World Health Organization
REGIONAL OFFICE FOR Europe

# GOOD PRACTICE BRIEF

# MULTISECTORAL MENTAL HEALTH NETWORKS IN BELGIUM: An example of successful mental health reform through service delivery redesign

Liesbeth Borgermans[1], Bernard Jacob[2], Magda Coture[3], Paul De Bock[4]

## Summary

Belgium has opted for a nationwide reform of the mental health sector in response to the need for improved people-centred approaches for people with mental health conditions, an efficiency imperative. The reform aimed to strengthen the community-based supply of care and to reduce the number of psychiatric hospital beds; it improved care integration, social rehabilitation and service users' recovery, including users' and carers' quality of life. Central to the reform are multisectoral mental health care networks offering outreach services, prevention, in-and outpatient mental health services, primary care, day care, and vocational, housing and social care services.

The nationwide reform is in line with WHO's Mental Health Action Plan 2013–2020 *(1)*, calling for a shift from institutional care to community services. The reform contributed to improving the long-term health of patients and reducing hospital stays. It also significantly reduced the number of psychiatric hospital beds in favour of outreach services to people with mental health conditions.

## Motivation

Belgium has traditionally relied on institutional psychiatric care to treat people with mental health and neurological disorders. With more than 150 psychiatric hospital beds per 100 000 inhabitants, Belgium ranked itself top three in the world. It has 68 psychiatric hospitals for a population of 11.3 million inhabitants (2015).

## Key Messages

- All federal, regional and community ministers competent in mental health and psychiatry have subscribed to the reform.
- The mental health reform was made possible by reallocating funds from long-term psychiatric beds to a collaboration between outpatient services and the community.
- Multisectoral mental health care networks are at the heart of the Belgian reform. The networks provide comprehensive care to adult mental health service users.
- The governance model is based on decentralized leadership and networks are free to include any type of partner within a chosen geographical area.
- The participation of users and their relatives is a central element of the reform, and the organization of care is built on the needs of users.
- The reform has significantly reduced the number of psychiatric hospital beds in favour of outreach services to people with mental health conditions.

[1] Consultant to the Division of Health Systems and Public Health, WHO Regional Office for Europe, Copenhagen, Denmark.
[2] Federal Coordinator, Mental Healthcare Reform, Federal Public Service of, Health, Food Chain Safety and the Environment, Directorate General for Healthcare, Brussels, Belgium.
[3] Assistant-Federal Coordinator, Mental Healthcare Reform, Federal Public Service of Health, Food Chain Safety and the Environment, Directorate General for Healthcare, Brussels, Belgium.
[4] General advisor, Head of department Psychosocial Healthcare, Federal Public Service of Health, Food Chain Safety and the Environment, Directorate General for Healthcare Brussels, Belgium.

Mental illnesses are the primary cause of invalidity in Belgium, and 27% of long-term absenteeism is related to mental issues. The lifetime prevalence of at least one mental disorder is approximately 30%. Suicide rates (18.3 per 100 000 population) appear to be considerably higher in Belgium than in other European countries *(2)*.

Furthermore, a significant treatment gap encompasses both people not getting treated and people receiving treatment far too late. Stigmatization, financial barriers, lack of collaboration between primary care and specialized care, poor accessibility and waiting lists are some of the factors that account for this situation.

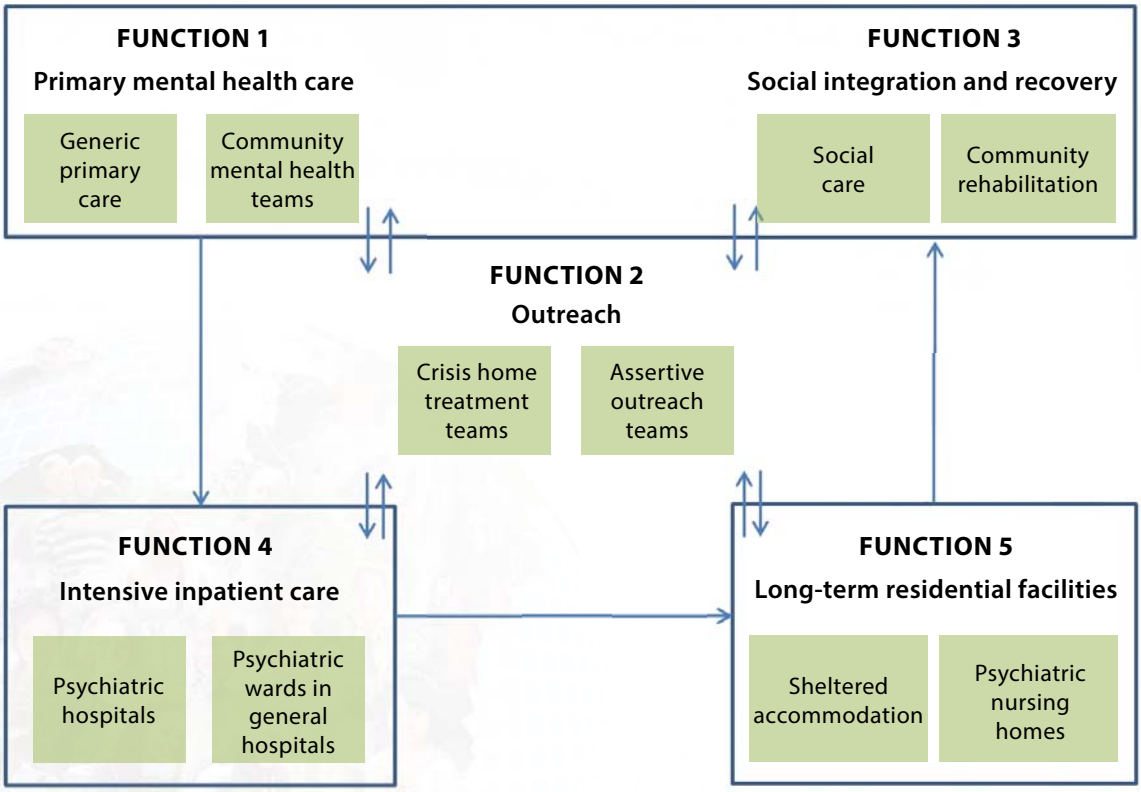
The federal government and the three communities (French-, Dutch- and German-speaking) share responsibility for mental health services in Belgium. Communities are qualified to promote services for mental health, prevention, rehabilitation and housing. In 2002, all ministers responsible for public health signed a joint declaration to provide acute and chronic mental health care through collaborating care networks and care circuits for three target groups (children and adolescents, adults and the elderly) *(3)*. A care circuit is the whole provision of care programmes and care services for a specific target group of (chronically ill) psychiatric patients. This was an important step in the reform, making care more demand-oriented in addressing the needs of people with mental health problems. Starting with the adult group, the aim is to broaden and deepen the reform over the next years to all regions and target groups.

## The mental health reform

In May 2010, public health authorities launched the *Guide to better mental health care through care circuits and care networks (4)*, thereby setting in motion the mental health reform for adults. The Guide describes a programme and an organizational model with multisectoral mental health care networks at the heart of the reform.

The governance model is based on decentralized leadership and informed by interactions among all network members *(5)*. The networks are free to include any type of partner and develop their

**Fig. 1. Care functionalities offered by multisectoral mental health care networks**




*Source:* adapted and reproduced by permission of the publisher from the *Guide to better mental health care through care circuits and networks (4).*

own governance mechanisms within a defined geographical area. They provide comprehensive care to adult mental health service users, and care providers have extensive autonomy in prioritizing patients for network care *(6)*. The care functionalities offered by the networks include (Fig. 1):

- prevention of mental health conditions and promotion of mental health care, early detection, screening and diagnostic activities (function 1);
- ambulatory teams offering intensive treatment for both acute and chronic mental health conditions (function 2);
- rehabilitation teams focusing on recovery and social inclusion (function 3);
- residential intensive treatment for people with both acute and chronic mental health problems (function 4); and
- specific housing facilities (function 5).

## Mobile teams in action

By reallocating funds from institutional care, the reform aimed to reduce the high number of psychiatric hospital beds in favour of new mobile treatment teams (function 2). The teams are composed of hospital-based staff and are financed from the hospital budget, but fully operate in the community. The teams actively liaise with health care practitioners and organizations at the primary care level, and the service is free of charge for patients. Shared care protocols between the mobile teams, primary care practitioners and hospitals are applied.

From the perspective of hospitals, the reform has been cost-neutral in the short run, and thus there were no financial reasons to oppose it. In the long run, the reforms can be cost-saving and are expected to provide better quality of life and outcomes for those with mental health problems.

**Multidisciplinary crisis teams provide crisis** resolution for people with (sub)acute psychological problems, through short-term home treatment and the strengthening of social networks. Working closely with primary care workers and social services, the crisis teams prevent or shorten psychiatric admissions through practical support, medication and family therapy.

**Multidisciplinary outreach teams** provide recovery-oriented care in the home environment for people with long-term severe mental health conditions who are often difficult to reach, focusing on employment and accommodation. Although the teams serve all persons eligible for an acute psychiatric admission, data show that priority is given to people with schizophrenia, personality disorders and poor psychosocial functioning. The teams make use of individual care plans developed in consultation with the patients and their (family) care givers. The care plans include warning signs of relapse and crisis plans, and tasks and responsibilities of all persons involved.

## Impact

In 2017, 22 operational networks were established. Approximately 59 mobile teams are currently active (including 24 mobile crisis teams and 35 mobile teams for chronic mental health problems). The implementation of the teams has resulted in a reduction of 1230 long-term psychiatric beds. During 2016, the teams followed more than 13 000 patients, and the treatment and care provided by these teams have been shown to prevent long-term hospitalization.

As a result of the reform, several additional ambulatory rehabilitation and recovery centres, focusing on housing and employment, were also founded.

The important attitude changes in the sector, combined with the new facilities in the community, have been associated with a significant reduction in the duration of hospital admissions. Furthermore, the accessibility of specialized care strongly benefitted from the intersectoral collaboration.

People with mental health conditions and their families value the opportunity to choose treatment options and generally prefer being treated and cared for in their home environment.

## Lessons learned

- Any mental health reform should be driven by the need to reintegrate mentally disordered persons into society and by shifting from large psychiatric hospitals towards alternative services in the community.
- The availability of a policy guide that sets out the strategy of the reform, as well as the implementation, is essential.
- Reform of mental health takes time. Several waves of reform took place over several decades, characterized by a strong deinstitutionalization movement prior to the mental health reform.
- Despite the fact that networks have established all functions, an even more integrated approach is needed to further improve the accessibility and continuity of care. This requires a formalization and rethinking of the governance structure of the networks.
- Networks vary greatly in terms of size and service types, density of network ties and centrality of key services. Whether one particular network structure is most suited to reach the multiple reform aims simultaneously remains unclear.

## References


1. Mental health action plan 2013–2020. Geneva: World Health Organization; 2013 (http://www.who.int/mental_health/publications/action_plan/en/, accessed 1 March 2018).
2. How healthy is mental health care in Belgium? The facts behind the myths. Brussels: Itinera Institute; 2013.
3. Lorant V, Grard A, Van Audenhove C, Helmer E, Vanderhaegen J, Nicaise P. Assessment of the priority target group of mental health service networks within a nation-wide reform of adult psychiatry in Belgium. BMC Health Serv Res. 2016:16:187.
4. Gids naar een betere geestelijke gezondheidszorg door de realisatie van zorgcircuits en netwerken [Guide to better mental health care through care circuits and care networks]. Brussels, 2010.
5. Lorant V, Grard A, Nicaise P; Title 107 Study Group. Implementing a nation-wide metal health care reform: an analysis of stakeholder's priorities. Community Ment Health J. 2016;52:343–52.
6. Leys M. Mental health care reforms in Belgium: organisational integration through the development of networks. Int J Int Care 2016;16(6):A108.


## Contact us

This brief is part of our work programme on strengthening the health system response to noncommunicable diseases. For other good practice briefs, visit our website at

http://www.euro.who.int/en/health-topics/Health-systems/health-systems-response-to-ncds.