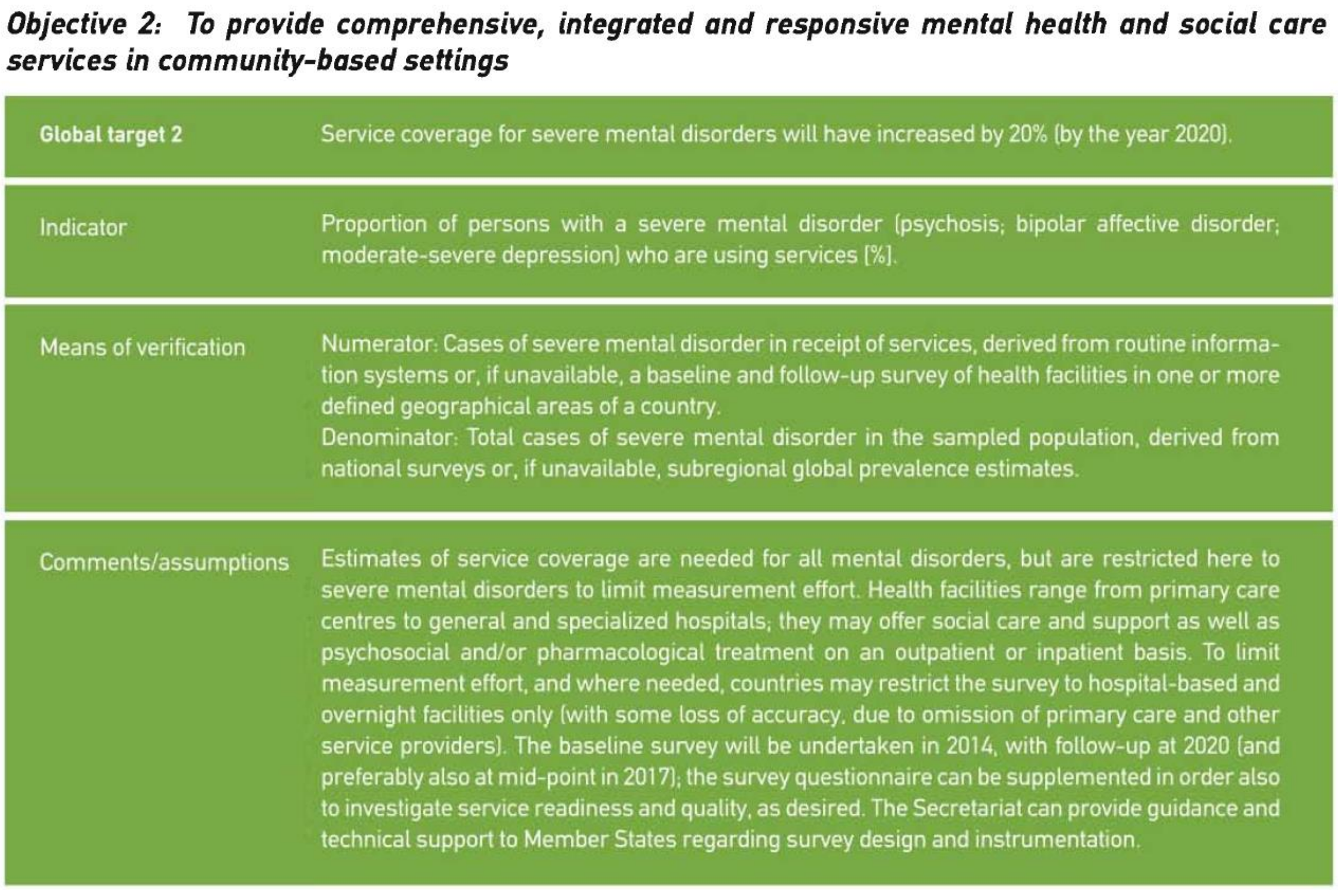
APPENDIX 1. INDICATORS FOR MEASURING PROGRESS TOWARDS DEFINED TARGETS OF THE WHO'S COMPRENHENSIVE MENTAL HEALTH ACTION PLAN 2013-2020[15]



Objective 1: To strengthen effective leadership and governance for mental health

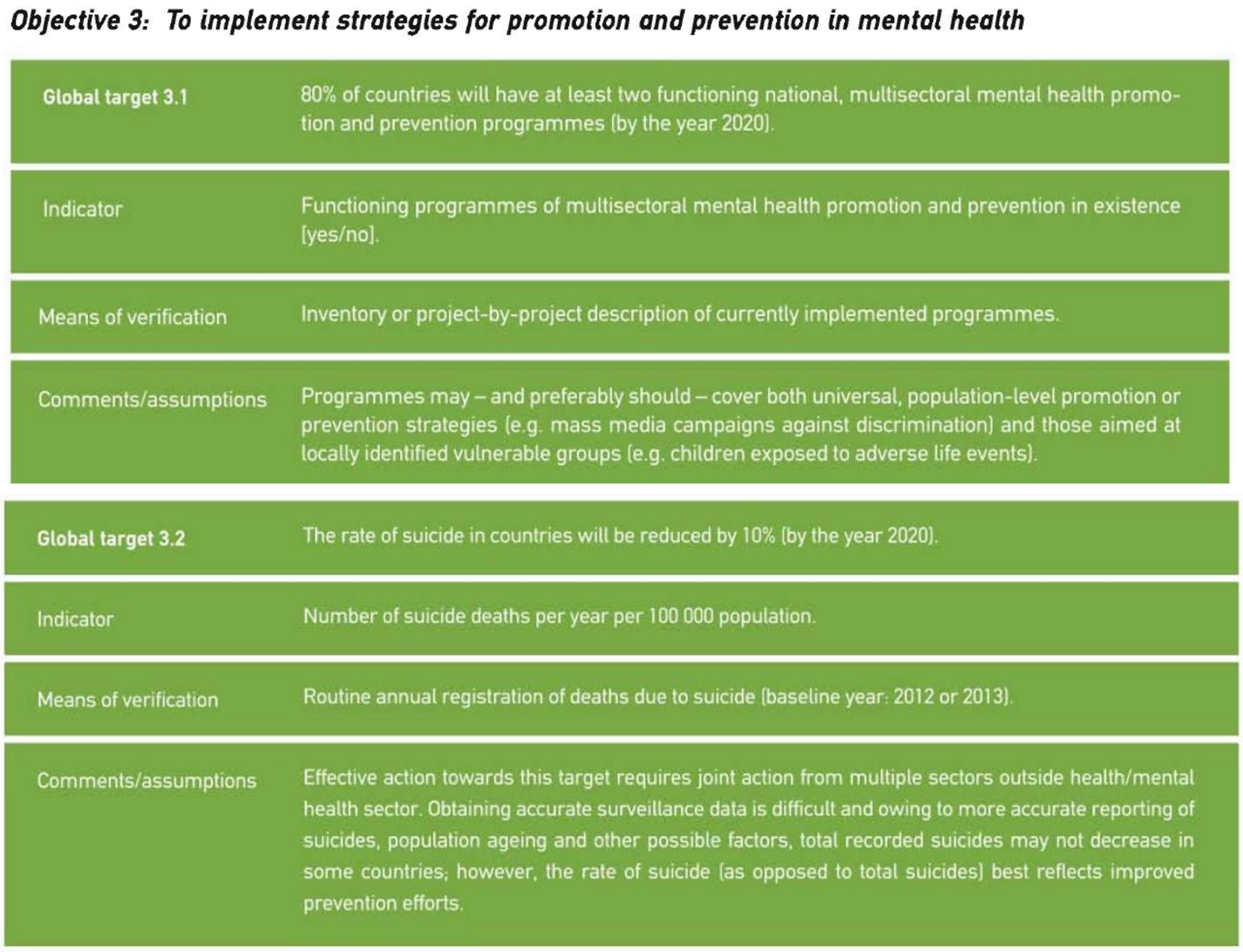
Global target 1.1	80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments (by the year 2020).
Indicator	Existence of a national policy and/or plan for mental health that is in line with international human rights instruments [yes/no].
Means of verification	Physical availability of the policy/plan and confirmation that it accords with international and regional human rights standards.
Comments/assumptions	Many policies and plans older than 10 years may not reflect recent developments in international human rights standards and evidence-based practice. For countries with a federated system, the indicator will refer to policies/plans of the majority of states/provinces within the country. Policies or plans for mental health may be stand-alone or integrated into other general health or disability policies or plans.

Global target 1.2	50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments (by the year 2020).
Indicator	Existence of a national law covering mental health that is in line with international human rights instruments [yes/no].
Means of verification	Physical availability of the law and confirmation that it accords with international and regional human rights standards.
Comments/assumptions	Laws older than 10 years may not reflect recent developments in international human rights standards and evidence-based practice. For countries with a federated system, the indicator will refer to the laws of the majority of states/provinces within the country. Laws for mental health may be stand-alone or integrated into other general health or disability laws.



Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings

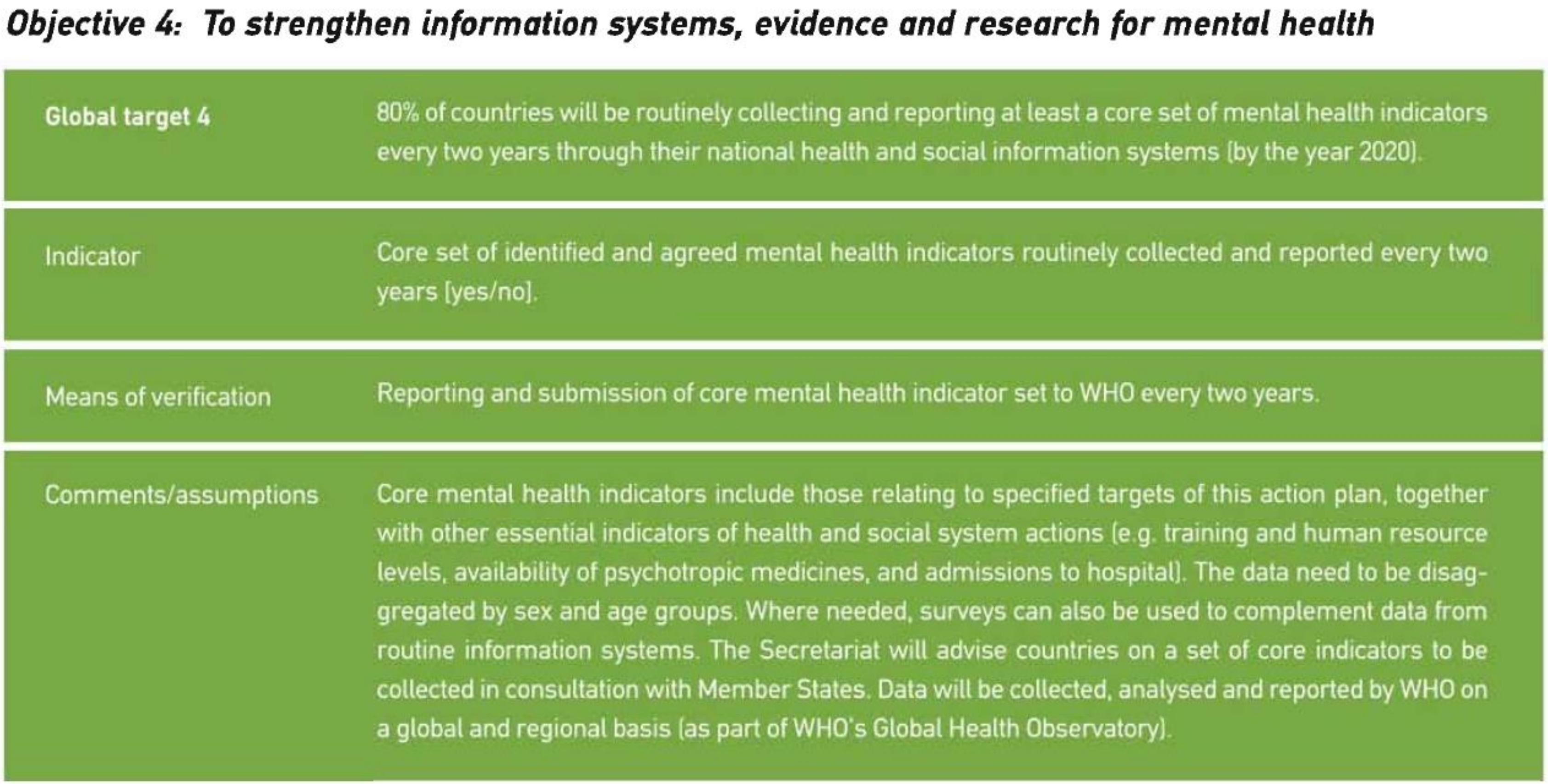
Global target 2	Service coverage for severe mental disorders will have increased by 20% (by the year 2020).
Indicator	Proportion of persons with a severe mental disorder (psychosis; bipolar affective disorder; moderate-severe depression) who are using services (%).
Means of verification	Numerator: Cases of severe mental disorder in receipt of services, derived from routine information systems or, if unavailable, a baseline and follow-up survey of health facilities in one or more defined geographical areas of a country. Denominator: Total cases of severe mental disorder in the sampled population, derived from national surveys or, if unavailable, subregional global prevalence estimates.
Comments/assumptions	Estimates of service coverage are needed for all mental disorders, but are restricted here to severe mental disorders to limit measurement effort. Health facilities range from primary care centres to general and specialized hospitals; they may offer social care and support as well as psychosocial and/or pharmacological treatment on an outpatient or inpatient basis. To limit measurement effort, and where needed, countries may restrict the survey to hospital-based and overnight facilities only (with some loss of accuracy, due to omission of primary care and other service providers). The baseline survey will be undertaken in 2014, with follow-up at 2020 (and preferably also at mid-point in 2017); the survey questionnaire can be supplemented in order also to investigate service readiness and quality, as desired. The Secretariat can provide guidance and technical support to Member States regarding survey design and instrumentation.



Objective 3: To implement strategies for promotion and prevention in mental health

Global target 3.1	80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020).
Indicator	Functioning programmes of multisectoral mental health promotion and prevention in existence (yes/no).
Means of verification	Inventory or project-by-project description of currently implemented programmes.
Comments/assumptions	Programmes may – and preferably should – cover both universal, population-level promotion or prevention strategies (e.g. mass media campaigns against discrimination) and those aimed at locally identified vulnerable groups (e.g. children exposed to adverse life events).

Global target 3.2	The rate of suicide in countries will be reduced by 10% (by the year 2020).
Indicator	Number of suicide deaths per year per 100 000 population.
Means of verification	Routine annual registration of deaths due to suicide (baseline year: 2012 or 2013).
Comments/assumptions	Effective action towards this target requires joint action from multiple sectors outside health/mental health sector. Obtaining accurate surveillance data is difficult and owing to more accurate reporting of suicides, population ageing and other possible factors, total recorded suicides may not decrease in some countries; however, the rate of suicide (as opposed to total suicides) best reflects improved prevention efforts.



Objective 4: To strengthen information systems, evidence and research for mental health

Global target 4	80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).
Indicator	Core set of identified and agreed mental health indicators routinely collected and reported every two years (yes/no).
Means of verification	Reporting and submission of core mental health indicator set to WHO every two years.
Comments/assumptions	Core mental health indicators include those relating to specified targets of this action plan, together with other essential indicators of health and social system actions (e.g. training and human resource levels, availability of psychotropic medicines, and admissions to hospital). The data need to be disaggregated by sex and age groups. Where needed, surveys can also be used to complement data from routine information systems. The Secretariat will advise countries on a set of core indicators to be collected in consultation with Member States. Data will be collected, analysed and reported by WHO on a global and regional basis (as part of WHO's Global Health Observatory).

APPENDIX 2. ACTIONS SUGGESTED BY THE WHO’S ACTION PLAN 2013-2020

Table 44 – Actions of the WHO action plan 2013-2020

Objective 1: To strengthen effective leadership and governance for mental health	
Policy and law	Develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including protective monitoring mechanisms and codes of practice, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.
Resource planning	Plan according to measured or systematically estimated need and allocate a budget, across all relevant sectors, that is commensurate with identified human and other resources required to implement agreed-upon, evidence-based mental health plans and actions.
Stakeholder collaboration	Engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.
Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations	Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policy, law and services.
Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	
Services reorganization and expanded coverage	Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including the use of stepped care principles, as appropriate) for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient, and outpatient care in general hospitals, primary care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing.
Integrated and responsive care	Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health and social services [including the promotion of the right to employment, housing and education) through service user driven treatment and recovery plans, and where appropriate, with the inputs of families and carers.
Mental health in humanitarian emergencies	Work with national emergency committees to include mental health and psychosocial support needs in emergency preparedness, and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for persons with (pre existing as well as emergency-induced) mental disorders or psychosocial problems, including for health and humanitarian workers, during and following emergencies, with due attention to the longer term funding required to build or rebuild a community-based mental health system after the emergency

Resource planning	Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally-appropriate and human rights-oriented mental health and social care services, for children and adolescents, inter alia, by introducing mental health into undergraduate and graduate curricula; and through training and mentoring health workers in the field, particularly in non-specialized settings, to identify and offer treatment and support to people with mental disorders as well as to refer people, as appropriate, to other levels of care.
Address disparities	Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.
Objective 3: To implement strategies for promotion and prevention in mental health	
Mental health promotion and prevention	Lead and coordinate a multisectoral strategy that combines universal and targeted interventions for: promoting mental health and preventing mental disorders, reducing stigmatization and human rights violations, and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.
Suicide prevention	Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context.
Objective 4: To strengthen information systems, evidence and research for mental health	
Information systems	Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age (including on completed and attempted suicides) to improve mental health service delivery, promotion and prevention strategies and to feed into the Global Mental Health Observatory.
Evidence and research	Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centres of excellence with dear standards, with the inputs of all relevant stakeholders including persons with mental disorders and psychological disabilities.

APPENDIX 3. ACTIONS SUGGESTED BY THE WHO/EUROPE ACTION PLAN

Table 45 – Objectives, outcomes and actions of the WHO/Europe action plan 2013-2020 8

Objectives	*Outcomes*	*Actions for European member states*
Objective 1. Everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk	• (a) raised **awareness of mental well-being** and factors that support it – in lifestyles, in the family, at work, in schools and kindergartens, in the community and in wider society; • (b) increased **support for mental health needs in antenatal and postnatal care**, including screening for domestic violence and alcohol abuse; • (c) increased **capacity in primary care** to enhance mental health promotion, the prevention and early recognition of mental disorders and low-threshold psychological support; • (d) increased **return to work** of people with mental health conditions; • (e) **reduced suicide rates** among the population as a whole and in subgroups related to age, sex, ethnicity and other vulnerable groups; and • (f) means of **measuring well-being** and the determinants of well-being **(in addition to measures of mental disorder**) throughout the life-course agreed and implemented.	• (a) develop and implement **suicide prevention strategies** that incorporate best evidence, combining a universal approach with activities protecting vulnerable groups; • (b) provide **support for family life**, ante-/postnatal care and parenting skills; • (c) provide **opportunities for pre-school education** and encourage parents to value the home as a learning environment, such as play, reading to children and family meals; • (d) reduce adverse childhood experiences (such as abuse, neglect, violence and exposure to drug and alcohol misuse) by raising awareness, increasing recognition, and ensuring early intervention; • (e) offer universal and targeted mental health promotion programmes in schools, including early identification of emotional problems in children and action on bullying; • (f) apply whole-of-community approaches to education in areas of multiple deprivation to **break the cycle linking poverty, deprivation and poor educational outcomes**; • (g) promote **lifelong learning**: improving literacy, numeracy and basic skills in those who are most deprived and excluded; • (h) create incentives for employers to reduce psychosocial and job-related stress, enhance stress management and introduce simple programmes to **promote well-being in the workplace**; • (i) encourage optimal organization of work and working hours to **achieve work-life balance**; • (j) promote **healthy nutrition and physical activity** for all age groups, through sport and other activities, and provide safe play space for children; • (k) promote the establishment and protection of **healthy places outdoors and contact with nature**; • (l) **provide living spaces and neighbourhoods that are safe, convenient and accessible, as defined by older people themselves**; and that facilitate their participation, mobility and autonomy; and • (m) provide opportunities for **e-learning for older people** to facilitate access to social networks and early intervention programmes.

Objective 2. People with mental health problems are citizens whose human rights are fully valued, respected and promoted	• (a) all human rights are guaranteed and **protection against discrimination** is safeguarded for people with mental health problems; • (b) opportunities associated with full citizenship, including **employment, housing and education for people with mental health problems are equal to those of other people**, taking into account adjustments required to compensate for any disability; and • (c) people subjected to involuntary care and/or treatment have **access to free information and legal advice**.	• (a) **adopt or update policies and legislation** according to ratified conventions and endorsed declarations, guaranteeing human rights and protection against discrimination associated with mental health problems in areas such as benefits, employment, education and housing; • (b) **address inequalities and discrimination** in access to and experience of mental health services; • (c) provide each patient and family member with **appropriate information**, in an accessible format, about rights, care standards and treatment options; • (d) create and/or identify mechanisms for **people with mental health problems to participate in** the design, delivery, monitoring and evaluation of **mental health policies and services**; • (e) enable the capacity of **patient and family advocacy groups**, including financial **support**, strengthening representation of their interests; • (f) ensure free access to **legal advice for people detained involuntarily**; • (g) conduct **evidence-based anti-stigma activities in communities**, targeting people who have the potential to impact the lives of those suffering from discrimination.
Objective 3. Mental health services are accessible, competent and affordable, available in the community according to need	• (a) mental health services are organized in order to **facilitate a (normal) life in society** and comprise a spectrum of care, **integrating specialist mental health and generic services**; • (b) **primary care can ensure correct** early diagnosis, treatment and referral for people with mental disorders; • (c) community-based mental health services are **accessible to all groups** in the population; • (d) **large institutions**, associated with neglect and abuse, **are closed**; • (e) **hospital care is therapeutic**, offering a range of treatment, care and support tailored to individual needs, **rather than simply confining patients**; • (f) mental health services are provided in **decent settings**; • (g) mental health services offer **appropriate care** for different age groups;	• (a) develop a national mental health strategy specifying the **priorities and responsibilities of national and local specialist and generic agencies**; • (b) establish **primary care as the first point of access** for people with mental health problems, and provide the capacity to deliver treatment for common mental disorders; • (c) base **community mental health services in accessible settings**, close to the most vulnerable groups and provide essential support services; • (d) offer **special outreach programmes** in areas with a high prevalence of risk populations such as poor minority groups or homeless people; • (e) create **community services** that are age-appropriate and competent to offer early intervention and continuing **support to young people with a first episode** of a severe mental health problem; • (f) develop **psychiatric units that are therapeutic**, with single sex facilities **with adequate privacy**, particularly bedrooms, toilets and bathrooms, and with staff that offer individualized and effective care in a respectful manner; • (g) provide **homes in the community**, offering dignified and person-centred living arrangements and care; • (h) ensure that **forensic services** for people with mental disorders are **managed by mental health services**, with special training and facilities;

	• (h) **family** capacity and needs are **assessed** periodically, and training **and support** provided; • (i) a **multidisciplinary workforce** is available in sufficient numbers; and • (j) mental health services can be accessed **without unfair financial barriers**.	• (i) identify and provide resources to **support families** that look after loved ones requiring long-term care, including education, relief services and adequate benefits; • (j) analyse and if required rectify health financing to create **incentives for the development of community based mental health services**; and • (k) **remove obstacles to access to services** for the most deprived by evaluating transport, finance and availability.
Objective 4. People are entitled to respectful, safe and effective treatment	• (a) all mental health **treatments**, whether medical, social or psychological are therapeutic, and **respect the dignity and preferences of the** service **users** and, where indicated, their families; • (b) **effective treatments** are made **available** on criteria of both efficiency and fairness; • (c) the **workforce** is properly qualified and **competent**, able to maintain a high morale; and • (d) international cooperation is established between governments and professional stakeholders to **benchmark training, competencies and standards of care**.	• (a) put in place **governance arrangements** to ensure accountability by clinicians for the delivery of interventions that are respectful, safe and effective; • (b) allow **service users to share in decisions** about the prioritization, development and implementation of innovative and effective treatments, at both system and individual levels; • (c) conduct **all practice according to ethical standards** confirmed by professional associations; • (d) include mental health competencies in undergraduate curricula for all doctors and other staff groups and ensure continuing **education for the primary care workforce**; • (e) assure that all staff posts in services are filled by competent professionals, and offer **lifelong learning opportunities** to adjust staff to change; and • (f) offer staff development opportunities and a **stimulating working environment**, fostering morale.
Objective 5. Health systems provide good physical and mental health care for all	• (a) people with mental health problems have a **life expectancy equal** to the age-/sex-matched general population; • (b) **access** of people with mental health problems **to physical health services** such as cardiovascular diseases, diabetes, cancer and dental care and the quality of the physical health care they receive is equal to access for the general population; and • (c) **mental health problems** in people with physical diseases are recognized and **treated adequately**.	• (a) ensure that people with severe mental health problems are **prioritized in health strategies**; • (b) ensure that all people have access to **physical and mental health care of equitable quality**; • (c) take actions to improve **access of people with mental disorders to physical health care**, particularly to emergency care; • (d) ensure that services are in place to **monitor health indicators and their risk factors and any adverse effects of medication** among all people with mental health problems in community services and hospital facilities; • (e) include **lifestyle modification** in education and treatment programmes for people with mental health problems; • (f) assess periodically the **mental health status of people with chronic physical diseases**; and • (g) offer **training for all primary care practitioners** on the detection and management of depression and anxiety in people with physical diseases.

Objective 6. Mental health systems work in well-coordinated partnership with other sectors	- (a) people with mental health problems receive the **benefits and services to which they are entitled**; - (b) patients can **access** care, including **specialized services**, through an integrated assessment procedure; - (c) funding systems offer **incentives for efficient ways of working**; and - (d) the expertise of service users and family members is used to allocate resources for their care.	- (a) specify **roles and responsibilities of generic and specialist mental health agencies** across sectors. Generic agencies can nominate lead staff for mental health related issues; - (b) ensure that the **coordination of welfare, employment, housing and education opportunities is an accepted responsibility for mental health services**; - (c) establish unified assessment **procedures between mental health and social care agencies**; - (d) offer incentives to **pool budgets of agencies** that need to work in close partnership; and - (e) create **opportunities for services users and/or families to plan their own services** by providing budgets, with clear accountability.
Objective 7. Mental health governance and delivery are driven by good information and knowledge	- (a) **indicator** sets for outcomes are selected, **relevant to the needs** of the target audience; - (b) **quality and safety is independently inspected**, involving service users and families; - (c) **research is coordinated and disseminated internationally**; - (d) staff numbers, distribution and their causes are known; and - (e) definitions of **terminology are internationally agreed**.	- (a) complete and return the **indicators of the Global Mental Health Action** Plan;1 - (b) **assess quality and safety by agencies independent of providers**, producing transparent reports; - (c) take measures to **share information** between clinicians and agencies while **protecting the confidentiality** of individuals; - (d) evaluate effects of public health measures with mental health impact assessments; - (e) **support research** capacity to assess needs, discover effective innovation and evaluate outcomes; and - (f) make **service users and family members an integral part of quality control**.

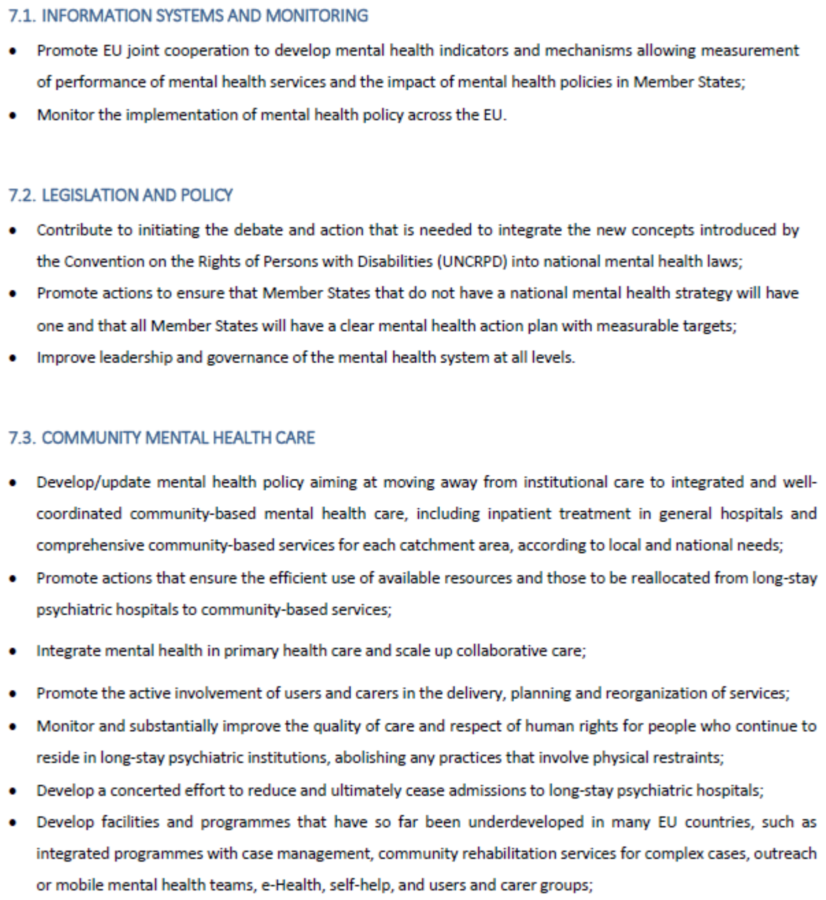
APPENDIX 4. KEY ACTIONS SUGGESTED BY THE EUROPEAN FRAMEWORK FOR ACTION 2016

Table 46 – Objectives of the Framework for action on MH and WB 9

Objectives	Key actions
Ensure the setup of sustainable and effective implementation of policies contributing to promotion of mental health and the prevention and treatment of mental disorders	• Develop and update mental health policies and legislation • Provide tools to estimate both the level of mental disorders and proportion receiving treatment, coverage of effective interventions to prevent mental disorders, promote mental wellbeing and provide treatment, as well as associated economic savings of improved coverage, including time frames and where such savings occur • Allocate the resources commensurate with the real needs of the populations • Improve leadership and governance of the mental health system • Set up cross-sectoral cooperation at local, regional, national and European level • Promote mental health awareness, (self-) empowerment and workforce skills • Improve literacy about public mental health among key sectors such as health, education, justice, workplaces and social affairs.
Develop mental health promotion and prevention and early intervention programmes, through integration of mental health in all policies and multi-sectoral cooperation	• Take action against depression • Take action to prevent suicide • Mainstream e-mental health interventions • Promote mental health at the workplace • Build up networks with schools, youth, and other stakeholders and institutions involved in mental health of children and adolescents
Ensure the transition to comprehensive mental health treatment and care of high quality in the community that is accessible to all, emphasizing the availability of mental health care for people with mental disorders, coordination of health and social care for people with more severe mental disorders as well as integrated care for mental and physical disorders	• Put in place community-based and socially inclusive mental health care, through well-coordinated primary care, specialised mental health services and social services • Make use of tools to assess, compare and level-up the quality of treatment and care provided • Implement evidence–based approaches for integrated care for mental disorders and other chronic diseases
Strengthen knowledge, the evidence base and good practices sharing in mental health	• Strengthen research into mental health • Collect data on population mental health • Promote dissemination of good practices of implementation of evidence-based public mental health interventions

	• Collect data on coverage and outcomes of evidence-based interventions to treat mental disorders, prevent mental disorders and promote mental health
Partnering for progress	• Develop cooperation between Member States in policy development, research projects, implementation and capacity building programmes • Make full use of EU-policies to support Member States and improve the implementation, monitoring and evaluation of mental health policies • Strengthen synergies between EU-health policy and further relevant EU policies, particularly those relating to human rights, employment, social support and research • Promote cooperation with relevant stakeholders and other international organisations in Europe • Empower users of mental health services as partners in all steps of mental health policy and its implementation

APPENDIX 5. RECOMMENDATIONS OF THE EU COMPASS FOR ACTION ON MENTAL HEALTH AND WELLBEING: UPDATE OF 2018 [31]



7.1. INFORMATION SYSTEMS AND MONITORING

- Promote EU joint cooperation to develop mental health indicators and mechanisms allowing measurement of performance of mental health services and the impact of mental health policies in Member States;
- Monitor the implementation of mental health policy across the EU.

7.2. LEGISLATION AND POLICY

- Contribute to initiating the debate and action that is needed to integrate the new concepts introduced by the Convention on the Rights of Persons with Disabilities (UNCRPD) into national mental health laws;
- Promote actions to ensure that Member States that do not have a national mental health strategy will have one and that all Member States will have a clear mental health action plan with measurable targets;
- Improve leadership and governance of the mental health system at all levels.

7.3. COMMUNITY MENTAL HEALTH CARE

- Develop/update mental health policy aiming at moving away from institutional care to integrated and well-coordinated community-based mental health care, including inpatient treatment in general hospitals and comprehensive community-based services for each catchment area, according to local and national needs;
- Promote actions that ensure the efficient use of available resources and those to be reallocated from long-stay psychiatric hospitals to community-based services;
- Integrate mental health in primary health care and scale up collaborative care;
- Promote the active involvement of users and carers in the delivery, planning and reorganization of services;
- Monitor and substantially improve the quality of care and respect of human rights for people who continue to reside in long-stay psychiatric institutions, abolishing any practices that involve physical restraints;
- Develop a concerted effort to reduce and ultimately cease admissions to long-stay psychiatric hospitals;
- Develop facilities and programmes that have so far been underdeveloped in many EU countries, such as integrated programmes with case management, community rehabilitation services for complex cases, outreach or mobile mental health teams, e-Health, self-help, and users and carer groups;

- Develop structured cooperation between mental health services, social services and employment services, to ensure that community-based residential facilities, vocational programmes, and other psychosocial rehabilitation interventions are available;
- Promote the use of the opportunities provided by the EU 2020 Strategy on research and development to improve the monitoring and evaluation of policies addressing the social exclusion of people suffering from mental disorders.

7.4. INTEGRATED GOVERNANCE/MENTAL HEALTH IN ALL POLICIES

- Promote actions to improve mental health literacy in the public sector and among the general public;
- Disseminate information demonstrating existing win-win situations, where objectives of different policy areas coincide to mutual benefit, and using language that is understandable to policy makers in different sectors;
- Enhance the inclusion of communities, social movements and civil society in the development, implementation and monitoring of "Mental health in all Policies";
- Develop tools for implementation of "Mental health in all Policies", such as tools for mental health impact assessment;
- Invest in the evidence and knowledge base of "Mental health in all Policies";
- Promote the utilization of joint budgeting of mental health strategies involving different sectors;
- Improve monitoring and audit of the mental health and equity effects of policy actions.
- Increase cooperation across Europe to gather data in a standard format that can track service and policy changes

APPENDIX 6. MENTAL HEALTH ATLAS 2017 BELGIUM PROFILE

Table 47 – Mental Health ATLAS 2017 Belgium profile [25]

General data		
Burden of mental disorders (WHO official estimates)	Disability-adjusted life years Suicide mortality rate	3 310.07/100 000 population 20.7/100 000 population
Total mental health expenditure	Not reported	
Availability of mental health reporting	A specific report focusing on mental health activities in both the public and private sector has been published by the Health Department or any other responsible government unit in the last two years	
Mental health system governance		
Mental health policy/plan	Stand-alone policy or plan for mental health (Year of policy/plan)	Yes (2010)
	The mental health policy / plan contains specified indicators or targets against which its implementation can be monitored	Yes
	Policy / plan is in line with human rights covenants (self-rated 5-point checklist score; 5 = fully in line)	4
	Plan or strategy for child and/or adolescent mental health (Year of policy / plan):	Yes (2014)
Mental health legislation	Stand-alone law for mental health (Year of law)	Yes (2014)
	The existence of a dedicated authority or independent body to assess compliance of mental health legislation with international human rights	Exist and provides irregular inspections of facilities and partial enforcement of mental health legislation
	Law is in line with human rights covenants (self-rated 5-point checklist score; 5 = fully in line)	4
Multisectoral collaboration	There is ongoing collaboration in the area of mental health with Service users and family or caregiver advocacy groups	Yes
Resources for mental health		
Mental health financing	The care and treatment of persons with major mental disorders (psychosis, bipolar disorder, depression) included in national health insurance or reimbursement schemes in your country	Yes
	How the majority of persons with mental disorders pay for mental health services	Persons pay nothing at the point of service use (fully insured)
	The government's total expenditure on mental health as % of total government health expenditure	None or not reported

Human resources for mental health	Total number of mental health professionals (gov. and nongov.)	19 601	
	Total mental health workers per 100,000 population	173.65	
	Total number of child psychiatrist (gov. and non-gov.)	None or not reported	
Mental health workforce	Psychiatrists	20.06/100 000 population	
	Child psychiatrists	None or not reported	
	Other specialist doctors	None or not reported	
	Mental health nurses	125.69/100 000 population	
	Psychologists	10.46/100 000 population	
	Social workers	17.43/100 000 population	
	Occupational therapists	None or not reported	
	Speech therapists	None or not reported	
	Other paid mental health workers	None or not reported	
Mental health service availability and uptake			
Example	Example	Example	Example
Outpatient care (total facilities)	Mental health outpatient facilities attached to a hospital	None or not reported	
	"Community-based / non-hospital" mental health outpatient facility	None or not reported	
	Other outpatient facility (e.g. Mental health day care or treatment facility)	None or not reported	
	Outpatient facility specifically for children and adolescents (including services for developmental disorders)	None or not reported	
	Other outpatient services for children and adolescents (e.g. day care)	None or not reported	
Outpatient care (per 100 000 population)	Number of visits made by service users in the last year in mental health outpatient facilities attached to a hospital	None or not reported	
	Number of visits made by service users in the last year in "Community-based / non-hospital" mental health outpatient facility	None or not reported	
	Number of visits made by service users in the last year in other outpatient facility (e.g. Mental health day care or treatment facility)	None or not reported	
	Number of visits made by service users in the last year in outpatient facility specifically for children and adolescents (including services for developmental disorders)	None or not reported	

	Number of visits made by service users in the last year in other outpatient services specifically for children and adolescents (e.g. day care)	None or not reported
Inpatient care (total facilities)	Mental hospitals	53
	Psychiatric units in general hospitals	63
	Forensic inpatient units	2
	Residential care facilities	128
	Inpatient facility specifically for children and adolescents	6
Inpatient care (per 100 000 population)	Mental hospital beds annual admissions	98.88/100 000 population 348.62/100 000 population
	General hospital psychiatric unit beds annual admissions	22.71/100 000 population 367.98/100 000 population
	Forensic inpatient unit beds annual admissions	2.34/100 000 population None or not reported
	Residential care beds annual admissions	65.36/100 000 population 21.72/100 000 population
	Child and adolescent specific inpatient beds annual admissions	1.42/100 000 population 7024/100 000 population
Mental hospitals	Total number of inpatients	15 701
	Admissions that are involuntary	7670
	Follow-up of people with mental disorder discharged from hospital in the last year	None or not reported
Mental hospitals length of stay	Inpatient staying less than 1 year	64%
	Inpatient staying 1-5 years	22.8%
	Inpatients staying more than 5 years	13.1%
Treated cases of severe mental disorder	Total cases Per 100 000 population	None or not reported None or not reported
Mental health promotion and prevention		
	Existence of at least two functioning programmes	No (or not reported)
	Existence of a suicide prevention strategy [i.e. as a standalone document or as an integrated element of the national policy/plan adopted by government]: the Health Goal Suicide Prevention	Yes

APPENDICES CHAPTER 5

APPENDIX 1. THE BELGIAN POPULATION

Table 48 – Repartition of the population through the Regions and community [105]

Population 01/01/2018				
Flanders	**Wallonia**	**Brussels**	**German Community**	**Belgium**
57,6%	31,9%	10.5%	0,7%	11 376 070

The majority of the population lives in Flanders, followed by Wallonia with a third of the population, Brussels with a tenth, and the German Community that represents less than a percent.

Table 49 – Repartition of the Belgian population per provinces [106]

Province	Population	%
Brussels	1 191 041	10,5%
Antwerp	1 844 924	16,2%
Limburg	870 294	7,7%
East Flanders	1 503 576	13,2%
Flemish Brabant	1 137 798	10,0%
West Flanders	1 190 193	10,5%
Walloon Brabant	400 985	3,5%
Hainaut	1 340 147	11,8%
Liège	1 103 745	9,7%
Luxemburg	282 946	2,5%
Namur	492 708	4,3%
Total Belgium	11 358 357	100%

Table 50 – Repartition of the gender in the Belgian population [105]

Gender	Belgium
Female	50,82%
Male	49,18%

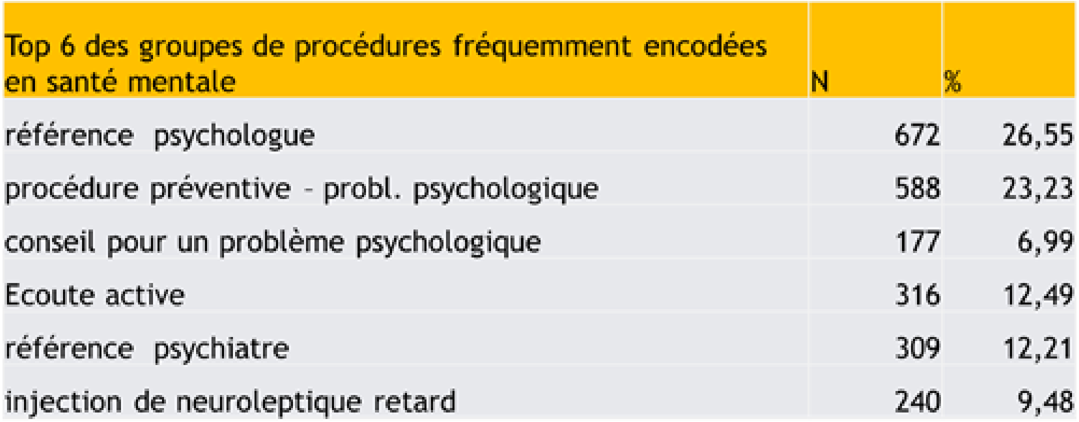
APPENDIX 2. BED DESCRIPTION

Bed type	Target population	Type of hospital / service	Programming norms
Neuropsychiatric beds for observation and treatment, A • Service A1 – day bed • Service A2 – night bed	Beds for neuropsychiatric observation and treatment of adult patients needing urgent care or active treatment. A1 and A2 beds correspond to day/night hospitalisation.	• Psychiatric hospital • Psychiatric ward in a general hospital • Specialised hospitals (between 2014 and 2016)[c]	Day and night hospitalization (A) - 0,5 bed/1000 inhabitants in HP - 0,27 bed/1000 inhabitants in PAAZ-SPHG Day or night hospitalization (A1, A2) - 0,15 bed/1000 inhabitants in HP - 0,075 bed/1000 inhabitants in PAAZ-SPHG
Psychiatric beds for treatment [a], T • Service T1 – day bed • Service T2 – night bed	Beds for neuropsychiatric treatment for an active social rehabilitation of adult patients. T1 and T2 beds correspond to day/night hospitalisation.	• Psychiatric hospital	Day and night hospitalization (T) - 0,9 bed/1000 inhabitants Day or night hospitalization (T1, T2) - 0,4 bed/1000 inhabitants
Psychiatric beds for geriatric patients requiring neuro-psychiatric treatment, Tg	Tg beds are for geriatric patients requiring neuro-psychiatric treatment.	• Psychiatric hospital	0.23 bed/1000 inhabitants
Intensive treatment of psychiatric patients, IB	Beds for intensive treatment of psychiatric young (less than 18 years) and adult patients (patients with greatly disturbed behaviour and aggressive patients).	• Psychiatric hospital	1 IB bed per 1 A or 1.33 T disused bed
Specialised psychogeriatric beds, Sp(6[b])	Beds for psychogeriatric patients requiring a diagnostic or treatment by multidisciplinary team.	• Psychiatric hospital • General hospital • Specialised hospitals	0,52 bed/1000 inhabitants

APPENDIX 3. MEDICALS HOMES

These data concern patients older than 15 years and are derived from 31 teams (all French speaking, 10 in Brussels and 21 in Wallonia) representing 41 931 patients at the 31/12/2016 (from the “tableau de bord des maisons médicales, by email from the federation [107]).

Table 51 – Top 6 of the procedures groups frequently encoded in mental health in medical homes



Top 6 des groupes de procédures fréquemment encodées en santé mentale	N	%
référence psychologue	672	26,55
procédure préventive - probl. psychologique	588	23,23
conseil pour un problème psychologique	177	6,99
Ecoute active	316	12,49
référence psychiatre	309	12,21
injection de neuroleptique retard	240	9,48

APPENDIX 4. CENTRE FOR GENERAL WELFARE

Table 52 – Number of FTE on 31 December 2015

CAW	Number of acknowledged FTE	Total FTE
CAW Limburg	139,28	217,2
CAW Anvers	206,31	423,78
CAW De Kempen	90,36	118,32
CAW Boom Mechelen Lier	56,13	66,8
CAW Brussel	85,47	134,6
CAW Halle Vilvoorde	73,67	97,3
CAW East-Brabant	104,92	142,3
CAW East-Flanders	286,25	418,8
CAW North-West-Flanders	131,48	197,2
CAW Central-West-Flanders	55,6	70,1
CAW South-West-Flanders	76,09	103,3
TOTAL	1305,56	1989,70

(Note: First column: Number of acknowledged FTE, second column: Total number of deployed employees; The last number is higher because not all employees work fulltime.)

Table 53 – Sort of guidance and offers of care in 2015

	Number of type modules	%
Individual guidance, psychological and personal problems, basis rights	7.083	29,30%
Residential shelter	3.762	15,56%
Assisted living	3.364	13,92%
Problems in partnership and parents support	2.761	11,42%
Visiting room	1.593	6,59%
Interfamily violence and group guidance	1.523	5.75%
Victimisation	1.390	5,75%

Offender counselling	1.306	5,40%
Family counselling and sexual problems	1.253	5,18%
Relatives and children of detainee	107	0,44%
Detention	28	0,12%
TOTAL	**24.170**	**100%**

Table 54 – CAW incomes in 2017

CAW	AWW-envelope Flemish government	Social maribel	Other funding	Donations and legates	TOTAL
CAW Limburg	9.989.180,18	463.188,25	2.345.995,68	16.598,81	15.814.528,27
CAW Anvers	15.166.892,14	767.117,60	13.512.529,41	160.409,50	31.484.977,65
CAW De Kempen	6.474.315,12	327.647,87	1.657.207,00	3.876,37	8.993.682,50
CAW Boom Mechelen Lier	3.832.879,38	257.037,08	529.542,67	6.422,65	4.784.430,82
CAW Brussel	5.852.535,40	442.797,77	2.448.533,48	26.906,04	9.241.900,74
CAW Halle Vilvoorde	5.335.692,11	320.675,74	512.704,61	/	6.202.014,46
CAW East-Brabant	7.552.832,95	381.106,00	565.818,55	12.930,00	8.840.982,50
CAW East-Flanders	20.169.487,07	1.027.622,12	4.729.056,67	60.912,65	27.935.789,94
CAW North-West-Flanders	9.150.720,00	581.885,00	2.637.577,00	39.610,00	13.131.489,00
CAW Central-West-Flanders	3.883.442,83	239.566,40	488.528,42	9.132,00	4.937.948,87
CAW South-West-Flanders	5.253.542,25	356.784,01	1.423.955,26	11.855,52	7.549.292,04

TOTAL	92.661.519,43	5.219.427,84	30.851.448,75	348.653,54	138.417.036,79

Figure 41 – Map of the CAW coverage

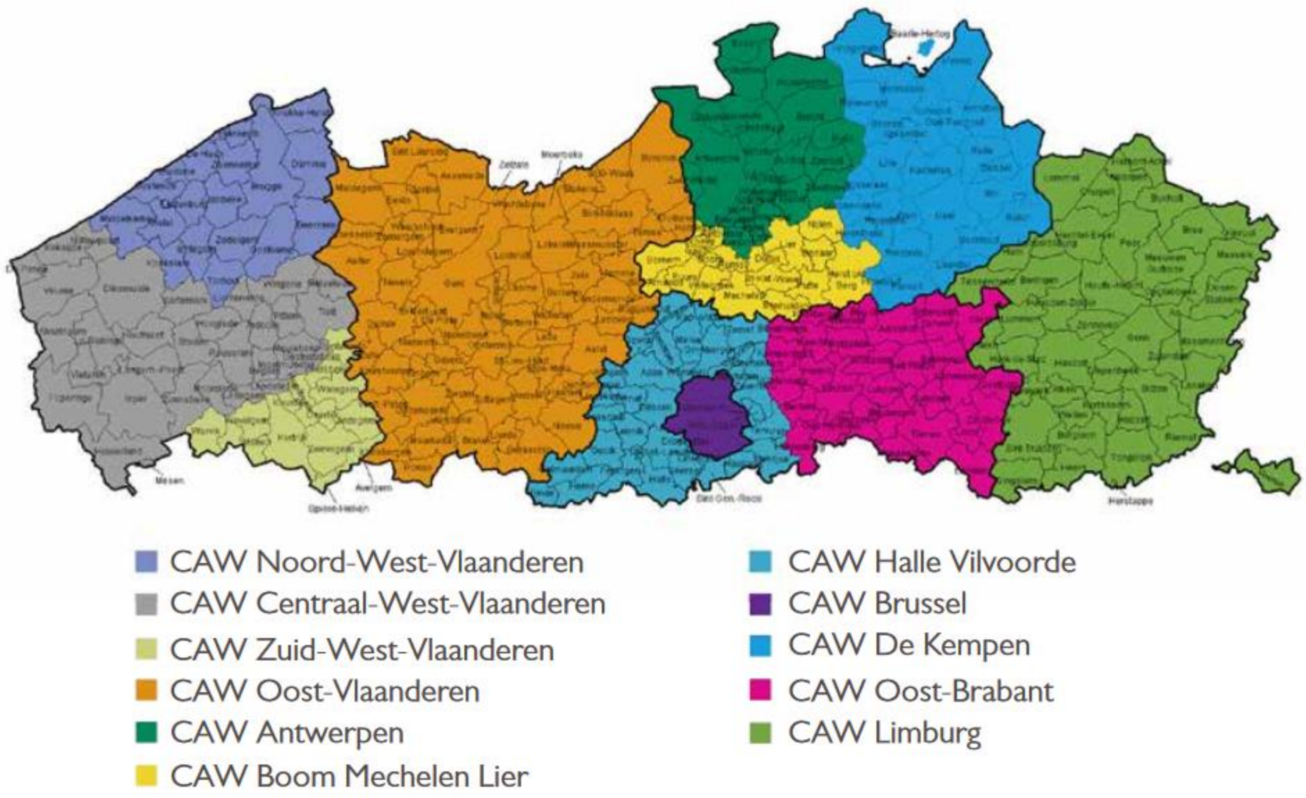


Table 55 – Number of volunteers in the CAW in 2017

CAW	Number of Volunteers
CAW Limburg	163
CAW Anvers	327
CAW De Kempen	282
CAW Boom Mechelen Lier	71
CAW Brussel	143
CAW Halle Vilvoorde	44
CAW East-Brabant	215
CAW East-Flanders	650
CAW North-West-Flanders	274
CAW Central-West-Flanders	108
CAW South-West-Flanders	237
TOTAL	**2514**

Table 56 – Types of contacts by guidance

Number of consultations (bureaugesprekken)	138.062
Number of visits at home	42.783
Number of mobile contacts	11.559
Number of phone calls	56.238
Number of mails	28.941
Number of group sessions	2.378

Table 57 – Distribution of the sort of problems

	Reception		Guidance	
Material and financial	32.136	26,35%	11.445	23,60%
Mental wellbeing	24.580	20,16%	12.324	25,41%
Partner relation, sexuality and birth	11.858	9,72%	4.296	8,86%
Family and breeding	11.663	9,56%	4.346	8,96%
Ethnic and cultural	7.886	6,47%	931	1,92%
Interfamily violence	7.283	5,97%	2.506	5,17%
Administration and caring	6.573	5,39%	2.662	5,49%
Judicial and juridical	5.887	4,83%	2.241	4,62%
Social situation	4.931	4,04%	2.458	5,07%
Mental health	2.839	2,33%	1.570	3,24%
Training and work	2.252	1,85%	1.502	3,10%
Physical health	1.960	1,61%	1.491	3,07%
Education	1.330	1,09%	247	0,51%
(Suspected) physical health	766	0,63%	486	1,00%
TOTAL	**121.944**	**100%**	**48.505**	**100%**

APPENDIX 5. CGG IN FLANDERS:

Table 58 – Most important numbers of 2015 and 2016[h] in CGG-SSM in Flanders

Key figures main clients CGG 2015-2016		
	2015	2016
Numbers for main clients		
Number of clients	57.287	57.901
Number of periods of care	58.198	58.886
Of which are new	*29.959*	*30.050*
Average duration (in days) from…		
Waiting time until intake (1e FTF in registration year)	44	44
Waiting time until intake (1e FTF) and start treatment	44	47
Treatment (from 1e FTF until last FTF)	612	623
Received care main clients		
Number of helpactivities (hulpactiviteiten)	533.937	538.345
From which received	*414.641*	*415.385*
From which received treatments	*312.543*	*312.555*
Average number of helpactivities (hulpactiviteiten) per period of care	9,2	9,1
From which received	7,1	7,1
From which received treatments	5,4	5,3
Staff (FTE) financed through envelope	804,5	802,4

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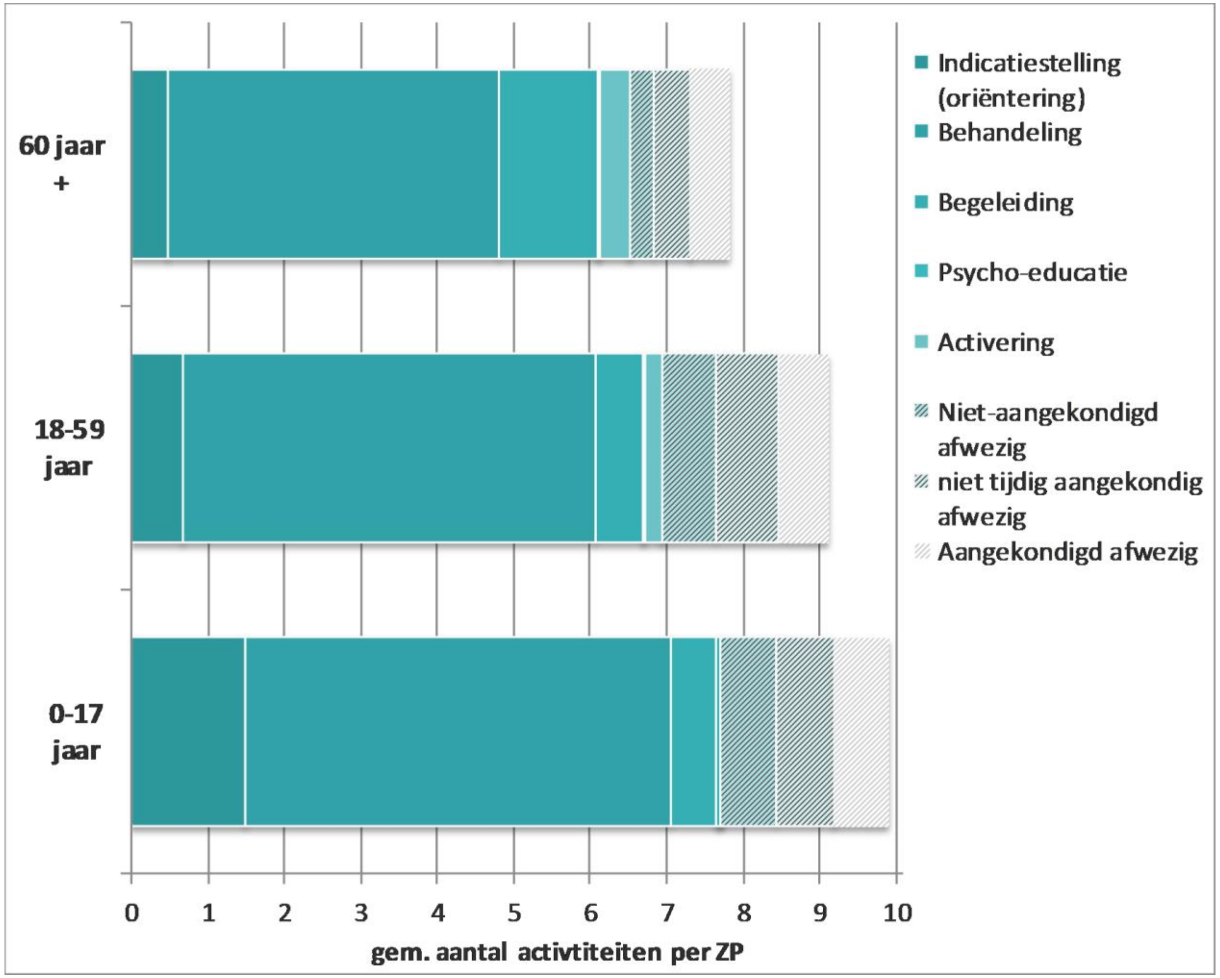
[h] EPD-registratiegegevens CGG, 2015-2016 – voortgangsrapporten 2015-2016

Table 59 – Number of FTE for CGG-SSM in Flanders

	2016	2015	2014	…	2010
FTE payed by envelope	802,4	804,5	800,7		759,7
FTE payed through other sources or as independent employees	219,9	214,6	218,9		171,6
FTE Total personnel CGG	**1022,3**	**1019,1**	**1019,6**		**931,3**
Average FTE per CGG	51,1	51,0	51,0		46,6

Evolution FTE (total and paid through envelope) for the 20 CGG, 2010-2016

Figure 42 – Activities per age-range in CGG-SSM in Flanders



Average number of activities in CGG by sort and age of the client, 2016

Table 60 – Evolution of total FTE through target population by clientwork (cliëntenwerking), 2011, 2015-2016

Population	2016		2015		…	2011	
	FTE	%	FTE	%		FTE	%
Adults	260,2	42%	263,3	43%		279,6	48%
Children and youth	220,7	36%	221,4	36%		202,7	34%
Elderly	42,2	7%	41,8	7%		33,6	6%
Forensic care	38,2	6%	39,4	6%		37,1	6%
Addiction care	37,8	6%	37,9	6%		28,4	5%
Mentally disabled	7,3	1,2%	7,1	1,1%		2,6	0%
Refugees	0,6	0,1%	0,7	0,7%		2,4	0%
Other population and population not mentioned	7,6	1,2%	5,4	0,9%		1,9	0%
Total Clientwork	**614,5**	**100%**	**617,0**	**100%**		**588,3**	**100%**

Table 61 – Number of FTE per target population (only clientwork (cliëntenwerking)) per 100.000 residents, per province, 2016

Province CGG	Clientwork				All categories
	0-17 year	18-59 year[2]	60+	All ages All populations	
Flemish Region	16,5	6,9	2,4	9,4	15,7
Flemish-Brabant and Brussel[1]	13,8	7,5	3,2	11,0	19,1
East-Flanders	22,8	9,2	2,5	11,0	18,4
Limburg	18,8	6,4	3,1	9,8	16,2
Antwerp	17,5	6,1	2,5	9,3	15,4
West-Flanders	12,2	5,8	1,3	6,9	10,9

1: 30% of the inhabitants of Brussels

2: By populations like addiction care and forensic care most clients are between 18-59 year: The number of FTE of these sorts of care is integrated in the total (all populations) but not in de population ‘adults’.

Table 62 – Number of FTE through work and discipline, for all sources of funding and envelope funding, 1/01/2016

	Discipline	All funding sources	Funding by envelope
Clientwork (Cat. 1)	Psychiatrist	60,34	35,52
	Psychologist	358,67	335,55
	Social worker	159,09	127,76
	Other care functions	36,42	31,02
	Subtotal	**614,52**	**529,85**
Prevention (Cat. 2)	Preventive functions	59,41	35,93
Specific work (Cat. 3)	Care functions	87,16	27,28
	Preventive functions	6,91	0,00
	Staff functions	0,45	0,20
	Administration and other functions	6,31	2,81
	Subtotal	**100,82**	**30,29**
Overhead (Cat. 4)	Staff functions	72,47	70,13
	Administration and other functions	175,08	136,22
	Subtotal	**247,55**	**206,34**
Total		**1022,30**	**802,41**

APPENDIX 6. ADULT MOBILE TEAM

Table 63 – Number of mobile team needed per network [64]

Regions	Number of mobile team needed in total		
	2a team	**2b team**	**total**
BELGIUM	**46,1**	**47**	**93,1**
BRUSSELS	**5,1**	**5,2**	**10,2**
Flanders	**26,3**	**26,8**	**53,1**
Network GGZ Noord West Vlaanderen	1,9	2	3,9
Network GGZ Zuid West Vlaanderen	1,2	1,2	2,5
Network GGZ Midden West Vlaanderen	1,5	1,6	3,1
het Pakt	3,7	3,8	7,5
Network GG ADS	2,4	2,4	4,8
Network GGZ Kempen	1,9	1,9	3,8
Network SaRa	3,9	4	7,8
Network Emergo	1,7	1,7	3,4
GGZ Network RELING	2,1	2,1	4,2
GGZ Network NOOLIM	1,5	1,5	3,0
Transmurale Zorg Leuven - Tervuren	2,4	2,4	4,8
SaVHA	2,1	2,2	4,3
Wallonia	**14,6**	**15,0**	**29,6**
Walloon Brabant	1,6	1,6	3,2
Réseau Santé Mentale Hainaut	2,4	2,5	4,9
Réseau en Santé Mentale de la Région du Centre	3	3,1	6,1
Réseau Santé Namur	2	2	4,0
Fusion Liège	3,3	3,4	6,7
ReSME	1,2	1,2	2,4
Réseau 107 Luxembourg	1,1	1,2	2,3

APPENDIX 7. SPECIALISED REHABILITATION CENTRES WITH CONVENTION

Table 64 – Budget of Specialised rehabilitation centres with convention (772 and 773) per province[i]

Budget per province in 2016		
	€)	
Antwerp	3 561 765	7 485 957
Walloon Brabant	1 647 617	
Brussels	10 353 120	9 565 582
Hainaut	2 353 421	10 016 166
Liège	3 813 968	4 913 664
Limburg	2 440 058	3 851 629
Namur	861 590	575 720
East Flanders		9 929 685
Flemish Brabant	476 604	5 102 540
West Flanders	3 376 227	5 133 921

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[i] (information received on demand at the RIZIV/INAMI)

APPENDIX 8. PSYCHIATRIC WARDS IN GENERAL HOSPITALS USERS DATA

Data compiled from [108]

Table 65 – Care periods per Region and index type.

The left column presents the total number of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the right column the percentage of the started care periods admissions in 2013 (from 01/01/2013 to 31/12/2013) for each Region of Belgium for each type of beds

	Flanders		Wallonia		Brussels		Belgium	
Beds types	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**
A	28508	96%	11365	95%	3424	93%	43297	95%
A1	2001	88%	2286	89%	284	71%	4571	88%
A2	2	100%	0	0%	1	100%	3	100%
T	0	0%	293	76%	0	0%	293	76%
T1	0	0%	97	70%	0	0%	97	70%
T2	0	0%	0	0%	0	0%	0	0%
Total	30511	95%	14041	93%	3709	91%	48261	94%
%	63%		29%		8%		100%	

The repartition of care periods is similar between psychiatric hospitals and PAAZ-SPHG

Table 66 – Evolution of the care periods over time in PAAZ-SPHG : for each year (2007,2010 and 2013

The left column presents the percentage of the total of care periods counted (for admissions before or during 2007/2010/2013, up to 31/12/2007/2010/2013) and in the adjacent column the percentage of the started care periods (from 01/01/2007/2010/2013 to 31/12/2007/2010/2013), for each type of beds with the number of periods for each column in the bottom line

Beds types	% care periods in 2007	% started care periods in 2007	% care periods in 2010	% started care periods in 2010	% care periods in 2013	% started care periods in 2013
A	93,0%	94,1%	91,0%	92,0%	89,7%	90,6%
A1	6,0%	5,0%	7,7%	6,8%	9,5%	8,8%
A2	0,3%	0,3%	0,6%	0,6%	0,0%	0,0%
T	0,7%	0,6%	0,6%	0,5%	0,6%	0,5%
T1	0,0%	0,0%	0,1%	0,1%	0,2%	0,1%
T2	0	0	0	0	0	0
Total	100%	100%	100%	100%	100%	100%
Total number	49031	46285	48063	45367	48261	45519

The number of care periods remain quite stable through the years, with a tendency to decrease.

Table 67 – Distribution of the care periods per age range in PAAZ-SPHG

The left column presents the percentage of the total of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the percentage of the started care periods for admissions in 2013 (from 01/01/2013 to 31/12/2013) for each Region of Belgium and for three age range. The last line shows the total number of periods for each column

	Flanders		Wallonia		Brussels		Belgium	
Age range	**% care periods in 2013**	**% started care periods in 2013**	**% care periods in 2013**	**%started care periods in 2013**	**% care periods in 2013**	**%started care periods in 2013**	**% care periods in 2013**	**% started care periods in 2013**
20-39	32%	33%	32%	33%	33%	33%	32%	33%
40-64	56%	56%	59%	58%	54%	54%	57%	56%
65+	11%	11%	9%	9%	13%	13%	11%	11%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Number of care periods	32873	30846	16178	13605	4351	3789	53402	48240

Table 68 – Number of care periods per Region depending on the province of residence in PAAZ-SPHG

The left column presents the total number of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the number of the started care periods for admissions in 2013 (from 01/01/2013 to 31/12/2013) for each Region (of care) depending on the province of residence of the patients

	Flanders		Wallonia		Brussels		Belgium	
Provinces of residence	**Total number of care periods in 2013**	**Number of started care periods in 2013**	**Total number of care periods in 2013**	**Number of started care periods in 2013**	**Total number of care periods in 2013**	**Number of started care periods in 2013**	**Total number of care periods in 2013**	**Number of started care periods in 2013**
Brussels	208	192	201	147	3141	2738	3550	3077
Antwerp	5232	4779	10	9	34	30	5276	4818
Limburg	3067	2866	53	43	559	502	3679	3411
East Flanders	3593	3385	11	10	1	1	3605	3396
Flemish Brabant	8224	7829	22	18	36	32	8282	7879
West Flanders	11497	10828	43	37	17	16	11557	10881
Walloon Brabant	294	277	9080	7371	209	174	9583	7822
Hainaut	24	22	3192	2946	33	25	3249	2993
Liège	12	12	560	511	11	8	583	531
Luxemburg	22	22	1915	1624	52	45	1989	1691
Namur	110	103	842	716	200	169	1152	988
Total Belgium	590	531	249	173	58	49	897	753
Brussels	32873	30846	16178	13605	4351	3789	53402	48240

As observed in psychiatric hospitals, Brussels PAAZ-SPHG provide 28% of their care periods to people from other (adjacent) provinces. Some people from Brussels still get care outside of the Region but in a smaller proportion (12% vs 21% for HP).

Table 69 – Distribution of the gender per Region in PAAZ-SPHG

The left column presents the percentage of the total of care periods in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the percentage of the started care periods for admissions in 2013 (from01/01/2013 to 31/12/2013) for each Region depending on the gender of the patients

	Flanders		Wallonia		Brussels		Belgium	
Gender	% care periods in 2013	% started care periods in 2013	% care periods in 2013	%started care periods in 2013	% care periods in 2013	%started care periods in 2013	% care periods in 2013	% started care periods in 2013
Male	47%	47%	46%	45%	46%	46%	47%	47%
Female	53%	53%	54%	55%	54%	54%	53%	53%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Total N	32873	30846	16178	13605	4351	3789	53402	48240

At the opposite of the observation for the psychiatric hospital, the female represents the larger group in the PAAZ-SPHG.

Table 70 – Distribution of the care periods per pathology at the entrance in PAAZ-SPHG in 2013.

	% of care periods per pathology in PAAZ/SPHG in 2013			
Pathologies	**Flanders**	**Wallonia**	**Brussels**	**Belgium**
Dementia & other cognitive disorders	1%	3%	1%	1%
Disorders of adaptation	14%	12%	6%	13%
Substance disorders	34%	24%	22%	30%
Schizophrenia & other psychotic disorders	6%	7%	17%	7%
Mood disorders	26%	33%	37%	29%
Anxiety disorders	3%	6%	5%	4%
Somatoform disorders	1%	0%	0%	1%
Factitious disorders	0%	0%	0%	0%
Dissociative disorders	0%	0%	0%	0%
Sexual disorders & sexual identity	0%	0%	0%	0%
Eating disorders	1%	0%	1%	1%
Sleeping disorders	0%	0%	0%	0%
Impulse disorders	1%	1%	0%	1%
Other situations	2%	1%	1%	2%
Additional codes	2%	3%	5%	2%
Mental retardation	0%	1%	0%	1%
Cl. A Personality Disorders	0%	0%	0%	0%
Cl. B Personality Disorders	2%	2%	2%	2%
Cl. C Personality Disorders	1%	1%	1%	1%

Main diagnosis Axis 3	1%	0%	1%	1%
Unfilled	4%	5%	1%	4%
Total	100%	100%	100%	100%

For Flanders, the pathology at the entrance is the same for HP and PAAZ-SPHG, substance disorders. In Wallonia and Brussels, the pathology is different from HP and is now, for both, mood disorders.

Table 71 – Distribution of the care periods per Region per care duration in PAAZ-SPHG in 2013

	% of care periods in PAAZ/SPHG in 2013			
Up to 1 day	15,3%	16,5%	5,0%	14,8%
Up to 1 week	24,0%	18,3%	12,9%	21,5%
Up to 1 month	39,5%	42,3%	42,7%	40,5%
From 1 to 3 months	18,3%	18,5%	31,4%	19,4%
From 3 to 6 months	2,4%	2,8%	6,4%	2,8%
From 6 months to 1 year	0,5%	0,8%	0,9%	0,6%
From 1 year to 3 years	0,1%	0,6%	0,7%	0,3%
More than 3 years	0,0%	0,2%	0,0%	0,0%
Total	100,0%	100,0%	100,0%	100,0%

The common length of stay is up to 1 month but there is a tendency in Brussels for longer care periods.

APPENDIX 9. INITIATIVES FOR SHELTERED ACCOMMODATION

Data compiled from [108]

Table 72 – Care periods per Region and index type

the left column presents the total number of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the right column the percentage of the started care periods admissions in 2013 (from 01/01/2013 to 31/12/2013) for each Region of Belgium in IBW-IHP for each Region of Belgium in IBW-IHP

	Flanders		Wallonia		Brussels		Belgium	
Bed type	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**
R	3535	28%	1161	41%	584	28%	5280	31%
%	67%		22%		11%		100%	

Table 73 – Evolution of the care periods over time in IBW-IHP

for each year (2007,2010 and 2013), the left column presents the total number of care periods counted (for admissions before or during 2007/2010/2013, up to 31/12/2007/2010/2013) and in the adjacent column the percentage of the started care periods (from 01/01/2007/2010/2013 to 31/12/2007/2010/2013)

	Belgium					
Bed type	**% care periods in 2007**	**% started care periods in 2007**	**% care periods in 2010**	**% started care periods in 2010**	**% care periods in 2013**	**% started care periods in 2013**
R	5094	34,3%	5106	30,9%	5280	31,0%

There is slight evolution of the number of care periods in the IBW-IHP between 2007 and 2013.

Table 74 – Distribution of the care periods per age range in IBW-IHP.

The left column presents the percentage of the total of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the percentage of the started care periods for admissions in 2013 (from 01/01/2013 to 31/12/2013) for each Region of Belgium and for three age range

	Flanders		Wallonia		Brussels		Belgium	
Age range	% care periods in 2013	% started care periods in 2013	% care periods in 2013	%started care periods in 2013	% care periods in 2013	%started care periods in 2013	% care periods in 2013	% started care periods in 2013
20-39	30%	43%	39%	49%	23%	27%	31%	43%
40-64	60%	52%	57%	49%	67%	63%	60%	52%
65+	11%	5%	4%	3%	10%	10%	9%	5%
Total	100%	100%	100%	100%	100%	100%	100%	100%

The main age category in Brussels is 40-64 like for Flanders but is the largest from the three Regions. In Wallonia, there is a large proportion of adults from 20-39 years old.

Table 75 – Number of care periods per Region depending on the province of residence in PVT-MSP

The left column presents the total number of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the number of the started care periods for admissions in 2013 (from 01/01/2013 to 31/12/2013) for each Region (of care) depending on the province of residence of the patients

	Flanders		Wallonia		Brussels		Belgium	
Provinces of residence	Total number of care periods in 2013	Number of started care periods in 2013	Total number of care periods in 2013	Number of started care periods in 2013	Total number of care periods in 2013	Number of started care periods in 2013	Total number of care periods in 2013	Number of started care periods in 2013
Brussels	15	1	25	14	588	147	668	153
Antwerp	666	153	0	0	2	0	628	162
Limburg	512	155	3	1	11	6	428	165
East Flanders	648	158	0	0	3	0	651	158
Flemish Brabant	916	255	4	4	1	0	344	130
West Flanders	801	267	2	0	0	0	92	41
Walloon Brabant	0	0	421	161	7	4	227	92
Hainaut	2	1	340	129	2	0	921	259
Liège	0	0	92	41	0	0	58	21
Luxemburg	1	1	220	90	6	1	526	162
Namur	2	1	56	25	9	3	803	267
Total Belgium	40	14	10	6	8	1	67	29
Brussels	3603	1006	1173	471	637	162	5413	1639

Unlike for HP and PAAZ-SPHG, the province of residence and the place of care are similar

Table 76 – Distribution of the gender per Region in IBW-IHP

The left column presents the percentage of the total of care periods in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the percentage of the started care periods for admissions in 2013 (from01/01/2013 to 31/12/2013) for each Region depending on the gender of the patients.

	Flanders		Wallonia		Brussels		Belgium	
Gender	**% care periods in 2013**	**% started care periods in 2013**	**% care periods in 2013**	**% started care periods in 2013**	**% care periods in 2013**	**% started care periods in 2013**	**% care periods in 2013**	**% started care periods in 2013**
Male	69%	66%	65%	67%	63%	59%	67%	66%
Female	31%	34%	35%	33%	37%	41%	33%	34%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Number of care periods	3603	1006	1173	471	637	162	5413	1639

There is clearly a larger number of male who benefit from care in IBW-IHP

Table 77 – Distribution of the care periods per pathology at the entrance in IBW-IHP in 2013.

	% of care periods in IBW/IHP in 2013			
Dementia & other cognitive disorders	1%	0%	0%	0%
Disorders of adaptation	1%	3%	1%	2%
Substance disorders	20%	16%	9%	18%
Schizophrenia & other psychotic disorders	36%	46%	68%	42%
Mood disorders	17%	17%	10%	16%
Anxiety disorders	2%	1%	1%	2%
Somatoform disorders	0%	1%	0%	0%
Factitious disorders	0%	0%	0%	0%
Dissociative disorders	0%	0%	1%	0%
Sexual disorders & sexual identity	1%	0%	0%	1%
Eating disorders	1%	0%	1%	1%
Sleeping disorders	0%	0%	0%	0%
Impulse disorders	1%	0%	0%	0%
Other situations	1%	0%	0%	1%
Additional codes	1%	1%	0%	1%
Mental retardation	2%	1%	0%	1%
Cl. A Personality Disorders	1%	3%	2%	2%
Cl. B Personality Disorders	7%	3%	3%	5%
Cl. C Personality Disorders	4%	4%	5%	4%
Main diagnosis Axis 3	0%	0%	0%	0%
Unfilled	3%	3%	1%	3%
Total	100%	100%	100%	100%

Schizophrenia & other psychotic disorders represent the main category; this is particularly true in Brussels with 68%.

Table 78– Distribution of the care periods per Region per care duration in IBW-IHP in 2013

	% of care periods in IBW/IHP in 2013			
Up to 1 day	0,6%	0,2%	0,0%	0,5%
Up to 1 week	2,2%	1,8%	3,4%	2,2%
Up to 1 month	5,0%	6,6%	5,5%	5,5%
From 1 to 3 months	11,9%	16,5%	11,0%	13,1%
From 3 to 6 months	16,3%	16,5%	11,6%	15,9%
From 6 months to 1 year	16,2%	16,3%	11,6%	15,8%
From 1 year to 3 years	26,6%	26,8%	27,4%	26,7%
More than 3 years	21,1%	15,4%	29,5%	20,2%
Total	100,0%	100,0%	100,0%	100,0%

The care length periods are large in IBW-IHP with stays of 1 to 3 years. The percentage of very long care (more than 3 years) is still large for Flanders and Brussels but drops for Wallonia.

APPENDIX 10. PSYCHIATRIC CARE HOMES

Data compiled from [108]

Table 79 – Care periods per Region and index type

the left column presents the total number of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the right column the percentage of the started care periods admissions in 2013 (from 01/01/2013 to 31/12/2013) for each Region of Belgium in PVT-MSP

	Flanders		Wallonia		Brussels		Belgium	
Beds types	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**
Q	2462	16%	1065	22%	314	19%	3841	18%

Table 80 – Evolution of the care periods over time in PVT-MSP

for each year (2007,2010 and 2013), the left column presents the total number of care periods counted (for admissions before or during 2007/2010/2013, up to 31/12/2007/2010/2013) and in the adjacent column the percentage of the started care periods (from 01/01/2007/2010/2013 to 31/12/2007/2010/2013).

	Belgium					
Beds types	**% care periods in 2007**	**% started care periods in 2007**	**% care periods in 2010**	**% started care periods in 2010**	**%care periods in 2013**	**% started care periods in 2013**
Q	3783	14,6%	3774	15,7%	3841	17,8%

There is a slight increase of the care periods over time in the PVT-MSP (1.5%) between 2007 and 2013.

Table 81 – Distribution of the care periods per age range in PVT-MSP

The left column presents the percentage of the total of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the percentage of the started care periods for admissions in 2013 (from 01/01/2013 to 31/12/2013) for each Region of Belgium and for three age range

	Flanders		Wallonia		Brussels		Belgium	
Age range	**% care periods in 2013**	**% started care periods in 2013**	**% care periods in 2013**	**%started care periods in 2013**	**% care periods in 2013**	**%started care periods in 2013**	**% care periods in 2013**	**% started care periods in 2013**
20-39	6%	13%	10%	16%	12%	22%	8%	15%
40-64	52%	56%	71%	76%	75%	73%	59%	63%
65+	41%	31%	19%	8%	13%	5%	33%	22%
Total	100%	100%	100%	100%	100%	100%	100%	100%

While the main age category is 40-64 for Wallonia and Brussels, Flanders tend to have older patients in PVT-MSP with 52% for the 40-64 age category and 41% for the 65+.

Table 82 – Number of care periods per Region depending on the province of residence in PVT-MSP

The left column presents the total number of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the number of the started care periods for admissions in 2013 (from 01/01/2013 to 31/12/2013) for each Region (of care) depending on the province of residence of the patients.

	Flanders		Wallonia		Brussels		Belgium	
Provinces of residence	**Total number of care periods in 2013**	**Number of started care periods in 2013**	**Total number of care periods in 2013**	**Number of started care periods in 2013**	**Total number of care periods in 2013**	**Number of started care periods in 2013**	**Total number of care periods in 2013**	**Number of started care periods in 2013**
Brussels	16	3	42	25	278	57	336	85
Antwerp	664	95	0	0	1	0	665	95
Limburg	297	128	1	1	21	2	319	131
East Flanders	459	99	1	0	1	0	461	99
Flemish Brabant	781	159	1	0	0	0	782	159
West Flanders	384	31	5	0	0	0	389	31
Walloon Brabant	3	0	393	58	2	0	398	58
Hainaut	3	0	316	67	2	0	321	67
Liège	1	0	52	11	2	0	55	11
Luxemburg	2	0	208	56	1	0	211	56
Namur	2	1	27	7	9	1	38	9
Total Belgium	4	0	27	12	0	0	31	12
Brussels	2616	516	1073	237	317	60	4006	813

The total count of care periods of the Region of Brussels includes 17% of care periods from people coming from outside of the Region and people from Brussels get care for 13 outside of their living area.

Table 83 – Distribution of the gender per Region in PVT-MSP:

The left column presents the percentage of the total of care periods in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the percentage of the started care periods for admissions in 2013 (from01/01/2013 to 31/12/2013) for each Region depending on the gender of the patients

	Flanders		Wallonia		Brussels		Belgium	
Gender	% care periods in 2013	% started care periods in 2013	% care periods in 2013	% started care periods in 2013	% care periods in 2013	% started care periods in 2013	% care periods in 2013	% started care periods in 2013
Male	61%	59%	67%	68%	56%	60%	63%	62%
Female	39%	41%	33%	32%	44%	40%	37%	38%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Number of care periods	2616	516	1073	237	317	60	4006	813

While there are largely more male in Flanders and Wallonia in PVT-MSP, this tendency is lower in Brussels.

Table 84 – Distribution of the care periods per pathology at the entrance in PVT-MSP in 2013.

	% of care periods in PVT/MSP in 2013		% of stays in psychiatric hospital in 2013	
Dementia & other cognitive disorders	5%	1%	0%	3%
Disorders of adaptation	1%	6%	0%	3%
Substance disorders	9%	12%	0%	9%
Schizophrenia & other psychotic disorders	41%	49%	88%	47%
Mood disorders	14%	9%	8%	12%
Anxiety disorders	1%	2%	0%	1%
Somatoform disorders	0%	0%	0%	0%
Factitious disorders	0%	0%	0%	0%
Dissociative disorders	0%	0%	0%	0%
Sexual disorders & sexual identity	1%	0%	0%	1%
Eating disorders	0%	0%	0%	0%
Sleeping disorders	0%	0%	0%	0%
Impulse disorders	1%	4%	0%	2%
Other situations	1%	0%	0%	1%
Additional codes	0%	0%	0%	0%
Mental retardation	10%	14%	0%	10%
Cl. A Personality Disorders	0%	0%	2%	0%
Cl. B Personality Disorders	6%	0%	2%	4%

Cl. C Personality Disorders	5%	2%	0%	4%
Main diagnosis Axis 3	0%	0%	0%	0%
Unfilled	4%	0%	0%	3%
Total	100%	100%	100%	100%

The majority of the pathologies at the admission is in Schizophrenia & other psychotic disorders category in the three Regions, this is particularly true for Brussels with 88% and it represent 41 and 49% in Flanders and in Wallonia.

Table 85 – Distribution of the care periods per Region per care duration in PVT-MSP in 2013

	% of care periods in PVT/MSP in 2013			
Up to 1 day	0,6%	0,4%	0,4%	0,5%
Up to 1 week	1,2%	13,5%	13,5%	7,4%
Up to 1 month	5,4%	7,4%	7,4%	6,4%
From 1 to 3 months	9,1%	8,6%	8,6%	8,9%
From 3 to 6 months	6,2%	7,4%	7,4%	6,8%
From 6 months to 1 year	12,2%	9,0%	9,0%	10,6%
From 1 year to 3 years	16,6%	16,0%	16,0%	16,3%
More than 3 years	48,7%	37,7%	37,7%	43,2%
Total	100,0%	100,0%	100,0%	100,0%

The care periods in PVT-MSP are long with the largest part of it being more than 3 years.

APPENDIX 11. PSYCHIATRIC HOSPITALS USERS DATA

Data compiled from [108]

Table 86 – Care periods per Region and index type

the left column presents the total number of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the right column the percentage of the started care periods admission in 2013 (from 01/01/2013 to 31/12/2013) for each Region of Belgium for each type of bed in PZ-HP

	Flanders		**Wallonia**		**Brussels**		**Belgium**	
Bed types	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**	**Total number of care periods in 2013**	**% of started care periods in 2013**
A	21506	92%	10173	90%	4060	91%	35739	91%
A1	4446	78%	1664	71%	333	67%	6443	76%
A2	168	73%	46	78%	80	74%	294	74%
T	7581	48%	3456	45%	335	33%	11372	47%
T1	3646	32%	1122	55%	104	32%	4872	38%
T2	215	45%	10	30%	1	0%	226	44%
IB	14	93%	36	92%	0	0%	50	92%
Number of care period	37576	75%	16507	76%	4913	84%	58996	76%
%	64%		28%		8%		100%	

Table 87 – Evolution of the care periods over time in PZ-HP

for each year (2007, 2010 and 2013), the left column presents the percentage of the total of care periods counted (for admissions before or during 2007/2010/2013, up to 31/12/2007/2010/2013) and in the adjacent column the percentage of the started care periods (from 01/01/2007/2010/2013 to 31/12/2007/2010/2013), for each type of bed with the number of periods for each column in the bottom line

	2007		2010		2013	
Bed types	% care periods in 2007	% started care periods in 2007	% care periods in 2010	% started periods in 2010	% care periods in 2013	% started care periods in 2013
A	61%	75%	61%	75%	61%	73%
A1	10%	10%	10%	10%	11%	11%
A2	1%	1%	1%	1%	0%	0%
T	20%	10%	20%	11%	19%	12%
T1	8%	4%	8%	4%	8%	4%
T2	1%	0%	1%	0%	0%	0%
IB	0%	0%	0%	0%	0%	0%
Total %	100%	100%	100%	100%	100%	100%
Number of care period	58183	42929	58783	43732	58996	45025

The evolution of the number of care periods is stable as is the repartition between the different indexes of beds.

Table 88 – Distribution of the care periods per age range in PZ-HP:

The left column presents the percentage of the total of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the percentage of the started care periods for admissions in 2013 (from 01/01/2013 to 31/12/2013) for each Region of Belgium and for three age range. The last line shows the total number of periods for each column.

	Flanders		Wallonia		Brussels		Belgium	
Age range	% care periods in 2013	% started care periods in 2013	% care periods in 2013	% started care periods in 2013	% care periods in 2013	% started care periods in 2013	% care periods in 2013	% started care periods in 2013
20-39	38%	41%	32%	34%	43%	44%	37%	39%
40-64	48%	47%	58%	57%	50%	50%	51%	50%
65+	13%	12%	10%	9%	7%	6%	12%	11%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Number of care period	36945	27424	16605	12459	5306	4143	58856	44026

The most important group is the 40-64 for the three Regions. There are more care periods concerning the 20-39 group in Brussels regarding the other Regions. This observation can be made in Flanders for the 65+ group.

The mean age in 2013 was 43 (±17) years old at the admission in psychiatric hospital.

Table 89 – Number of care periods per Region depending on the province of residence

The left column presents the total number of care periods counted in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the number of the started care periods for admissions in 2013 (from 01/01/2013 to 31/12/2013) for each Region (of care) depending on the province of residence of the patients.

	Flanders		Wallonia		Brussels		Belgium	
Provinces of residence	**Total number of care periods in 2013**	**Number of started care periods in 2013**	**Total number of care periods in 2013**	**Number of started care periods in 2013**	**Total number of care periods in 2013**	**Number of started care periods in 2013**	**Total number of care periods in 2013**	**Number of started care periods in 2013**
Brussels	315	226	805	536	4239	3304	5359	4066
Antwerp	10928	8158	20	11	30	19	10978	8188
Limburg	5834	4636	155	108	371	286	6360	5030
East Flanders	5386	4297	18	14	4	3	5408	4314
Flemish Brabant	9592	6938	59	44	25	19	9676	7001
West Flanders	6776	4833	52	40	17	14	6845	4887
Walloon Brabant	133	101	5548	4207	249	204	5930	4512
Hainaut	28	20	6070	4695	85	68	6183	4783
Liège	6	5	1394	1068	39	28	1439	1101
Luxemburg	13	13	2548	1817	105	85	2666	1915
Namur	40	31	920	681	403	308	1363	1020
Total Belgium	623	547	219	146	100	68	942	761
Brussels	39674	29805	17808	13367	5667	4406	63149	47578

A quarter of the care periods (CP) in Brussels are for people living outside of the Region (often bordering). Also, people from the Brussels Region get care outside of the Region (21%).

Table 90 – Distribution of the gender per Region in PZ-HP

The left column presents the percentage of the total of care periods in 2013 (for admissions before or during 2013, up to 31/12/2013) and in the adjacent column the percentage of the started care periods for admissions in 2013 (from01/01/2013 to 31/12/2013) for each Region depending on the gender of the patients

	Flanders		Wallonia		Brussels		Belgium	
Gender	**% care periods in 2013**	**% started care periods in 2013**	**% care periods in 2013**	**% started care periods in 2013**	**% care periods in 2013**	**% started care periods in 2013**	**% care periods in 2013**	**% started care periods in 2013**
Male	54%	53%	55%	54%	53%	54%	54%	53%
Female	46%	47%	45%	46%	47%	46%	46%	47%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Number of care periods	39674	29805	17808	13367	5667	4406	63149	47578

Through the different Regions, there is a stable tendency to have more male in the psychiatric hospitals.

Table 91 – Distribution of the care periods per pathology at the entrance in PZ-HP in 2013.

	% of care periods per pathology in psychiatric hospital in 2013			
Dementia & other cognitive disorders	4%	2%	0%	3%
Disorders of adaptation	8%	6%	9%	7%
Substance disorders	30%	32%	25%	30%
Schizophrenia & other psychotic disorders	16%	19%	33%	19%
Mood disorders	21%	24%	23%	22%
Anxiety disorders	3%	2%	3%	3%
Somatoform disorders	0%	0%	0%	0%
Factitious disorders	0%	0%	0%	0%
Dissociative disorders	0%	0%	0%	0%
Sexual disorders & sexual identity	0%	0%	0%	0%
Eating disorders	1%	1%	2%	1%
Sleeping disorders	1%	0%	0%	1%
Impulse disorders	1%	1%	0%	1%
Other situations	1%	1%	0%	1%
Additional codes	3%	1%	1%	2%
Mental retardation	1%	1%	0%	1%
Cl. A Personality Disorders	0%	0%	0%	0%

Cl. B Personality Disorders	5%	2%	2%	4%
Cl. C Personality Disorders	2%	1%	1%	2%
Main diagnosis Axis 3	0%	4%	0%	1%
Unfilled	1%	1%	0%	1%
Total	100%	100%	100%	100%

The most common pathology substance disorder in Flanders and Wallonia, and Schizophrenia & other psychotic disorders in Brussels.

Table 92 – Distribution of the care periods per Region per care duration in PZ-HP in 2013

	% of care periods in psychiatric hospital in 2013			
Length of cares ended in 2013	**Flanders**	**Wallonia**	**Brussels**	**Belgium**
Up to 1 day	6,2%	5,6%	1,9%	5,6%
Up to 1 week	13,4%	11,1%	15,3%	12,9%
Up to 1 month	23,0%	26,7%	33,1%	25,0%
From 1 to 3 months	28,3%	32,9%	33,3%	30,1%
From 3 to 6 months	14,0%	11,2%	8,9%	12,8%
From 6 months to 1 year	8,6%	5,9%	4,1%	7,4%
From 1 year to 3 years	4,7%	4,6%	2,4%	4,4%
More than 3 years	1,75%	2%	1%	2%
Total	100%	100%	100%	100%

The most common length in the three Regions is from 1 to 3 months. Brussels tends to have more shorter stays. Flanders tend to have more longer stays and Wallonia is mixed.

APPENDIX 12. CONTACTS

- Adjoint au coordinateur fédéral de la réforme des soins en santé mentale, SPF Service Public Fédéral
- Administration générale des maisons de justice, service partenariat
- Agence pour une vie de qualité (AViQ), département bien-être et santé
- Agence pour une vie de qualité (AViQ), département handicap
- Attentia
- Belgische Federatie van Psychologen - Fédération Belge des Psychologues
- CAW
- Coordinateur fédéral de la réforme des soins en santé mentale (art 107), SPF Service Public Fédéral
- Coordinateur trajet de soins internés
- Coordinatrice d'un SPAD (Soins Psychiatriques pour personnes séjournant A Domicile)
- Employee Assistance Program (EAP)
- Équipe du CRéSaM
- Eurotox
- Faresa
- Federatie van sociale ondernemingen, asbl (SOM)
- Fédération des CPAS
- Fédération des maisons médicales
- Fédération wallonne des institutions pour toxicomanes (Fédito wallonne)
- Housing First Belgium-LAB
- ICAS
- INAMI
- Les coordinateurs des plateformes de concertation en santé mentale

- Les coordinateurs des réseaux Psy107
- Ligue bruxelloise francophone pour la santé mentale (LBFSM)
- Office de la Naissance et de l’Enfance, Service SOS enfants
- POBOS
- Pulso
- Securex
- Service public de Wallonie, Direction générale opérationnelle des Pouvoirs locaux et de l'Action sociale, Département de l’action sociale (DGO5)
- Service public de Wallonie, Direction générale opérationnelle des Pouvoirs locaux et de l'Action sociale, Direction de l'Egalité des Chances et de l'Intégration
- Service public fédéral de programmation Intégration sociale (SPP IS)
- Service public francophone bruxellois, Service de la santé
- Service public francophone bruxellois, Service des affaires sociales
- Steunpunt Mens en Samenleving asbl (SAM)
- The human link
- UNion En Soins de SAnté (UNESSA)

APPENDIX CHAPTER 6

APPENDIX 1. FOCUS GROUP TOPIC GUIDE

Appendix 1.1. FOCUS GROUP INTRODUCTION [10 minutes]

Presentation:

- **Contexte de la recherche**: recherche qualitative commanditée par le KCE et réalisée par l'Institut de Recherche Santé et Société de l'UCL en collaboration avec LUCAS, KUL
- **Organisation de la recherche** : partie 1 : 10 FGs en Wallonie, en Flandres et à Bruxelles ; ensuite, partie 2, entre janvier et mars, un questionnaire réalisé à partir des résultats des FGs, afin de voir s'ils sont généralisables.
- **Objet de la recherche** : organisation des soins de santé mentale : composition du système, c'est-à-dire, quelles institutions et structures offrent des soins de santé mentale ; mais aussi aux questions de leur coordination et de leur financement.
- **L'objecti**f est d'avoir une « photographie » de l'offre en se demandant :
    - quels services permettent d'adresser les besoins en santé mentale de la population de manière satisfaisante ?
    - quels services manquent ?
    - quels services proposent des soins similaires ou substituables ?
    - comment améliorer la coordination de ces services afin que les usagers reçoivent la bonne réponse au bon moment et au bon endroit ?
    - quels changements dans le financement des soins de santé mentale permettraient d'améliorer la coordination des services ?
- **Organisation du Focus Group**: en trois temps

3. **Tour de table** : présentation (profession, expérience professionnelle et situation actuelle) et avis personnel sur l'organisation de l'offre de soins de santé mentale dans votre région
4. **Discussion à partir de vignettes organisationnelles**

    a. Afin d'examiner l'organisation de l'offre, nous allons utiliser des vignettes, que nous appelons vignettes organisationnelles et qui nous permettent de réfléchir à partir d'une situation concrète exposant différentes phases du parcours d'une personne, qui s'appelle Ahmed et qui a des problèmes de santé mentale complexes, qui ont différentes dimensions, non seulement psychiques mais aussi médicales et sociales.

    b. A partir de l'histoire de cette personne, nous nous posons, avec vous, des questions qui concernent UNIQUEMENT des décisions d'organisation. Très concrètement, face aux difficultés que notre personnage va rencontrer, nous allons nous demander avec qui, avec quel service on penserait ou souhaiterait travailler et pourquoi, comment on va communiquer avec ce service, et de quelles façons on pourrait améliorer les réponses apportées à notre personnage.

c. Les informations présentées dans la vignette sont les seules dont nous disposons : pas de détails supplémentaires ni sur le diagnostic, ni sur l'environnement social et familial de A.

5. Discussion ouverte sur les alternatives en termes de financement des SSM

- Enregistrement ? Anonymat
- Autres questions?
- Votre avis, à partir de votre expérience quotidienne et concrète ; l'avis de tous

PRESENTATION DES PARTICIPANTS [20 min]

- Tour de table
  - Présentation (service, profession)
  - En trois mots clés :

« Que pensez-vous de l'organisation des soins de santé mentale dans votre région ? »

VIGNETTE ORGANISATIONNELLE [10 min.]

Ahmed a 45 ans, il est sans emploi et vit à [Ville] dans une IHP. Il souffre de troubles psychotiques depuis l'âge de 25 ans et un diagnostic de diabète de type 2 a été posé il y a trois ans. Ahmed est suivi par un psychiatre traitant, un médecin généraliste ainsi que le personnel de l'IHP qui comprend un éducateur référent. Il a un frère aîné qu'il ne voit plus depuis plusieurs années.

Ahmed développe avec le personnel de l'IHP le projet de se réinsérer professionnellement avant d'intégrer son propre appartement. Il a été inscrit dans une entreprise de travail adapté et commencera une activité professionnelle dans dix jours. Malgré son enthousiasme, Ahmed est bouleversé face à ce projet qui se concrétise.

Ces dernières semaines, Ahmed présente des comportements inhabituels. Il ne s'est pas rendu à sa dernière consultation chez son psychiatre traitant et ne participe plus à aucune activité de l'IHP. Plusieurs résidents de l'IHP se plaignent qu'Ahmed se montre intrusif (il sonne fréquemment chez ses voisins à toute heure de la journée et de la nuit) et son référent à l'IHP remarque que celui-ci semble désorienté.

VIGNETTE ORGANISATIONNELLE : QUESTIONS [1h10]

THEMATIQUE

Questions introductives
- *Questions de relance*

1. PROVISION

Quels services/intervenants sont les mieux placés pour intervenir dans la trajectoire d'Ahmed ?

- *Pour quelles raisons ce service/intervenant est-il le mieux placé ?*
- *Quels autres services/interventions pourraient être impliqués ?*
- *Auraient-ils dû être impliqués avant ? Pourquoi ?*
- *Quelles difficultés pourraient compliquer l'accès aux services/intervenants appropriés ? (ex. liste d'attente, processus d'admission…)*
- *Quels services/intervenants seraient les mieux placés pour faire face à la situation d'Ahmed dans le cas d'une crise/d'une décompensation ?*
- *Quels services/intervenants seraient les mieux placés pour faire face à la situation d'Ahmed si celui-ci ne vivait pas dans une IHP mais dans un logement indépendant ?*

Comment les préférences d'Ahmed peuvent-elles être prises en compte ?

- *Quels services/intervenants devraient les (ré)évaluer ?*
- *Comment les proches d'Ahmed peuvent-ils être impliqués ?*

2. COORDINATION/GOUVERNANCE

Comment les services/intervenants travaillent-ils ensemble et communiquent-ils dans la situation d'Ahmed ?

- *Collaborent-ils de manière formelle/informelle ? Comment ?*
- *Quels outils de communication/procédures de travail et de concertation faciliteraient leurs relations ?*
  - *Au niveau de l'échange d'information ?*
  - *Au niveau de l'organisation des soins ?*
  - *Au niveau du travail en réseau ?*
- *Quelles difficultés pourraient compliquer la mise en place de ces outils ?*
- *Qui devrait être inclus/exclus de ces outils ?*
- *Qui pourrait suggérer/choisir d'introduire ces outils ?*
- *Qui pourrait suggérer/choisir d'introduire un nouveau service/intervenant pour faciliter la coordination ?*

Comment les préférences d'Ahmed peuvent-elles être prises en compte ?

- *Comment Ahmed/ses proches pourraient-ils être impliqués dans les décisions liées à la coordination des soins ?*
- *Dans la mise en place des outils/procédures de travail et de concertation ?*

3. FINANCEMENT

Est-ce qu'un changement dans le financement des soins pourrait améliorer l'organisation et la coordination des soins ?

- *Quels mécanismes de financement pourraient faciliter/compliquer l'intervention d'un service/intervenant appropriés ?*
- *Quels mécanismes de financement pourraient faciliter la coordination/l'intégration des soins ?*
- *Que pensez-vous de l'idée de mutualiser les financements pour faciliter la coordination ?*
- *Que penseriez-vous d'introduire une évaluation des soins basée sur les résultats dans les mécanismes de financement ?*

- CONCLUSION [10 min.]

- Questions/remarques supplémentaires.
- Accord pour participer à la deuxième phase de l’étude et coordonnées de participants supplémentaires.
- Un feedback sera fourni par le KCE (à discuter).

APPENDIX CHAPTER 7

APPENDIX 1. QUESTIONNAIRE – FRENCH VERSION

SURVEY FIRST PAGE: Objectif de l'enquête

Madame, Monsieur,

Cette enquête vise à identifier des solutions organisationnelles permettant une transition vers un modèle de soins de santé mentale dans la communauté. Cette enquête vous prendra environ 15 minutes. L'objectif est de tenir compte de l'avis d'acteurs impliqués dans l'organisation des soins de santé mentale lors de la formulation de recommandations. C'est à ce titre que vous êtes contacté.

Avant d'aller plus loin dans le questionnaire, nous vous invitons à lire attentivement le texte suivant afin de donner votre consentement.

Il n'y a aucune obligation relative à la participation à cette étude. Vous pouvez mettre fin à votre participation à tout moment. Toutes les informations communiquées sont utilisées uniquement dans le cadre de cette recherche et de publications scientifiques. Elles sont strictement confidentielles et seront anonymisées dans la présentation des résultats. Ces données ne seront jamais transmises à des tiers et seront conservées pour la durée nécessaire de la recherche, conformément à la législation applicable en matière de droit à la vie privée (loi du 8 décembre 1992 relative à la protection de la vie privée à l'égard des traitements de données à caractère personnel et Règlement 2016/679 du Parlement européen et du Conseil du 27 avril 2016 relatif à la protection des personnes physiques à l'égard du traitement des données à caractère personnel et à la libre circulation de ces données, et abrogeant la directive 95/46/CE).

Conformément aux réglementations en vigueur, vous disposez d'un droit d'accès aux données qui vous concernent ainsi qu'un droit de correction et un droit d'opposition au traitement de vos données. Nous nous tenons à votre disposition pour tout renseignement complémentaire à l'adresse courriel : kce-hsr@uclouvain.be

Acceptez-vous de participer à cette enquête ? Oui / Non

SURVEY PART 1/7: Objectifs

Voici différents objectifs poursuivis par la réforme actuelle dans l’organisation des soins de santé mentale pour la population belge adulte. Veuillez attribuer un total de 100 points entre ces différents objectifs selon leur importance à vos yeux.

Les différents objectifs ont actuellement un score de 0, vous pouvez attribuer un score de 0 à 100 à un ou plusieurs objectifs, le score total doit être de 100.

Objectifs	**Importance**
Impliquer les usagers dans le développement et l’offre de nouveaux services	
Soigner les usagers au sein de leur communauté	
Offrir des hospitalisations de courte durée	
Garantir une continuité entre les différents secteurs de l’aide et du soin	
Aider les usagers à établir des liens avec leur quartier et communauté	
Soutenir les usagers dans l’atteinte de leurs objectifs de vie	
Total	

SURVEY PART 2/7: Objectif (attribués aléatoirement) et Analyse conjointe

Décision 1: Vous êtes invité à donner votre avis sur l'organisation des soins de santé mentale en Belgique afin de soutenir **l'intégration sociale** (soutenir les personnes dans leurs objectifs de vie et les aider à établir des liens avec leur communauté) des personnes adultes ayant des besoins en santé mentale. Veuillez garder cet objectif à l'esprit lorsque vous répondez aux différentes parties de l'enquête.

Décision 2: Vous êtes invité à donner votre avis sur l'organisation des soins de santé mentale en Belgique afin de soutenir **les soins dans la communauté** des personnes adultes ayant des besoins en santé mentale. Veuillez garder cet objectif à l'esprit lorsque vous répondez aux différentes parties de l'enquête.

2.1) Quels aspects de l’organisation des soins faut-il privilégier pour **soutenir l’intégration sociale** des personnes adultes ayant des besoins en santé mentale ?

Pour les étapes suivantes de l’enquête, il est nécessaire de sélectionner pour chaque caractéristique de l’organisation des soins, la proposition que vous préférez (colonne de droite) et celle que vous appréciez le moins (colonne de gauche) pour soutenir l’objectif d’intégration sociale.

BIS : Quels aspects de l’organisation des soins faut-il privilégier pour **soutenir les soins dans la communauté** des personnes adultes ayant des besoins en santé mentale ?

Pour les étapes suivantes de l’enquête, il est nécessaire de sélectionner pour chaque caractéristique de l’organisation des soins, la proposition que vous préférez (colonne de droite) et celle que vous appréciez le moins (colonne de gauche) pour soutenir l’objectif de soins dans la communauté.

Quel devrait être le public cible principal des interventions ?	**Moins apprécié**	**Préféré**
L’ensemble de la population adulte avec des besoins en santé mentale	O	O
Les personnes souffrant de troubles de santé mentale sévères (diagnostic psychiatrique sévère, persistant depuis plus de 2 ans, incapacités dans le quotidien)	O	O
La population précarisée avec des besoins en santé mentale	O	O
Comment les soins devraient être organisés sur le territoire ?	**Moins apprécié**	**Préféré**

Les soins devraient être organisés sur base d’une zone géographique définie / bassin de soins	O	O
Les soins ne devraient pas être organisés sur base d’une zone géographique définie / bassin de soins	O	O
Quels prestataires / services devraient principalement prester les soins de santé mentale ?	**Moins apprécié**	**Préféré**
Des services généralistes	O	O
Des services spécialisés	O	O
Comment devrait être organisé le parcours de soins des patients entre les prestataires / services ?	**Moins apprécié**	**Préféré**
Le parcours de soins des patients devrait être organisé par des règles / guidelines formels	O	O
Le parcours de soins des patients devrait être organisé de manière informelle entre le patient et ses prestataires	O	O
Comment devrait être organisée la coordination entre les prestataires ?	**Moins apprécié**	**Préféré**
Le patient devrait coordonner les soins entre ses différents prestataires	O	O
Les prestataires devraient se coordonner entre eux	O	O
Les différents services devraient être intégrés au sein d’une même structure	O	O
Comment les prestataires / services devraient être principalement financés ?	**Moins apprécié**	**Préféré**
Sur une base forfaitaire par épisode de soins	O	O

Sur base de leur activité (ex : paiement à l’acte, journée d’hospitalisation)	O	O
À quel niveau les soins devraient être financés ?	**Moins apprécié**	**Préféré**
Les soins devraient être financés par service ou prestataire	O	O
Les soins devraient être financés au niveau d’un réseau (ensemble de services couvrant une patientèle)	O	O

2.2) Vos réponses de la page précédente sont indiquées avec un score de 10 et de 0. Toujours pour **soutenir l’objectif d’intégration sociale**, veuillez attribuer un score entre 1 et 9 à la troisième proposition que vous n'avez pas choisie.

BIS : Vos réponses de la page précédente sont indiquées avec un score de 10 et de 0. Toujours pour **soutenir l’objectif de soins dans la communauté**, veuillez attribuer un score entre 1 et 9 à la troisième proposition que vous n'avez pas choisie.

Quel devrait être le public cible principal des interventions ?	**Moins apprécié**										**Préféré**
	0	1	2	3	4	5	6	7	8	9	10
L’ensemble de la population adulte avec des besoins en santé mentale	*Selon les réponses de la section 2.1*										
Les personnes souffrant de troubles de santé mentale sévères (diagnostic psychiatrique sévère, persistant depuis plus de 2 ans, incapacités dans le quotidien)	*Selon les réponses de la section 2.1*										
La population précarisée avec des besoins en santé mentale	*Selon les réponses de la section 2.1*										

Comment devrait être organisée la coordination entre les prestataires ?	**Moins apprécié**										**Préféré**
	0	1	2	3	4	5	6	7	8	9	10
Le patient devrait coordonner les soins entre ses différents prestataires	*Selon les réponses de la section 2.1*										
Les prestataires devraient se coordonner entre eux	*Selon les réponses de la section 2.1*										
Les différents services devraient être intégrés au sein d’une même structure	*Selon les réponses de la section 2.1*										

2.3) Voici vos préférences. Veuillez distribuer un total de 100 points entre les différents aspects de l’organisation des soins en fonction de leur importance pour **soutenir l’intégration sociale.**

Les différents aspects de l‘organisation des soins sont actuellement à 0, vous pouvez attribuer un score de 0 à 100 à un ou plusieurs aspects, le score total doit être de 100.

BIS : Voici vos préférences. Veuillez distribuer un total de 100 points entre les différents aspects de l’organisation des soins en fonction de leur importance pour **soutenir les soins dans la communauté.**

Les différents aspects de l‘organisation des soins ont actuellement un score de 0, vous pouvez attribuer un score de 0 à 100 à un ou plusieurs aspects, le score total doit être de 100.

Caractéristique	**Niveau**	**Importance**
Quel devrait être le public cible principal des interventions ?	*Selon les réponses de la section 2.1*	
Comment les soins devraient être organisés sur le territoire ?	*Selon les réponses de la section 2.1*	

Quels prestataires / services devraient principalement prester les soins de santé mentale ?	*Selon les réponses de la section 2.1*	
Comment devrait être organisé le parcours de soins des patients entre les prestataires / services ?	*Selon les réponses de la section 2.1*	
Comment devrait être organisée la coordination entre les prestataires ?	*Selon les réponses de la section 2.1*	
Comment les prestataires / services devraient être principalement financés ?	*Selon les réponses de la section 2.1*	
À quel niveau les soins devraient être financés ?	*Selon les réponses de la section 2.1*	
Total :		**100**

SURVEY PART 3/7: Interventions concrètes

Quelle intervention est la plus appropriée pour **soutenir l’intégration sociale** des personnes adultes ayant des besoins en santé mentale ?

Cliquez sur l’intervention la plus appropriée. Une intervention peut ne pas être optimale, choisissez alors l’intervention qui vous semble la plus appropriée pour soutenir l’objectif d’intégration sociale

BIS : Quelle intervention est la plus appropriée pour **soutenir les soins dans la communauté** des personnes adultes ayant des besoins en santé mentale ?

Cliquez sur l’intervention la plus appropriée. Une intervention peut ne pas être optimale, choisissez alors l’intervention qui vous semble la plus appropriée pour soutenir l’objectif de soins dans la communauté.

Augmenter l’offre d'hébergement pour les personnes souffrant d’un trouble psychiatrique sévère. L’offre d’hébergement est financée sur une base forfaitaire pour un ensemble de services du réseau.	VS	Augmenter l’offre d'hébergement pour toute personne ayant un besoin d'hébergement. L’offre d’hébergement est financée sur une base forfaitaire par service.
Augmenter l’offre de services d’accueil inconditionnel et immédiat visant la population avec des besoins en santé mentale sur un territoire donné.	VS	Augmenter l’offre de services d’accueil inconditionnel et immédiat visant les personnes souffrant d’un trouble psychiatrique sévère sur tout le territoire.
Intégrer du soutien à l’emploi pour les personnes avec un trouble psychiatrique dans des services spécialisés qui offrent du soin en santé mentale.	VS	Implémenter du soutien à l’emploi pour les personnes avec un trouble psychiatrique dans des services sociaux génériques de soutien à l'emploi existants et coordonnés avec le secteur de la santé mentale.

Veuillez classer les trois interventions que vous venez de choisir par ordre de priorité pour **soutenir l'intégration sociale** des personnes adultes ayant des besoins en santé mentale, 1 étant l'intervention prioritaire et 3 la moins prioritaire.

Cliquez sur les interventions pour les faire glisser par ordre de priorité.

BIS : Veuillez classer les trois interventions que vous venez de choisir par ordre de priorité pour **soutenir les soins dans la communauté** des personnes adultes ayant des besoins en santé mentale, 1 étant l'intervention prioritaire et 3 la moins prioritaire.

Cliquez sur les interventions pour les faire glisser par ordre de priorité.

Interventions	**Ordre de priorité (1 à 3)**
Augmenter l'offre en hébergement	
Augmenter l'offre de services d'accueil inconditionnel et immédiat	
Offrir du soutien à l'emploi	

Quelle intervention est la plus appropriée pour **soutenir l'intégration sociale** des personnes adultes ayant des besoins en santé mentale ?

Cliquez sur l'intervention la plus appropriée. Une intervention peut ne pas être optimale, choisissez alors l'intervention qui vous semble la plus appropriée pour soutenir l'objectif d'intégration sociale

BIS : Quelle intervention est la plus appropriée pour **soutenir les soins dans la communauté** des personnes adultes ayant des besoins en santé mentale ?

Cliquez sur l'intervention la plus appropriée. Une intervention peut ne pas être optimale, choisissez alors l'intervention qui vous semble la plus appropriée pour soutenir l'objectif de soins dans la communauté.

Augmenter l’offre de services de psychothérapie, accessible sur référence d'autres services du réseau. Chaque service est financé individuellement.	VS	Augmenter l’offre de services de psychothérapie, accessible sans référence. L’activité est financée pour un ensemble des services du réseau.
Implémenter un plan de soins individualisé par patient en partage avec les services d'un territoire donné. Le plan est autogéré par le patient.	VS	Implémenter un plan de soins individualisé par patient. Le plan est géré par un gestionnaire de cas en collaboration avec le patient.
Implémenter un système d'enregistrement et de partage des données entre les services du secteur de la santé mentale. Le système est financé pour un ensemble de services au niveau du réseau.	VS	Permettre aux services du secteur de la santé mentale qui le souhaitent d'enregistrer et de partager des données. Le système est financé par une contribution de chaque service participant.

Veuillez classer les trois interventions que vous venez de choisir par ordre de priorité pour **soutenir l’intégration sociale** des personnes adultes ayant des besoins en santé mentale, 1 étant l’intervention prioritaire et 3 la moins prioritaire.

Cliquez sur les interventions pour les faire glisser par ordre de priorité.

BIS : Veuillez classer les trois interventions que vous venez de choisir par ordre de priorité pour **soutenir les soins dans la communauté** des personnes adultes ayant des besoins en santé mentale, 1 étant l’intervention prioritaire et 3 la moins prioritaire.

Cliquez sur les interventions pour les faire glisser par ordre de priorité.

Interventions	**Ordre de priorité (1 à 3)**
Augmenter l'offre de services de psychothérapie	
Implémenter le plan de soins individualisé	
Implémenter un système d'enregistrement et de partage	

Dernier paquet d'interventions. Quelle intervention est la plus appropriée pour **soutenir l'intégration sociale** des personnes adultes ayant des besoins en santé mentale ?

Cliquez sur l'intervention la plus appropriée. Une intervention peut ne pas être optimale, choisissez alors l'intervention qui vous semble la plus appropriée pour soutenir l'objectif d'intégration sociale

BIS : Dernier paquet d'interventions. Quelle intervention est la plus appropriée pour **soutenir les soins dans la communauté** des personnes adultes ayant des besoins en santé mentale ?

Cliquez sur l'intervention la plus appropriée. Une intervention peut ne pas être optimale, choisissez alors l'intervention qui vous semble la plus appropriée pour soutenir l'objectif de soins dans la communauté.

Offrir un incitant financier forfaitaire par patient au personnel médical travaillant en service ambulatoire avec des patients ayant des besoins en santé mentale.	VS	Offrir un incitant financier par acte de soins au personnel médical travaillant en service ambulatoire avec des patients souffrant d'un trouble psychiatrique sévère.
Financer l'hospitalisation psychiatrique en tenant compte de la durée de séjour, avec un incitant financier lorsque le patient est référé vers un service ambulatoire du réseau à la sortie.	VS	Financer l'hospitalisation psychiatrique par une enveloppe budgétaire forfaitaire modulable sur base des caractéristiques de l'épisode de soins.

Mettre en place une structure de gouvernance locale qui a le pouvoir de coordonner l'offre de soins en santé mentale sur un territoire donné. Les services de soins de santé mentale sont financés individuellement par les pouvoirs publics.	VS	Mettre en place une structure de gouvernance locale qui a le pouvoir de coordonner l'offre de soins en santé mentale sur un territoire donné et d'attribuer les ressources financières correspondantes.

Veuillez classer les trois interventions que vous venez de choisir par ordre de priorité pour **soutenir l'intégration sociale** des personnes adultes ayant des besoins en santé mentale, 1 étant l'intervention prioritaire et 3 la moins prioritaire.

Cliquez sur les interventions pour les faire glisser par ordre de priorité.

BIS : Veuillez classer les trois interventions que vous venez de choisir par ordre de priorité pour **soutenir les soins dans la communauté** des personnes adultes ayant des besoins en santé mentale, 1 étant l'intervention prioritaire et 3 la moins prioritaire.

Cliquez sur les interventions pour les faire glisser par ordre de priorité.

Interventions	**Ordre de priorité (1 à 3)**
Offrir un incitant financier pour les professionnels travaillant en service ambulatoire	
Modifier le financement de l'hospitalisation psychiatrique	
Mettre en place une structure de gouvernance locale	

SURVEY PART 4/7: Personnes à contacter

Cette enquête s'adresse aux personnes clés en matière d'organisation des soins de santé mentale, nous souhaiterions nous assurer que nous n'avons oublié personne d'important.

Pourriez-vous citer les noms, prénoms et si possible l'institution d'une à cinq personnes que vous considérez comme importantes et influentes en matière d'organisation des soins de santé mentale en Belgique ?

	NOM	PRENOM	INSTITUTION
1ère personne			
2ème personne			
3ème personne			
4ème personne			
5ème personne			

SURVEY PART 5/7: Informations sociodémographiques

À propos de vous :

- Depuis combien d'années travaillez-vous dans le secteur de la santé / santé mentale ?
- Veuillez cocher la ou les cases décrivant votre activité professionnelle principale (plusieurs réponses possibles)
    - ○ Clinicien ou en contact avec les patients (santé/social)
    - ○ Membre d'une association de soutien aux usagers ou aux familles
    - ○ Responsable de l'administration
    - ○ Responsable politique
    - ○ Chercheur / Expert

  - Manager / Gestionnaire d’institution
  - Autre, merci de préciser :
- Dans quel(s) type(s) de service(s)/institution(s) travaillez-vous (plusieurs réponses possible) ?
  - Administration ou cabinet fédéral, communautaire ou régional
  - INAMI – RIZIV ou Mutuelles
  - Université ou organisation scientifique
  - Fédération de services ou organisme de coordination
  - Association professionnelle
  - Hôpital, service de santé ou service social
  - Autre, merci de préciser :
- Afin de nous assurer de la diversité géographique des répondants, pouvez-vous nous donner le code postal de votre service/institution :

SURVEY PART 6/7: Evaluation de la capacité d’influence

- A votre avis, quelle est l’influence de votre institution sur l’organisation des soins de santé mentale ?

1 Très faible, 2 Faible, 3 Modérée, 4 Importante, 5 Très importante

- Dans vos activités professionnelles globalement, participez-vous aux décisions de recrutement de personnel ou à leur promotion ?

1 Jamais, 2 Rarement, 3 Parfois, 4 Souvent, 5 Très souvent

- Dans votre institution, participez-vous aux décisions budgétaires ?

1 Jamais, 2 Rarement, 3 Parfois, 4 Souvent, 5 Très souvent

- Dans vos activités professionnelles globalement, vous arrive-t-il de participer aux décisions sur la réalisation de nouvelles activités, ou l’adoption de nouvelles politiques ou programmes ?

1 Jamais, 2 Rarement, 3 Parfois, 4 Souvent, 5 Très souvent

SURVEY PART 7/7: Question ouverte

Avez-vous des commentaires par rapport à ce questionnaire ou à l’étude ?

SURVEY END MESSAGE

Nous vous remercions d'avoir pris le temps de participer à cette enquête.

En cas de questions et de remarques, n'hésitez pas à contacter :

Pierre Smith
Chercheur
Institut de Recherche Santé et Société
Université catholique de Louvain
kce-hsr@uclouvain.be

Pour les équipes de recherche UCL-IRSS et KU Leuven LUCAS,

Vincent Lorant, Pablo Nicaise, Sophie Thunus, Pierre Smith, Carole Walker, Chantal Van Audenhove, Inge Neyens, Kirsten Hermans.

APPENDIX 2. QUESTIONNAIRE – DUTCH VERSION

VRAGENLIJST EERSTE PAGINA: Doel van het onderzoek

Geachte mevrouw, Geachte heer,

Deze vragenlijst heeft als doel organisatorische oplossingen aan te reiken om een model voor geestelijke gezondheidszorg in de samenleving te ontwikkelen. Het duurt ongeveer 15 minuten om de vragenlijst in te vullen. Het doel is om op basis van de input van belangrijke stakeholders aanbevelingen te formuleren met betrekking tot de organisatie van de geestelijke gezondheidszorg. Om die reden hebben we contact met u opgenomen.

Vooraleer u de vragenlijst doorneemt, verzoeken we u om onderstaande tekst grondig na te lezen en vragen we uw akkoord tot deelname aan het onderzoek.

Er is geen enkele verplichting omtrent de deelname aan deze studie. U kan uw deelname te allen tijde stopzetten. Alle informatie die u verstrekt, wordt uitsluitend gebruikt in het kader van dit onderzoek en wetenschappelijke publicaties. Deze gegevens zijn strikt vertrouwelijk en zullen anoniem weergegeven worden in de resultaten. De gegevens zullen nooit met derden gedeeld worden en zullen bewaard worden zolang dit nodig is voor het onderzoek, in overeenstemming met de wetgeving die van toepassing is in het kader van het recht op privacy (wet van 8 december 1992 tot bescherming van de persoonlijke levenssfeer ten opzichte van de verwerking van persoonsgegevens en Verordening 2016/679 van het Europees Parlement en de Raad van 27 april 2016 betreffende de bescherming van natuurlijke personen in verband met de verwerking van persoonsgegevens en betreffende het vrije verkeer van die gegevens en tot intrekking van Richtlijn 95/46/EG).

Overeenkomstig de verordeningen die van kracht zijn, heeft u toegang tot de gegevens die door u ingevuld werden en heeft u het recht om deze te corrigeren en de verwerking van de gegevens te weigeren. Wij staan tot uw beschikking als u bijkomende informatie wilt. U kunt ons bereiken via email: kce-hsr@uclouvain.be

Gaat u ermee akkoord aan dit onderzoek deel te nemen? Ja / Nee

VRAGENLIJST DEEL 1/7: Doelstellingen

Hieronder staan verschillende doelstellingen die met de huidige hervorming van de geestelijke gezondheidszorg voor volwassenen in België nagestreefd worden. Gelieve in totaal 100 punten te verdelen over de verschillende doelstellingen volgens het belang dat ze volgens u hebben.

De verschillende doelstellingen hebben momenteel een score van 0. Gelieve aan een of meerdere doelstellingen een score tussen 0 en 100 toe te kennen. De totaalscore moet gelijk zijn aan 100.

Doelstellingen	**Belang**
De gebruikers betrekken bij het ontwikkelen en aanbieden van nieuwe diensten	
De zorg voor gebruikers integreren in de samenleving	
Hospitalisaties van korte duur aanbieden	
Continuïteit garanderen tussen de verschillende zorg- en welzijnssectoren	
De gebruikers helpen bij het maken van connecties in hun buurt en gemeenschap	
De gebruikers ondersteunen bij het bereiken van hun levensdoelen	
Totaal	

VRAGENLIJST DEEL 2/7: Doelstelling (willekeurig toegewezen) en daaraan gekoppelde analyse

Beslissing 1: Graag horen we uw mening over hoe de geestelijke gezondheidszorg in België georganiseerd kan worden om **de sociale integratie** (personen ondersteunen bij het bereiken van hun levensdoelen en hen helpen bij het maken van connecties in de gemeenschap) van volwassenen met psychische zorgnoden te ondersteunen. Gelieve deze doelstelling in uw achterhoofd te houden tijdens het beantwoorden van de verschillende delen van de vragenlijst.

Beslissing 2: Graag horen we uw mening over hoe de geestelijke gezondheidszorg in België georganiseerd kan worden om de **zorg** voor volwassenen met psychische zorgnoden **in de gemeenschap** te ondersteunen. Gelieve deze doelstelling in uw achterhoofd te houden tijdens het beantwoorden van de verschillende delen van de vragenlijst.

2.1) Welke dimensies, gerelateerd aan de organisatie van de geestelijke gezondheidszorg, zijn volgens u prioritair om **de sociale integratie** van volwassenen met psychische zorgnoden te ondersteunen? *In dit deel van de vragenlijst moet u selecteren welk voorstel het meest uw voorkeur heeft (rechterkolom) en welk voorstel het minst uw voorkeur heeft (linkerkolom) om sociale integratie te ondersteunen.*

BIS: Welke dimensies, gerelateerd aan de organisatie van de geestelijke gezondheidszorg, zijn volgens u prioritair om **de zorg** aan volwassenen met psychische zorgnoden **in de gemeenschap** te ondersteunen? *In dit deel van de vragenlijst moet u selecteren welk voorstel het meest uw voorkeur heeft (rechterkolom) en welk voorstel het minst uw voorkeur heeft (linkerkolom) om de zorg in de gemeenschap te ondersteunen.*

Op welke doelgroep dient de hervorming van de geestelijke gezondheidszorg vooral gericht te zijn?	**Minste voorkeur**	**Meeste voorkeur**
De totale volwassen bevolking met psychische zorgnoden	○	○
Personen met ernstige psychische problemen (gediagnosticeerd met een ernstige psychiatrische aandoening; gedurende meer dan twee jaar aanwezig; beperkingen in het dagelijkse leven)	○	○
Kwetsbare groepen met psychische zorgnoden	○	○
Hoe moet de hulpverlening geografisch georganiseerd worden?	**Minste voorkeur**	**Meeste voorkeur**
De hulpverlening moet georganiseerd worden binnen een geografisch afgebakende regio	○	○
De hulpverlening mag niet georganiseerd worden binnen een geografisch afgebakende regio	○	○
Welke hulpverleners / diensten zouden voornamelijk geestelijke gezondheidszorg moeten bieden?	**Minste voorkeur**	**Meeste voorkeur**

Algemene diensten	O	O
Gespecialiseerde diensten	O	O
Hoe moet het zorgtraject van patiënten georganiseerd worden tussen hulpverleners / diensten?	**Minste voorkeur**	**Meeste voorkeur**
Het zorgtraject van patiënten moet georganiseerd worden door middel van formele regels / richtlijnen	O	O
Het zorgtraject van patiënten moet op een informele manier georganiseerd worden tussen de patiënt en zijn hulpverleners	O	O
Hoe moet de coördinatie tussen de hulpverleners georganiseerd worden?	**Minste voorkeur**	**Meeste voorkeur**
De patiënt moet zijn/haar verschillende hulpverleners coördineren	O	O
De hulpverleners moeten de zorg onderling coördineren	O	O
De verschillende diensten moeten binnen dezelfde structuur geïntegreerd worden	O	O
Hoe moeten hulpverleners / diensten gefinancierd worden?	**Minste voorkeur**	**Meeste voorkeur**
Op forfaitaire basis per verzorgingsfase	O	O
Op basis van hun activiteit (bv. betaling per behandeling, hospitalisatiedag)	O	O
Op welk niveau moet de hulpverlening gefinancierd worden?	**Minste voorkeur**	**Meeste voorkeur**
De hulpverlening per dienst of hulpverlener gefinancierd worden	O	O
De hulpverlening moet gefinancierd worden op netwerkniveau	O	O

2.2) De antwoorden die u gaf op de vorige pagina impliceren een score 0 en een score 10. Gelieve aan het derde voorstel dat u niet heeft gekozen een score tussen 1 en 9 toe te kennen (betreffende **de sociale integratie)**.

BIS: De antwoorden die u gaf op de vorige pagina, impliceren een score 0 en een score 10. Gelieve aan het derde voorstel dat u niet heeft gekozen een score tussen 1 en 9 toe te kennen (betreffende **de zorg in de gemeenschap)**.

Op welke doelgroep dient de hervorming van de geestelijke gezondheidszorg vooral gericht te zijn?	**Minst belangrijk**						**Meest belangrijk**				
	0	1	2	3	4	5	6	7	8	9	10
De totale volwassen bevolking met psychische zorgnoden	Gebaseerd op de antwoorden van 2.1										
Personen met ernstige psychische problemen (diagnose van een ernstige psychiatrische aandoening; gedurende meer dan twee jaar aanwezig; beperkingen in het dagelijkse leven)	Gebaseerd op de antwoorden van 2.1										
Kwetsbare groepen met psychische zorgnoden	Gebaseerd op de antwoorden van 2.1										

Hoe moet de coördinatie tussen de hulpverleners georganiseerd worden?	**Minst belangrijk**						**Meest belangrijk**				
	0	1	2	3	4	5	6	7	8	9	10
De patiënt moet zijn/haar verschillende hulpverleners coördineren	Gebaseerd op de antwoorden van 2.1										
De hulpverleners moeten de zorg onderling coördineren	Gebaseerd op de antwoorden van 2.1										
De verschillende diensten moeten binnen dezelfde structuur geïntegreerd worden	Gebaseerd op de antwoorden van 2.1										

2.3) Dit zijn de voorkeuren die u aanduidde. Gelieve in totaal 100 punten te verdelen over de verschillende doelstellingen in functie van hun belang voor **het ondersteunen van de sociale integratie**.

De verschillende dimensies die gerelateerd zijn aan de organisatie van de geestelijke gezondheidszorg, hebben momenteel een score van 0. Gelieve aan een of meerdere dimensies een score tussen 0 en 100 toe te kennen. De totaalscore moet gelijk zijn aan 100.

BIS: Dit zijn de voorkeuren die u aanduidde. Gelieve in totaal 100 punten te verdelen over de verschillende dimensies in functie van hun belang voor **de ondersteuning van de zorg in de gemeenschap**.

De verschillende dimensies die gerelateerd zijn aan de organisatie van de geestelijke gezondheidszorg, hebben momenteel een score van 0. Gelieve aan een of meerdere dimensies een score tussen 0 en 100 toe te kennen. De totaalscore moet gelijk zijn aan 100.

Kenmerk	Dimensie	Belang
Op welke doelgroep dient de hervorming van de geestelijke gezondheidszorg vooral gericht te zijn?	Gebaseerd op de antwoorden van 2.1	
Hoe moet de hulpverlening geografisch georganiseerd worden?	Gebaseerd op de antwoorden van 2.1	
Welke hulpverleners / diensten zouden in de eerste plaats geestelijke gezondheidszorg moeten bieden?	Gebaseerd op de antwoorden van 2.1	
Hoe moet het zorgtraject van patiënten georganiseerd worden tussen hulpverleners / diensten?	Gebaseerd op de antwoorden van 2.1	

Hoe moet de coördinatie tussen hulpverleners georganiseerd worden?	Gebaseerd op de antwoorden van 2.1	
Hoe moeten hulpverleners / diensten gefinancierd worden?	Gebaseerd op de antwoorden van 2.1	
Op welk niveau moet de hulpverlening gefinancierd worden?	Gebaseerd op de antwoorden van 2.1	
Totaal:		**100**

VRAGENLIJST DEEL 3/7: Concrete interventies

2.1) Welke interventie is het meest geschikt om **de sociale integratie** van volwassenen met psychische zorgnoden te ondersteunen?

Klik op de meest geschikte interventie. Mogelijks is een interventie niet optimaal. Kies dan de interventie die volgens u het meest geschikt is ter ondersteuning van de doelstelling rond sociale integratie.

BIS: Welke interventie is het meest geschikt om de **zorg** voor volwassenen met psychische zorgnoden **in de gemeenschap** te ondersteunen?

Klik op de meest geschikte interventie. Mogelijks is een interventie niet optimaal. Kies dan de interventie die volgens u het meest geschikt is ter ondersteuning van de doelstelling rond zorg in de gemeenschap.

Het huisvestingsaanbod uitbreiden voor personen met een ernstige psychiatrische aandoening. Het huisvestingsaanbod wordt op forfaitaire basis gefinancierd voor verschillende diensten binnen het netwerk.	vs.	Het huisvestingsaanbod uitbreiden voor iedereen die nood heeft aan huisvesting. Het huisvestingsaanbod wordt op forfaitaire basis gefinancierd per dienst.
Uitbreiding van het aanbod van onthaaldiensten die onmiddellijk toegankelijk zijn voor personen met psychische zorgnoden in een bepaalde regio, zonder dat men aan bepaalde voorwaarden moet voldoen.	vs.	Uitbreiding van het aanbod van onthaaldiensten die onmiddellijk toegankelijk zijn voor personen met een ernstige psychiatrische aandoening in het hele land, zonder dat men aan bepaalde voorwaarden moet voldoen.
Loopbaanbegeleiding voorzien voor personen met een psychiatrische aandoening in gespecialiseerde diensten geestelijke gezondheidszorg.	vs.	Loopbaanbegeleiding voorzien voor personen met een psychiatrische aandoening in bestaande algemene diensten voor loopbaanbegeleiding en in samenspraak met de geestelijke gezondheidszorgsector.

Gelieve de drie interventies die u gekozen heeft om **de sociale integratie** van volwassenen met psychische zorgnoden te ondersteunen te ordenen in volgorde van hun belang, waarbij 1 de belangrijkste interventie is en 3 de minst belangrijke interventie.

Klik op de interventies om ze in de gewenste volgorde van belang te slepen.

BIS: Gelieve de drie interventies die u heeft gekozen om de zorg aan volwassenen met psychische zorgnoden **in de gemeenschap** te ondersteunen te ordenen in volgorde van hun belang, waarbij 1 de belangrijkste interventie is en 3 de minst belangrijke interventie.

Klik op de interventies om ze in de gewenste volgorde van belang te slepen.

Interventies	**Volgorde van belang (1 tot 3)**
Het huisvestingsaanbod uitbreiden	
Uitbreiding van het aanbod van onthaaldiensten die onmiddellijk toegankelijk zijn, zonder dat men aan bepaalde voorwaarden moet voldoen	
Loopbaanbegeleiding aanbieden	

2.2) Welke interventie is het meest geschikt om **de sociale integratie** van volwassenen met psychische zorgnoden te ondersteunen?

Klik op de meest geschikte interventie. Mogelijks is een interventie niet optimaal. Kies dan de interventie die volgens u het meest geschikt is ter ondersteuning van de doelstelling rond sociale integratie.

BIS: Welke interventie is het meest geschikt om de **zorg** voor volwassenen met psychische zorgnoden **in de gemeenschap** te ondersteunen?

Klik op de meest geschikte interventie. Mogelijks is een interventie niet optimaal. Kies dan de interventie die volgens u het meest geschikt is ter ondersteuning van de doelstelling rond zorg in de gemeenschap.

Uitbreiding van het aanbod van psychotherapeutische diensten die toegankelijk zijn via doorverwijzing door andere diensten van het netwerk. Elke dienst wordt afzonderlijk gefinancierd.	vs.	Uitbreiding van het aanbod van psychotherapeutische diensten die toegankelijk zijn zonder doorverwijzing. De dienstverlening wordt gefinancierd voor de verschillende diensten binnen een netwerk.
Een individueel zorgplan per patiënt invoeren dat gedeeld wordt binnen de diensten in een bepaalde regio. Het plan wordt beheerd door de patiënt zelf.	vs.	Een individueel zorgplan per patiënt invoeren. Het plan wordt beheerd door de casemanager en wordt samen met de patiënt opgesteld.

Een systeem implementeren dat het registreren en delen van gegevens tussen de diensten geestelijke gezondheidszorg mogelijk maakt. Het systeem wordt gefinancierd op netwerkniveau.	vs.	De diensten geestelijke gezondheidszorg de mogelijkheid geven om gegevens te registreren en te delen. Het systeem wordt gefinancierd per deelnemende dienst.

Gelieve de drie interventies die u gekozen heeft om **de sociale integratie** van volwassenen met psychische zorgnoden te ondersteunen te ordenen in volgorde van hun belang, waarbij 1 de belangrijkste interventie is en 3 de minst belangrijke interventie.

Klik op de interventies om ze in de gewenste volgorde van belang te slepen.

BIS: Gelieve de drie interventies die u heeft gekozen om de zorg aan volwassenen met psychische zorgnoden **in de gemeenschap** te ondersteunen te ordenen in volgorde van hun belang, waarbij 1 de belangrijkste interventie is en 3 de minst belangrijke interventie.

Klik op de interventies om ze in de gewenste volgorde van belang te slepen.

Interventies	**Volgorde van belang (1 tot 3)**
Het aanbod van psychotherapeutische diensten uitbreiden	
Een individueel zorgplan invoeren	
Een systeem implementeren dat het registreren en delen van gegevens mogelijk maakt	

2.3) Welke interventie is het meest geschikt om **de sociale integratie** van volwassenen met psychische zorgnoden te ondersteunen?

Klik op de meest geschikte interventie. Mogelijks is een interventie niet optimaal. Kies dan de interventie die volgens u het meest geschikt is ter ondersteuning van de doelstelling rond sociale integratie.

BIS: Welke interventie is het meest geschikt om de **zorg** voor volwassenen met psychische zorgnoden **in de gemeenschap** te ondersteunen?

Klik op de meest geschikte interventie. Mogelijks is een interventie niet optimaal. Kies dan de interventie die volgens u het meest geschikt is ter ondersteuning van de doelstelling rond zorg in de gemeenschap.

Per patiënt een forfaitaire financiële incentive geven aan het medisch personeel dat tewerkgesteld is in een ambulante dienst voor patiënten met psychische zorgnoden.	vs.	Per zorgactiviteit een financiële incentive geven aan medisch personeel dat tewerkgesteld is in een ambulante dienst voor patiënten met een ernstige psychiatrische aandoening.
Psychiatrische hospitalisatie financieren, (rekening houdend met de duur van het verblijf) met een financiële incentive wanneer de patiënt doorverwezen wordt naar een ambulante dienst binnen het netwerk.	vs.	Psychiatrische hospitalisatie financieren op basis van een modulaire forfaitair begrote som op basis van de kenmerken van de zorgperiode.
Een lokale bestuursstructuur invoeren die de bevoegdheid heeft om het aanbod van geestelijke gezondheidszorg in een bepaalde regio te coördineren. De diensten voor geestelijke gezondheidszorg worden afzonderlijk gefinancierd door de overheid.	vs.	Een lokale bestuursstructuur invoeren die de bevoegdheid heeft om het aanbod van geestelijke gezondheidszorg in een bepaalde regio te coördineren en de overeenkomstige financiële middelen toe te kennen.

Gelieve de drie interventies die u gekozen heeft om **de sociale integratie** van volwassenen met psychische zorgnoden te ondersteunen te ordenen in volgorde van hun belang, waarbij 1 de belangrijkste interventie is en 3 de minst belangrijke interventie.

Klik op de interventies om ze in de gewenste volgorde van belang te slepen.

BIS: Gelieve de drie interventies die u heeft gekozen om de zorg aan volwassenen met psychische zorgnoden **in de gemeenschap** te ondersteunen te ordenen in volgorde van hun belang, waarbij 1 de belangrijkste interventie is en 3 de minst belangrijke interventie.

Klik op de interventies om ze in de gewenste volgorde van belang te slepen

Interventies	**Volgorde van belang (1 tot 3)**
Een financiële incentive geven aan professionals die in een ambulante dienst werken	
Het financieringssysteem voor psychiatrische hospitalisatie wijzigen	
Een lokale bestuursstructuur invoeren	

VRAGENLIJST DEEL 4/7: Contactpersonen

Deze vragenlijst richt zich tot stakeholders met expertise in de organisatie van de geestelijke gezondheidszorg. Wij willen er graag zeker van zijn dat we geen belangrijke personen over het hoofd hebben gezien.

Zou u ons de naam, voornaam en indien mogelijk de instelling kunnen geven van één tot vijf mensen die u belangrijk en invloedrijk vindt op het vlak van de organisatie van geestelijke gezondheidszorg in België?

	NAAM	VOORNAAM	INSTELLING
Eerste persoon			
Tweede persoon			
Derde persoon			
Vierde persoon			
Vijfde persoon			

VRAGENLIJST DEEL 5/7: Socio-demografische gegevens

Wij zouden graag weten wie u bent, welke rol u vervult en welke functie u binnen uw organisatie bekleedt.

- Hoeveel jaren werkt u al in de geestelijke gezondheidszorg?
- Gelieve het vakje of de vakjes aan te vinken die uw hoofdberoep beschrijven (meerdere antwoorden zijn mogelijk):
  - ○ Hulpverlener (gezondheid/welzijn)
  - ○ Lid van een organisatie die personen met psychische zorgnoden of hun familieleden ondersteunt
  - ○ Administratief medewerker
  - ○ Beleidsmaker
  - ○ Onderzoeker/ Expert
  - ○ Manager van een instelling
  - ○ Andere, gelieve toe te lichten:
- In welk type dienst/instelling werkt u (meerdere antwoorden mogelijk)?
  - ○ Administratie of kabinet (federale, gemeenschaps- of regionaal)
  - ○ RIZIV/INAMI of mutualiteit
  - ○ Universiteit of wetenschappelijke organisatie
  - ○ Bestuursorganisatie of koepelorganisatie
  - ○ Vereniging van professionals
  - ○ Ziekenhuis, dienst gezondheidszorg of sociale dienst
  - ○ Andere, gelieve toe te lichten:
- Gelieve de postcode van uw dienst/ instelling in te vullen zodat we zicht krijgen op de geografische diversiteit van de deelnemers:

VRAGENLIJST DEEL 6/7: De impact van uw instelling

- Hoeveel impact heeft uw instelling volgens u op de organisatie van geestelijke gezondheidszorg?

1 Heel weinig, 2 Weinig, 3 Gemiddeld, 4 Veel, 5 Heel veel

- Beslist u binnen uw professionele activiteiten over het algemeen mee over de aanwerving of promotie van personeel?

1 Nooit, 2 Zelden, 3 Soms, 4 Vaak, 5 Heel vaak

- Neemt u binnen uw instelling budgettaire beslissingen?

1 Nooit, 2 Zelden, 3 Soms, 4 Vaak, 5 Heel vaak

- Beslist u binnen uw professionele activiteiten over het algemeen mee over de uitvoering van nieuwe activiteiten of het invoeren van nieuwe beleidspunten of programma's?

1 Nooit, 2 Zelden, 3 Soms, 4 Vaak, 5 Heel vaak

VRAGENLIJST DEEL 7/7: Open vraag

Heeft u opmerkingen over deze vragenlijst of over het onderzoek?

SLOTWOORD

Hartelijk dank voor uw deelname aan het onderzoek.

Indien u vragen of opmerkingen heeft, aarzel dan niet om contact op te nemen met:

Inge Neyens
Senior onderzoeker
KU Leuven LUCAS
kce-hsr@uclouvain.be

Namens de onderzoeksteams van UCL-IRSS en KU Leuven LUCAS,

Vincent Lorant, Pablo Nicaise, Sophie Thunus, Pierre Smith, Carole Walker, Chantal Van Audenhove, Inge Neyens, Kirsten Hermans.

APPENDIX 3. COMPARISON BETWEEN EARLY AND LATE RESPONDENTS

Table 93 – Priority objectives of the reform - comparison between early and late respondents

	Early respondents	Late respondents	
Reform objectives	**Mean (SD)** **(0 = low priority, 100 = high priority)**	**Mean (SD)** **(0 = low priority, 100 = high priority)**	**T-test (p-value)**
Ensure continuity between the social and care sectors	25.3 (13.5)	25.1 (14.4)	1.2 (0.7)
Support users to develop life goals	18.8 (13.8)	17.5 (11.8)	1.3 (0.07)
Treating users in their community	18.6 (10.3)	18.8 (12.6)	1.2 (0.1)
Support users to connect with their community	12.7 (8.5)	14.8 (8.7)	1.1 (0.6)
Involve users in developing and offering new services	13.1 (9.9)	12.8 (9.1)	1.2 (0.2)
Provide short hospitalisations	12.5 (11.6)	11.1 (13.1)	1.3 (0.09)

Table 94 – Organisational interventions – comparison between early and late respondents

		Early respondents *N (%)*	Late respondents *N (%)*	Chi square (p-value)
Implement housing facilities	Increase the supply of accommodation for people with severe mental illness. Funded on a lump sum basis for a set services of the network.	141 (46)	67 (44)	0.2 (0.6)
	Increase the supply of accommodation for people with a need for accommodation. Funded on a lump sum basis for each service.	163 (54)	85 (56)	
Implement psychotherapy services	Increase the supply of psychotherapy services, accessible by reference from other services of the network. Each service is individually funded.	121 (40)	48 (32)	2.9 (0.08)
	Increase the supply of psychotherapy services, accessible without reference. The activity is funded for a set services of the network.	183 (60)	104 (68)	
Change the payment of psychiatric hospitalisations	Finance psychiatric hospitalisation taking into account the length of stay, with a financial incentive when the patient is referred to an outpatient service of the network at discharge.	171 (56)	76 (50)	1.59 (0.2)
	Finance psychiatric hospitalisation with a flexible budget based on the characteristics of the episode of care.	133 (44)	76 (50)	
Implement a local governance structure	Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory. Mental health care services are financed individually by the public authorities.	140 (46)	63 (42)	0.9 (0.3)
	Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory and to allocate the corresponding financial resources.	164 (54)	89 (58)	

APPENDIX 4. COMPARISON BETWEEN RESPONDENTS AND NON-RESPONDENTS

Table 95 – Priority objectives of the reform - comparison between respondents and non-respondents

	Respondents (n= 456)	Non-respondents (n = 58)	
Reform objectives	**Mean (SD) (0 = low priority, 100 = high priority)**	**Mean (SD) (0 = low priority, 100 = high priority)**	**T-test (p-value)**
Ensure continuity between the social and care sectors	25.2 (14.5)	26.2 (18.2)	1.1 (0.2)
Support users to develop life goals	18.4 (13.1)	18.1 (12.2)	0.2 (0.8)
Treating users in their community	17.9 (11.1)	19.0 (11.4)	0.6 (0.5)
Support users to connect with their community	13.4 (12.6)	11.3 (9.1)	1.7 (0.07)
Involve users in developing and offering new services	12.9 (9.7)	14.6 (10.3)	1.1 (0.2)
Provide short hospitalisations	12.0 (12.1)	9.4 (8.0)	1.6 (0.1)

Table 96 – Organisational interventions – comparison between respondents and non-respondents

		Early respondents N (%)	Late respondents N (%)	Chi square (p-value)
Implement housing facilities	Increase the supply of accommodation for people with severe mental illness. Funded on a lump sum basis for a set services of the network.	208 (45.6)	22 (37.9)	1.2 (0.26)
	Increase the supply of accommodation for people with a need for accommodation. Funded on a lump sum basis for each service.	248 (54.4)	36 (62.1)	
Implement psychological support	Increase the supply of psychotherapy services, accessible by reference from other services of the network. Each service is individually funded.	169 (37.1)	25 (43.1)	0.8 (0.37)
	Increase the supply of psychotherapy services, accessible without reference. The activity is funded for a set services of the network.	287 (62.9)	33 (56.9)	
Implement a local governance structure	Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory. Mental health care services are financed individually by the public authorities.	203 (44.5)	21 (36.2)	1.4 (0.23)
	Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory and to allocate the corresponding financial resources.	253 (55.5)	37 (63.8)	

APPENDIX 5. STAKEHOLDERS ASSIGNED TO THE OBJECTIVE OF SOCIAL INTEGRATION AND CARE IN THE COMMUNITY

Table 97 – Randomized stakeholders in both objectives

	Objectives		
	Social integration (n = 237)	Community care (n = 219)	χ2 (p-value)
Stakeholders' profile			1.84 (0.39)
• Policymakers and experts	68 (28.7)	51 (23.3)	
• Clinicians – Managers	152 (64.1)	153 (69.9)	
• Users' representatives	17 (7.2)	15 (6.8)	
Regions			0.48 (0.78)
• Brussels	66 (27.9)	61 (28.4)	
• Flanders	120 (51.0)	114 (53.0)	
• Wallonia	50 (21.1)	40 (18.6)	

APPENDIX 6. PREFERRED ORGANISATIONAL INTERVENTIONS BY REGION AND STAKEHOLDERS

Table 98 – Preferences in organisational interventions aiming social inclusion and recovery

		Overall sample	Preference by region N (%)				Preference by stakeholders' profile N (%)			
		N (%)	Flanders	Brussels	Wallonia	χ2 (p)	Clinicians - Managers	Users' representatives	Policymakers - Experts	χ2 (p)
Implement housing facilities	Increase the supply of accommodation for people with severe mental illness. Funded on a lump sum basis for a set services of the network.	208 (45.6)	108 (46.1)	62 (48.8)	36 (40)	1.69 (0.42)	137 (44.9)	12 (37.5)	59 (49.8)	1.66 (0.43)
	Increase the supply of accommodation for people with a need for accommodation. Funded on a lump sum basis for each service.	248 (54.4)	126 (53.9)	65 (51.2)	54 (60)		168 (55.1)	20 (62.5)	60 (50.4)	
Implement low-threshold services	Increase the supply of low-threshold services targeting the population with mental health needs in a given territory.	320 (70.2)	176 (75.2)	83 (65.3)	59 (65.6)	5.17 (0.07)	212 (69.5)	24 (75)	84 (70.6)	0.43 (0.80)
	Increase the supply of low-threshold services targeting people with severe mental illness, throughout the territory.	136 (29.8)	44 (35.6)	44 (34.7)	31 (34.4)		93 (30.5)	8 (25)	35 (29.4)	
Implement employment support interventions	Integrate employment support for people with a psychiatric disorder into specialised services that provide mental health care.	132 (28.9)	58 (24.8)	44 (34.6)	28 (31.1)	4.18 (0.12)	86 (28.2)	10 (31.2)	36 (30.2)	0.26 (0.87)
	Implement employment support for people with a psychiatric disorder in existing generic social services, coordinated with the mental health sector.	324 (71.1)	176 (75.2)	83 (65.4)	62 (68.9)		219 (71.8)	22 (68.8)	83 (69.8)	

Table 99 – Preferences in organisational interventions aiming decategorisation and continuity of care

		Overall sample	Preference by region N (%)				Preference by stakeholders' profile N (%)			
		N (%)	Flanders	Brussels	Wallonia	χ2 (p)	Clinicians - Managers	Users' representatives	Policymakers - Experts	χ2 (p)
Implement psychotherapy services	Increase the supply of psychotherapy services, accessible by reference from other services of the network. Each service is individually funded.	169 (37.1)	86 (36.7)	39 (30.7)	40 (44.4)	4.2 (0.11)	109 (35.7)	9 (28.1)	51 (42.9)	3.1 (0.21)
	Increase the supply of psychotherapy services, accessible without reference. The activity is funded for a set services of the network.	287 (62.9)	148 (63.3)	88 (69.3)	50 (55.6)		196 (64.3)	23 (71.9)	68 (57.1)	
Implement personalised care planning	Implement an individualised care plan per patient, shared with services of a given territory. The plan is self-managed by the patient.	143 (31.4)	75 (32.1)	42 (33.1)	24 (26.7)	1.14 (0.56)	96 (31.5)	8 (25)	39 (32.7)	0.71 (0.69)
	Implement an individualised care plan per patient. The plan is managed by a case manager in collaboration with the patient.	313 (68.6)	159 (67.9)	85 (66.9)	66 (73.3)		209 (68.5)	24 (75)	80 (67.7)	
Implement data sharing and recording system	Implement a data sharing and recording system between mental health services. The system is funded for a set of services of the network.	312 (68.4)	187 (79.9)	63 (49.6)	59 (65.6)	**35.5 (<0.01)**	203 (66.6)	24 (75)	85 (71.4)	1.62 (0.44)
	Implement a data sharing and recording system for mental health services that want to record and share data. The system is funded by a	144 (31.6)	47 (20.1)	64 (50.4)	31 (34.4)		102 (33.4)	8 (25)	34 (28.6)	

	contribution from each participating service.

Table 100 – Preferences in organisational interventions aiming deinstitutionalization and care in the community

		Overall sample	Preference by region N (%)				Preference by stakeholders' profile N (%)			
		N (%)	Flanders	Brussels	Wallonia	χ2 (p)	Clinicians - Managers	Users' representatives	Policymakers - Experts	χ2 (p)
Increase professional attractiveness in outpatient services	Provide a lump sum financial incentive per patient for outpatient medical professionals working with patients with mental health needs.	289 (63.4)	137 (58.5)	87 (68.5)	61 (67.8)	4.52 (0.10)	201 (65.9)	19 (59.4)	69 (57.9)	2.55 (0.27)
	Provide a financial incentive by act of care for outpatient medical professionals working with severe mental illness patients.	167 (36.6)	97 (31.5)	40 (31.5)	29 (32.2)		104 (34.1)	13 (40.6)	50 (42.1)	
Change the payment of psychiatric hospitalisations	Finance psychiatric hospitalisation taking into account the length of stay, with a financial incentive when the patient is referred to an outpatient service of the network at discharge.	247 (54.2)	131 (55.9)	64 (50.4)	49 (54.4)	1.04 (0.59)	171 (56.1)	16 (50)	60 (50.4)	1.33 (0.51)
	Finance psychiatric hospitalisation with a flexible budget based on the characteristics of the episode of care.	209 (45.8)	103 (44.1)	63 (49.6)	41 (45.6)		134 (43.9)	16 (50)	59 (49.6)	
Implement a local governance structure	Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory. Mental health	203 (44.5)	93 (39.7)	56 (44.1)	51 (56.7)	**7.5 (0.02)**	135 (44.3)	15 (46.9)	53 (44.5)	0.08 (0.96)

	care services are financed individually by the public authorities.								
	Establish a local governance structure that has the power to coordinate the provision of mental health services in a given territory and to allocate the corresponding financial resources.	253 (55.5)	141 (60.3)	71 (55.9)	39 (43.3)		170 (55.7)	17 (53.1)	66 (55.5)

APPENDIX CHAPTER 8

APPENDIX 1. MAIN ANALYSES OF THE SURVEY

Appendix 1.1. Description of the sample

Figure 43 – Number of diminishing responses by consecutive themes.

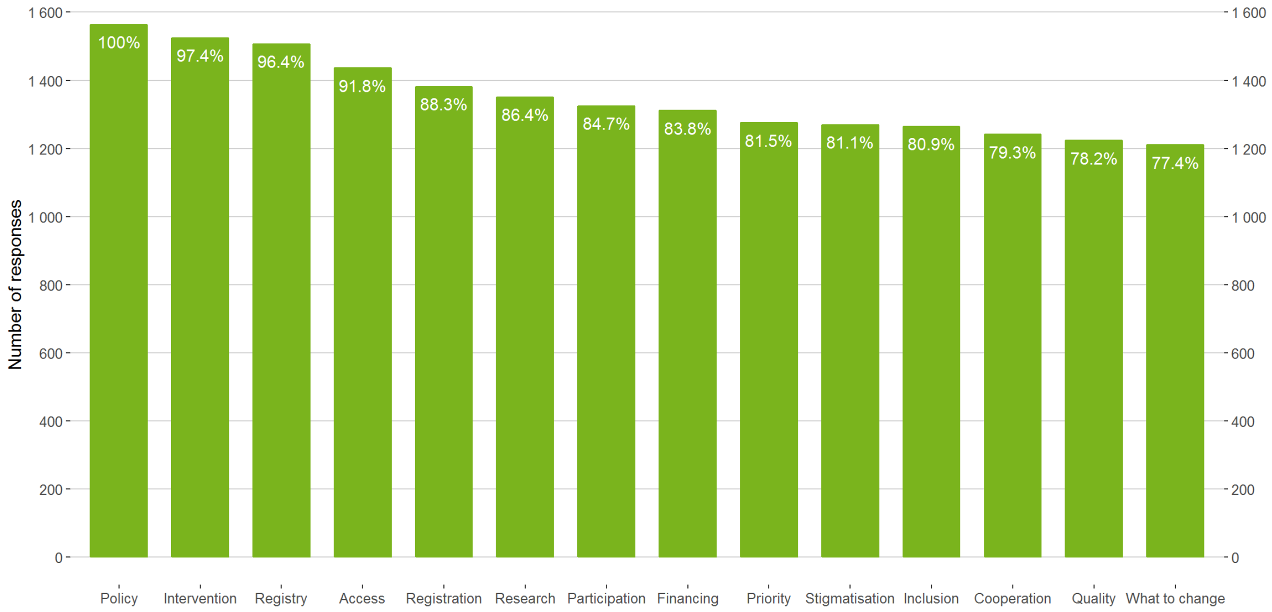


Figure 44 – Number of respondents by capacity (multiple capacities were possible).

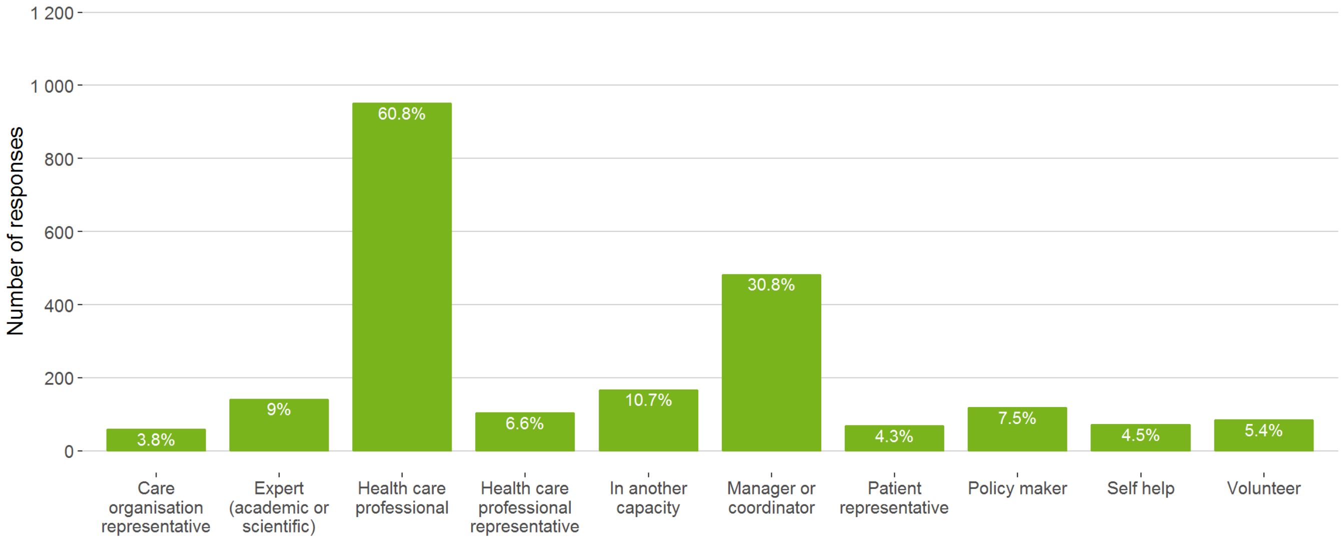
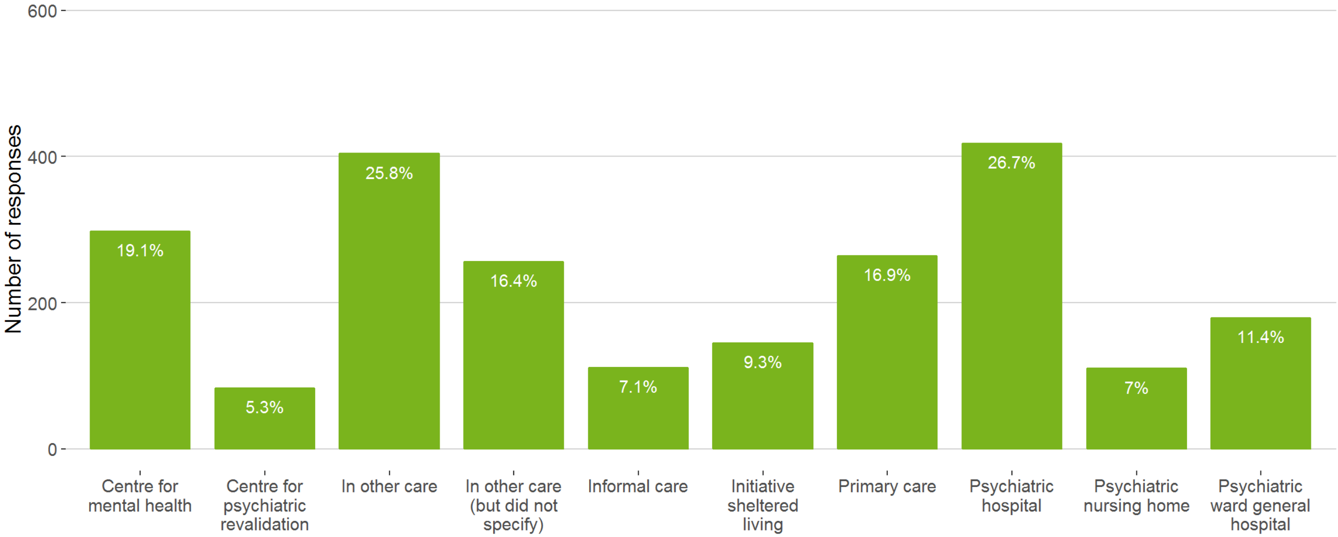
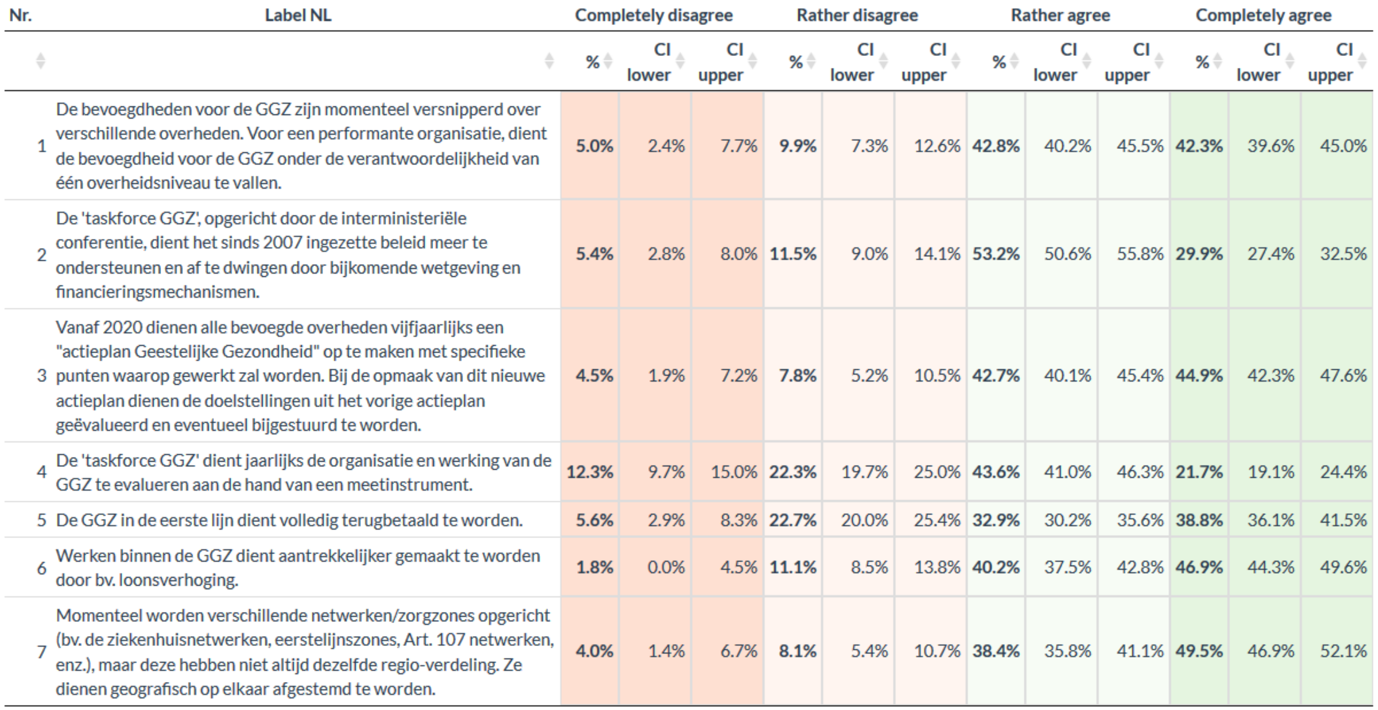


Figure 45 – Number of respondents by care organization (multiple care organizations were possible).



Appendix 1.2. Policy theme

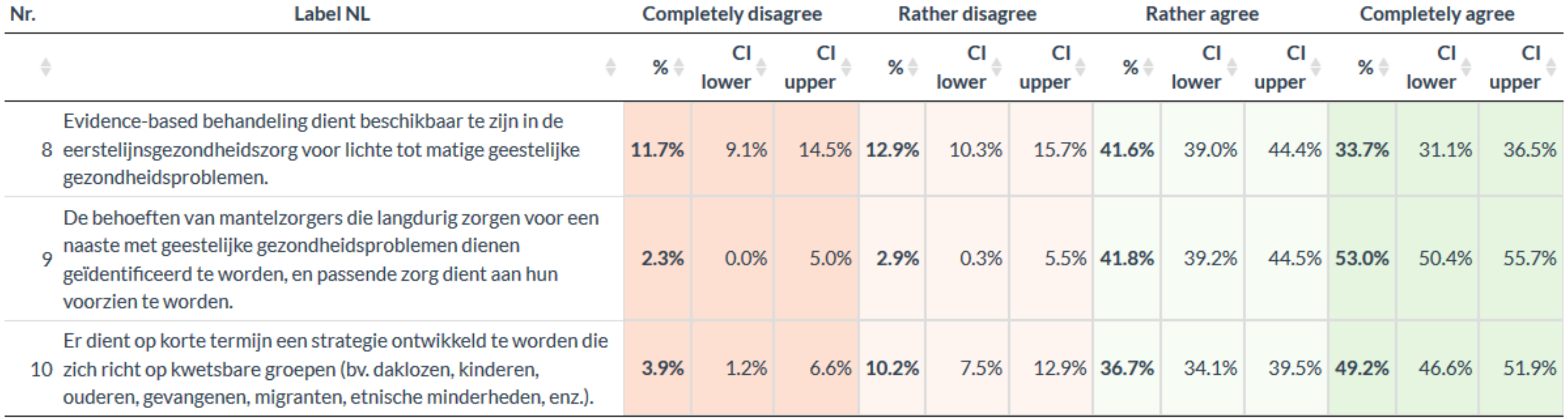
Figure 46 – Agreement on policy theme statements (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
1	De bevoegdheden voor de GGZ zijn momenteel versnipperd over verschillende overheden. Voor een performante organisatie, dient de bevoegdheid voor de GGZ onder de verantwoordelijkheid van één overheidsniveau te vallen.	**5.0%**	2.4%	7.7%	**9.9%**	7.3%	12.6%	**42.8%**	40.2%	45.5%	**42.3%**	39.6%	45.0%
2	De 'taskforce GGZ', opgericht door de interministeriële conferentie, dient het sinds 2007 ingezette beleid meer te ondersteunen en af te dwingen door bijkomende wetgeving en financieringsmechanismen.	**5.4%**	2.8%	8.0%	**11.5%**	9.0%	14.1%	**53.2%**	50.6%	55.8%	**29.9%**	27.4%	32.5%
3	Vanaf 2020 dienen alle bevoegde overheden vijfjaarlijks een "actieplan Geestelijke Gezondheid" op te maken met specifieke punten waarop gewerkt zal worden. Bij de opmaak van dit nieuwe actieplan dienen de doelstellingen uit het vorige actieplan geëvalueerd en eventueel bijgestuurd te worden.	**4.5%**	1.9%	7.2%	**7.8%**	5.2%	10.5%	**42.7%**	40.1%	45.4%	**44.9%**	42.3%	47.6%
4	De 'taskforce GGZ' dient jaarlijks de organisatie en werking van de GGZ te evalueren aan de hand van een meetinstrument.	**12.3%**	9.7%	15.0%	**22.3%**	19.7%	25.0%	**43.6%**	41.0%	46.3%	**21.7%**	19.1%	24.4%
5	De GGZ in de eerste lijn dient volledig terugbetaald te worden.	**5.6%**	2.9%	8.3%	**22.7%**	20.0%	25.4%	**32.9%**	30.2%	35.6%	**38.8%**	36.1%	41.5%
6	Werken binnen de GGZ dient aantrekkelijker gemaakt te worden door bv. loonsverhoging.	**1.8%**	0.0%	4.5%	**11.1%**	8.5%	13.8%	**40.2%**	37.5%	42.8%	**46.9%**	44.3%	49.6%
7	Momenteel worden verschillende netwerken/zorgzones opgericht (bv. de ziekenhuisnetwerken, eerstelijnszones, Art. 107 netwerken, enz.), maar deze hebben niet altijd dezelfde regio-verdeling. Ze dienen geografisch op elkaar afgestemd te worden.	**4.0%**	1.4%	6.7%	**8.1%**	5.4%	10.7%	**38.4%**	35.8%	41.1%	**49.5%**	46.9%	52.1%

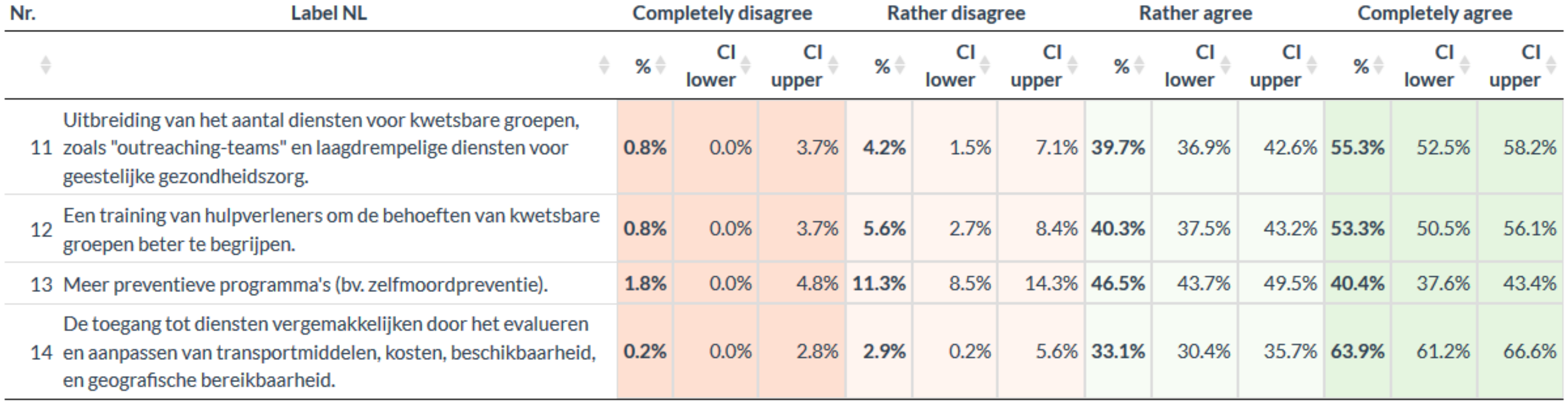
Appendix 1.3. Intervention theme

Figure 47 – Agreement on intervention theme statements (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
8	Evidence-based behandeling dient beschikbaar te zijn in de eerstelijnsgezondheidszorg voor lichte tot matige geestelijke gezondheidsproblemen.	**11.7%**	9.1%	14.5%	**12.9%**	10.3%	15.7%	**41.6%**	39.0%	44.4%	**33.7%**	31.1%	36.5%
9	De behoeften van mantelzorgers die langdurig zorgen voor een naaste met geestelijke gezondheidsproblemen dienen geïdentificeerd te worden, en passende zorg dient aan hun voorzien te worden.	**2.3%**	0.0%	5.0%	**2.9%**	0.3%	5.5%	**41.8%**	39.2%	44.5%	**53.0%**	50.4%	55.7%
10	Er dient op korte termijn een strategie ontwikkeld te worden die zich richt op kwetsbare groepen (bv. daklozen, kinderen, ouderen, gevangenen, migranten, etnische minderheden, enz.).	**3.9%**	1.2%	6.6%	**10.2%**	7.5%	12.9%	**36.7%**	34.1%	39.5%	**49.2%**	46.6%	51.9%

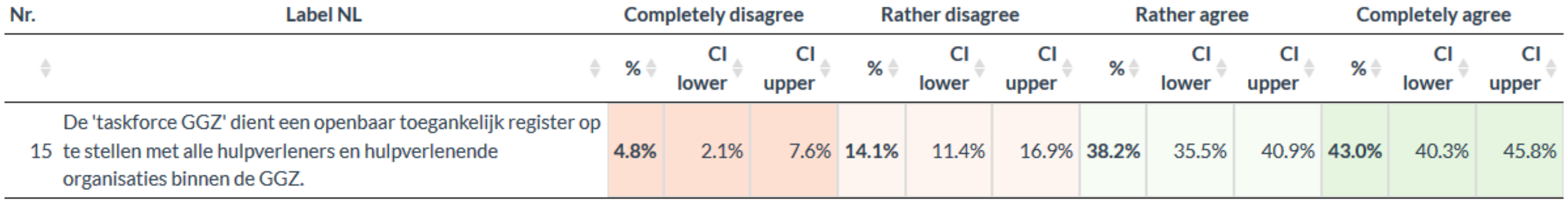
Figure 48 – Agreement on intervention theme ‘strategy’ statements (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
11	Uitbreiding van het aantal diensten voor kwetsbare groepen, zoals "outreaching-teams" en laagdrempelige diensten voor geestelijke gezondheidszorg.	**0.8%**	0.0%	3.7%	**4.2%**	1.5%	7.1%	**39.7%**	36.9%	42.6%	**55.3%**	52.5%	58.2%
12	Een training van hulpverleners om de behoeften van kwetsbare groepen beter te begrijpen.	**0.8%**	0.0%	3.7%	**5.6%**	2.7%	8.4%	**40.3%**	37.5%	43.2%	**53.3%**	50.5%	56.1%
13	Meer preventieve programma's (bv. zelfmoordpreventie).	**1.8%**	0.0%	4.8%	**11.3%**	8.5%	14.3%	**46.5%**	43.7%	49.5%	**40.4%**	37.6%	43.4%
14	De toegang tot diensten vergemakkelijken door het evalueren en aanpassen van transportmiddelen, kosten, beschikbaarheid, en geografische bereikbaarheid.	**0.2%**	0.0%	2.8%	**2.9%**	0.2%	5.6%	**33.1%**	30.4%	35.7%	**63.9%**	61.2%	66.6%

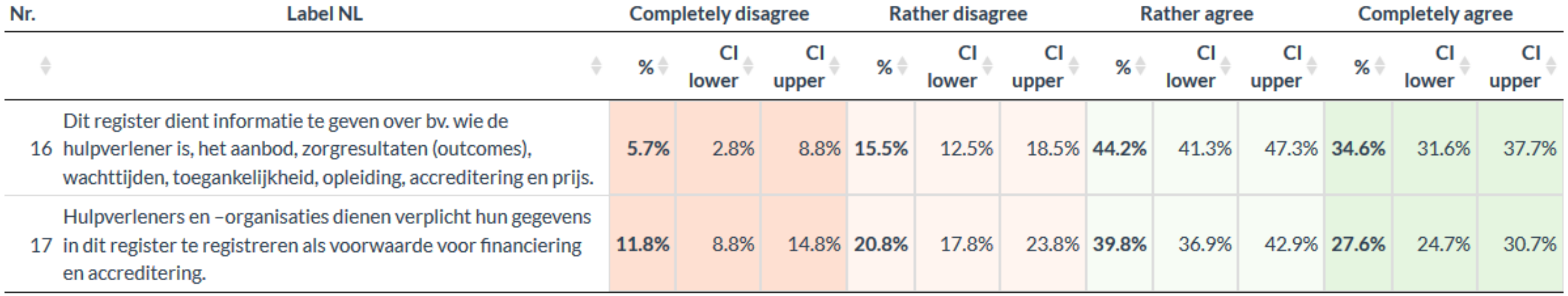
Appendix 1.4. Registry theme

Figure 49 – Agreement on registry theme statement (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
15	De 'taskforce GGZ' dient een openbaar toegankelijk register op te stellen met alle hulpverleners en hulpverlenende organisaties binnen de GGZ.	**4.8%**	2.1%	7.6%	**14.1%**	11.4%	16.9%	**38.2%**	35.5%	40.9%	**43.0%**	40.3%	45.8%

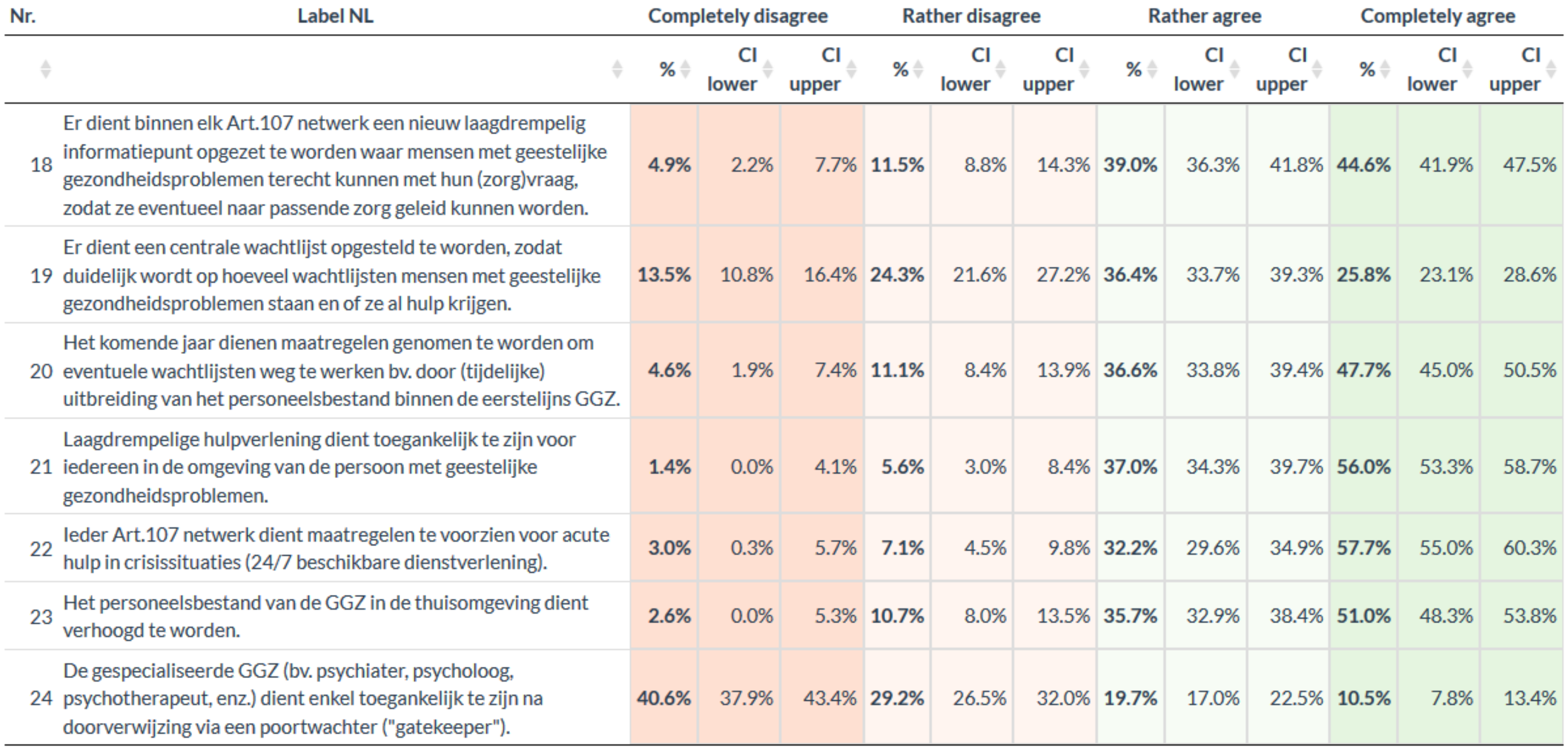
Figure 50 – Agreement on registry details theme statement (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
16	Dit register dient informatie te geven over bv. wie de hulpverlener is, het aanbod, zorgresultaten (outcomes), wachttijden, toegankelijkheid, opleiding, accreditering en prijs.	**5.7%**	2.8%	8.8%	**15.5%**	12.5%	18.5%	**44.2%**	41.3%	47.3%	**34.6%**	31.6%	37.7%
17	Hulpverleners en –organisaties dienen verplicht hun gegevens in dit register te registreren als voorwaarde voor financiering en accreditering.	**11.8%**	8.8%	14.8%	**20.8%**	17.8%	23.8%	**39.8%**	36.9%	42.9%	**27.6%**	24.7%	30.7%

Appendix 1.5. Access theme

Figure 51 – Agreement on access theme statements (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
18	Er dient binnen elk Art.107 netwerk een nieuw laagdrempelig informatiepunt opgezet te worden waar mensen met geestelijke gezondheidsproblemen terecht kunnen met hun (zorg)vraag, zodat ze eventueel naar passende zorg geleid kunnen worden.	**4.9%**	2.2%	7.7%	**11.5%**	8.8%	14.3%	**39.0%**	36.3%	41.8%	**44.6%**	41.9%	47.5%
19	Er dient een centrale wachtlijst opgesteld te worden, zodat duidelijk wordt op hoeveel wachtlijsten mensen met geestelijke gezondheidsproblemen staan en of ze al hulp krijgen.	**13.5%**	10.8%	16.4%	**24.3%**	21.6%	27.2%	**36.4%**	33.7%	39.3%	**25.8%**	23.1%	28.6%
20	Het komende jaar dienen maatregelen genomen te worden om eventuele wachtlijsten weg te werken bv. door (tijdelijke) uitbreiding van het personeelsbestand binnen de eerstelijns GGZ.	**4.6%**	1.9%	7.4%	**11.1%**	8.4%	13.9%	**36.6%**	33.8%	39.4%	**47.7%**	45.0%	50.5%
21	Laagdrempelige hulpverlening dient toegankelijk te zijn voor iedereen in de omgeving van de persoon met geestelijke gezondheidsproblemen.	**1.4%**	0.0%	4.1%	**5.6%**	3.0%	8.4%	**37.0%**	34.3%	39.7%	**56.0%**	53.3%	58.7%
22	Ieder Art.107 netwerk dient maatregelen te voorzien voor acute hulp in crisissituaties (24/7 beschikbare dienstverlening).	**3.0%**	0.3%	5.7%	**7.1%**	4.5%	9.8%	**32.2%**	29.6%	34.9%	**57.7%**	55.0%	60.3%
23	Het personeelsbestand van de GGZ in de thuisomgeving dient verhoogd te worden.	**2.6%**	0.0%	5.3%	**10.7%**	8.0%	13.5%	**35.7%**	32.9%	38.4%	**51.0%**	48.3%	53.8%
24	De gespecialiseerde GGZ (bv. psychiater, psycholoog, psychotherapeut, enz.) dient enkel toegankelijk te zijn na doorverwijzing via een poortwachter ("gatekeeper").	**40.6%**	37.9%	43.4%	**29.2%**	26.5%	32.0%	**19.7%**	17.0%	22.5%	**10.5%**	7.8%	13.4%

Figure 52 – Access theme: gatekeeper choices non-exclusive (95% confidence intervals).

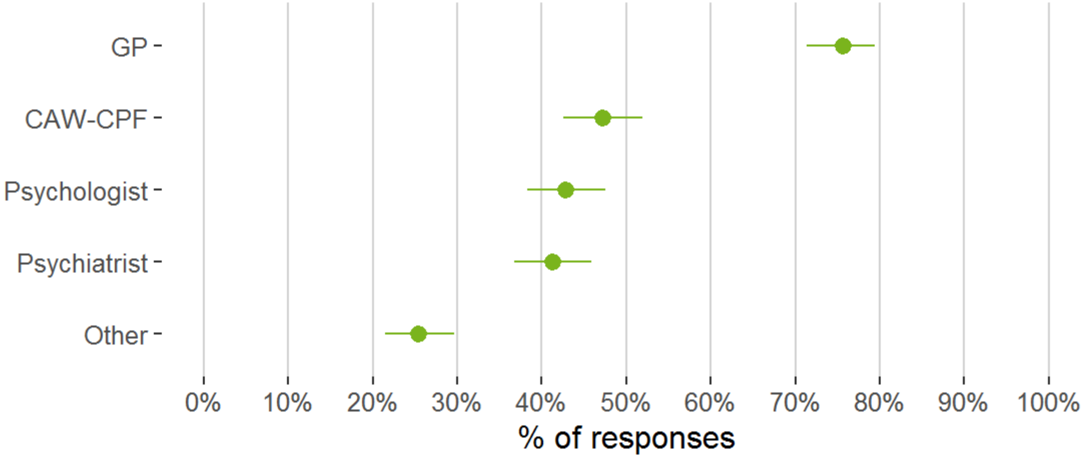
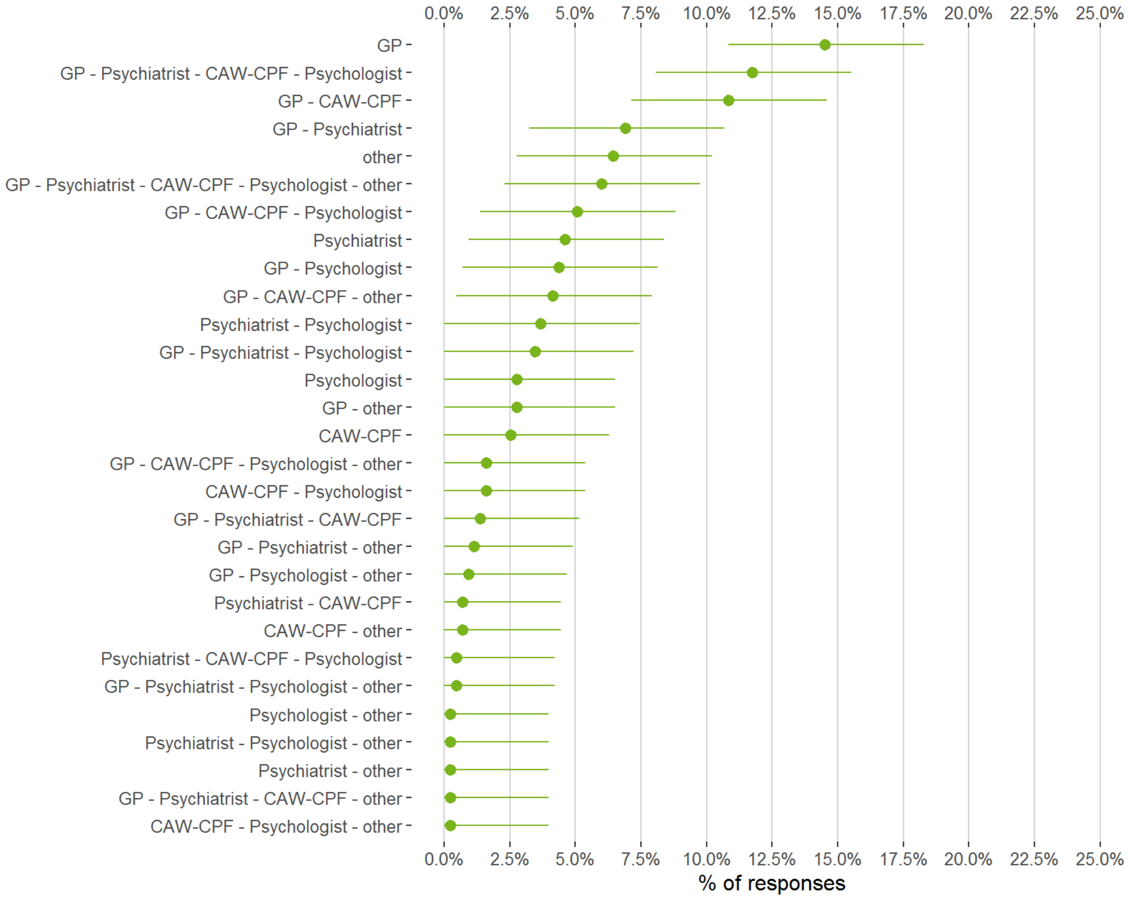
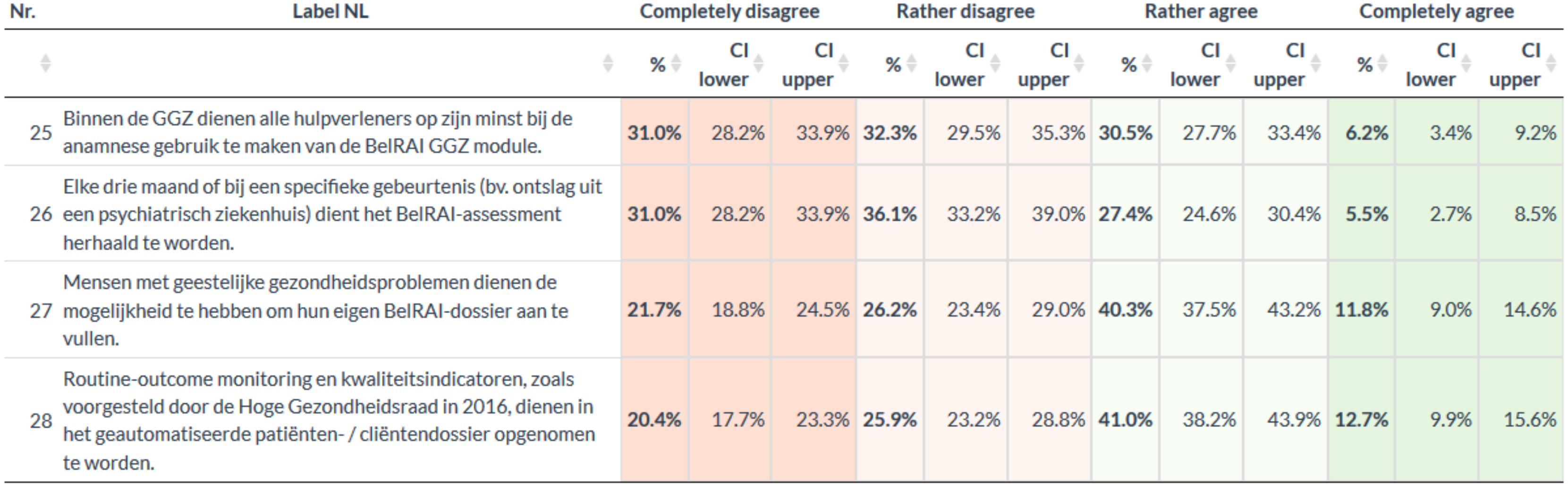


Figure 53 – Access theme: gatekeeper combinations (95% simultaneous confidence intervals)



Appendix 1.6. Registration theme

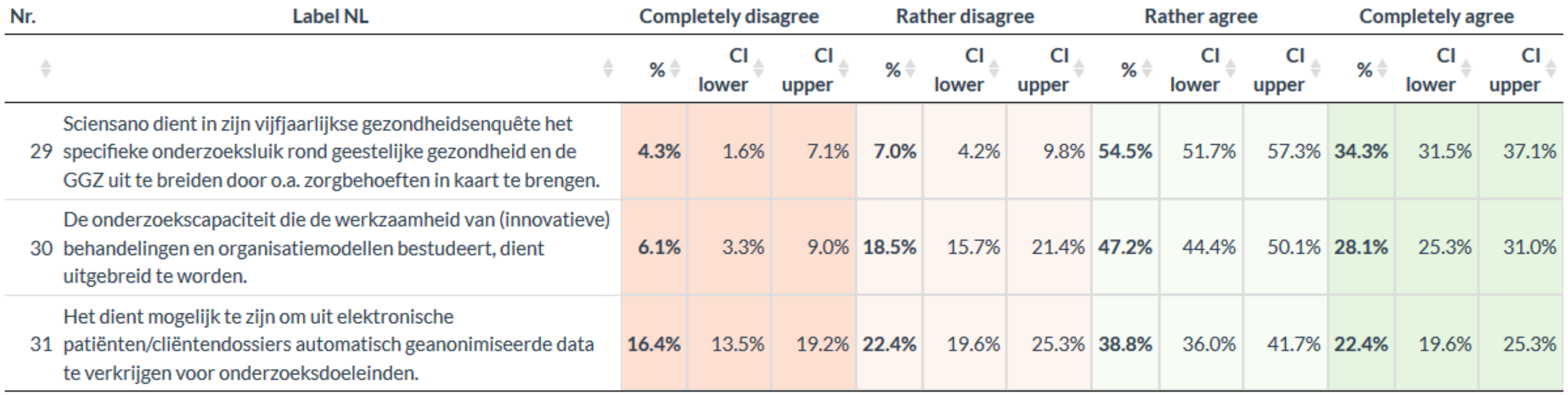
Figure 54 – Agreement on registration theme statements (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
25	Binnen de GGZ dienen alle hulpverleners op zijn minst bij de anamnese gebruik te maken van de BelRAI GGZ module.	**31.0%**	28.2%	33.9%	**32.3%**	29.5%	35.3%	**30.5%**	27.7%	33.4%	**6.2%**	3.4%	9.2%
26	Elke drie maand of bij een specifieke gebeurtenis (bv. ontslag uit een psychiatrisch ziekenhuis) dient het BelRAI-assessment herhaald te worden.	**31.0%**	28.2%	33.9%	**36.1%**	33.2%	39.0%	**27.4%**	24.6%	30.4%	**5.5%**	2.7%	8.5%
27	Mensen met geestelijke gezondheidsproblemen dienen de mogelijkheid te hebben om hun eigen BelRAI-dossier aan te vullen.	**21.7%**	18.8%	24.5%	**26.2%**	23.4%	29.0%	**40.3%**	37.5%	43.2%	**11.8%**	9.0%	14.6%
28	Routine-outcome monitoring en kwaliteitsindicatoren, zoals voorgesteld door de Hoge Gezondheidsraad in 2016, dienen in het geautomatiseerde patiënten- / cliëntendossier opgenomen te worden.	**20.4%**	17.7%	23.3%	**25.9%**	23.2%	28.8%	**41.0%**	38.2%	43.9%	**12.7%**	9.9%	15.6%

Appendix 1.7. Research theme

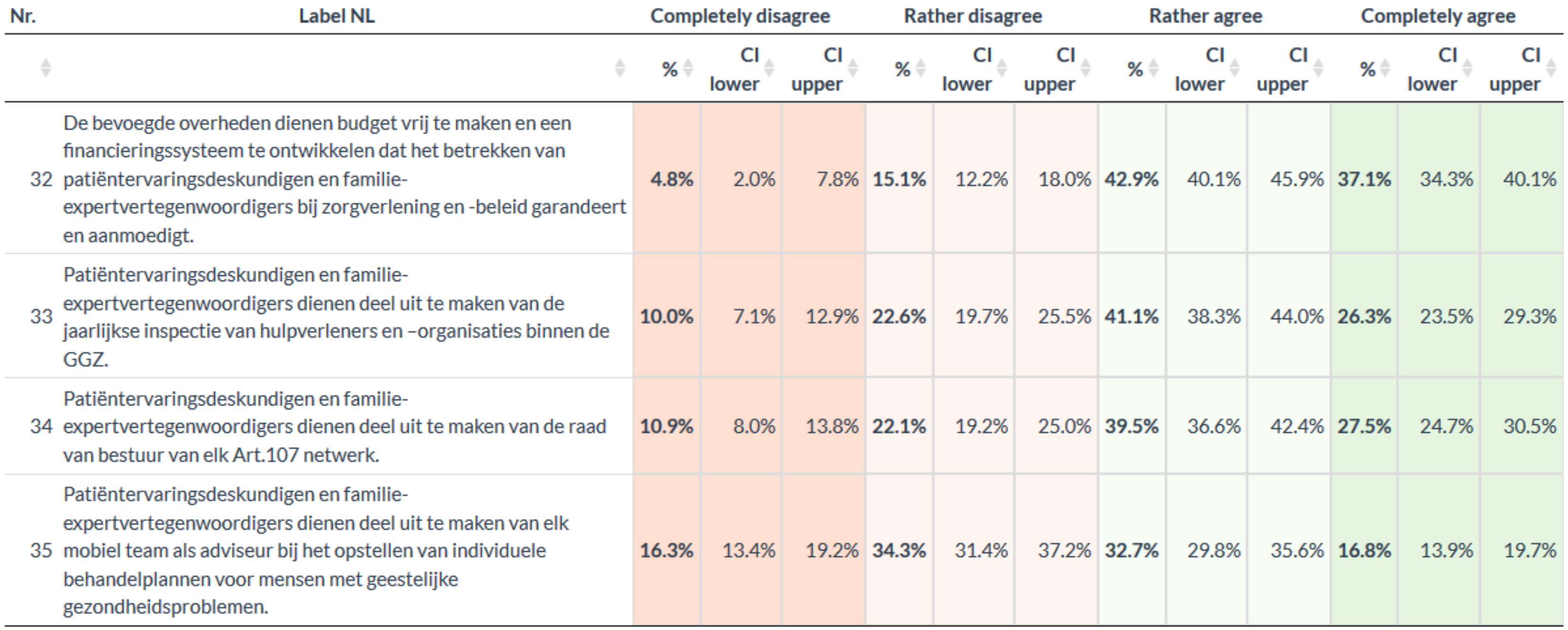
Figure 55 – Agreement on research theme statements (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
29	Sciensano dient in zijn vijfjaarlijkse gezondheidsenquête het specifieke onderzoeksluik rond geestelijke gezondheid en de GGZ uit te breiden door o.a. zorgbehoeften in kaart te brengen.	**4.3%**	1.6%	7.1%	**7.0%**	4.2%	9.8%	**54.5%**	51.7%	57.3%	**34.3%**	31.5%	37.1%
30	De onderzoekscapaciteit die de werkzaamheid van (innovatieve) behandelingen en organisatiemodellen bestudeert, dient uitgebreid te worden.	**6.1%**	3.3%	9.0%	**18.5%**	15.7%	21.4%	**47.2%**	44.4%	50.1%	**28.1%**	25.3%	31.0%
31	Het dient mogelijk te zijn om uit elektronische patiënten/cliëntendossiers automatisch geanonimiseerde data te verkrijgen voor onderzoeksdoeleinden.	**16.4%**	13.5%	19.2%	**22.4%**	19.6%	25.3%	**38.8%**	36.0%	41.7%	**22.4%**	19.6%	25.3%

Appendix 1.8. Participation theme

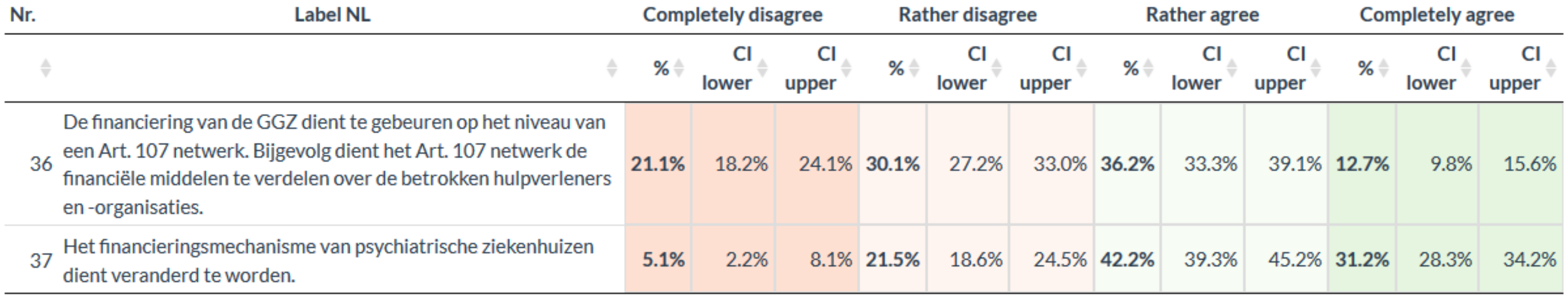
Figure 56 – Agreement on participation theme statements (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
32	De bevoegde overheden dienen budget vrij te maken en een financieringssysteem te ontwikkelen dat het betrekken van patiëntervaringsdeskundigen en familie-expertvertegenwoordigers bij zorgverlening en -beleid garandeert en aanmoedigt.	**4.8%**	2.0%	7.8%	**15.1%**	12.2%	18.0%	**42.9%**	40.1%	45.9%	**37.1%**	34.3%	40.1%
33	Patiëntervaringsdeskundigen en familie-expertvertegenwoordigers dienen deel uit te maken van de jaarlijkse inspectie van hulpverleners en –organisaties binnen de GGZ.	**10.0%**	7.1%	12.9%	**22.6%**	19.7%	25.5%	**41.1%**	38.3%	44.0%	**26.3%**	23.5%	29.3%
34	Patiëntervaringsdeskundigen en familie-expertvertegenwoordigers dienen deel uit te maken van de raad van bestuur van elk Art.107 netwerk.	**10.9%**	8.0%	13.8%	**22.1%**	19.2%	25.0%	**39.5%**	36.6%	42.4%	**27.5%**	24.7%	30.5%
35	Patiëntervaringsdeskundigen en familie-expertvertegenwoordigers dienen deel uit te maken van elk mobiel team als adviseur bij het opstellen van individuele behandelplannen voor mensen met geestelijke gezondheidsproblemen.	**16.3%**	13.4%	19.2%	**34.3%**	31.4%	37.2%	**32.7%**	29.8%	35.6%	**16.8%**	13.9%	19.7%

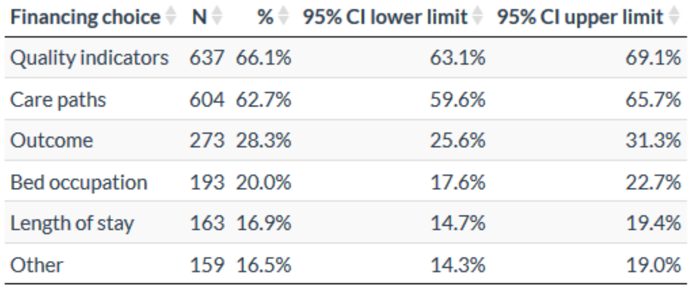
Appendix 1.9. Financing theme

Figure 57 – Agreement on financing theme statements (95% confidence intervals (CI))



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
36	De financiering van de GGZ dient te gebeuren op het niveau van een Art. 107 netwerk. Bijgevolg dient het Art. 107 netwerk de financiële middelen te verdelen over de betrokken hulpverleners en -organisaties.	**21.1%**	18.2%	24.1%	**30.1%**	27.2%	33.0%	**36.2%**	33.3%	39.1%	**12.7%**	9.8%	15.6%
37	Het financieringsmechanisme van psychiatrische ziekenhuizen dient veranderd te worden.	**5.1%**	2.2%	8.1%	**21.5%**	18.6%	24.5%	**42.2%**	39.3%	45.2%	**31.2%**	28.3%	34.2%

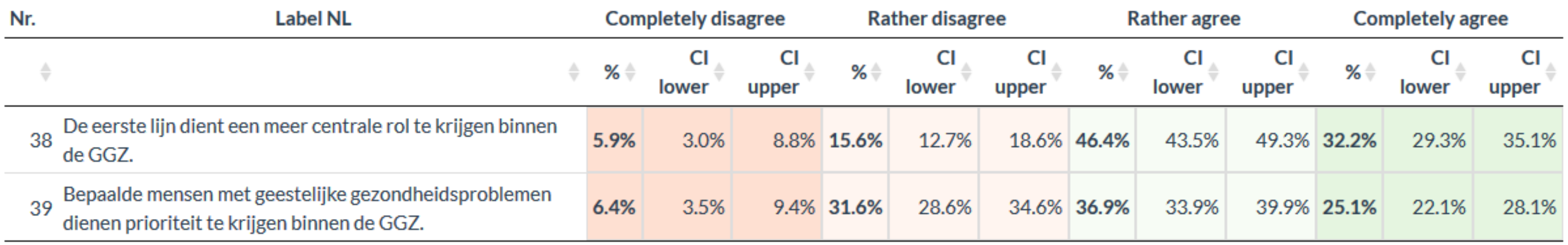
Figure 58 – Financing psychiatric hospitals choices, non-exclusive (95% confidence intervals (CI))



Financing choice	N	%	95% CI lower limit	95% CI upper limit
Quality indicators	637	66.1%	63.1%	69.1%
Care paths	604	62.7%	59.6%	65.7%
Outcome	273	28.3%	25.6%	31.3%
Bed occupation	193	20.0%	17.6%	22.7%
Length of stay	163	16.9%	14.7%	19.4%
Other	159	16.5%	14.3%	19.0%

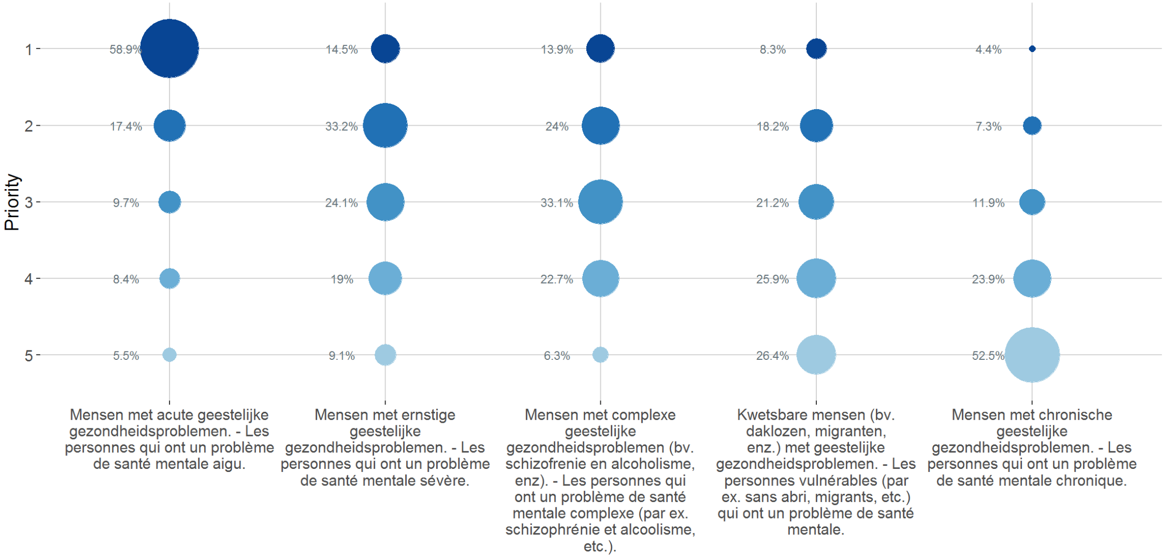
Appendix 1.10. Priority theme

Figure 59 – Agreement on priority theme statements (95% confidence intervals (CI)).



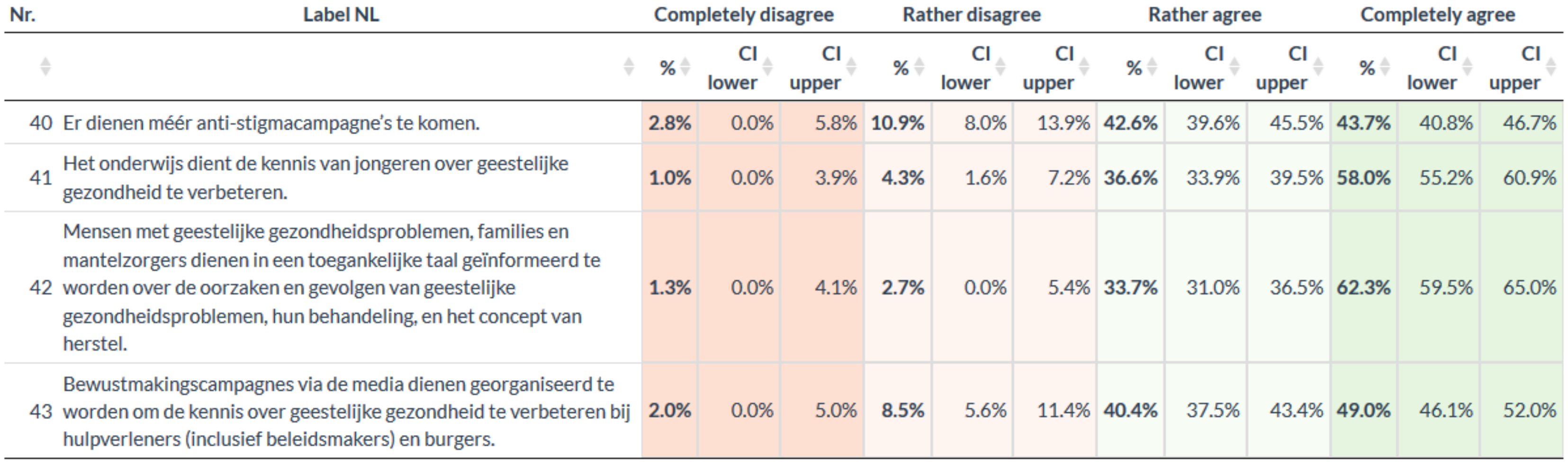
Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
38	De eerste lijn dient een meer centrale rol te krijgen binnen de GGZ.	**5.9%**	3.0%	8.8%	**15.6%**	12.7%	18.6%	**46.4%**	43.5%	49.3%	**32.2%**	29.3%	35.1%
39	Bepaalde mensen met geestelijke gezondheidsproblemen dienen prioriteit te krijgen binnen de GGZ.	**6.4%**	3.5%	9.4%	**31.6%**	28.6%	34.6%	**36.9%**	33.9%	39.9%	**25.1%**	22.1%	28.1%

Figure 60 – Priority theme: percentage of responses per priority level by chosen subgroup with mental health problems.



Appendix 1.11. Stigmatizing and health literacy theme

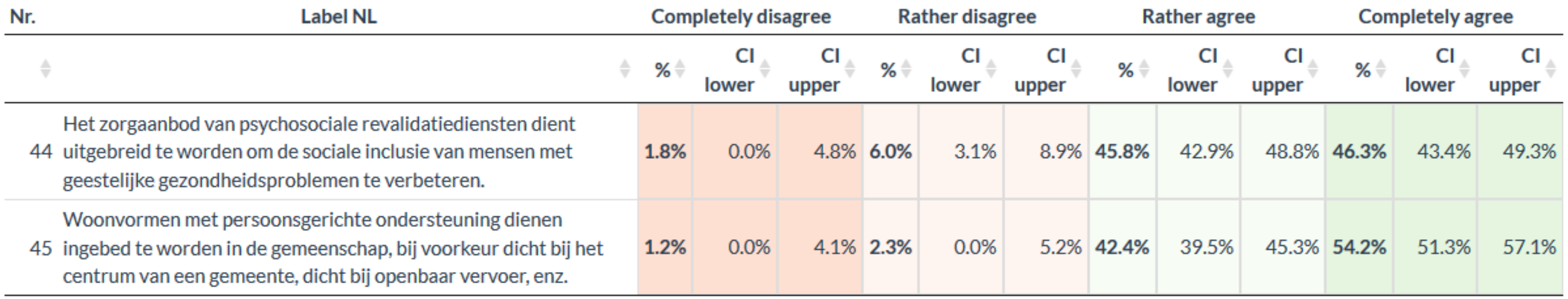
Figure 61 – Agreement on stigmatizing and health literacy theme statements (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
40	Er dienen méér anti-stigmacampagne's te komen.	**2.8%**	0.0%	5.8%	**10.9%**	8.0%	13.9%	**42.6%**	39.6%	45.5%	**43.7%**	40.8%	46.7%
41	Het onderwijs dient de kennis van jongeren over geestelijke gezondheid te verbeteren.	**1.0%**	0.0%	3.9%	**4.3%**	1.6%	7.2%	**36.6%**	33.9%	39.5%	**58.0%**	55.2%	60.9%
42	Mensen met geestelijke gezondheidsproblemen, families en mantelzorgers dienen in een toegankelijke taal geïnformeerd te worden over de oorzaken en gevolgen van geestelijke gezondheidsproblemen, hun behandeling, en het concept van herstel.	**1.3%**	0.0%	4.1%	**2.7%**	0.0%	5.4%	**33.7%**	31.0%	36.5%	**62.3%**	59.5%	65.0%
43	Bewustmakingscampagnes via de media dienen georganiseerd te worden om de kennis over geestelijke gezondheid te verbeteren bij hulpverleners (inclusief beleidsmakers) en burgers.	**2.0%**	0.0%	5.0%	**8.5%**	5.6%	11.4%	**40.4%**	37.5%	43.4%	**49.0%**	46.1%	52.0%

Appendix 1.12. Inclusion theme

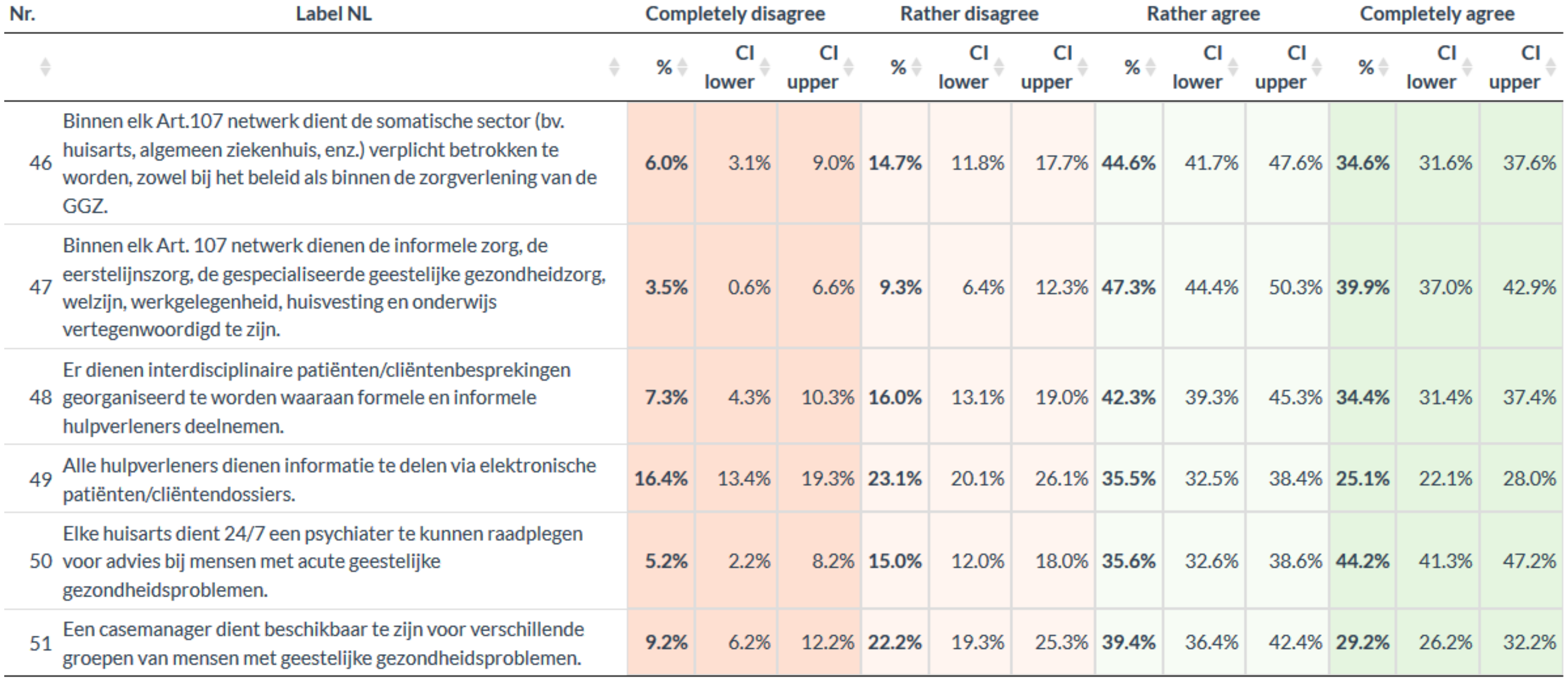
Figure 62 – Agreement on inclusion theme statements (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
44	Het zorgaanbod van psychosociale revalidatiediensten dient uitgebreid te worden om de sociale inclusie van mensen met geestelijke gezondheidsproblemen te verbeteren.	**1.8%**	0.0%	4.8%	**6.0%**	3.1%	8.9%	**45.8%**	42.9%	48.8%	**46.3%**	43.4%	49.3%
45	Woonvormen met persoonsgerichte ondersteuning dienen ingebed te worden in de gemeenschap, bij voorkeur dicht bij het centrum van een gemeente, dicht bij openbaar vervoer, enz.	**1.2%**	0.0%	4.1%	**2.3%**	0.0%	5.2%	**42.4%**	39.5%	45.3%	**54.2%**	51.3%	57.1%

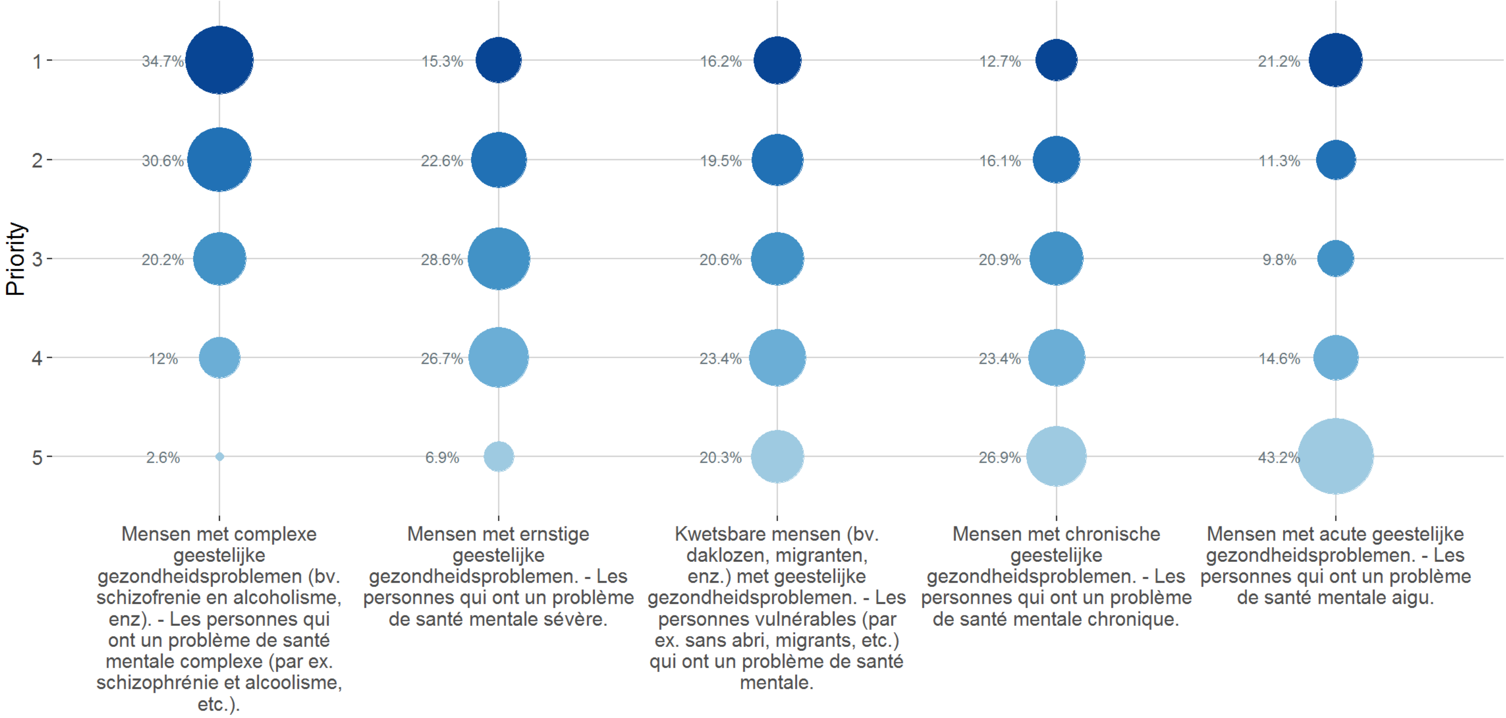
Appendix 1.13. Cooperation theme

Figure 63 – Agreement on cooperation theme statements (95% confidence intervals (CI)).



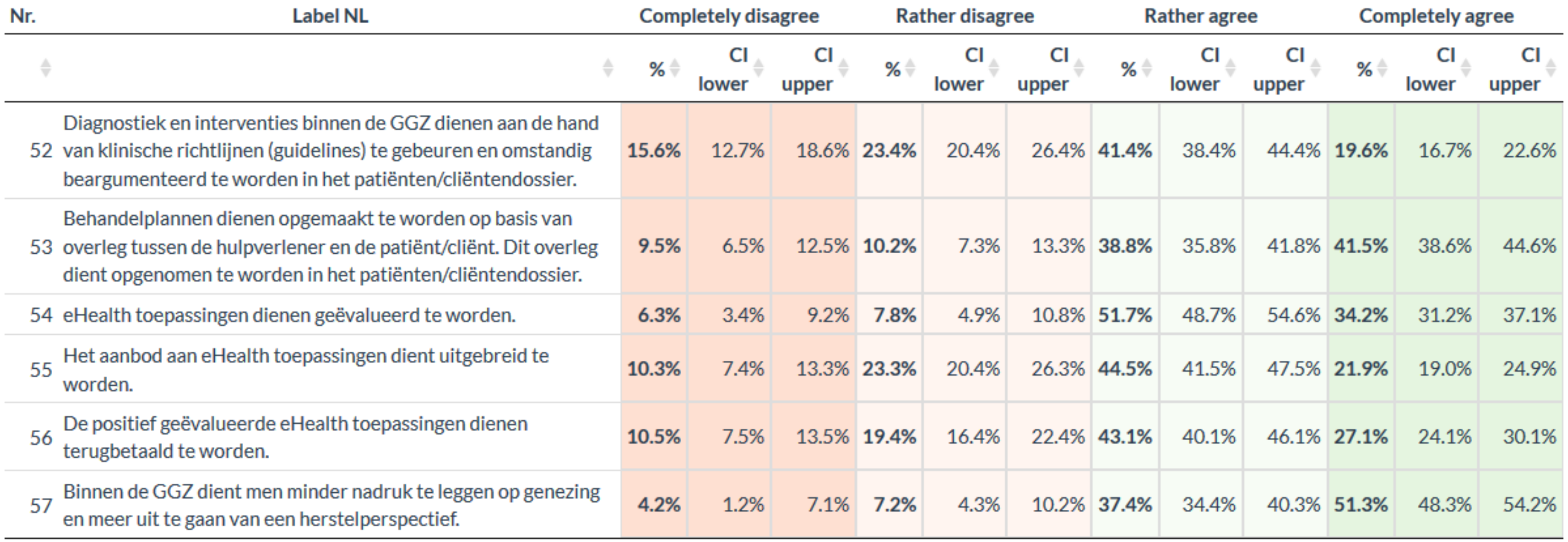
Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
46	Binnen elk Art.107 netwerk dient de somatische sector (bv. huisarts, algemeen ziekenhuis, enz.) verplicht betrokken te worden, zowel bij het beleid als binnen de zorgverlening van de GGZ.	**6.0%**	3.1%	9.0%	**14.7%**	11.8%	17.7%	**44.6%**	41.7%	47.6%	**34.6%**	31.6%	37.6%
47	Binnen elk Art. 107 netwerk dienen de informele zorg, de eerstelijnszorg, de gespecialiseerde geestelijke gezondheidzorg, welzijn, werkgelegenheid, huisvesting en onderwijs vertegenwoordigd te zijn.	**3.5%**	0.6%	6.6%	**9.3%**	6.4%	12.3%	**47.3%**	44.4%	50.3%	**39.9%**	37.0%	42.9%
48	Er dienen interdisciplinaire patiënten/cliëntenbesprekingen georganiseerd te worden waaraan formele en informele hulpverleners deelnemen.	**7.3%**	4.3%	10.3%	**16.0%**	13.1%	19.0%	**42.3%**	39.3%	45.3%	**34.4%**	31.4%	37.4%
49	Alle hulpverleners dienen informatie te delen via elektronische patiënten/cliëntendossiers.	**16.4%**	13.4%	19.3%	**23.1%**	20.1%	26.1%	**35.5%**	32.5%	38.4%	**25.1%**	22.1%	28.0%
50	Elke huisarts dient 24/7 een psychiater te kunnen raadplegen voor advies bij mensen met acute geestelijke gezondheidsproblemen.	**5.2%**	2.2%	8.2%	**15.0%**	12.0%	18.0%	**35.6%**	32.6%	38.6%	**44.2%**	41.3%	47.2%
51	Een casemanager dient beschikbaar te zijn voor verschillende groepen van mensen met geestelijke gezondheidsproblemen.	**9.2%**	6.2%	12.2%	**22.2%**	19.3%	25.3%	**39.4%**	36.4%	42.4%	**29.2%**	26.2%	32.2%

Figure 64 – Cooperation theme: percentage of responses per priority level by chosen subgroup with mental health problems.



Appendix 1.14. Quality theme

Figure 65 – Agreement on quality theme statements (95% confidence intervals (CI)).



Nr.	Label NL	Completely disagree			Rather disagree			Rather agree			Completely agree		
		%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper	%	CI lower	CI upper
52	Diagnostiek en interventies binnen de GGZ dienen aan de hand van klinische richtlijnen (guidelines) te gebeuren en omstandig beargumenteerd te worden in het patiënten/cliëntendossier.	**15.6%**	12.7%	18.6%	**23.4%**	20.4%	26.4%	**41.4%**	38.4%	44.4%	**19.6%**	16.7%	22.6%
53	Behandelplannen dienen opgemaakt te worden op basis van overleg tussen de hulpverlener en de patiënt/cliënt. Dit overleg dient opgenomen te worden in het patiënten/cliëntendossier.	**9.5%**	6.5%	12.5%	**10.2%**	7.3%	13.3%	**38.8%**	35.8%	41.8%	**41.5%**	38.6%	44.6%
54	eHealth toepassingen dienen geëvalueerd te worden.	**6.3%**	3.4%	9.2%	**7.8%**	4.9%	10.8%	**51.7%**	48.7%	54.6%	**34.2%**	31.2%	37.1%
55	Het aanbod aan eHealth toepassingen dient uitgebreid te worden.	**10.3%**	7.4%	13.3%	**23.3%**	20.4%	26.3%	**44.5%**	41.5%	47.5%	**21.9%**	19.0%	24.9%
56	De positief geëvalueerde eHealth toepassingen dienen terugbetaald te worden.	**10.5%**	7.5%	13.5%	**19.4%**	16.4%	22.4%	**43.1%**	40.1%	46.1%	**27.1%**	24.1%	30.1%
57	Binnen de GGZ dient men minder nadruk te leggen op genezing en meer uit te gaan van een herstelperspectief.	**4.2%**	1.2%	7.1%	**7.2%**	4.3%	10.2%	**37.4%**	34.4%	40.3%	**51.3%**	48.3%	54.2%

Appendix 1.15. Sub-analyses of the survey

Appendix 1.15.1. Sub-analyses of the care organizations region

Figure 66 – Agreement on policy theme statements by the region of the care organization.

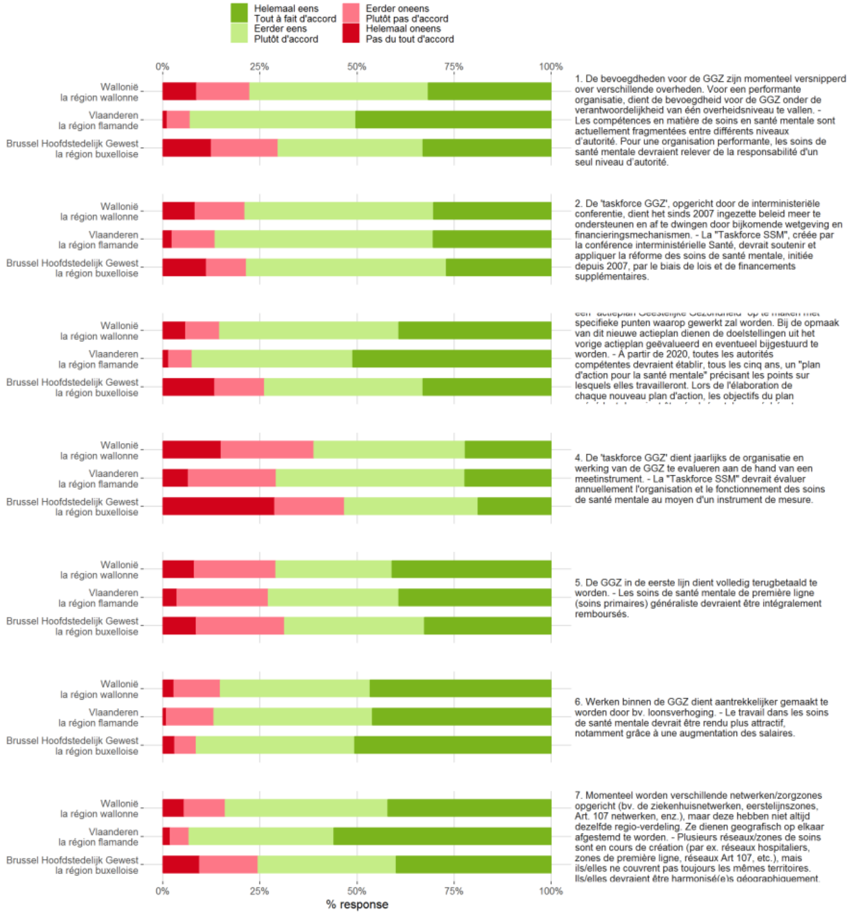


Figure 67 – Agreement on intervention theme statements by the region of the care organization

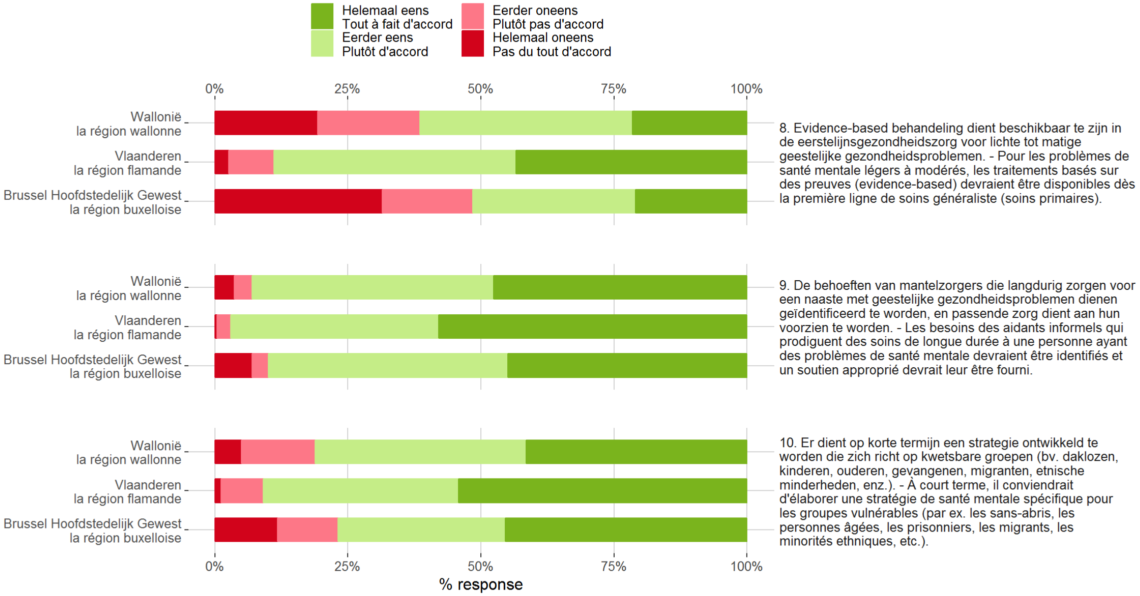


Figure 68 – Agreement on intervention theme ‘strategy’ statements by the region of the care organization.

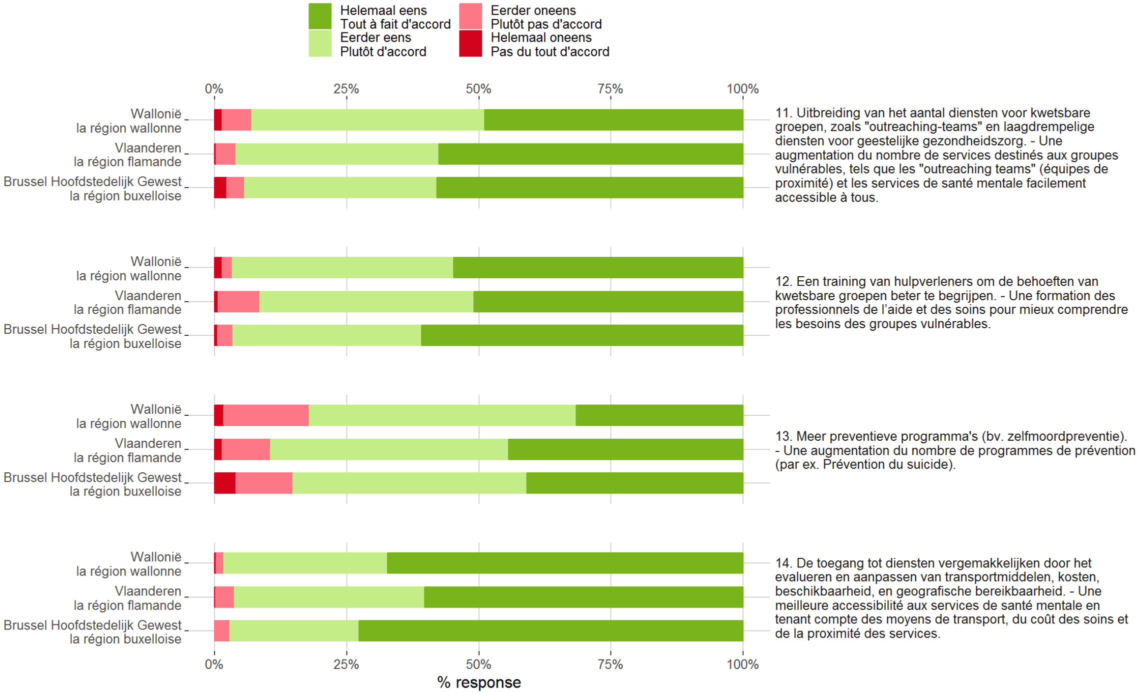


Figure 69 – Agreement on registry theme statement by the region of the care organization.

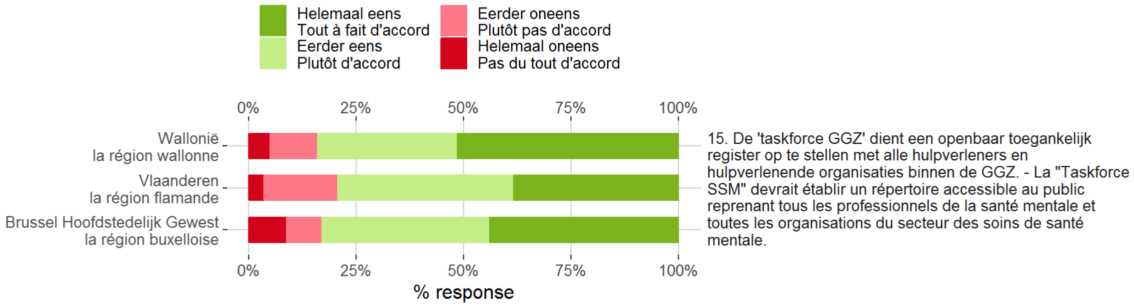


Figure 70 – Agreement on access theme statements by the region of the care organization.

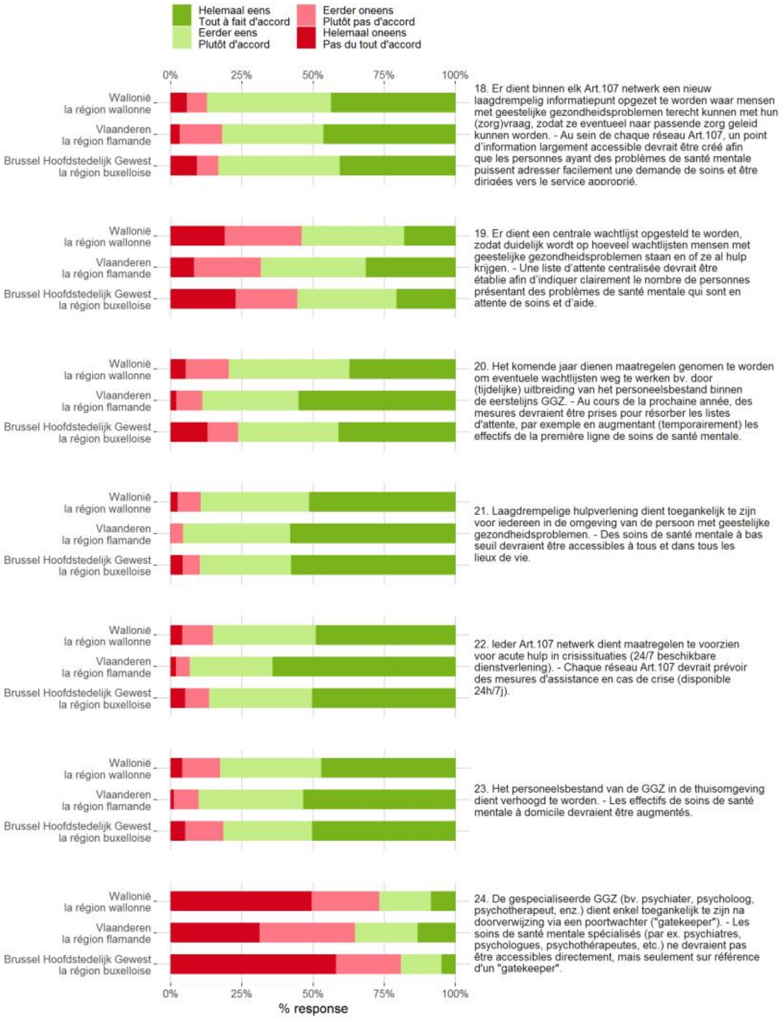


Figure 71 – Agreement on registration theme statements by the region of the care organization.

Figure 72 – Agreement on research theme statements by the region of the care organization.

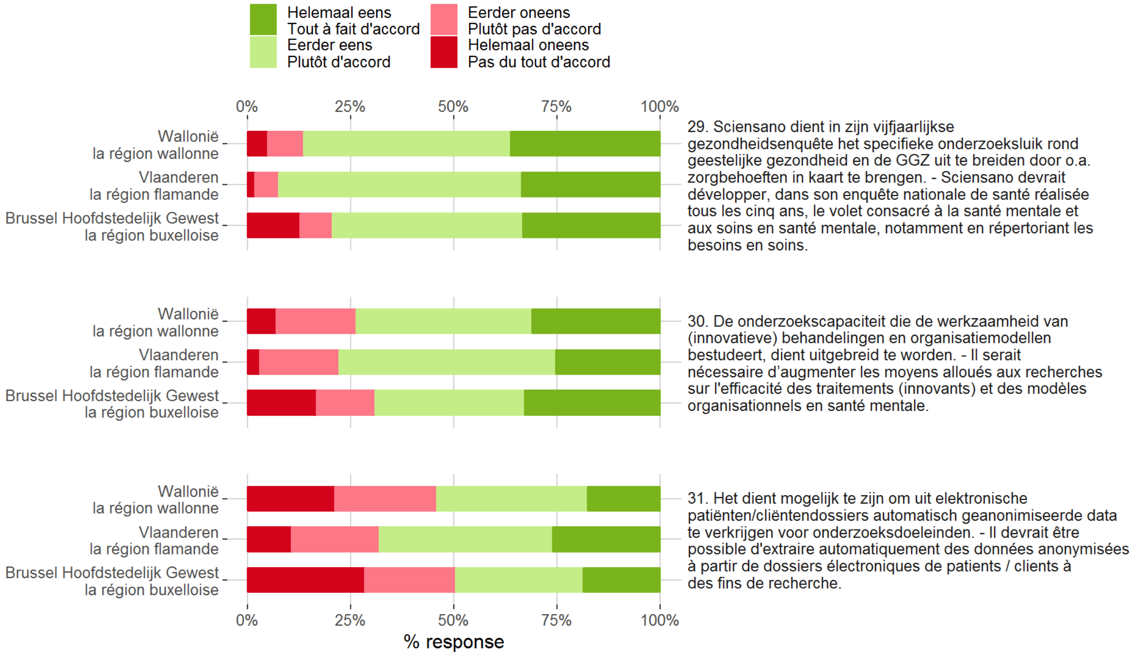


Figure 73 – Agreement on participation theme statements by the region of the care organization.

Figure 74 – Agreement on financing theme statements by the region of the care organization.

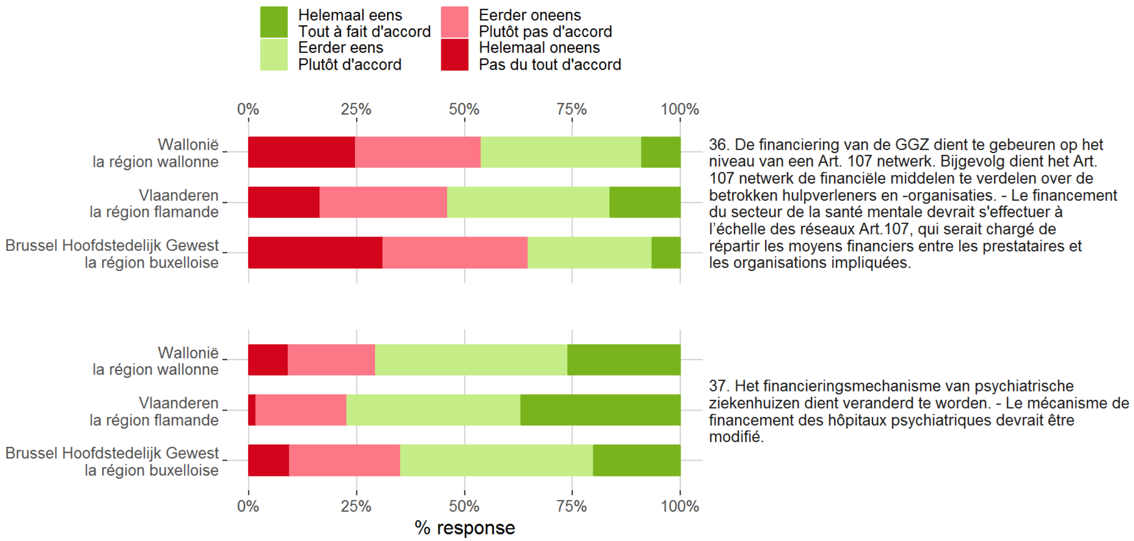


Figure 75 – Financing psychiatric hospitals choices (non-exclusive) by region.

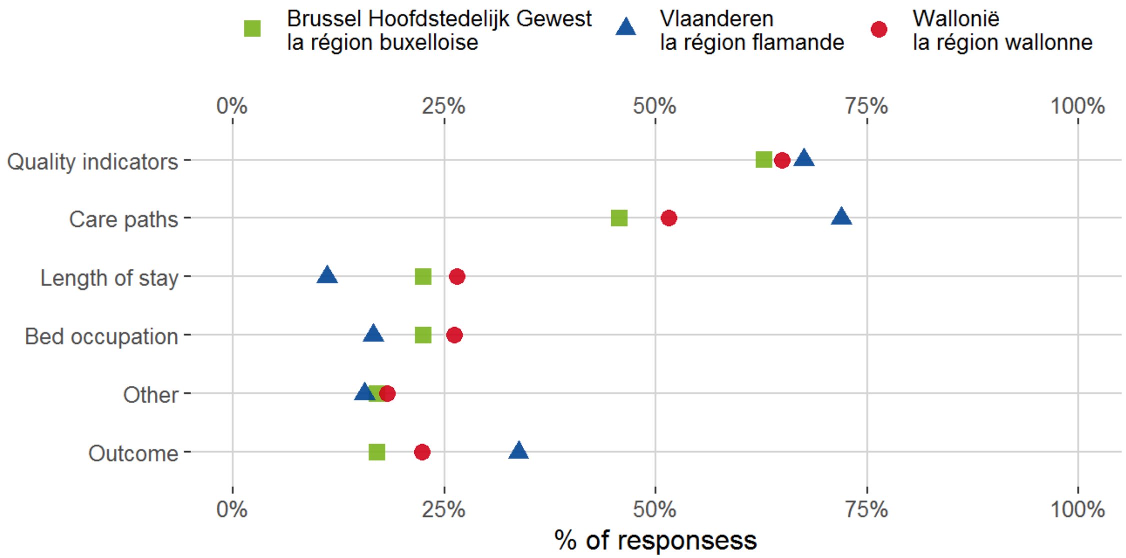


Figure 76 – Agreement on priority theme statements by the region of the care organization.

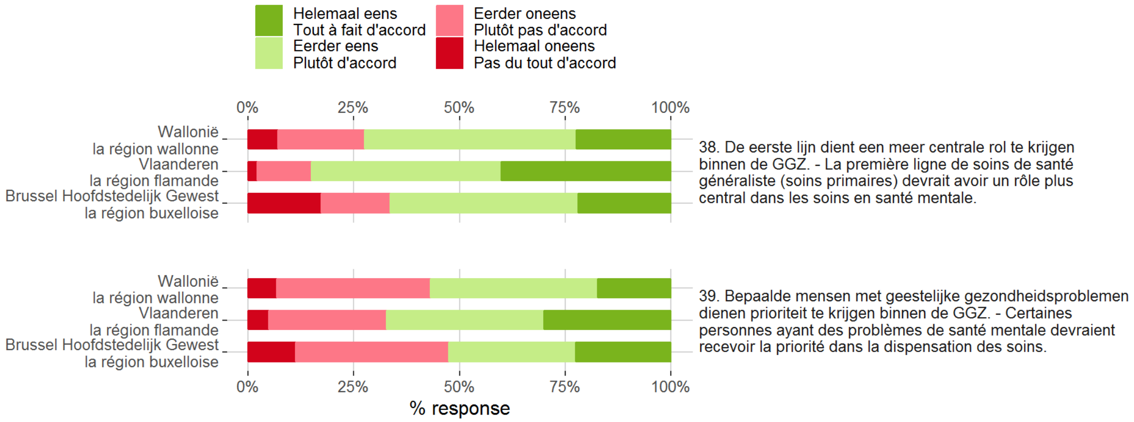


Figure 77 – Agreement on stigmatizing or health literacy theme statements by the region of the care organization.

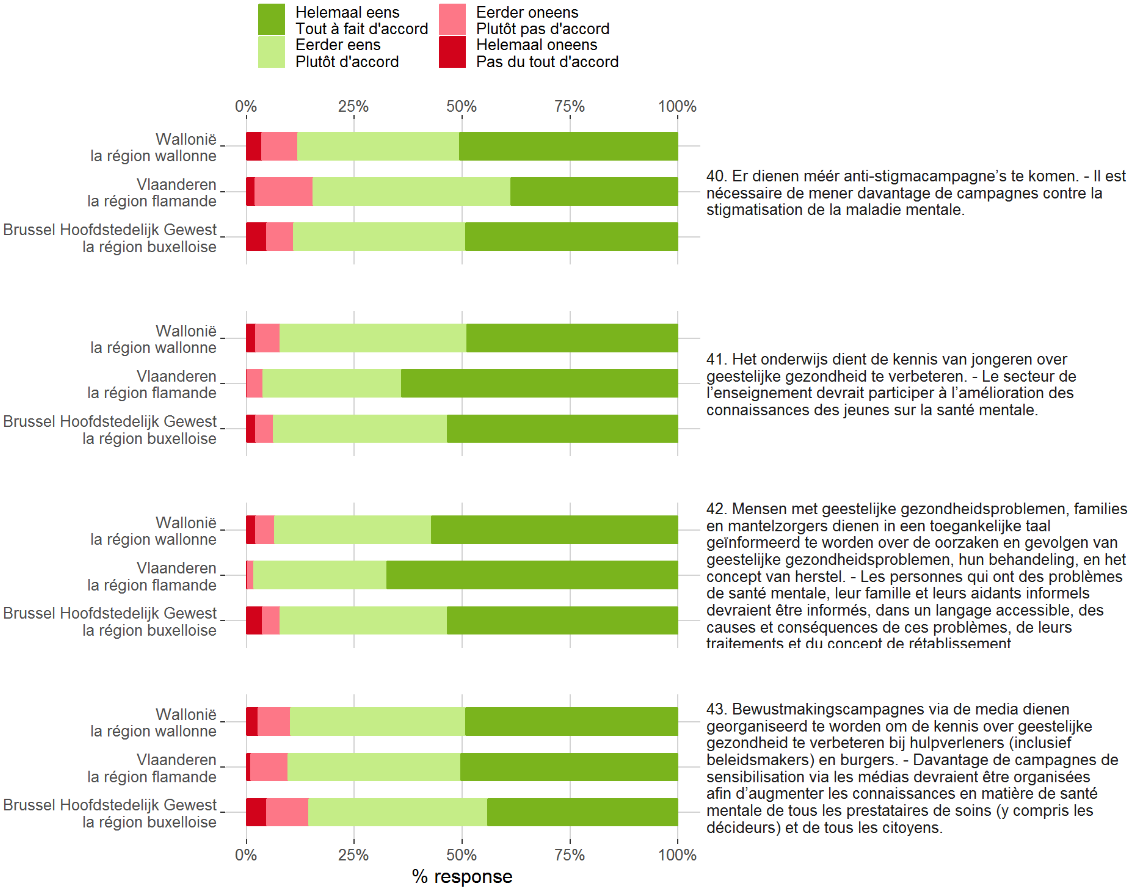


Figure 78 – Agreement on inclusion theme statements by the region of the care organization.

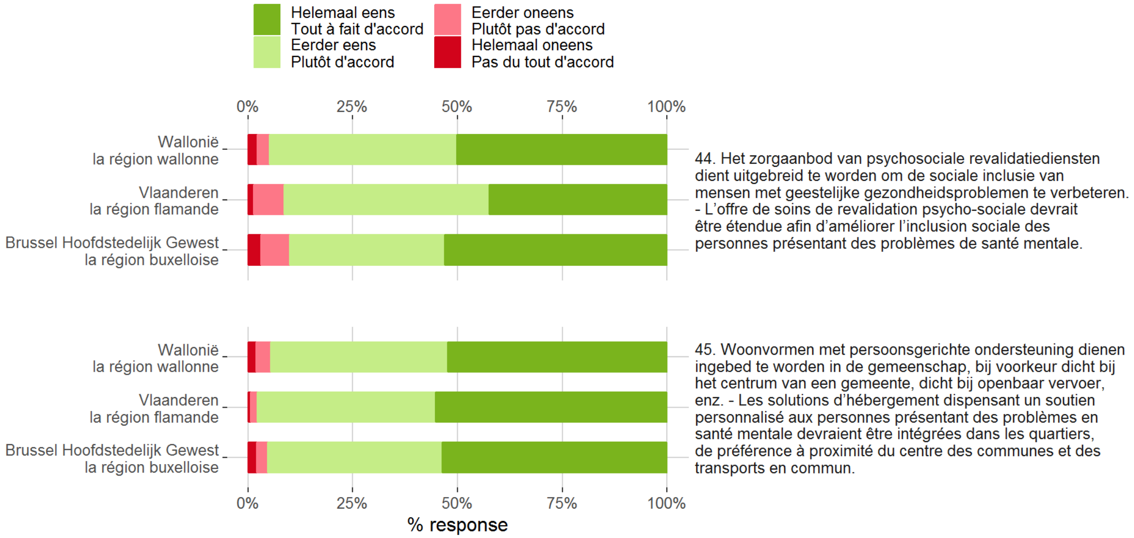
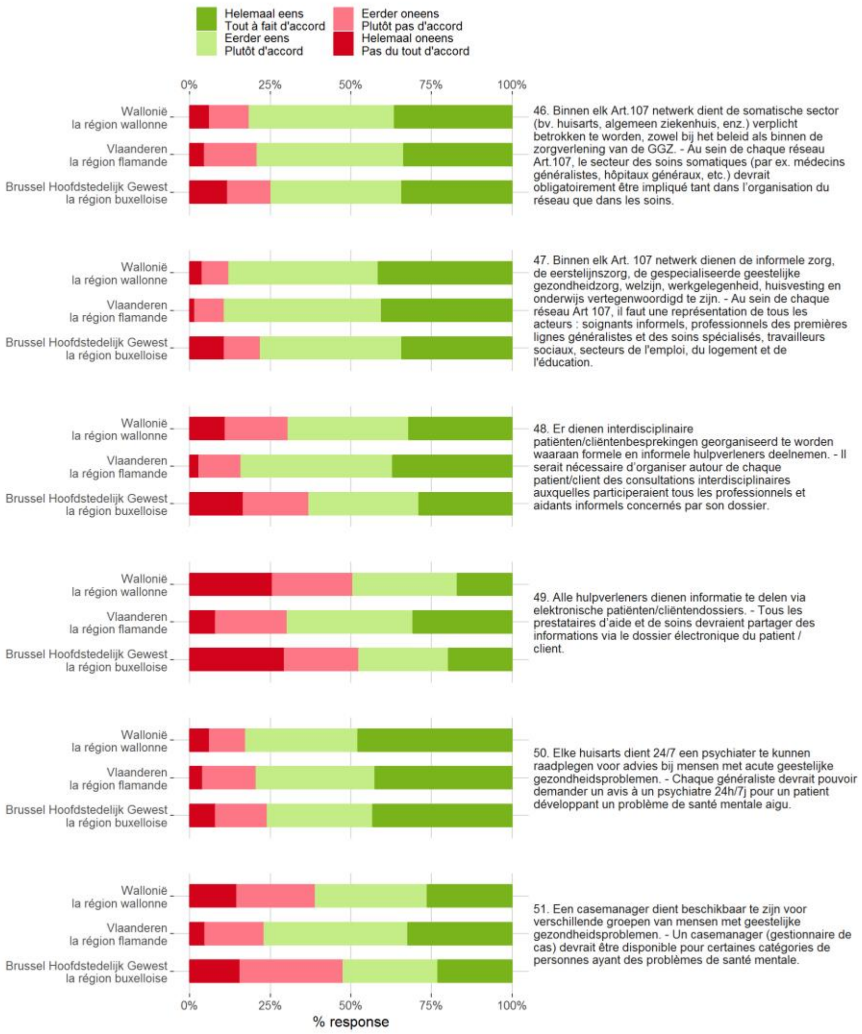


Figure 79 – Agreement on cooperation theme statements by the region of the care organization.



46. Binnen elk Art.107 netwerk dient de somatische sector (bv. huisarts, algemeen ziekenhuis, enz.) verplicht betrokken te worden, zowel bij het beleid als binnen de zorgverlening van de GGZ. - Au sein de chaque réseau Art.107, le secteur des soins somatiques (par ex. médecins généralistes, hôpitaux généraux, etc.) devrait obligatoirement être impliqué tant dans l'organisation du réseau que dans les soins.

47. Binnen elk Art. 107 netwerk dienen de informele zorg, de eerstelijnszorg, de gespecialiseerde geestelijke gezondheidzorg, welzijn, werkgelegenheid, huisvesting en onderwijs vertegenwoordigd te zijn. - Au sein de chaque réseau Art 107, il faut une représentation de tous les acteurs : soignants informels, professionnels des premières lignes généralistes et des soins spécialisés, travailleurs sociaux, secteurs de l'emploi, du logement et de l'éducation.

48. Er dienen interdisciplinaire patiënten/cliëntenbesprekingen georganiseerd te worden waaraan formele en informele hulpverleners deelnemen. - Il serait nécessaire d'organiser autour de chaque patient/client des consultations interdisciplinaires auxquelles participeraient tous les professionnels et aidants informels concernés par son dossier.

49. Alle hulpverleners dienen informatie te delen via elektronische patiënten/cliëntendossiers. - Tous les prestataires d'aide et de soins devraient partager des informations via le dossier électronique du patient / client.

50. Elke huisarts dient 24/7 een psychiater te kunnen raadplegen voor advies bij mensen met acute geestelijke gezondheidsproblemen. - Chaque généraliste devrait pouvoir demander un avis à un psychiatre 24h/7j pour un patient développant un problème de santé mentale aigu.

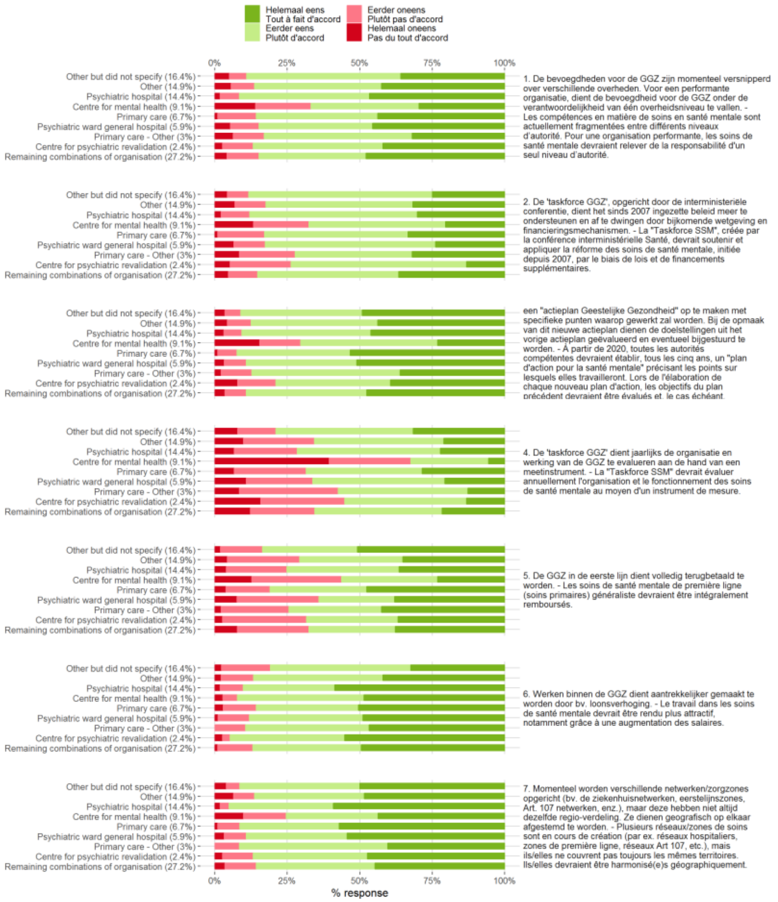
51. Een casemanager dient beschikbaar te zijn voor verschillende groepen van mensen met geestelijke gezondheidsproblemen. - Un casemanager (gestionnaire de cas) devrait être disponible pour certaines catégories de personnes ayant des problèmes de santé mentale.

Figure 80 – Agreement on quality theme statements by the region of the care organization.

Appendix 1.15.2. Sub-analyses of the care organizations

Each response is counted in only one category but ‘remaining’ can include already mentioned categories but in other combinations.

Figure 81 – Agreement on policy theme statements by care organization.



1. De bevoegdheden voor de GGZ zijn momenteel versnipperd over verschillende overheden. Voor een performante organisatie, dient de bevoegdheid voor de GGZ onder de verantwoordelijkheid van één overheidsniveau te vallen. - Les compétences en matière de soins en santé mentale sont actuellement fragmentées entre différents niveaux d'autorité. Pour une organisation performante, les soins de santé mentale devraient relever de la responsabilité d'un seul niveau d'autorité.

2. De 'taskforce GGZ', opgericht door de interministeriële conferentie, dient het sinds 2007 ingezette beleid meer te ondersteunen en af te dwingen door bijkomende wetgeving en financieringsmechanismen. - La "Taskforce SSM", créée par la conférence interministérielle Santé, devrait soutenir et appliquer la réforme des soins de santé mentale, initiée depuis 2007, par le biais de lois et de financements supplémentaires.

een "actieplan Geestelijke Gezondheid" op te maken met specifieke punten waarop gewerkt zal worden. Bij de opmaak van dit nieuwe actieplan dienen de doelstellingen uit het vorige actieplan geëvalueerd en eventueel bijgestuurd te worden. - À partir de 2020, toutes les autorités compétentes devraient établir, tous les cinq ans, un "plan d'action pour la santé mentale" précisant les points sur lesquels elles travailleront. Lors de l'élaboration de chaque nouveau plan d'action, les objectifs du plan précédent devraient être évalués et, le cas échéant

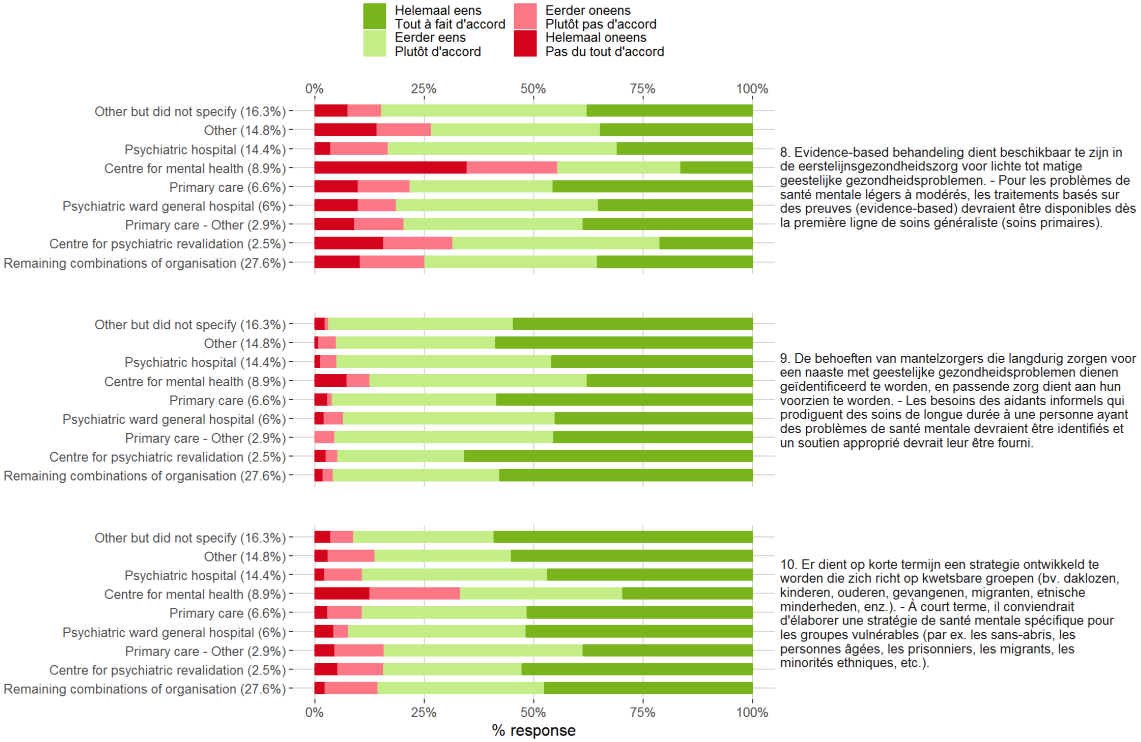
4. De 'taskforce GGZ' dient jaarlijks de organisatie en werking van de GGZ te evalueren aan de hand van een meetinstrument. - La "Taskforce SSM" devrait évaluer annuellement l'organisation et le fonctionnement des soins de santé mentale au moyen d'un instrument de mesure.

5. De GGZ in de eerste lijn dient volledig terugbetaald te worden. - Les soins de santé mentale de première ligne (soins primaires) généraliste devraient être intégralement remboursés.

6. Werken binnen de GGZ dient aantrekkelijker gemaakt te worden door bv. loonsverhoging. - Le travail dans les soins de santé mentale devrait être rendu plus attractif, notamment grâce à une augmentation des salaires.

7. Momenteel worden verschillende netwerken/zorgzones opgericht (bv. de ziekenhuisnetwerken, eerstelijnszones, Art. 107 netwerken, enz.), maar deze hebben niet altijd dezelfde regio-verdeling. Ze dienen geografisch op elkaar afgestemd te worden. - Plusieurs réseaux/zones de soins sont en cours de création (par ex. réseaux hospitaliers, zones de première ligne, réseaux Art 107, etc.), mais ils/elles ne couvrent pas toujours les mêmes territoires. Ils/elles devraient être harmonisé(e)s géographiquement.

Figure 82 – Agreement on intervention theme statements by care organization.



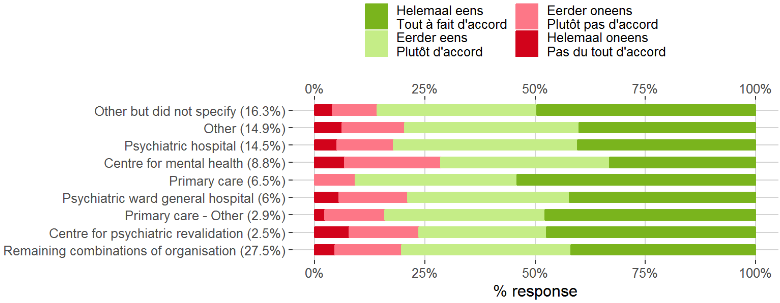
8. Evidence-based behandeling dient beschikbaar te zijn in de eerstelijnsgezondheidszorg voor lichte tot matige geestelijke gezondheidsproblemen. - Pour les problèmes de santé mentale légers à modérés, les traitements basés sur des preuves (evidence-based) devraient être disponibles dès la première ligne de soins généraliste (soins primaires).

9. De behoeften van mantelzorgers die langdurig zorgen voor een naaste met geestelijke gezondheidsproblemen dienen geïdentificeerd te worden, en passende zorg dient aan hun voorzien te worden. - Les besoins des aidants informels qui prodiguent des soins de longue durée à une personne ayant des problèmes de santé mentale devraient être identifiés et un soutien approprié devrait leur être fourni.

10. Er dient op korte termijn een strategie ontwikkeld te worden die zich richt op kwetsbare groepen (bv. daklozen, kinderen, ouderen, gevangenen, migranten, etnische minderheden, enz.). - À court terme, il conviendrait d'élaborer une stratégie de santé mentale spécifique pour les groupes vulnérables (par ex. les sans-abris, les personnes âgées, les prisonniers, les migrants, les minorités ethniques, etc.).

Figure 83 – Agreement on intervention theme ‘strategy’ statements by care organization.

Figure 84 – Agreement on registry theme statement by care organization.



15. De 'taskforce GGZ' dient een openbaar toegankelijk register op te stellen met alle hulpverleners en hulpverlenende organisaties binnen de GGZ. - La "Taskforce SSM" devrait établir un répertoire accessible au public reprenant tous les professionnels de la santé mentale et toutes les organisations du secteur des soins de santé mentale.

Figure 85 – Agreement on access theme statements by care organization.

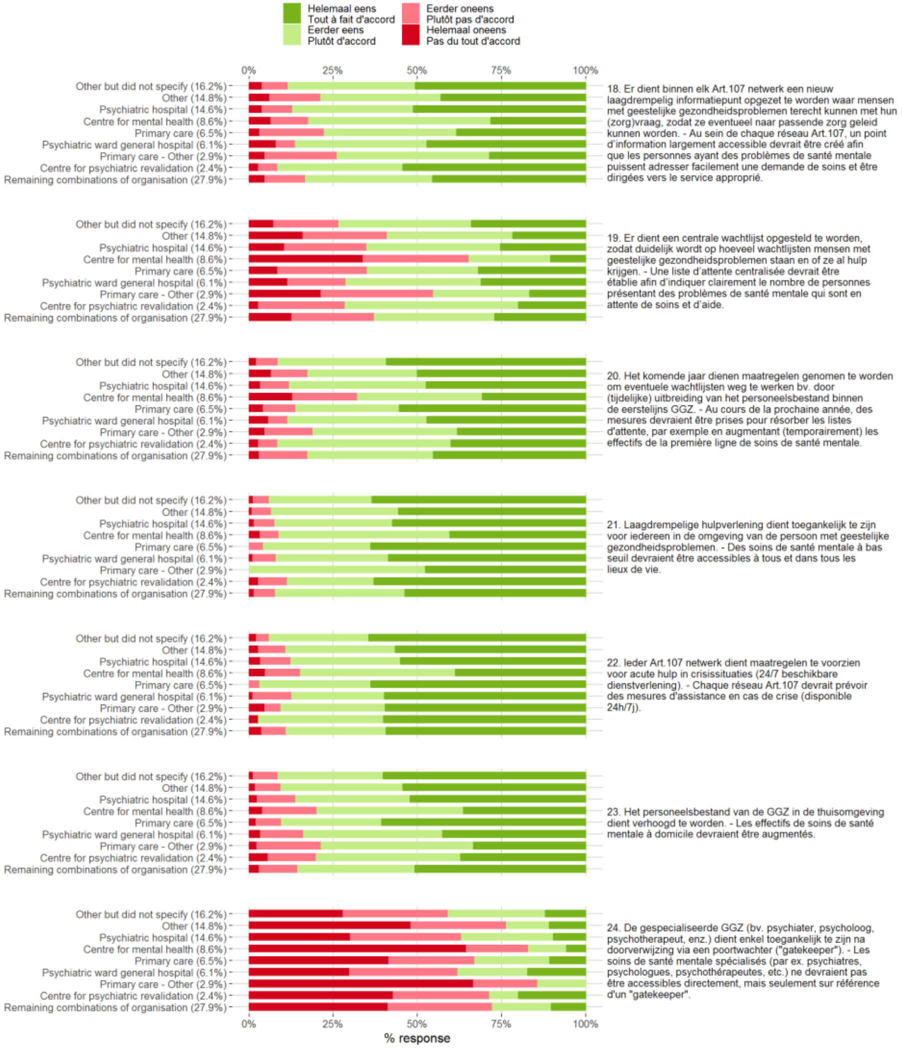


Figure 86 – Agreement on registration theme statements by care organization.

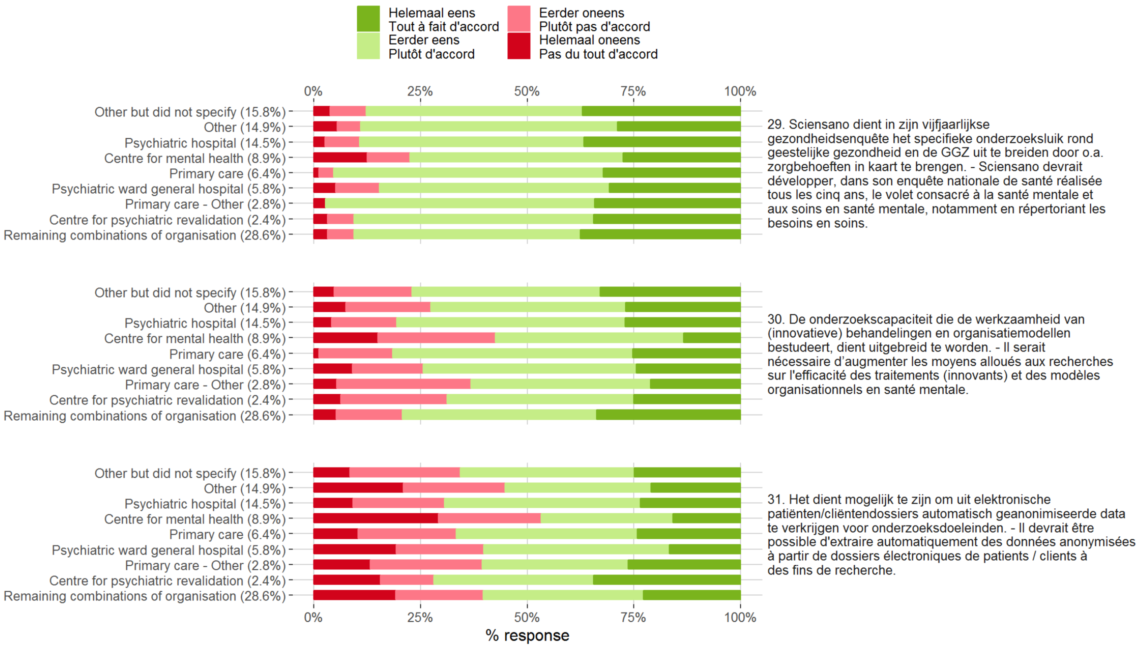
25. Binnen de GGZ dienen alle hulpverleners op zijn minst bij de anamnese gebruik te maken van de BelRAI GGZ module. - Tous les intervenants du secteur de la santé mentale, devraient au minimum remplir le module BelRAI santé mentale lors de l'anamnèse.

26. Elke drie maand of bij een specifieke gebeurtenis (bv. ontslag uit een psychiatrisch ziekenhuis) dient het BelRAI-assessment herhaald te worden. - L'évaluation BelRAI devrait être répétée tous les trois mois ou lors d'évènements spécifiques (par exemple sortie d'hospitalisation en psychiatrie).

27. Mensen met geestelijke gezondheidsproblemen dienen de mogelijkheid te hebben om hun eigen BelRAI-dossier aan te vullen. - Les personnes ayant des problèmes de santé mentale devraient avoir la possibilité de compléter leur propre dossier BelRAI.

28. Routine-outcome monitoring en kwaliteitsindicatoren, zoals voorgesteld door de Hoge Gezondheidsraad in 2016, dienen in het geautomatiseerde patiënten- / cliëntendossier opgenomen te worden. - Le suivi systématique des résultats (routine-outcome monitoring) et les indicateurs de qualité, proposés par le Conseil Supérieur de la Santé en 2016, devraient être inclus dans le dossier automatisé du patient / client.

Figure 87 – Agreement on research theme statements by care organization.



29. Sciensano dient in zijn vijfjaarlijkse gezondheidsenquête het specifieke onderzoeksluik rond geestelijke gezondheid en de GGZ uit te breiden door o.a. zorgbehoeften in kaart te brengen. - Sciensano devrait développer, dans son enquête nationale de santé réalisée tous les cinq ans, le volet consacré à la santé mentale et aux soins en santé mentale, notamment en répertoriant les besoins en soins.

30. De onderzoekscapaciteit die de werkzaamheid van (innovatieve) behandelingen en organisatiemodellen bestudeert, dient uitgebreid te worden. - Il serait nécessaire d’augmenter les moyens alloués aux recherches sur l'efficacité des traitements (innovants) et des modèles organisationnels en santé mentale.

31. Het dient mogelijk te zijn om uit elektronische patiënten/cliëntendossiers automatisch geanonimiseerde data te verkrijgen voor onderzoeksdoeleinden. - Il devrait être possible d'extraire automatiquement des données anonymisées à partir de dossiers électroniques de patients / clients à des fins de recherche.

Figure 88 – Agreement on participation theme statements by care organization.

32. De bevoegde overheden dienen budget vrij te maken en een financieringssysteem te ontwikkelen dat het betrekken van patiëntervaringsdeskundigen en familie-expertvertegenwoordigers bij zorgverlening en -beleid garandeert en aanmoedigt. - Les autorités compétentes devraient dégager un budget permettant de financer un système garantissant et encourageant la participation de patients et de représentants des familles experts du vécu dans les soins de santé mentale et dans les décisions politiques s'y rapportant.

33. Patiëntervaringsdeskundigen en familie-expertvertegenwoordigers dienen deel uit te maken van de jaarlijkse inspectie van hulpverleners en –organisaties binnen de GGZ. - Les patients et représentants des familles experts du vécu devraient prendre part à l'évaluation annuelle des prestataires de soins et des organisations du secteur de la santé mentale.

34. Patiëntervaringsdeskundigen en familie-expertvertegenwoordigers dienen deel uit te maken van de raad van bestuur van elk Art.107 netwerk. - Les patients et représentants des familles experts du vécu devraient faire partie du conseil d'administration de chaque réseau Art.107.

35. Patiëntervaringsdeskundigen en familie-expertvertegenwoordigers dienen deel uit te maken van elk mobiel team als adviseur bij het opstellen van individuele behandelplannen voor mensen met geestelijke gezondheidsproblemen. - Un patient et un représentant des familles experts du vécu devraient faire partie de chaque équipe mobile en tant que conseiller pour l'élaboration des plans de traitement individuels pour les personnes qui ont des problèmes de santé mentale.

Figure 89 – Agreement on financing theme statements by care organization.

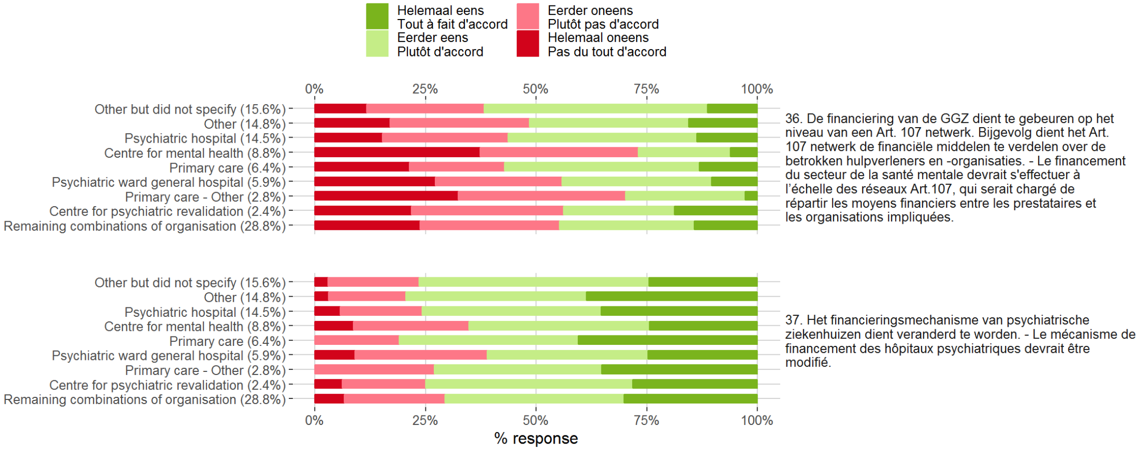


Figure 90 – Financing psychiatric hospitals choices (non-exclusive) by care organization.

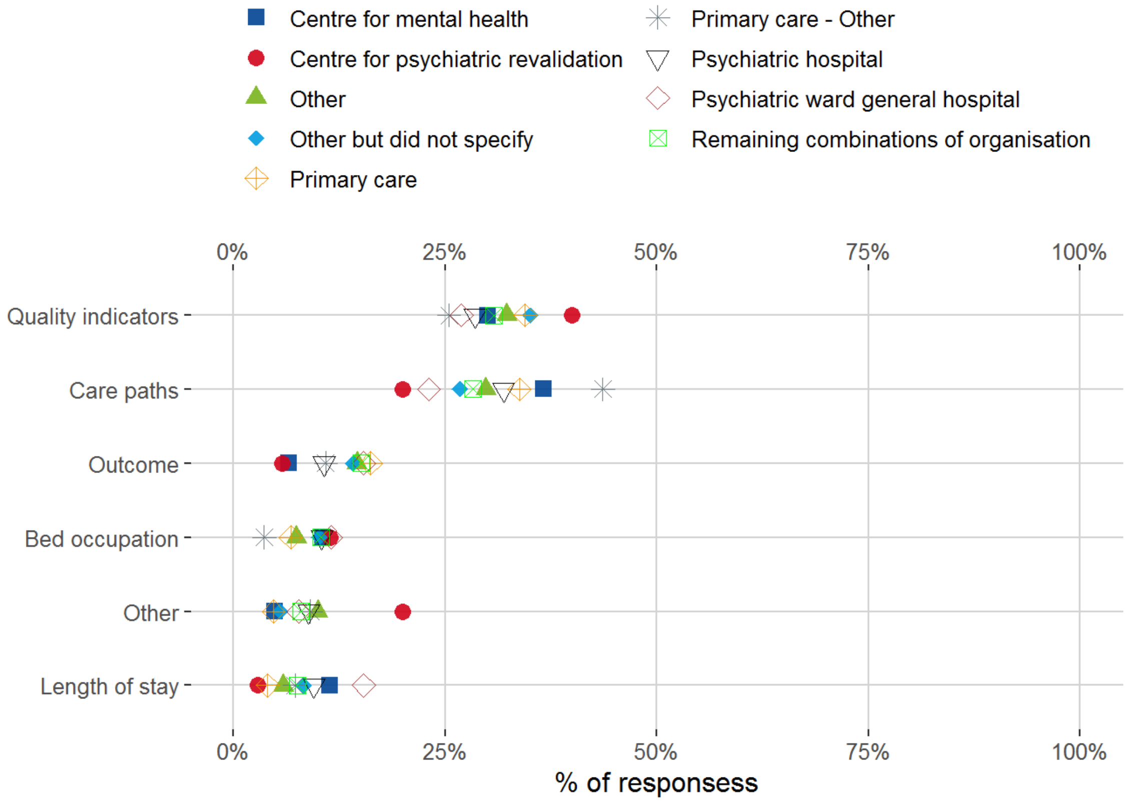


Figure 91 – Agreement on priority theme statements by care organization.

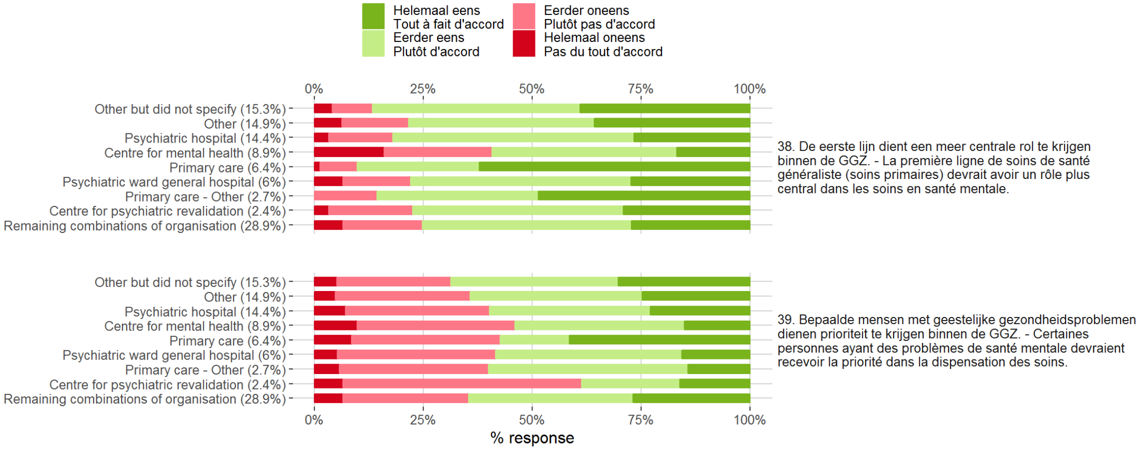
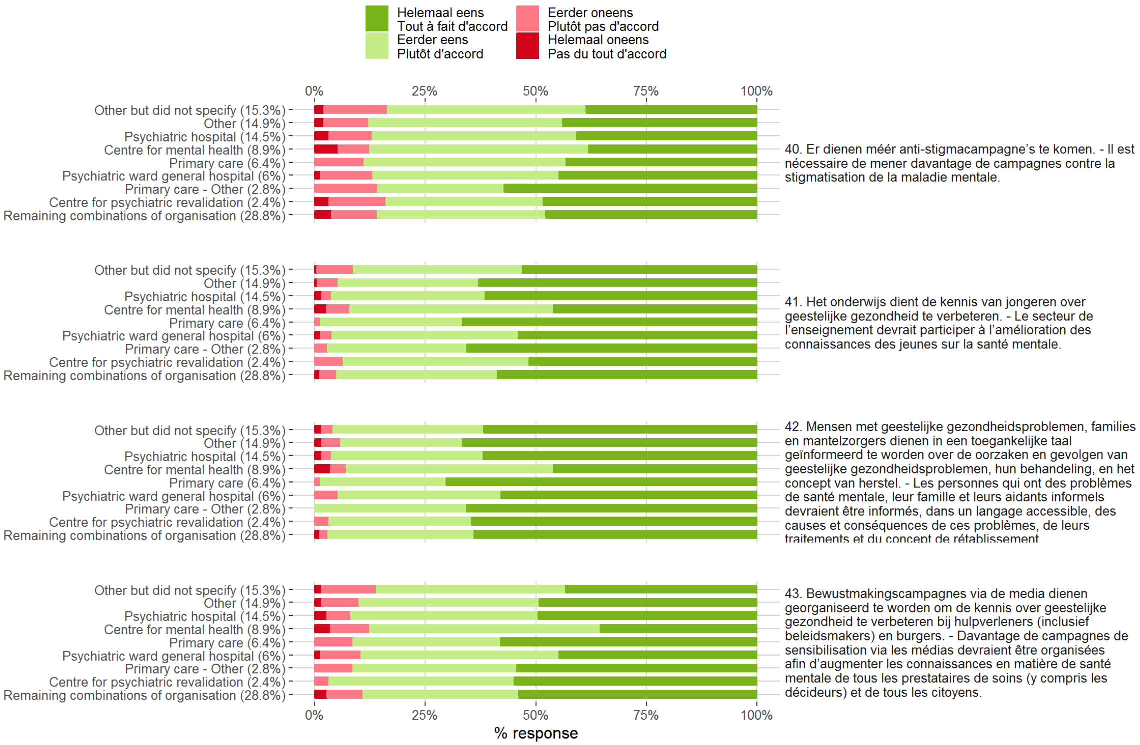


Figure 92 – Agreement on stigmatization or health literacy theme statements by care organization.



40. Er dienen méér anti-stigmacampagne's te komen. - Il est nécessaire de mener davantage de campagnes contre la stigmatisation de la maladie mentale.

41. Het onderwijs dient de kennis van jongeren over geestelijke gezondheid te verbeteren. - Le secteur de l'enseignement devrait participer à l'amélioration des connaissances des jeunes sur la santé mentale.

42. Mensen met geestelijke gezondheidsproblemen, families en mantelzorgers dienen in een toegankelijke taal geïnformeerd te worden over de oorzaken en gevolgen van geestelijke gezondheidsproblemen, hun behandeling, en het concept van herstel. - Les personnes qui ont des problèmes de santé mentale, leur famille et leurs aidants informels devraient être informés, dans un langage accessible, des causes et conséquences de ces problèmes, de leurs traitements et du concept de rétablissement

43. Bewustmakingscampagnes via de media dienen georganiseerd te worden om de kennis over geestelijke gezondheid te verbeteren bij hulpverleners (inclusief beleidsmakers) en burgers. - Davantage de campagnes de sensibilisation via les médias devraient être organisées afin d'augmenter les connaissances en matière de santé mentale de tous les prestataires de soins (y compris les décideurs) et de tous les citoyens.

Figure 93 – Agreement on inclusion theme statements by care organization.

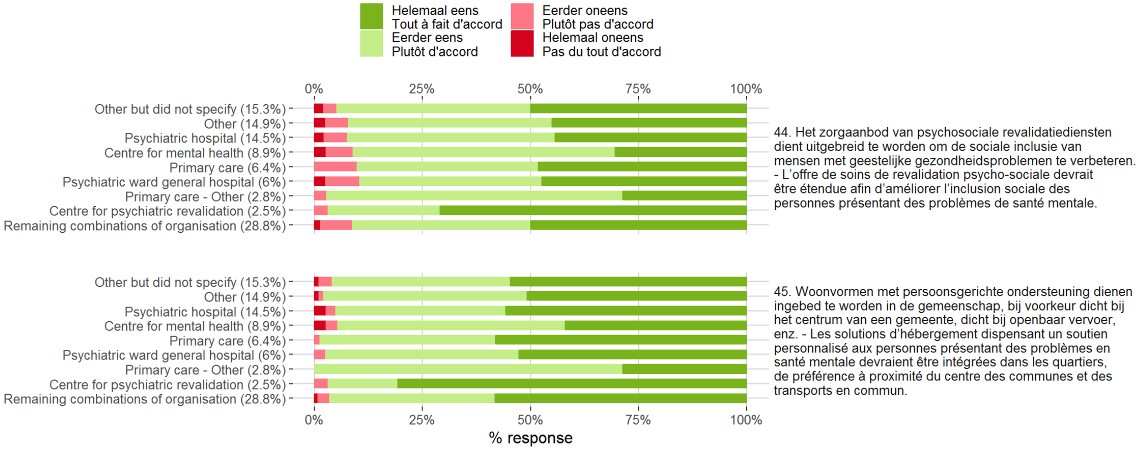


Figure 94 – Agreement on cooperation theme statements by care organization.

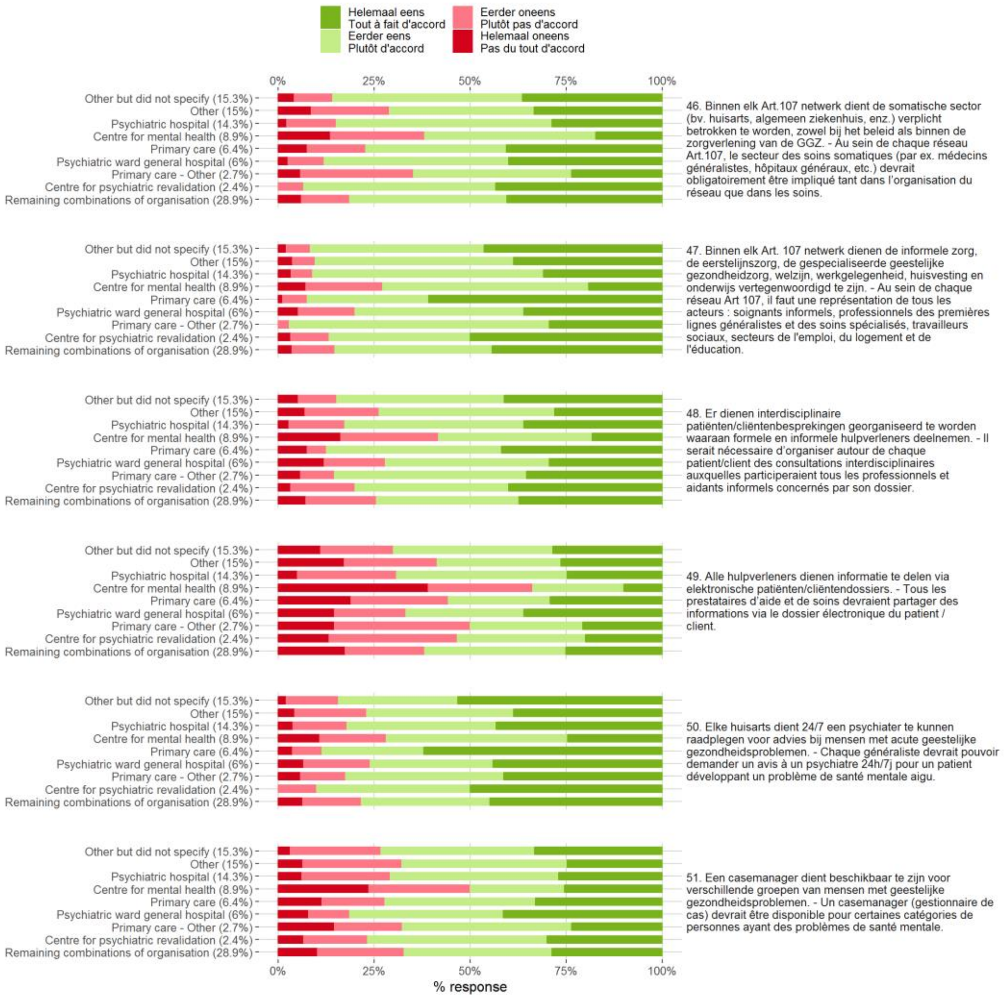
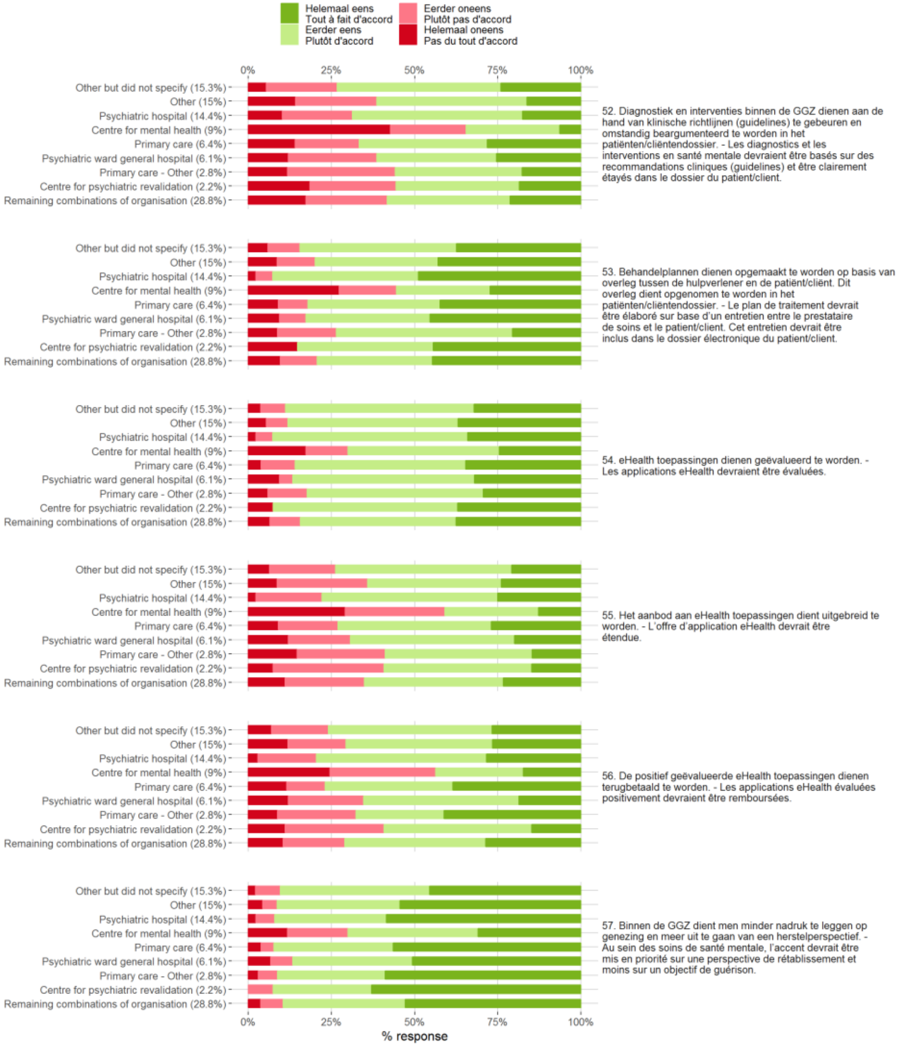


Figure 95 – Agreement on quality theme statements by care organization.



APPENDIX 2. QUESTIONNAIRE IN DUTCH

Tijdens het invullen van de enquête, kan u op elk moment teruggaan naar vorige vragen of ze onderbreken en op een later tijdstip verder beantwoorden. Zolang u de enquête niet verstuurt, kan u uw antwoorden nog wijzigen.

Hoelang duurt het om de enquête in te vullen?

Het duurt ongeveer 20 minuten om deze enquête in te vullen.

Is deze enquête anoniem?

Ja. Uw naam wordt niet bewaard en uw antwoorden blijven volledig anoniem.

Waarom werd ik gecontacteerd?

Wij vragen aan alle organisaties, instellingen en overheden die betrokken zijn bij de GGZ, deze enquête onder hun leden, collega's of werknemers te verspreiden.

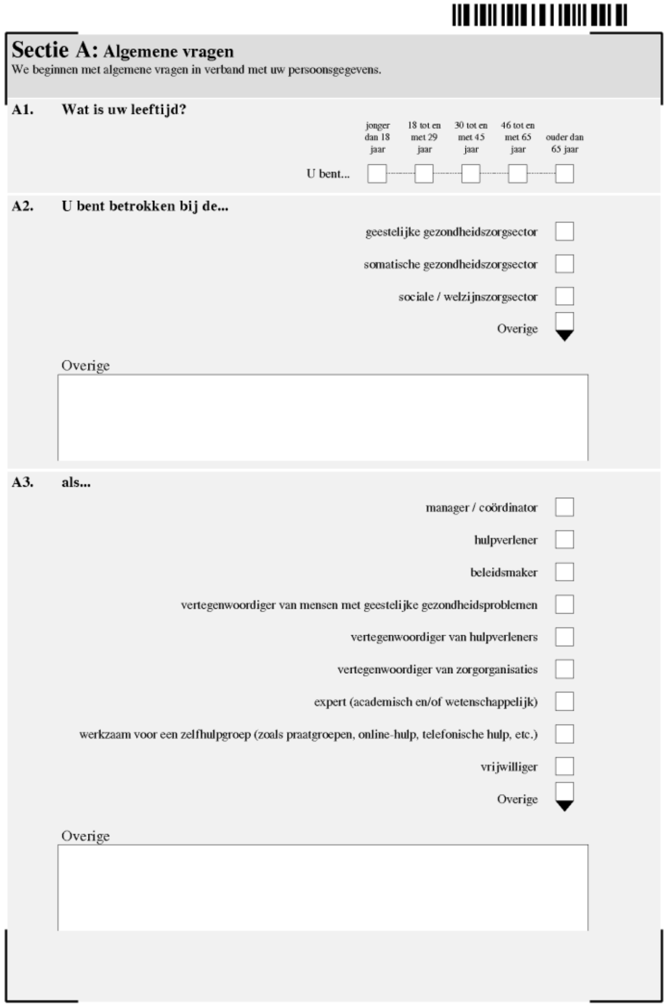
Wat als ik niet wens deel te nemen?

De deelname aan de enquête is volledig vrijwillig.

Wat gebeurt er met mijn antwoorden?

Alle antwoorden worden anoniem geregistreerd en gedurende vijf jaar bewaard op een beveiligde server. Ze zijn enkel toegankelijk voor de onderzoekers van het KCE voor analyse. De resultaten worden gepubliceerd in een KCE rapport in de loop van 2019. Dit rapport zal gratis beschikbaar zijn op de website van het KCE. Het rapport zal geen enkele informatie bevatten over de identiteit van de deelnemers, noch over hun individuele antwoorden.

Waarom wordt deze enquête afgenomen?



Sectie A: **Algemene vragen**

We beginnen met algemene vragen in verband met uw persoonsgegevens.

A1. Wat is uw leeftijd?

	jonger dan 18 jaar	18 tot en met 29 jaar	30 tot en met 45 jaar	46 tot en met 65 jaar	ouder dan 65 jaar
U bent...	☐	☐	☐	☐	☐

A2. U bent betrokken bij de...

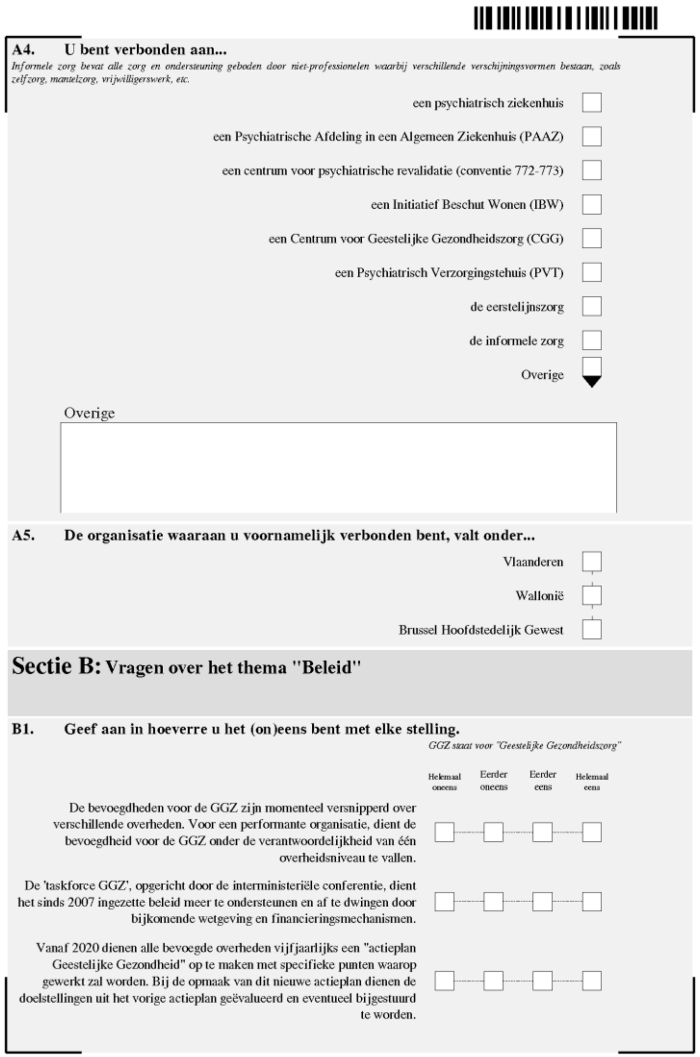
- geestelijke gezondheidszorgsector ☐
- somatische gezondheidszorgsector ☐
- sociale / welzijnszorgsector ☐
- Overige ☐

Overige

A3. als...

- manager / coördinator ☐
- hulpverlener ☐
- beleidsmaker ☐
- vertegenwoordiger van mensen met geestelijke gezondheidsproblemen ☐
- vertegenwoordiger van hulpverleners ☐
- vertegenwoordiger van zorgorganisaties ☐
- expert (academisch en/of wetenschappelijk) ☐
- werkzaam voor een zelfhulpgroep (zoals praatgroepen, online-hulp, telefonische hulp, etc.) ☐
- vrijwilliger ☐
- Overige ☐

Overige



A4. U bent verbonden aan...

Informele zorg bevat alle zorg en ondersteuning geboden door niet-professionelen waarbij verschillende verschijningsvormen bestaan, zoals zelfzorg, mantelzorg, vrijwilligerswerk, etc.

een psychiatrisch ziekenhuis	☐
een Psychiatrische Afdeling in een Algemeen Ziekenhuis (PAAZ)	☐
een centrum voor psychiatrische revalidatie (conventie 772-773)	☐
een Initiatief Beschut Wonen (IBW)	☐
een Centrum voor Geestelijke Gezondheidszorg (CGG)	☐
een Psychiatrisch Verzorgingstehuis (PVT)	☐
de eerstelijnszorg	☐
de informele zorg	☐
Overige	☐

Overige

☐

A5. De organisatie waaraan u voornamelijk verbonden bent, valt onder...

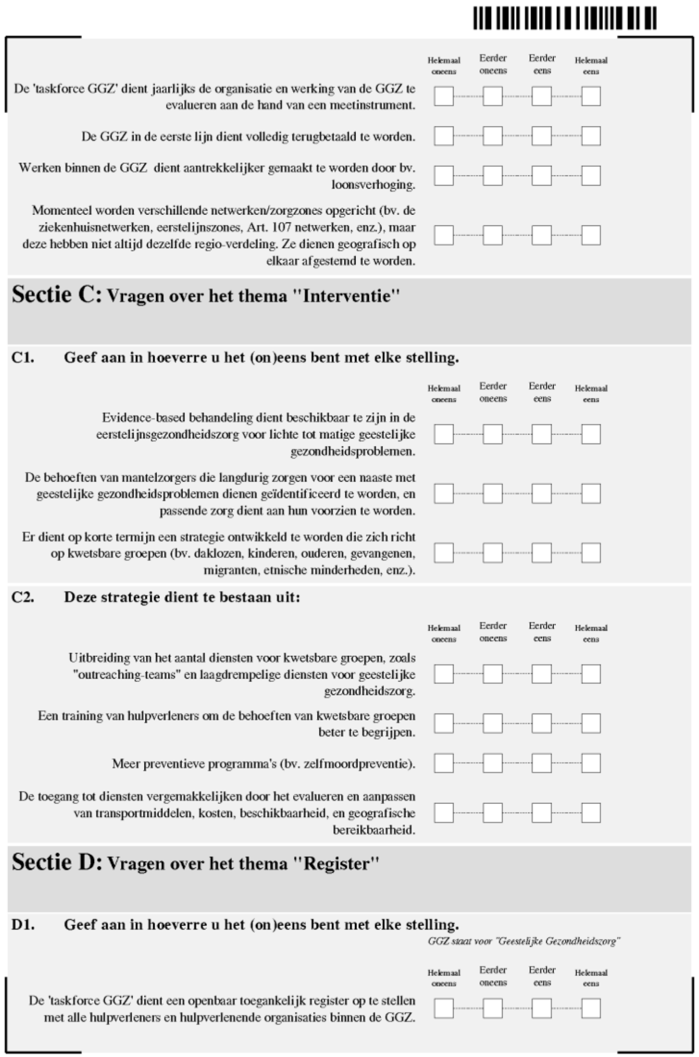
Vlaanderen	☐
Wallonië	☐
Brussel Hoofdstedelijk Gewest	☐

Sectie B: Vragen over het thema "Beleid"

B1. Geef aan in hoeverre u het (on)eens bent met elke stelling.

GGZ staat voor "Geestelijke Gezondheidszorg"

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
De bevoegdheden voor de GGZ zijn momenteel versnipperd over verschillende overheden. Voor een performante organisatie, dient de bevoegdheid voor de GGZ onder de verantwoordelijkheid van één overheidsniveau te vallen.	☐	☐	☐	☐
De 'taskforce GGZ', opgericht door de interministeriële conferentie, dient het sinds 2007 ingezette beleid meer te ondersteunen en af te dwingen door bijkomende wetgeving en financieringsmechanismen.	☐	☐	☐	☐
Vanaf 2020 dienen alle bevoegde overheden vijfjaarlijks een "actieplan Geestelijke Gezondheid" op te maken met specifieke punten waarop gewerkt zal worden. Bij de opmaak van dit nieuwe actieplan dienen de doelstellingen uit het vorige actieplan geëvalueerd en eventueel bijgestuurd te worden.	☐	☐	☐	☐



	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
De 'taskforce GGZ' dient jaarlijks de organisatie en werking van de GGZ te evalueren aan de hand van een meetinstrument.	☐	☐	☐	☐
De GGZ in de eerste lijn dient volledig terugbetaald te worden.	☐	☐	☐	☐
Werken binnen de GGZ dient aantrekkelijker gemaakt te worden door bv. loonsverhoging.	☐	☐	☐	☐
Momenteel worden verschillende netwerken/zorgzones opgericht (bv. de ziekenhuisnetwerken, eerstelijnszones, Art. 107 netwerken, enz.), maar deze hebben niet altijd dezelfde regio-verdeling. Ze dienen geografisch op elkaar afgestemd te worden.	☐	☐	☐	☐

Sectie C: Vragen over het thema "Interventie"

C1. Geef aan in hoeverre u het (on)eens bent met elke stelling.

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
Evidence-based behandeling dient beschikbaar te zijn in de eerstelijnsgezondheidszorg voor lichte tot matige geestelijke gezondheidsproblemen.	☐	☐	☐	☐
De behoeften van mantelzorgers die langdurig zorgen voor een naaste met geestelijke gezondheidsproblemen dienen geïdentificeerd te worden, en passende zorg dient aan hun voorzien te worden.	☐	☐	☐	☐
Er dient op korte termijn een strategie ontwikkeld te worden die zich richt op kwetsbare groepen (bv. daklozen, kinderen, ouderen, gevangenen, migranten, etnische minderheden, enz.).	☐	☐	☐	☐

C2. Deze strategie dient te bestaan uit:

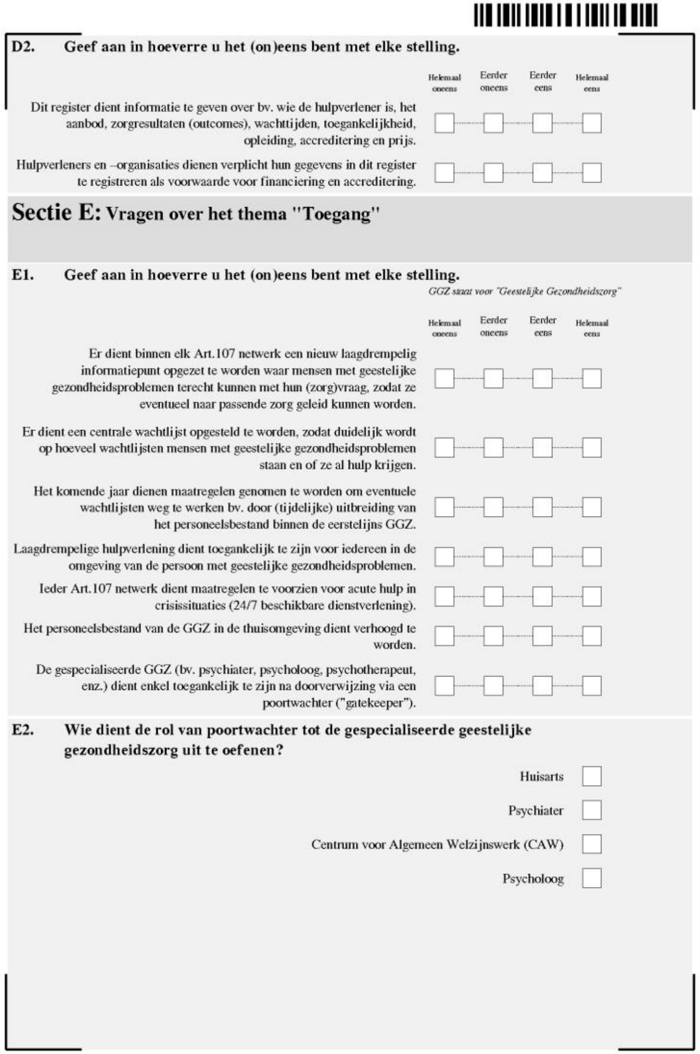
	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
Uitbreiding van het aantal diensten voor kwetsbare groepen, zoals "outreaching-teams" en laagdrempelige diensten voor geestelijke gezondheidszorg.	☐	☐	☐	☐
Een training van hulpverleners om de behoeften van kwetsbare groepen beter te begrijpen.	☐	☐	☐	☐
Meer preventieve programma's (bv. zelfmoordpreventie).	☐	☐	☐	☐
De toegang tot diensten vergemakkelijken door het evalueren en aanpassen van transportmiddelen, kosten, beschikbaarheid, en geografische bereikbaarheid.	☐	☐	☐	☐

Sectie D: Vragen over het thema "Register"

D1. Geef aan in hoeverre u het (on)eens bent met elke stelling.

GGZ staat voor "Geestelijke Gezondheidszorg"

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
De 'taskforce GGZ' dient een openbaar toegankelijk register op te stellen met alle hulpverleners en hulpverlenende organisaties binnen de GGZ.	☐	☐	☐	☐



D2. **Geef aan in hoeverre u het (on)eens bent met elke stelling.**

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
Dit register dient informatie te geven over bv. wie de hulpverlener is, het aanbod, zorgresultaten (outcomes), wachttijden, toegankelijkheid, opleiding, accreditering en prijs.	☐	☐	☐	☐
Hulpverleners en –organisaties dienen verplicht hun gegevens in dit register te registreren als voorwaarde voor financiering en accreditering.	☐	☐	☐	☐

Sectie E: Vragen over het thema "Toegang"

E1. **Geef aan in hoeverre u het (on)eens bent met elke stelling.**

GGZ staat voor "Geestelijke Gezondheidszorg"

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
Er dient binnen elk Art.107 netwerk een nieuw laagdrempelig informatiepunt opgezet te worden waar mensen met geestelijke gezondheidsproblemen terecht kunnen met hun (zorg)vraag, zodat ze eventueel naar passende zorg geleid kunnen worden.	☐	☐	☐	☐
Er dient een centrale wachtlijst opgesteld te worden, zodat duidelijk wordt op hoeveel wachtlijsten mensen met geestelijke gezondheidsproblemen staan en of ze al hulp krijgen.	☐	☐	☐	☐
Het komende jaar dienen maatregelen genomen te worden om eventuele wachtlijsten weg te werken bv. door (tijdelijke) uitbreiding van het personeelsbestand binnen de eerstelijns GGZ.	☐	☐	☐	☐
Laagdrempelige hulpverlening dient toegankelijk te zijn voor iedereen in de omgeving van de persoon met geestelijke gezondheidsproblemen.	☐	☐	☐	☐
Ieder Art.107 netwerk dient maatregelen te voorzien voor acute hulp in crisissituaties (24/7 beschikbare dienstverlening).	☐	☐	☐	☐
Het personeelsbestand van de GGZ in de thuisomgeving dient verhoogd te worden.	☐	☐	☐	☐
De gespecialiseerde GGZ (bv. psychiater, psycholoog, psychotherapeut, enz.) dient enkel toegankelijk te zijn na doorverwijzing via een poortwachter ("gatekeeper").	☐	☐	☐	☐

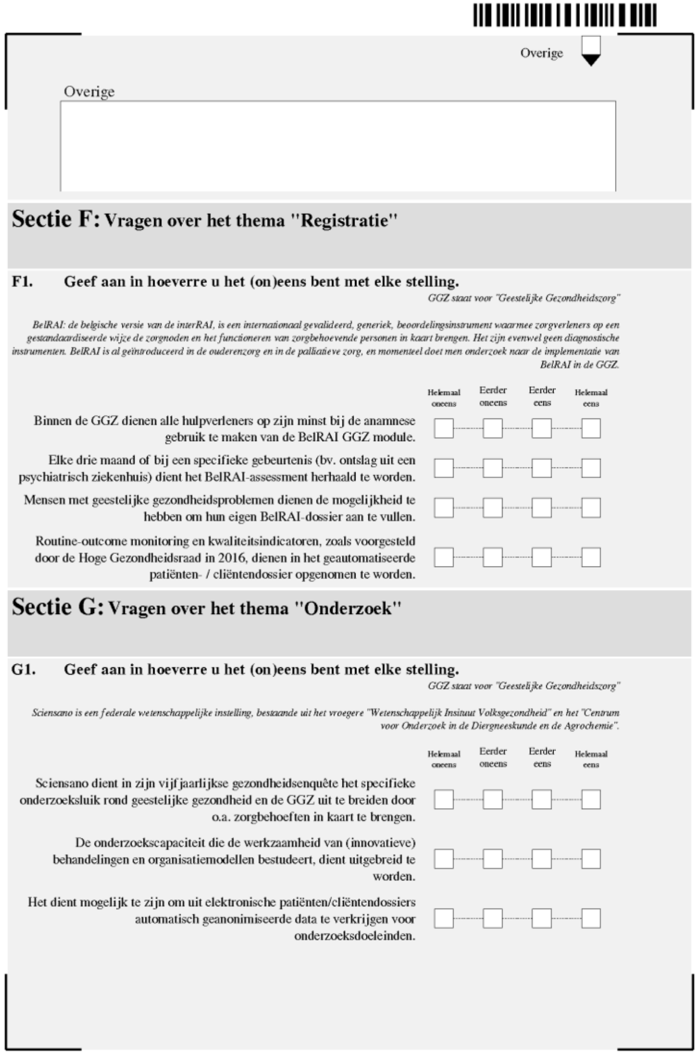
E2. **Wie dient de rol van poortwachter tot de gespecialiseerde geestelijke gezondheidszorg uit te oefenen?**

Huisarts ☐

Psychiater ☐

Centrum voor Algemeen Welzijnswerk (CAW) ☐

Psycholoog ☐



Overige ☐

Overige

☐

Sectie F: Vragen over het thema "Registratie"

F1. **Geef aan in hoeverre u het (on)eens bent met elke stelling.**

GGZ staat voor "Geestelijke Gezondheidszorg"

BelRAI: de belgische versie van de interRAI, is een internationaal gevalideerd, generiek, beoordelingsinstrument waarmee zorgverleners op een gestandaardiseerde wijze de zorgnoden en het functioneren van zorgbehoevende personen in kaart brengen. Het zijn evenwel geen diagnostische instrumenten. BelRAI is al geïntroduceerd in de ouderenzorg en in de palliatieve zorg, en momenteel doet men onderzoek naar de implementatie van BelRAI in de GGZ.

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
Binnen de GGZ dienen alle hulpverleners op zijn minst bij de anamnese gebruik te maken van de BelRAI GGZ module.	☐	☐	☐	☐
Elke drie maand of bij een specifieke gebeurtenis (bv. ontslag uit een psychiatrisch ziekenhuis) dient het BelRAI-assessment herhaald te worden.	☐	☐	☐	☐
Mensen met geestelijke gezondheidsproblemen dienen de mogelijkheid te hebben om hun eigen BelRAI-dossier aan te vullen.	☐	☐	☐	☐
Routine-outcome monitoring en kwaliteitsindicatoren, zoals voorgesteld door de Hoge Gezondheidsraad in 2016, dienen in het geautomatiseerde patiënten- / cliëntendossier opgenomen te worden.	☐	☐	☐	☐

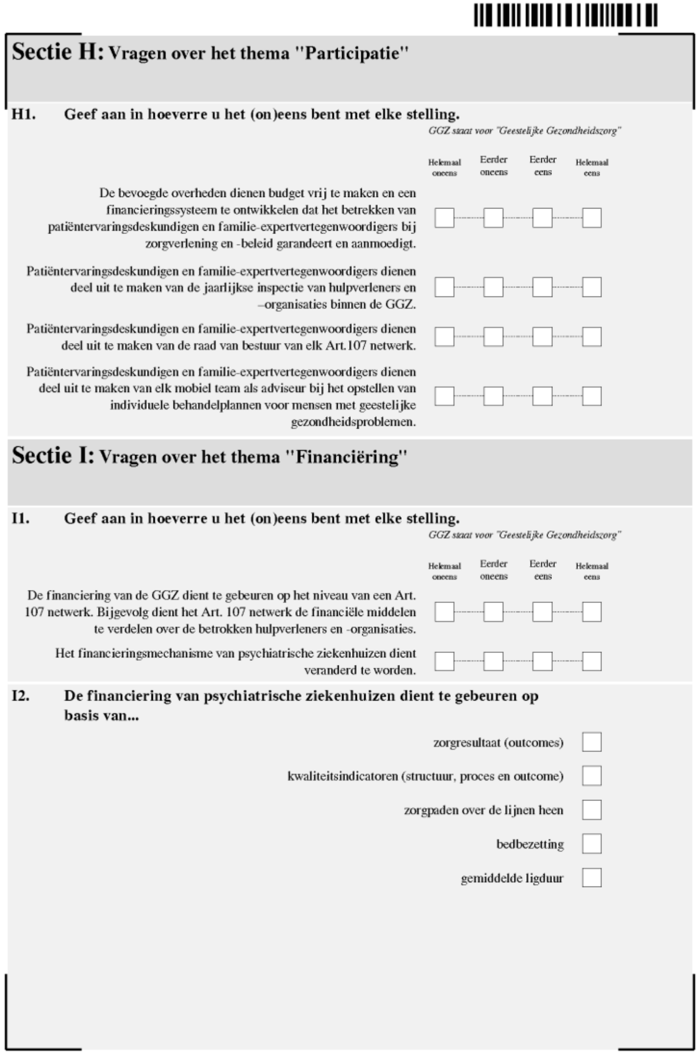
Sectie G: Vragen over het thema "Onderzoek"

G1. **Geef aan in hoeverre u het (on)eens bent met elke stelling.**

GGZ staat voor "Geestelijke Gezondheidszorg"

Sciensano is een federale wetenschappelijke instelling, bestaande uit het vroegere "Wetenschappelijk Insituut Volksgezondheid" en het "Centrum voor Onderzoek in de Diergneeskunde en de Agrochemie".

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
Sciensano dient in zijn vijfjaarlijkse gezondheidsenquête het specifieke onderzoeksluik rond geestelijke gezondheid en de GGZ uit te breiden door o.a. zorgbehoeften in kaart te brengen.	☐	☐	☐	☐
De onderzoekscapaciteit die de werkzaamheid van (innovatieve) behandelingen en organisatiemodellen bestudeert, dient uitgebreid te worden.	☐	☐	☐	☐
Het dient mogelijk te zijn om uit elektronische patiënten/cliëntendossiers automatisch geanonimiseerde data te verkrijgen voor onderzoeksdoeleinden.	☐	☐	☐	☐



Sectie H: Vragen over het thema "Participatie"

H1. Geef aan in hoeverre u het (on)eens bent met elke stelling.

GGZ staat voor "Geestelijke Gezondheidszorg"

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
De bevoegde overheden dienen budget vrij te maken en een financieringssysteem te ontwikkelen dat het betrekken van patiëntervaringsdeskundigen en familie-expertvertegenwoordigers bij zorgverlening en -beleid garandeert en aanmoedigt.	☐	☐	☐	☐
Patiëntervaringsdeskundigen en familie-expertvertegenwoordigers dienen deel uit te maken van de jaarlijkse inspectie van hulpverleners en –organisaties binnen de GGZ.	☐	☐	☐	☐
Patiëntervaringsdeskundigen en familie-expertvertegenwoordigers dienen deel uit te maken van de raad van bestuur van elk Art.107 netwerk.	☐	☐	☐	☐
Patiëntervaringsdeskundigen en familie-expertvertegenwoordigers dienen deel uit te maken van elk mobiel team als adviseur bij het opstellen van individuele behandelplannen voor mensen met geestelijke gezondheidsproblemen.	☐	☐	☐	☐

Sectie I: Vragen over het thema "Financiëring"

I1. Geef aan in hoeverre u het (on)eens bent met elke stelling.

GGZ staat voor "Geestelijke Gezondheidszorg"

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
De financiering van de GGZ dient te gebeuren op het niveau van een Art. 107 netwerk. Bijgevolg dient het Art. 107 netwerk de financiële middelen te verdelen over de betrokken hulpverleners en -organisaties.	☐	☐	☐	☐
Het financieringsmechanisme van psychiatrische ziekenhuizen dient veranderd te worden.	☐	☐	☐	☐

I2. De financiering van psychiatrische ziekenhuizen dient te gebeuren op basis van...

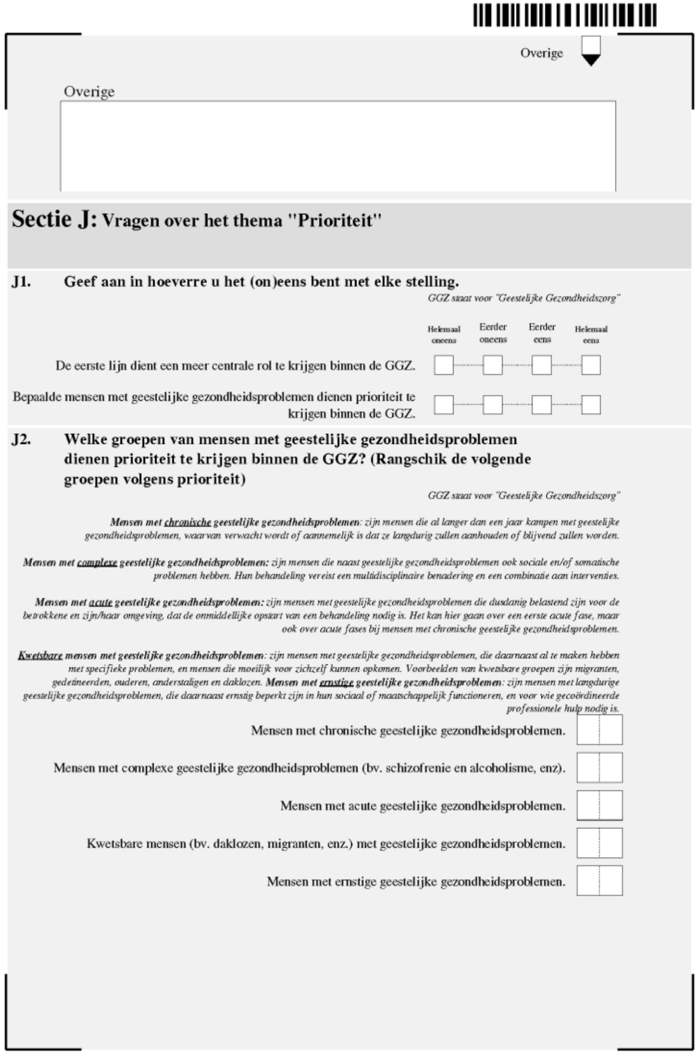
zorgresultaat (outcomes) ☐

kwaliteitsindicatoren (structuur, proces en outcome) ☐

zorgpaden over de lijnen heen ☐

bedbezetting ☐

gemiddelde ligduur ☐



Overige ☐

Overige

Sectie J: Vragen over het thema "Prioriteit"

J1. Geef aan in hoeverre u het (on)eens bent met elke stelling.

GGZ staat voor "Geestelijke Gezondheidszorg"

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
De eerste lijn dient een meer centrale rol te krijgen binnen de GGZ.	☐	☐	☐	☐
Bepaalde mensen met geestelijke gezondheidsproblemen dienen prioriteit te krijgen binnen de GGZ.	☐	☐	☐	☐

J2. Welke groepen van mensen met geestelijke gezondheidsproblemen dienen prioriteit te krijgen binnen de GGZ? (Rangschik de volgende groepen volgens prioriteit)

GGZ staat voor "Geestelijke Gezondheidszorg"

***Mensen met chronische geestelijke gezondheidsproblemen**: zijn mensen die al langer dan een jaar kampen met geestelijke gezondheidsproblemen, waarvan verwacht wordt of aannemelijk is dat ze langdurig zullen aanhouden of blijvend zullen worden.*

***Mensen met complexe geestelijke gezondheidsproblemen:** zijn mensen die naast geestelijke gezondheidsproblemen ook sociale en/of somatische problemen hebben. Hun behandeling vereist een multidisciplinaire benadering en een combinatie aan interventies.*

***Mensen met acute geestelijke gezondheidsproblemen:** zijn mensen met geestelijke gezondheidsproblemen die dusdanig belastend zijn voor de betrokkene en zijn/haar omgeving, dat de onmiddellijke opstart van een behandeling nodig is. Het kan hier gaan over een eerste acute fase, maar ook over acute fases bij mensen met chronische geestelijke gezondheidsproblemen.*

***Kwetsbare mensen met geestelijke gezondheidsproblemen**: zijn mensen met geestelijke gezondheidsproblemen, die daarnaast al te maken hebben met specifieke problemen, en mensen die moeilijk voor zichzelf kunnen opkomen. Voorbeelden van kwetsbare groepen zijn migranten, gedetineerden, ouderen, anderstaligen en daklozen. **Mensen met ernstige geestelijke gezondheidsproblemen**: zijn mensen met langdurige geestelijke gezondheidsproblemen, die daarnaast ernstig beperkt zijn in hun sociaal of maatschappelijk functioneren, en voor wie gecoördineerde professionele hulp nodig is.*

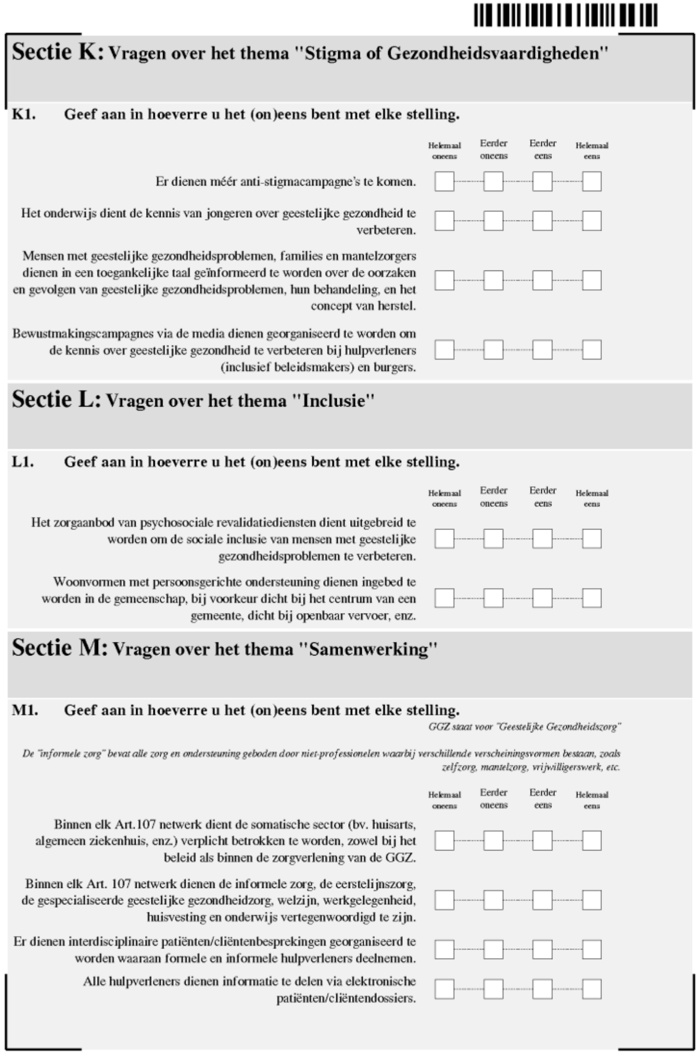
Mensen met chronische geestelijke gezondheidsproblemen. ☐☐

Mensen met complexe geestelijke gezondheidsproblemen (bv. schizofrenie en alcoholisme, enz). ☐☐

Mensen met acute geestelijke gezondheidsproblemen. ☐☐

Kwetsbare mensen (bv. daklozen, migranten, enz.) met geestelijke gezondheidsproblemen. ☐☐

Mensen met ernstige geestelijke gezondheidsproblemen. ☐☐



Sectie K: Vragen over het thema "Stigma of Gezondheidsvaardigheden"

K1. Geef aan in hoeverre u het (on)eens bent met elke stelling.

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
Er dienen méér anti-stigmacampagne's te komen.	☐	☐	☐	☐
Het onderwijs dient de kennis van jongeren over geestelijke gezondheid te verbeteren.	☐	☐	☐	☐
Mensen met geestelijke gezondheidsproblemen, families en mantelzorgers dienen in een toegankelijke taal geïnformeerd te worden over de oorzaken en gevolgen van geestelijke gezondheidsproblemen, hun behandeling, en het concept van herstel.	☐	☐	☐	☐
Bewustmakingscampagnes via de media dienen georganiseerd te worden om de kennis over geestelijke gezondheid te verbeteren bij hulpverleners (inclusief beleidsmakers) en burgers.	☐	☐	☐	☐

Sectie L: Vragen over het thema "Inclusie"

L1. Geef aan in hoeverre u het (on)eens bent met elke stelling.

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
Het zorgaanbod van psychosociale revalidatiediensten dient uitgebreid te worden om de sociale inclusie van mensen met geestelijke gezondheidsproblemen te verbeteren.	☐	☐	☐	☐
Woonvormen met persoonsgerichte ondersteuning dienen ingebed te worden in de gemeenschap, bij voorkeur dicht bij het centrum van een gemeente, dicht bij openbaar vervoer, enz.	☐	☐	☐	☐

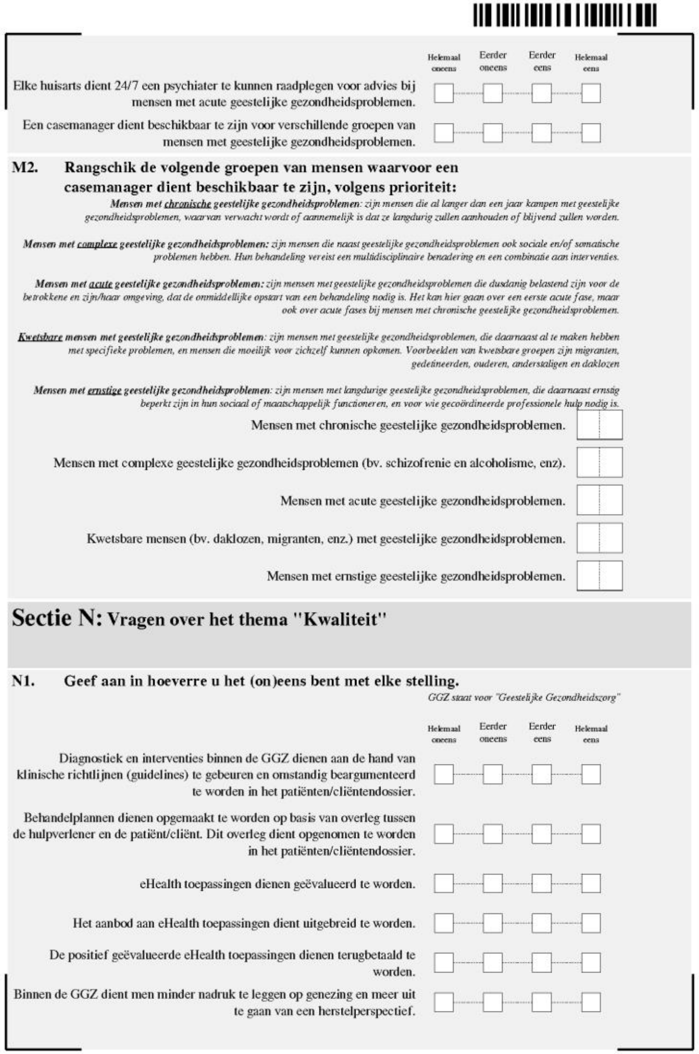
Sectie M: Vragen over het thema "Samenwerking"

M1. Geef aan in hoeverre u het (on)eens bent met elke stelling.

GGZ staat voor "Geestelijke Gezondheidszorg"

De "informele zorg" bevat alle zorg en ondersteuning geboden door niet-professionelen waarbij verschillende verscheiningsvormen bestaan, zoals zelfzorg, mantelzorg, vrijwilligerswerk, etc.

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
Binnen elk Art.107 netwerk dient de somatische sector (bv. huisarts, algemeen ziekenhuis, enz.) verplicht betrokken te worden, zowel bij het beleid als binnen de zorgverlening van de GGZ.	☐	☐	☐	☐
Binnen elk Art. 107 netwerk dienen de informele zorg, de eerstelijnszorg, de gespecialiseerde geestelijke gezondheidzorg, welzijn, werkgelegenheid, huisvesting en onderwijs vertegenwoordigd te zijn.	☐	☐	☐	☐
Er dienen interdisciplinaire patiënten/cliëntenbesprekingen georganiseerd te worden waaraan formele en informele hulpverleners deelnemen.	☐	☐	☐	☐
Alle hulpverleners dienen informatie te delen via elektronische patiënten/cliëntendossiers.	☐	☐	☐	☐



	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
Elke huisarts dient 24/7 een psychiater te kunnen raadplegen voor advies bij mensen met acute geestelijke gezondheidsproblemen.	☐	☐	☐	☐
Een casemanager dient beschikbaar te zijn voor verschillende groepen van mensen met geestelijke gezondheidsproblemen.	☐	☐	☐	☐

M2. Rangschik de volgende groepen van mensen waarvoor een casemanager dient beschikbaar te zijn, volgens prioriteit:

***Mensen met <u>chronische</u> geestelijke gezondheidsproblemen**: zijn mensen die al langer dan een jaar kampen met geestelijke gezondheidsproblemen, waarvan verwacht wordt of aannemelijk is dat ze langdurig zullen aanhouden of blijvend zullen worden.*

***Mensen met <u>complexe</u> geestelijke gezondheidsproblemen:** zijn mensen die naast geestelijke gezondheidsproblemen ook sociale en/of somatische problemen hebben. Hun behandeling vereist een multidisciplinaire benadering en een combinatie aan interventies.*

***Mensen met <u>acute</u> geestelijke gezondheidsproblemen:** zijn mensen met geestelijke gezondheidsproblemen die dusdanig belastend zijn voor de betrokkene en zijn/haar omgeving, dat de onmiddellijke opstart van een behandeling nodig is. Het kan hier gaan over een eerste acute fase, maar ook over acute fases bij mensen met chronische geestelijke gezondheidsproblemen.*

***<u>Kwetsbare</u> mensen met geestelijke gezondheidsproblemen**: zijn mensen met geestelijke gezondheidsproblemen, die daarnaast al te maken hebben met specifieke problemen, en mensen die moeilijk voor zichzelf kunnen opkomen. Voorbeelden van kwetsbare groepen zijn migranten, gedetineerden, ouderen, anderstaligen en daklozen*

***Mensen met <u>ernstige</u> geestelijke gezondheidsproblemen**: zijn mensen met langdurige geestelijke gezondheidsproblemen, die daarnaast ernstig beperkt zijn in hun sociaal of maatschappelijk functioneren, en voor wie gecoördineerde professionele hulp nodig is.*

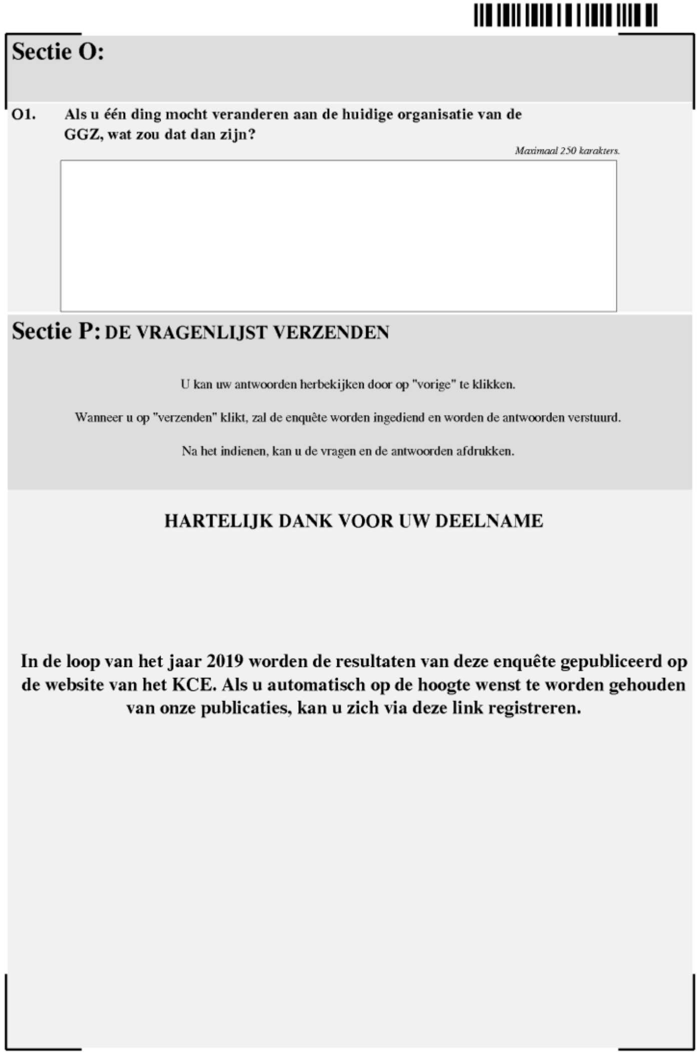
Mensen met chronische geestelijke gezondheidsproblemen.	☐☐
Mensen met complexe geestelijke gezondheidsproblemen (bv. schizofrenie en alcoholisme, enz).	☐☐
Mensen met acute geestelijke gezondheidsproblemen.	☐☐
Kwetsbare mensen (bv. daklozen, migranten, enz.) met geestelijke gezondheidsproblemen.	☐☐
Mensen met ernstige geestelijke gezondheidsproblemen.	☐☐

Sectie N: Vragen over het thema "Kwaliteit"

N1. Geef aan in hoeverre u het (on)eens bent met elke stelling.

GGZ staat voor "Geestelijke Gezondheidszorg"

	Helemaal oneens	Eerder oneens	Eerder eens	Helemaal eens
Diagnostiek en interventies binnen de GGZ dienen aan de hand van klinische richtlijnen (guidelines) te gebeuren en omstandig beargumenteerd te worden in het patiënten/cliëntendossier.	☐	☐	☐	☐
Behandelplannen dienen opgemaakt te worden op basis van overleg tussen de hulpverlener en de patiënt/cliënt. Dit overleg dient opgenomen te worden in het patiënten/cliëntendossier.	☐	☐	☐	☐
eHealth toepassingen dienen geëvalueerd te worden.	☐	☐	☐	☐
Het aanbod aan eHealth toepassingen dient uitgebreid te worden.	☐	☐	☐	☐
De positief geëvalueerde eHealth toepassingen dienen terugbetaald te worden.	☐	☐	☐	☐
Binnen de GGZ dient men minder nadruk te leggen op genezing en meer uit te gaan van een herstelperspectief.	☐	☐	☐	☐



Sectie O:

O1. **Als u één ding mocht veranderen aan de huidige organisatie van de GGZ, wat zou dat dan zijn?**

Maximaal 250 karakters.

Sectie P: DE VRAGENLIJST VERZENDEN

U kan uw antwoorden herbekijken door op "vorige" te klikken.

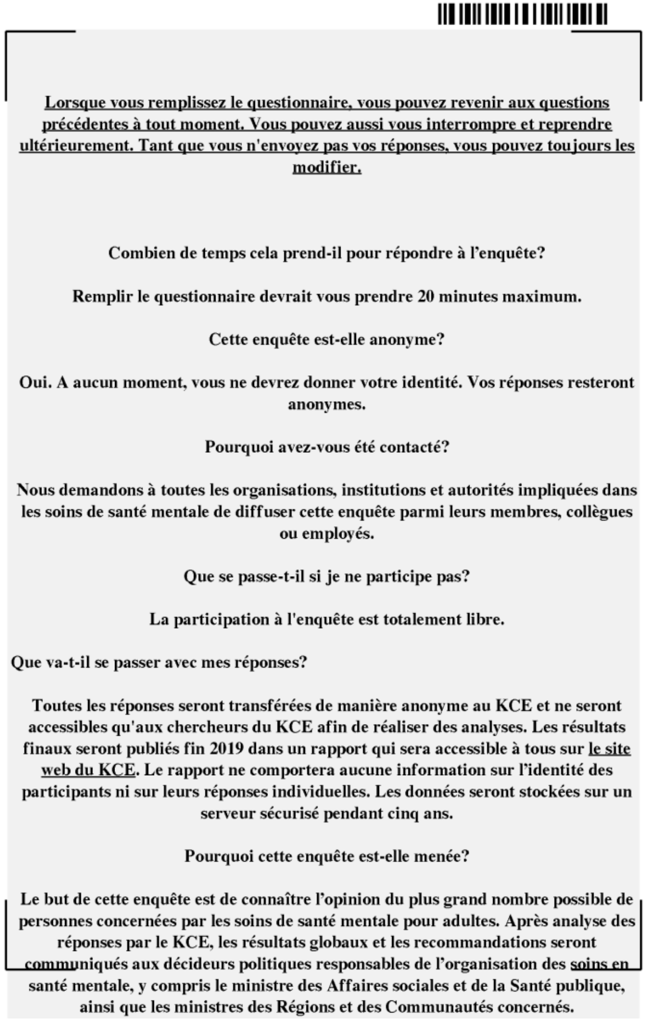
Wanneer u op "verzenden" klikt, zal de enquête worden ingediend en worden de antwoorden verstuurd.

Na het indienen, kan u de vragen en de antwoorden afdrukken.

HARTELIJK DANK VOOR UW DEELNAME

In de loop van het jaar 2019 worden de resultaten van deze enquête gepubliceerd op de website van het KCE. Als u automatisch op de hoogte wenst te worden gehouden van onze publicaties, kan u zich via deze link registreren.

APPENDIX 3. QUESTIONNAIRE IN FRENCH



Lorsque vous remplissez le questionnaire, vous pouvez revenir aux questions précédentes à tout moment. Vous pouvez aussi vous interrompre et reprendre ultérieurement. Tant que vous n'envoyez pas vos réponses, vous pouvez toujours les modifier.

Combien de temps cela prend-il pour répondre à l'enquête?

Remplir le questionnaire devrait vous prendre 20 minutes maximum.

Cette enquête est-elle anonyme?

Oui. A aucun moment, vous ne devrez donner votre identité. Vos réponses resteront anonymes.

Pourquoi avez-vous été contacté?

Nous demandons à toutes les organisations, institutions et autorités impliquées dans les soins de santé mentale de diffuser cette enquête parmi leurs membres, collègues ou employés.

Que se passe-t-il si je ne participe pas?

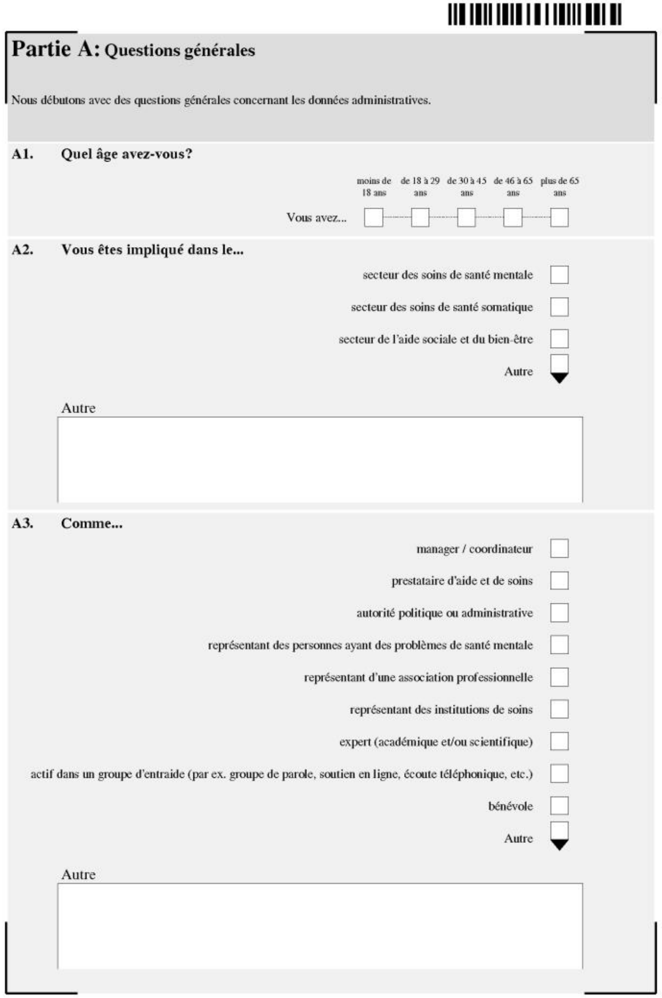
La participation à l'enquête est totalement libre.

Que va-t-il se passer avec mes réponses?

Toutes les réponses seront transférées de manière anonyme au KCE et ne seront accessibles qu'aux chercheurs du KCE afin de réaliser des analyses. Les résultats finaux seront publiés fin 2019 dans un rapport qui sera accessible à tous sur le site web du KCE. Le rapport ne comportera aucune information sur l'identité des participants ni sur leurs réponses individuelles. Les données seront stockées sur un serveur sécurisé pendant cinq ans.

Pourquoi cette enquête est-elle menée?

Le but de cette enquête est de connaître l'opinion du plus grand nombre possible de personnes concernées par les soins de santé mentale pour adultes. Après analyse des réponses par le KCE, les résultats globaux et les recommandations seront communiqués aux décideurs politiques responsables de l'organisation des soins en santé mentale, y compris le ministre des Affaires sociales et de la Santé publique, ainsi que les ministres des Régions et des Communautés concernés.



Partie A: Questions générales

Nous débutons avec des questions générales concernant les données administratives.

A1. Quel âge avez-vous?

	moins de 18 ans	de 18 à 29 ans	de 30 à 45 ans	de 46 à 65 ans	plus de 65 ans
Vous avez...	☐	☐	☐	☐	☐

A2. Vous êtes impliqué dans le...

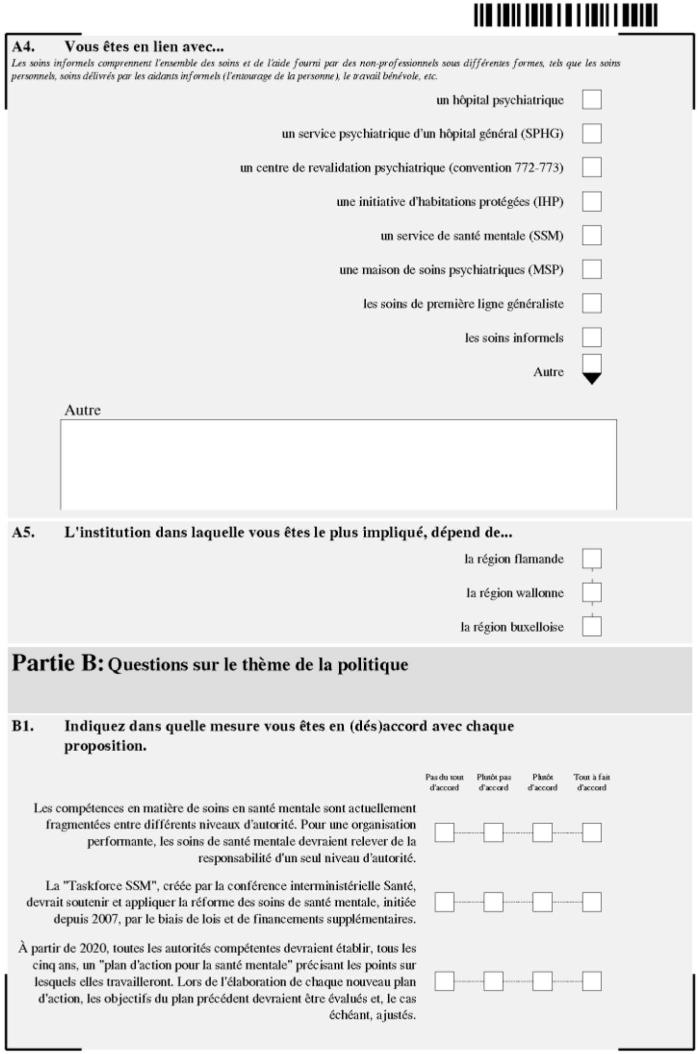
secteur des soins de santé mentale ☐
secteur des soins de santé somatique ☐
secteur de l'aide sociale et du bien-être ☐
Autre ☐

Autre

A3. Comme...

manager / coordinateur ☐
prestataire d'aide et de soins ☐
autorité politique ou administrative ☐
représentant des personnes ayant des problèmes de santé mentale ☐
représentant d'une association professionnelle ☐
représentant des institutions de soins ☐
expert (académique et/ou scientifique) ☐
actif dans un groupe d'entraide (par ex. groupe de parole, soutien en ligne, écoute téléphonique, etc.) ☐
bénévole ☐
Autre ☐

Autre



A4. Vous êtes en lien avec...

Les soins informels comprennent l'ensemble des soins et de l'aide fourni par des non-professionnels sous différentes formes, tels que les soins personnels, soins délivrés par les aidants informels (l'entourage de la personne), le travail bénévole, etc.

un hôpital psychiatrique ☐
un service psychiatrique d'un hôpital général (SPHG) ☐
un centre de revalidation psychiatrique (convention 772-773) ☐
une initiative d'habitations protégées (IHP) ☐
un service de santé mentale (SSM) ☐
une maison de soins psychiatriques (MSP) ☐
les soins de première ligne généraliste ☐
les soins informels ☐
Autre ☐

Autre

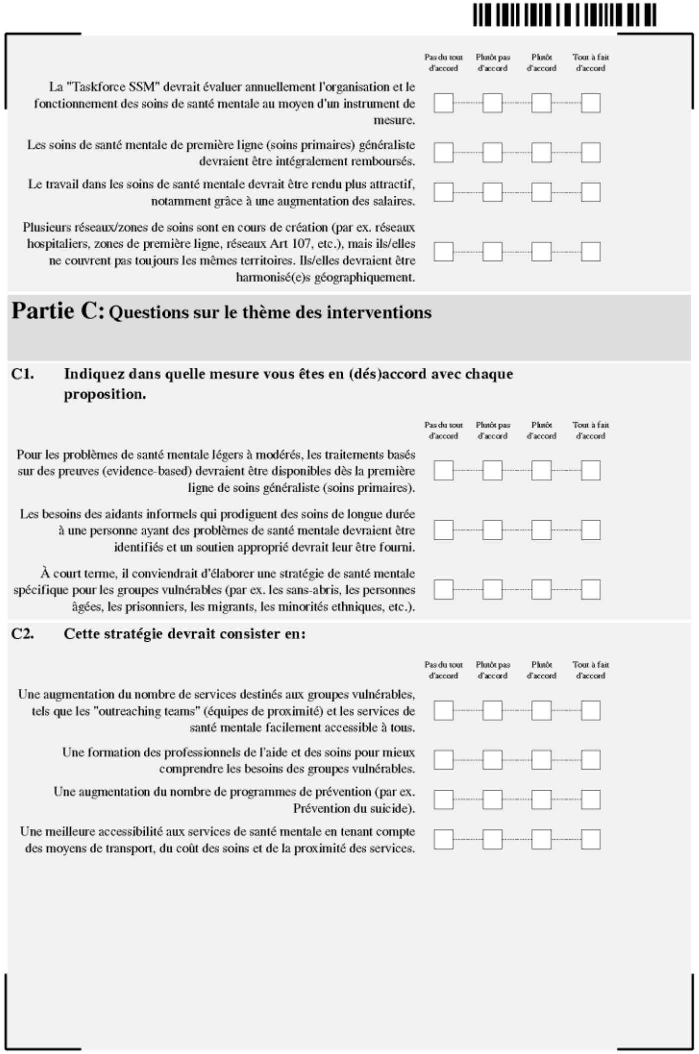
A5. L'institution dans laquelle vous êtes le plus impliqué, dépend de...

la région flamande ☐
la région wallonne ☐
la région buxelloise ☐

Partie B: Questions sur le thème de la politique

B1. Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Les compétences en matière de soins en santé mentale sont actuellement fragmentées entre différents niveaux d'autorité. Pour une organisation performante, les soins de santé mentale devraient relever de la responsabilité d'un seul niveau d'autorité.	☐	☐	☐	☐
La "Taskforce SSM", créée par la conférence interministérielle Santé, devrait soutenir et appliquer la réforme des soins de santé mentale, initiée depuis 2007, par le biais de lois et de financements supplémentaires.	☐	☐	☐	☐
À partir de 2020, toutes les autorités compétentes devraient établir, tous les cinq ans, un "plan d'action pour la santé mentale" précisant les points sur lesquels elles travailleront. Lors de l'élaboration de chaque nouveau plan d'action, les objectifs du plan précédent devraient être évalués et, le cas échéant, ajustés.	☐	☐	☐	☐



	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
La "Taskforce SSM" devrait évaluer annuellement l'organisation et le fonctionnement des soins de santé mentale au moyen d'un instrument de mesure.	☐	☐	☐	☐
Les soins de santé mentale de première ligne (soins primaires) généraliste devraient être intégralement remboursés.	☐	☐	☐	☐
Le travail dans les soins de santé mentale devrait être rendu plus attractif, notamment grâce à une augmentation des salaires.	☐	☐	☐	☐
Plusieurs réseaux/zones de soins sont en cours de création (par ex. réseaux hospitaliers, zones de première ligne, réseaux Art 107, etc.), mais ils/elles ne couvrent pas toujours les mêmes territoires. Ils/elles devraient être harmonisé(e)s géographiquement.	☐	☐	☐	☐

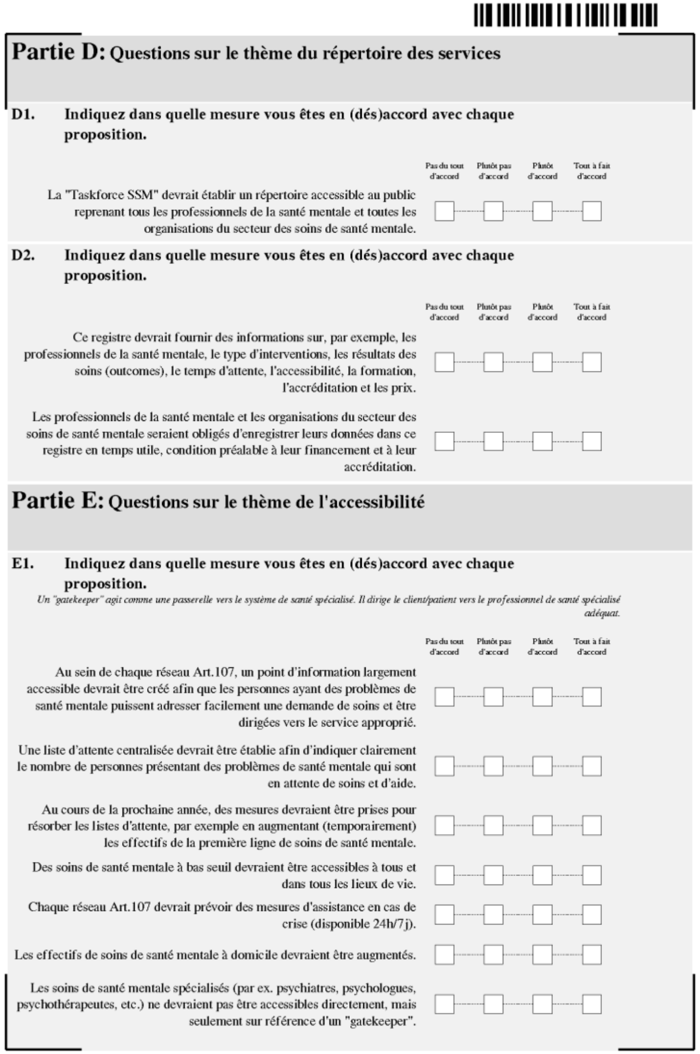
Partie C: Questions sur le thème des interventions

C1. Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Pour les problèmes de santé mentale légers à modérés, les traitements basés sur des preuves (evidence-based) devraient être disponibles dès la première ligne de soins généraliste (soins primaires).	☐	☐	☐	☐
Les besoins des aidants informels qui prodiguent des soins de longue durée à une personne ayant des problèmes de santé mentale devraient être identifiés et un soutien approprié devrait leur être fourni.	☐	☐	☐	☐
À court terme, il conviendrait d'élaborer une stratégie de santé mentale spécifique pour les groupes vulnérables (par ex. les sans-abris, les personnes âgées, les prisonniers, les migrants, les minorités ethniques, etc.).	☐	☐	☐	☐

C2. Cette stratégie devrait consister en:

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Une augmentation du nombre de services destinés aux groupes vulnérables, tels que les "outreaching teams" (équipes de proximité) et les services de santé mentale facilement accessible à tous.	☐	☐	☐	☐
Une formation des professionnels de l'aide et des soins pour mieux comprendre les besoins des groupes vulnérables.	☐	☐	☐	☐
Une augmentation du nombre de programmes de prévention (par ex. Prévention du suicide).	☐	☐	☐	☐
Une meilleure accessibilité aux services de santé mentale en tenant compte des moyens de transport, du coût des soins et de la proximité des services.	☐	☐	☐	☐



Partie D: Questions sur le thème du répertoire des services

D1. **Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.**

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
La "Taskforce SSM" devrait établir un répertoire accessible au public reprenant tous les professionnels de la santé mentale et toutes les organisations du secteur des soins de santé mentale.	☐	☐	☐	☐

D2. **Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.**

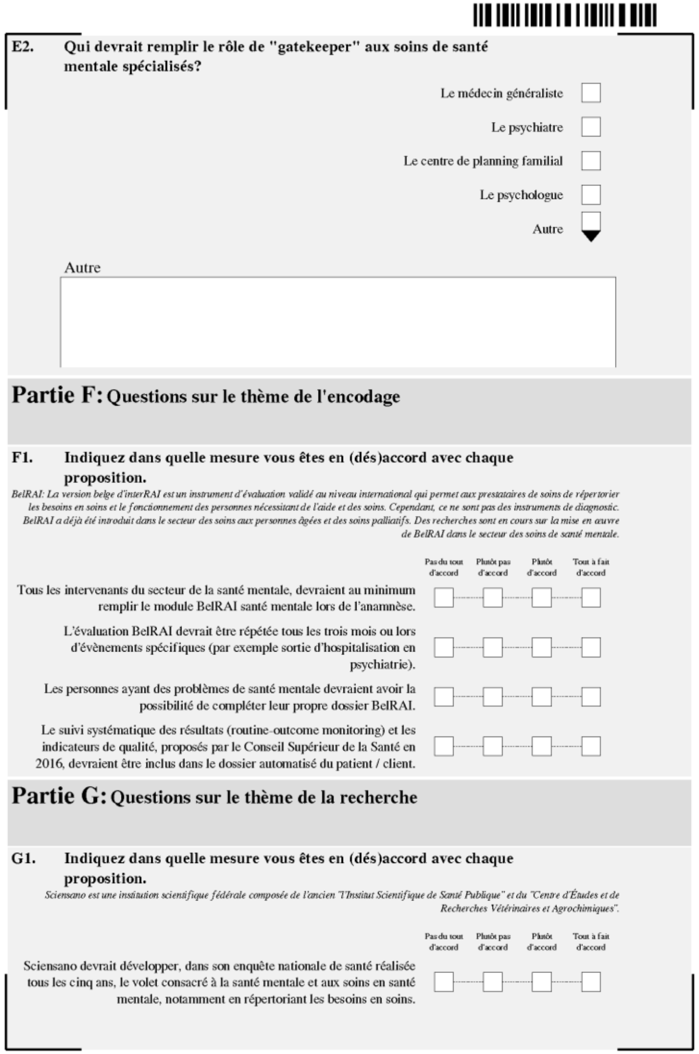
	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Ce registre devrait fournir des informations sur, par exemple, les professionnels de la santé mentale, le type d'interventions, les résultats des soins (outcomes), le temps d'attente, l'accessibilité, la formation, l'accréditation et les prix.	☐	☐	☐	☐
Les professionnels de la santé mentale et les organisations du secteur des soins de santé mentale seraient obligés d'enregistrer leurs données dans ce registre en temps utile, condition préalable à leur financement et à leur accréditation.	☐	☐	☐	☐

Partie E: Questions sur le thème de l'accessibilité

E1. **Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.**

Un "gatekeeper" agit comme une passerelle vers le système de santé spécialisé. Il dirige le client/patient vers le professionnel de santé spécialisé adéquat.

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Au sein de chaque réseau Art.107, un point d'information largement accessible devrait être créé afin que les personnes ayant des problèmes de santé mentale puissent adresser facilement une demande de soins et être dirigées vers le service approprié.	☐	☐	☐	☐
Une liste d'attente centralisée devrait être établie afin d'indiquer clairement le nombre de personnes présentant des problèmes de santé mentale qui sont en attente de soins et d'aide.	☐	☐	☐	☐
Au cours de la prochaine année, des mesures devraient être prises pour résorber les listes d'attente, par exemple en augmentant (temporairement) les effectifs de la première ligne de soins de santé mentale.	☐	☐	☐	☐
Des soins de santé mentale à bas seuil devraient être accessibles à tous et dans tous les lieux de vie.	☐	☐	☐	☐
Chaque réseau Art.107 devrait prévoir des mesures d'assistance en cas de crise (disponible 24h/7j).	☐	☐	☐	☐
Les effectifs de soins de santé mentale à domicile devraient être augmentés.	☐	☐	☐	☐
Les soins de santé mentale spécialisés (par ex. psychiatres, psychologues, psychothérapeutes, etc.) ne devraient pas être accessibles directement, mais seulement sur référence d'un "gatekeeper".	☐	☐	☐	☐



E2. **Qui devrait remplir le rôle de "gatekeeper" aux soins de santé mentale spécialisés?**

Le médecin généraliste ☐

Le psychiatre ☐

Le centre de planning familial ☐

Le psychologue ☐

Autre ☐

Autre

Partie F: Questions sur le thème de l'encodage

F1. **Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.**

BelRAI: La version belge d'interRAI est un instrument d'évaluation validé au niveau international qui permet aux prestataires de soins de répertorier les besoins en soins et le fonctionnement des personnes nécessitant de l'aide et des soins. Cependant, ce ne sont pas des instruments de diagnostic. BelRAI a déjà été introduit dans le secteur des soins aux personnes âgées et des soins palliatifs. Des recherches sont en cours sur la mise en œuvre de BelRAI dans le secteur des soins de santé mentale.

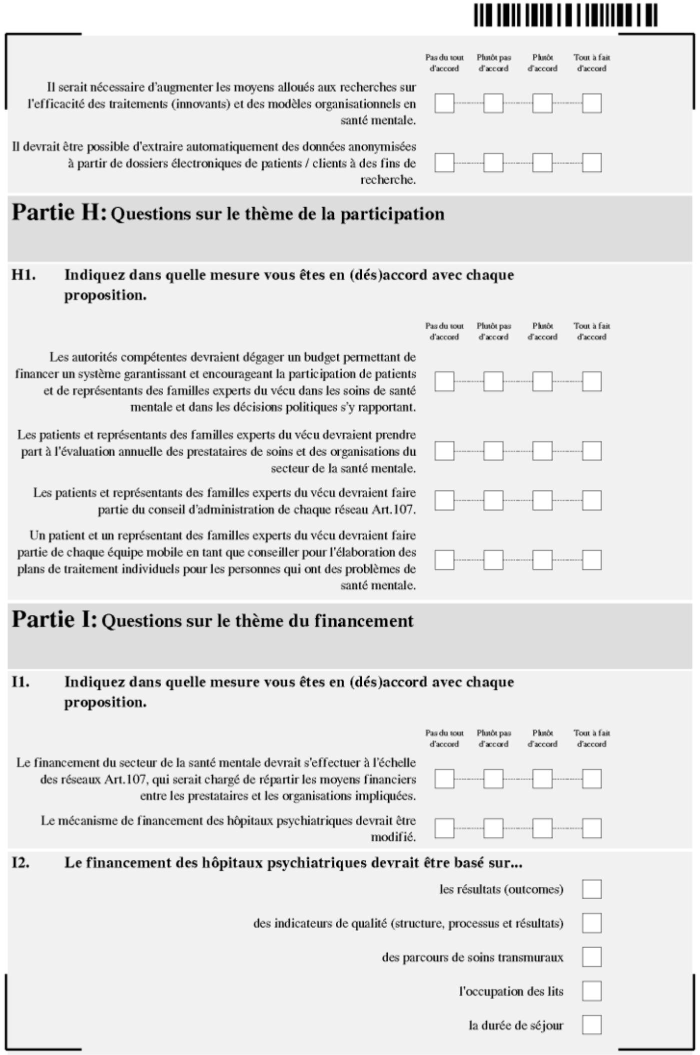
	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Tous les intervenants du secteur de la santé mentale, devraient au minimum remplir le module BelRAI santé mentale lors de l'anamnèse.	☐	☐	☐	☐
L'évaluation BelRAI devrait être répétée tous les trois mois ou lors d'évènements spécifiques (par exemple sortie d'hospitalisation en psychiatrie).	☐	☐	☐	☐
Les personnes ayant des problèmes de santé mentale devraient avoir la possibilité de compléter leur propre dossier BelRAI.	☐	☐	☐	☐
Le suivi systématique des résultats (routine-outcome monitoring) et les indicateurs de qualité, proposés par le Conseil Supérieur de la Santé en 2016, devraient être inclus dans le dossier automatisé du patient / client.	☐	☐	☐	☐

Partie G: Questions sur le thème de la recherche

G1. **Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.**

Sciensano est une institution scientifique fédérale composée de l'ancien "l'Institut Scientifique de Santé Publique" et du "Centre d'Études et de Recherches Vétérinaires et Agrochimiques".

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Sciensano devrait développer, dans son enquête nationale de santé réalisée tous les cinq ans, le volet consacré à la santé mentale et aux soins en santé mentale, notamment en répertoriant les besoins en soins.	☐	☐	☐	☐



	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Il serait nécessaire d'augmenter les moyens alloués aux recherches sur l'efficacité des traitements (innovants) et des modèles organisationnels en santé mentale.	☐	☐	☐	☐
Il devrait être possible d'extraire automatiquement des données anonymisées à partir de dossiers électroniques de patients / clients à des fins de recherche.	☐	☐	☐	☐

Partie H: Questions sur le thème de la participation

H1. Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Les autorités compétentes devraient dégager un budget permettant de financer un système garantissant et encourageant la participation de patients et de représentants des familles experts du vécu dans les soins de santé mentale et dans les décisions politiques s'y rapportant.	☐	☐	☐	☐
Les patients et représentants des familles experts du vécu devraient prendre part à l'évaluation annuelle des prestataires de soins et des organisations du secteur de la santé mentale.	☐	☐	☐	☐
Les patients et représentants des familles experts du vécu devraient faire partie du conseil d'administration de chaque réseau Art.107.	☐	☐	☐	☐
Un patient et un représentant des familles experts du vécu devraient faire partie de chaque équipe mobile en tant que conseiller pour l'élaboration des plans de traitement individuels pour les personnes qui ont des problèmes de santé mentale.	☐	☐	☐	☐

Partie I: Questions sur le thème du financement

I1. Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Le financement du secteur de la santé mentale devrait s'effectuer à l'échelle des réseaux Art.107, qui serait chargé de répartir les moyens financiers entre les prestataires et les organisations impliquées.	☐	☐	☐	☐
Le mécanisme de financement des hôpitaux psychiatriques devrait être modifié.	☐	☐	☐	☐

I2. Le financement des hôpitaux psychiatriques devrait être basé sur...

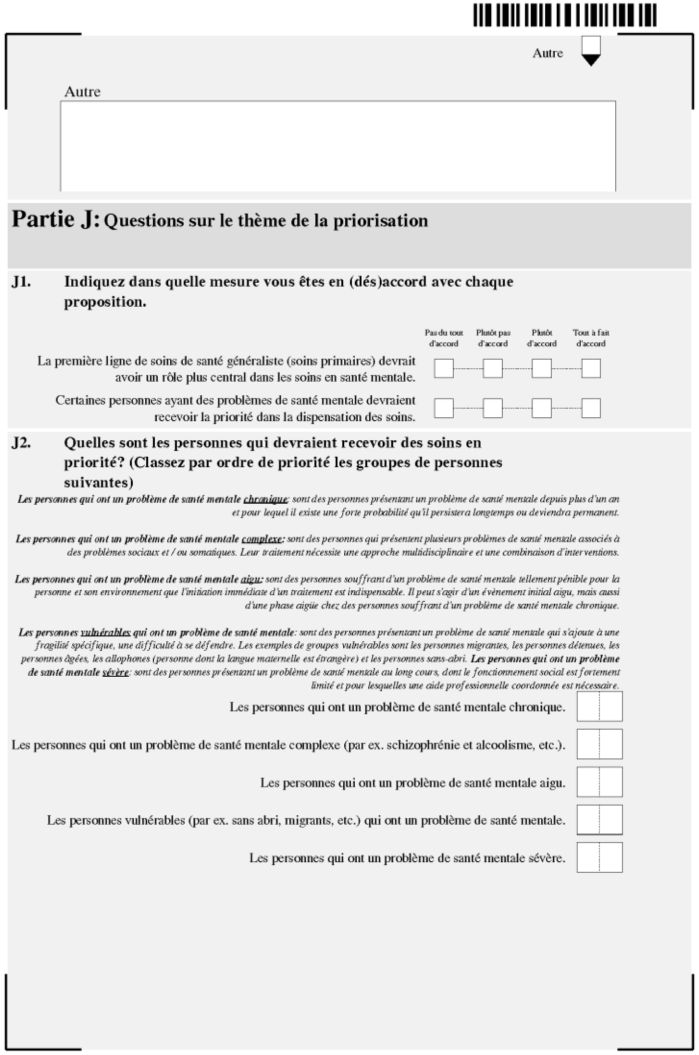
les résultats (outcomes) ☐

des indicateurs de qualité (structure, processus et résultats) ☐

des parcours de soins transmuraux ☐

l'occupation des lits ☐

la durée de séjour ☐



Autre ☐

Autre

Partie J: Questions sur le thème de la priorisation

J1. Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
La première ligne de soins de santé généraliste (soins primaires) devrait avoir un rôle plus central dans les soins en santé mentale.	☐	☐	☐	☐
Certaines personnes ayant des problèmes de santé mentale devraient recevoir la priorité dans la dispensation des soins.	☐	☐	☐	☐

J2. Quelles sont les personnes qui devraient recevoir des soins en priorité? (Classez par ordre de priorité les groupes de personnes suivantes)

Les personnes qui ont un problème de santé mentale chronique: *sont des personnes présentant un problème de santé mentale depuis plus d'un an et pour lequel il existe une forte probabilité qu'il persistera longtemps ou deviendra permanent.*

Les personnes qui ont un problème de santé mentale complexe: *sont des personnes qui présentent plusieurs problèmes de santé mentale associés à des problèmes sociaux et / ou somatiques. Leur traitement nécessite une approche multidisciplinaire et une combinaison d'interventions.*

Les personnes qui ont un problème de santé mentale aigu: *sont des personnes souffrant d'un problème de santé mentale tellement pénible pour la personne et son environnement que l'initiation immédiate d'un traitement est indispensable. Il peut s'agir d'un évènement initial aigu, mais aussi d'une phase aigüe chez des personnes souffrant d'un problème de santé mentale chronique.*

Les personnes vulnérables qui ont un problème de santé mentale*: sont des personnes présentant un problème de santé mentale qui s'ajoute à une fragilité spécifique, une difficulté à se défendre. Les exemples de groupes vulnérables sont les personnes migrantes, les personnes détenues, les personnes âgées, les allophones (personne dont la langue maternelle est étrangère) et les personnes sans-abri.* ***Les personnes qui ont un problème de santé mentale sévère:*** *sont des personnes présentant un problème de santé mentale au long cours, dont le fonctionnement social est fortement limité et pour lesquelles une aide professionnelle coordonnée est nécessaire.*

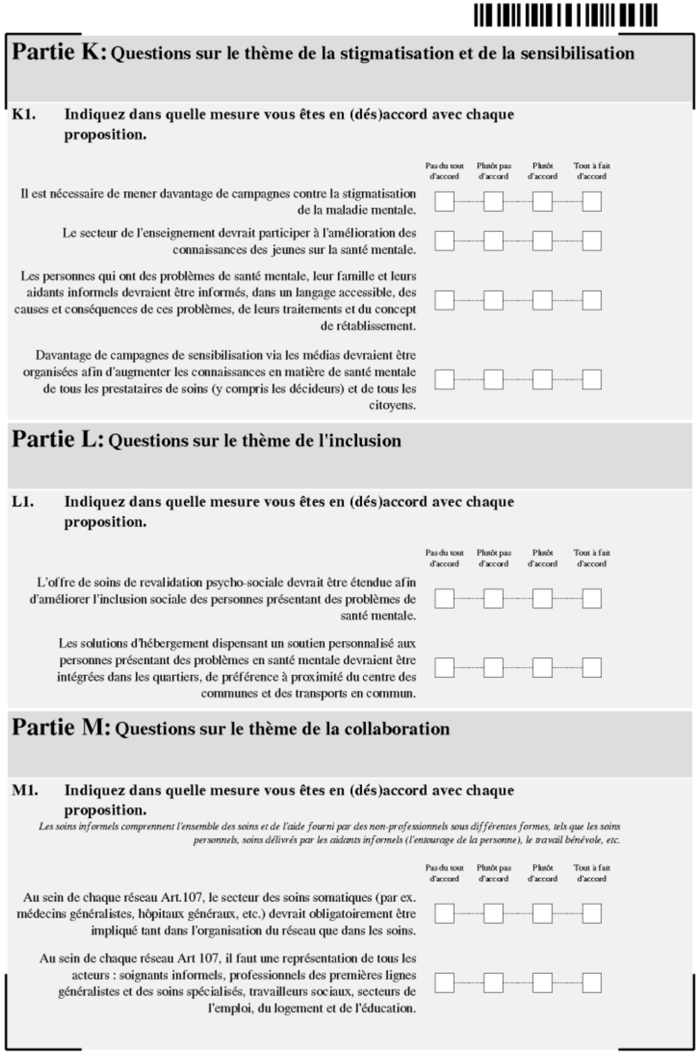
Les personnes qui ont un problème de santé mentale chronique. ☐☐

Les personnes qui ont un problème de santé mentale complexe (par ex. schizophrénie et alcoolisme, etc.). ☐☐

Les personnes qui ont un problème de santé mentale aigu. ☐☐

Les personnes vulnérables (par ex. sans abri, migrants, etc.) qui ont un problème de santé mentale. ☐☐

Les personnes qui ont un problème de santé mentale sévère. ☐☐



Partie K: Questions sur le thème de la stigmatisation et de la sensibilisation

K1. Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Il est nécessaire de mener davantage de campagnes contre la stigmatisation de la maladie mentale.	☐	☐	☐	☐
Le secteur de l'enseignement devrait participer à l'amélioration des connaissances des jeunes sur la santé mentale.	☐	☐	☐	☐
Les personnes qui ont des problèmes de santé mentale, leur famille et leurs aidants informels devraient être informés, dans un langage accessible, des causes et conséquences de ces problèmes, de leurs traitements et du concept de rétablissement.	☐	☐	☐	☐
Davantage de campagnes de sensibilisation via les médias devraient être organisées afin d'augmenter les connaissances en matière de santé mentale de tous les prestataires de soins (y compris les décideurs) et de tous les citoyens.	☐	☐	☐	☐

Partie L: Questions sur le thème de l'inclusion

L1. Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.

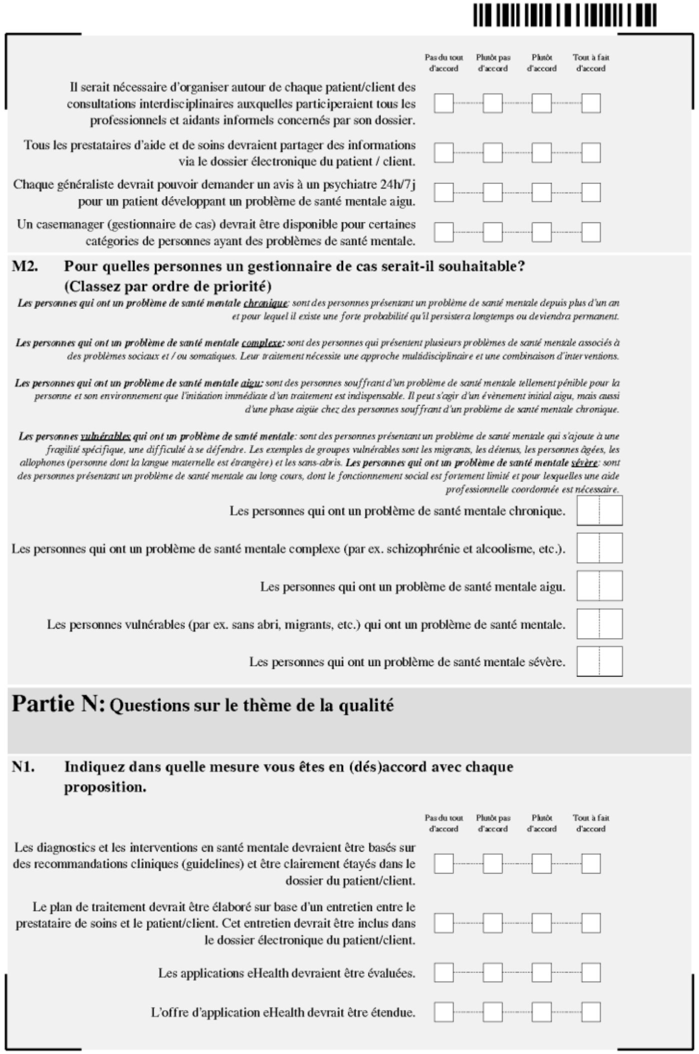
	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
L'offre de soins de revalidation psycho-sociale devrait être étendue afin d'améliorer l'inclusion sociale des personnes présentant des problèmes de santé mentale.	☐	☐	☐	☐
Les solutions d'hébergement dispensant un soutien personnalisé aux personnes présentant des problèmes en santé mentale devraient être intégrées dans les quartiers, de préférence à proximité du centre des communes et des transports en commun.	☐	☐	☐	☐

Partie M: Questions sur le thème de la collaboration

M1. Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.

Les soins informels comprennent l'ensemble des soins et de l'aide fourni par des non-professionnels sous différentes formes, tels que les soins personnels, soins délivrés par les aidants informels (l'entourage de la personne), le travail bénévole, etc.

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Au sein de chaque réseau Art.107, le secteur des soins somatiques (par ex. médecins généralistes, hôpitaux généraux, etc.) devrait obligatoirement être impliqué tant dans l'organisation du réseau que dans les soins.	☐	☐	☐	☐
Au sein de chaque réseau Art 107, il faut une représentation de tous les acteurs : soignants informels, professionnels des premières lignes généralistes et des soins spécialisés, travailleurs sociaux, secteurs de l'emploi, du logement et de l'éducation.	☐	☐	☐	☐



	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Il serait nécessaire d'organiser autour de chaque patient/client des consultations interdisciplinaires auxquelles participeraient tous les professionnels et aidants informels concernés par son dossier.	☐	☐	☐	☐
Tous les prestataires d'aide et de soins devraient partager des informations via le dossier électronique du patient / client.	☐	☐	☐	☐
Chaque généraliste devrait pouvoir demander un avis à un psychiatre 24h/7j pour un patient développant un problème de santé mentale aigu.	☐	☐	☐	☐
Un casemanager (gestionnaire de cas) devrait être disponible pour certaines catégories de personnes ayant des problèmes de santé mentale.	☐	☐	☐	☐

M2. Pour quelles personnes un gestionnaire de cas serait-il souhaitable? (Classez par ordre de priorité)

Les personnes qui ont un problème de santé mentale chronique*: sont des personnes présentant un problème de santé mentale depuis plus d'un an et pour lequel il existe une forte probabilité qu'il persistera longtemps ou deviendra permanent.*

Les personnes qui ont un problème de santé mentale complexe: *sont des personnes qui présentent plusieurs problèmes de santé mentale associés à des problèmes sociaux et / ou somatiques. Leur traitement nécessite une approche multidisciplinaire et une combinaison d'interventions.*

Les personnes qui ont un problème de santé mentale aigu: *sont des personnes souffrant d'un problème de santé mentale tellement pénible pour la personne et son environnement que l'initiation immédiate d'un traitement est indispensable. Il peut s'agir d'un évènement initial aigu, mais aussi d'une phase aigüe chez des personnes souffrant d'un problème de santé mentale chronique.*

Les personnes vulnérables qui ont un problème de santé mentale*: sont des personnes présentant un problème de santé mentale qui s'ajoute à une fragilité spécifique, une difficulté à se défendre. Les exemples de groupes vulnérables sont les migrants, les détenus, les personnes âgées, les allophones (personne dont la langue maternelle est étrangère) et les sans-abris.* ***Les personnes qui ont un problème de santé mentale sévère****: sont des personnes présentant un problème de santé mentale au long cours, dont le fonctionnement social est fortement limité et pour lesquelles une aide professionnelle coordonnée est nécessaire.*

Les personnes qui ont un problème de santé mentale chronique. ☐☐

Les personnes qui ont un problème de santé mentale complexe (par ex. schizophrénie et alcoolisme, etc.). ☐☐

Les personnes qui ont un problème de santé mentale aigu. ☐☐

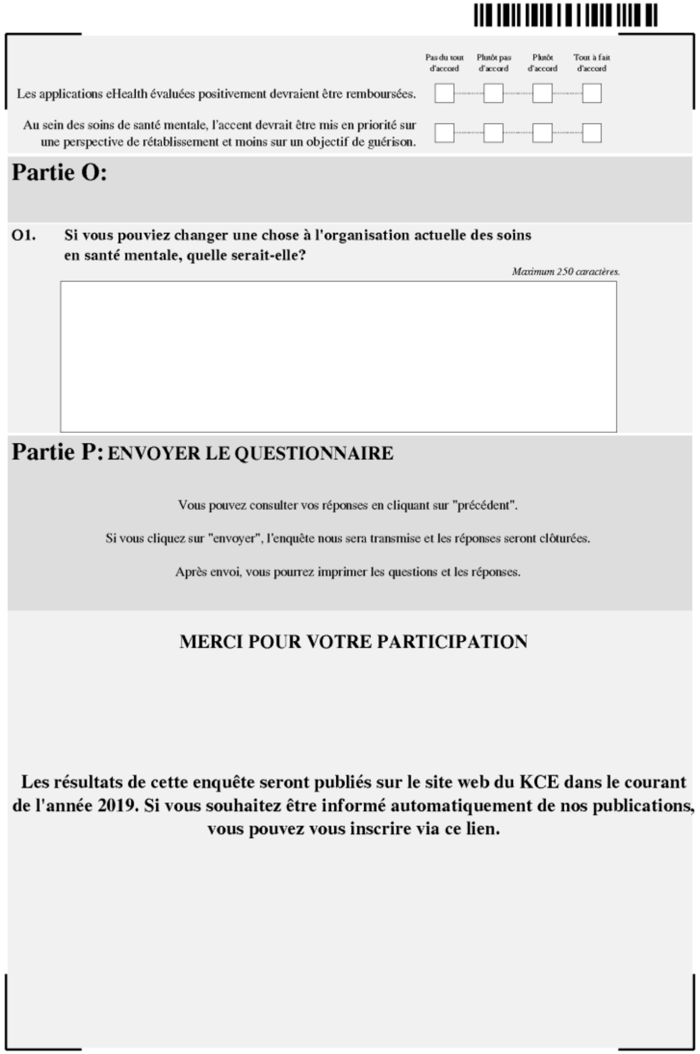
Les personnes vulnérables (par ex. sans abri, migrants, etc.) qui ont un problème de santé mentale. ☐☐

Les personnes qui ont un problème de santé mentale sévère. ☐☐

Partie N: Questions sur le thème de la qualité

N1. Indiquez dans quelle mesure vous êtes en (dés)accord avec chaque proposition.

	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Les diagnostics et les interventions en santé mentale devraient être basés sur des recommandations cliniques (guidelines) et être clairement étayés dans le dossier du patient/client.	☐	☐	☐	☐
Le plan de traitement devrait être élaboré sur base d'un entretien entre le prestataire de soins et le patient/client. Cet entretien devrait être inclus dans le dossier électronique du patient/client.	☐	☐	☐	☐
Les applications eHealth devraient être évaluées.	☐	☐	☐	☐
L'offre d'application eHealth devrait être étendue.	☐	☐	☐	☐



	Pas du tout d'accord	Plutôt pas d'accord	Plutôt d'accord	Tout à fait d'accord
Les applications eHealth évaluées positivement devraient être remboursées.	☐	☐	☐	☐
Au sein des soins de santé mentale, l'accent devrait être mis en priorité sur une perspective de rétablissement et moins sur un objectif de guérison.	☐	☐	☐	☐

Partie O:

O1. Si vous pouviez changer une chose à l'organisation actuelle des soins en santé mentale, quelle serait-elle?

Maximum 250 caractères.

Partie P: ENVOYER LE QUESTIONNAIRE

Vous pouvez consulter vos réponses en cliquant sur "précédent".

Si vous cliquez sur "envoyer", l'enquête nous sera transmise et les réponses seront clôturées.

Après envoi, vous pourrez imprimer les questions et les réponses.

MERCI POUR VOTRE PARTICIPATION

Les résultats de cette enquête seront publiés sur le site web du KCE dans le courant de l'année 2019. Si vous souhaitez être informé automatiquement de nos publications, vous pouvez vous inscrire via ce lien.