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How are Ambulatory Treatment and Personalised Care Being Implemented in Psychiatry? An Analysis of Eight Years of Activity Records of a Belgian Mobile Crisis Team Developed in the Context of the 'Psy 107' Reform

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Abstract
Since 2009, the 'Reform 107' has been carrying out a substantial transformation of mental healthcare in Belgium, underpinned by two high ideals: ambulatory treatment and personalised care. Whilst there is broad support for the reform, its implementation is not without its problems and little data exists as to its effects. With that in mind, this article endeavours to assess the care provided by a Brussels-based mobile crisis team. Established by funding generated for the reform, this team has taken these ideals fully on board and, as a crisis response measure providing intensive and short-term care, is playing a central role in the organisation and management of mental healthcare across its territory. Therefore, with an approach at the intersection of the sociology of health and the sociology of public action, this article asks the following question: how are these ambitions– ambulatory treatment and personalised care– enacted in concrete terms in this mobile crisis team's care provision practices? The analysis, based on eight years of activity records of this team, has brought to light that, on the one hand, the care interventions provided and patient referrals, when they occur, are for the most part ambulatory, but that hospitalisations still play a prominent role. On the other hand, this mobile team's care provision is personalised, in particular regarding its duration. It emerges that this duration is correlated with certain individual characteristics, but the analyses nevertheless highlight the presence of other circumstantial determinants, calling for more research to be carried out as to their impact.

Keywords Mental health · Psychiatry · Mobile team · Ambulatory care · Personalised care

Introduction

Since 2009, mental healthcare, in Belgium, has been undergoing a comprehensive restructuring, by means of a national reform commonly known as the 'Reform 107'. This reconfiguration is fully in line with directives issued by the World Health Organization (2001) and the transition it is carrying out has thus proven to be similar to that observed in several European countries: a de-institutionalisation of healthcare, which primarily involves the transformation of hospital treatment into care in the community. The objective is expressed in the following way: "The end purpose is to keep people within their environment and their original social fabric through the establishment of individualised therapeutic pathways" (Service Soins De Santé Psychosociaux, 2010, p.10)[1]. To do so, the reform is encouraging increased collaboration not only amongst the professionals working in the sector, in ways that ensure the continuity of care, but also amongst care providers and users so that the healthcare is more individualised and geared towards social reintegration. More specifically, five 'functions' have been formulated, conceived of as five sub-objectives to be put in

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[1] All quotations originally in French are my translations.

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place: (1) early detection and intervention, appropriate for new patients, (2) the setting-up of mobile teams capable of providing intensive care at home, (3) coordination between care givers and social services aiming for the inclusion and social reintegration of the patients, (4) the reduction (in number and duration) of hospital stays when they cannot be avoided and (5) the creation of residential solutions adapted to stabilised chronic patients whose social reintegration options are limited (Thunus & Lorquet, 2014).

At the centre of the reform's second function, the mobile teams are responsible for providing mental healthcare within patients' living settings. They thereby contribute to the wish to expand and encourage the offer of ambulatory mental healthcare. As a matter of fact, the ambulatory offer being relatively underdeveloped, this new measure has been thought through in ways meant to facilitate access to healthcare for patients who may have difficulties in making effective use of it (Service Soins De Santé Psychosociaux, 2010). Initially, two types of mobile team were defined: those dedicated to crisis situations and those established to manage chronic situations. The former have the objective of providing care, in the short term, for patients in a crisis situation, whilst the latter provide support for patients in chronic situations, with a view to their reintegration and rehabilitation (Service Soins De Santé Psychosociaux, 2017). From 2011 onwards, several structures of this type were thus created, followed a little later by other teams more specifically dedicated to providing care for patients faced with particular situations and needs, such as children, patients who are affected by both psychiatric disorders and mental disabilities, those who are living in at-risk conditions, etc. Generally, all of these teams are multidisciplinary and intervene, across the territory assigned to them, for patients (and their families and friends) whose profiles correspond to their mission.

Whilst, on the face of it, this reform project seems to have acquired widespread backing (amongst politicians, care providers, patients and associations), its implementation has been open to question. Several research studies have in fact demonstrated not only a lack of reliable data required to study the reform, but also, when data is available, difficulties in implementing and achieving the targeted goals, in particular those pertaining to the continuity of care, social integration and patients' quality of life. The ongoing central role of hospitals in therapeutic pathways has also been illustrated (Grard et al., 2015; Mistiaen et al., 2019). Marquis and Susswein (2020) have highlighted several avenues aiming to explain these implementation issues. There are first of all organisational factors: the invitation for healthcare providers (principally network coordinators and hospitals) to think through and develop in bottom-up ways new measures and network systems can render the operationalisation of the reform hesitant and open to being interpreted in different ways. Moreover, the funding system has been thought through as a reallocation of resources: no durable funding has been granted and the costs of these new measures must be borne by the closing of hospital beds by the psychiatric hospitals taking part in this project. As well as these practical reasons, other more theoretical issues have been subject to debate. Effectively, the reform is beset by a tension between the vague aspirations for a personalisation of healthcare and the universalising claims made for them, insofar as the reform proposes to redefine principles applicable to the whole territory. Next, it is also the notion of 'good care' which is being redefined: in sync with the ideals of recovery, the notions of autonomy, empowerment and the patient's project are becoming shared values, on the basis of which the care pathway is constructed (Marquis, 2019). Whilst this therapeutic ideal might seem to correspond to some patients, it does not do so for all in ways which are as obvious. Therefore, some of them may not concur with it (notably owing to their illness) and/or may not have sufficient (social) resources to go through with it. It may therefore be possible that, in the cases of patients for whom community-based care is not appropriate, the impact of the reform has been to increase the number of short duration hospital stays (Marquis & Susswein, 2020).

In summary, the reform is underpinned by two major ambitions: to make care more ambulatory and to make it more personalised. To this end, care providers and professionals in the field have been encouraged to develop and implement innovative practices and systems. These include mobile teams, whose project is fully in line with the reform. However, monitoring the implementation of these ambitions and analysing their impact is proving difficult, not only because of the practical difficulties associated with the bottom-up approach that governs this implementation, but also because of the lack of existing data (which is a general problem in the field of mental health in Belgium and particularly in French-speaking Belgium or Brussels, recognised by both researchers and public authorities– see Mistiaen et al., 2019). Research on this topic includes either 'micro' qualitative studies that focus on one or another care system or on specific practices and experiences of those working in this field (see, among others, Thunus & Lorquet, 2014; Walker et al., 2019; Marquis & Pesesse, 2021), or more 'macro' research that draws more general conclusions about mental health care in Belgium and/or by region, using statistical indicators such as changes in active files, inpatient bed occupancy rates, etc. (see, among others, Grard et al., 2015; Mistiaen et al., 2019; Susswein, 2022). With the intention of linking these two levels, this article aims to question the distance between the normative ideals pursued as part of the reform and the day-to-day care practices of a team at the heart of the reform: a mobile crisis team in Brussels.

This 'meso' level, which is still little explored by research, will be explored on the basis of statistical data recording the activities of this team since its creation (which have so far only been analysed in the context of national budgetary evaluations). From a perspective at the crossroads of health sociology and public action, the aim is to answer the following question: « How do the objectives of the reform translate into the daily practice of the mobile crisis team, and what problems and tensions related to the application of the reform can be reported through the team's statistical data? ». The analyses will focus in particular on the place occupied by the two central dimensions of the new vision of mental health care advocated by the reform, namely outpatient care and personalisation. The first part of the article will therefore focus on the organisation of the mental health care network in Brussels and will describe the important role played by outpatient care before and after the interventions of the mobile crisis team. The second part of the article will be devoted to the personalisation of care: it will review the definition given in the reform and then analyse one of the forms it can take during the care provided by the mobile crisis team, namely the duration of care. The analyses will show that this can be adapted to the characteristics of the patient, but that certain economic factors also appear to be decisive, which calls for further study and consideration of the context in which the objectives set by the reform are implemented.

Analysis of the Data Involving a Brussels-Based Mobile Crisis Team

It was in 2011 that the mobile crisis team studied within the context of this article (hereafter abbreviated to the 'MCT') entered into service. Like the others active across the territory, it consists of a multidisciplinary team: psychiatrists, psychologists, nurses and social workers work hand-in-hand as part of it. Its primary mission is to provide care, in the short-term, for patients who are in a crisis situation and/or in a psychiatric emergency, who are refusing a priori the care offered and for whom no ambulatory alternative exists. It thus intervenes at the request of third parties (often a relative or another professional) and, if the situation effectively matches their domain and their area of responsibility, they take charge of it for the duration of the crisis and the time necessary to set up longer term follow-up care, should that prove necessary.

But what is a crisis and how is it defined? Some of the criteria are objective; for example related to the psychatric assessment of the condition of the patient. But it is not only a set of personal characteristics of a patient that defines a *crisis situation*. Team members evaluate and discuss various aspects of a situation, which they try to approach in a holistic way. In this regards, many criteria are more subjective and are related to the fact that team members find the situation as a whole worrying or not (for more information about this type of assessment and decision making in situations of psychiatric crisis and/or emergency, see Marquis & Pesesse, 2021). In practical terms, some members of the mobile crisis team go to the patient's accompanied by the person who made the call, to meet him and gather information. They then report on the visit to the rest of the team to decide whether they can provide care or whether they should refer the patient to another service (this is the 'case assessment of the case file' phase that is mentioned in the article).

Since the beginning of its activity, the mobile crisis team has coded data relating to its activities and the patients referred to it. In the first years, it did this on its own initiative, but since 2014, the coding of information has been systematised and reorganised by the *SPF Santé Publique*, which requested to receive this data. Variables were added and methods were coded and organised in drop-down menus to facilitate coding and interpretation, but the system for collecting data within the team remained the same: the nurse in charge of the situation completed the ad hoc paper form, which was then transcribed into an annual Excel file by a volunteer nurse in charge of this task. These files, from 2012 to 2020, were made available to the researcher for analysis. As the pandemic significantly changed the organisation of the mobile crisis team, it was decided to stop at 2020 to limit bias in interpretation. In these files are found quantitative data on the number of requests received each year, the number of them which lead to care provision and the number of them which are referred. In the latter case, the data encoded is less numerous, but it exists nonetheless: it concerns the reasons for this referral and a few details on the socio-medical situation of the patient. During a care provision intervention, information is gathered throughout its duration and is thus more detailed. They bear on the patient's socio-medical characteristics, but also on the medical actions taken during this period, its key dates as well as the clinical handover established at the end of this intervention. In concrete terms, the database inventories information for 1,744 interventions carried out by the mobile team, which took place between January 2012 and February 2020. Out of these interventions, 40.3% involve care provision, 23.6% requests referred after assessment of the case file, and 36.1% immediate referrals (which respectively corresponds to 703, 411 and 630 interventions.

Several operations were required to merge the annual files into a single database. First, the data were pseudonymised. The hospital administrative number, which was the only identifier left when the files were received, could not be kept for ethical reasons. It was therefore replaced by a research-specific

alphanumeric code (e.g. 'P0001'). Secondly, as the variables and conditions had changed slightly over the years, they were harmonised to facilitate analysis. The principle was to retain as much information as possible. For example, the diagnosis 'mood disorder' was coded under this general category until 2015, when more detailed modalities appeared, namely 'mood disorder/manic state', 'mood disorder/depressive state' and 'mood disorder/mixed state'. All of these modalities were encoded in the database to retain as much information as possible, although certain interpretations will group them under the generic modality for greater consistency and precision in longitudinal analyses. Finally, missing values, coding errors and duplicates were checked and corrected to ensure the quality of the database. All these steps were carried out with the help of the nurse who coded the Excel files, which ensured the consistency of the operations carried out and also allowed the researcher to familiarise herself with the database and understand the way in which the information had been coded[2]. The database was then imported into SPSS and analysed independently by the researcher. Initial univariate analyses were used to describe the work of the mobile crisis team, then supplemented by bivariate analyses to provide more detailed explanations. A focus group was then held to present the findings to the mobile crisis team and to refine the interpretation (although this is the sole responsibility of the researcher).

On the *Ambulatory* Character of Healthcare

The Mobile Crisis Team as the Repository of a Large Number of Mental Healthcare Requests

One striking initial finding leaps out immediately when one looks into the MCT's data: this reveals that beyond its primary role, which is to provide ambulatory care for its target demographic, the MCT also carries out important work referring patients (and their relatives) across the mental healthcare network[3] in Brussels. In fact, a little over 4 out of 10 patients sent to the MCT are referred by the team to another of the network's actors, immediately on receiving the request or after the case file has been evaluated. More specifically, the data indicates that 37.4% of the total requests made of the MCT did not meet its care provision criteria: the patient was willing and able to seek care, not in a crisis situation, outside the zone, not in the age bracket, or an ambulatory network was active and available to take charge of the patient, or even no other alternative had been previously attempted. This relatively high percentage raises questions about the access to and the use made of mental healthcare across the territory.

Two hypotheses, widely shared in the literature, may explain the incompatibility between the MCT's criteria and the requests addressed to it. First of all, it is related to the complexity of the local mental healthcare system. In fact, if the landscape of healthcare provision is vast in Brussels, its organisation still remains complex in the eyes of the care providers and professionals in the field, but also in the eyes of the patients (Mistiaen et al., 2019). One of the research studies to have looked at this issue thus summarises the comments gathered from users and the different actors in the field: "The healthcare system is characterised firstly by the existence of a rich and diversified provision of services, but which at times is insufficiently integrated and coordinated, and difficult to access. Its diversity is viewed as a plus, because it enables multiple situations to be responded to in flexible ways. Nevertheless, insufficient collaboration and a lack of readability as regards the supply prevent this richness and diversity being fully made the best use of" (Walker et al., 2019, p.15). It should be noted that, since then, care provision identification and clarification initiatives have been set up[4] and it is to be hoped that they will promptly yield positive results.

The second hypothesis suggests that this difficult situation is compounded by a general saturation of services. The increase in the number of patients seeking mental healthcare has also occurred in Brussels, which has inevitably restricted the places available and brought about a lengthening of the waiting times to access them. The Health Interview Survey, carried out every 4 or 5 years by Sciensano, in 2018 reported a significant increase in the number of people aged 15 and over expressing psychological malaise (the percentage was 32.8% that year, against 30.9% in 2013 and 30.3% in 1997). Moreover, a larger number of people declared themselves to be suffering from depression, whilst this prevalence appeared relatively stable between 1997 and 2008. Whilst these people prove to be less inclined to consult a doctor or a healthcare professional than previously and fewer in number take medication, more of them engage in psychotherapy: that was the case for 42.7% of them in 2018, against 40.5% in 2008 (Gisle et al., 2020). In terms of the saturation of the mental healthcare network, to date

[2] The author would like to express her sincere thanks to this person (whose name cannot be mentioned for ethical reasons) for all the help and time spent on the coding the data.

[3] The concept of a network needs to be clarified in that it is both an emic term, used by both policy makers and carers in their professional practice, and a social science concept used to analyse developments and practices in the world of mental health. In the analyses, the term 'network' is used in its sociological meaning, referring not only to the formal organisation of healthcare in the Brussels area as planned by the reform, but it also refers to the informal contacts and interactions between practitioners and actors of the mental healthcare services (Marquis et al., 2010; Thunus & Lorquet, 2014).

[4] See in particular the directory produced by the Plateforme Bruxelloise pour la Santé Mentale (online: https://santementale.brussels).

few indicators exist to assess its level. Nonetheless, a recent study on this subject involving the ambulatory Brussels-based mental health services (the commonly called the "SSM-CGG") has demonstrated that, between November 2020 and December 2021,[5] these services were obliged to refuse a third of the patients who requested their aid, due to a lack of care capacity (Susswein, 2022).

How do the patients, their relatives and the care providers manage to adequately find their bearings/refer those in need in such a context, marked by the saturation of services and an unreadability of the existing supply? One of the variables encoded by the mobile crisis team opens an interesting avenue, in the absence of a systematic investigation into the rationale for seeking care: it involves 'the sender', a term which designates the person who has recommended the MCT to the person making and supporting the request for intervention. An analysis of it in fact reveals the existence of a significant correlation between the profile of the sender and whether or not the situation is dealt with by the team after the case file has been evaluated or referred elsewhere (cfr. Figure 1).

Thereby, it can be noted that a majority (55.9%) of the patients sent to the MCT on the recommendation of the family or someone close to the person have subsequently been provided with care by the team, whilst 20.4% were referred elsewhere after the case file wasassessed and 23.7% were referred immediately.[6] Taking into consideration all of the patients sent to the MCT on the advice of an ambulatory mental health service, 45.5% were provided with care by the team, 23.6% had their request assessed and then referred elsewhere and 30.9% were referred immediately. Conversely, the people sent to the MCT on the recommendation of certain actors more rarely lead to the provision of care by the team: that is the case when they are sent by a medical specialist (57.5% of these patients are immediately referred and 17.5% are referred after the case file is assessed), by an emergency service (in this case these percentages both come to 40%), or when this sender is unknown or unspecified (here the percentages are respectively 55.9% and 15.7%). Likewise, only 28.6% of the patients are provided with care when they are sent by a residential mental health service and 18.9% when they appear to have played the role of sender. Finally, the percentages of patients referred either after the case file is assessed or immediately are similar to the sample as a whole when they are sent by frontline actors or by a general practitioner. To summarise, the data seems

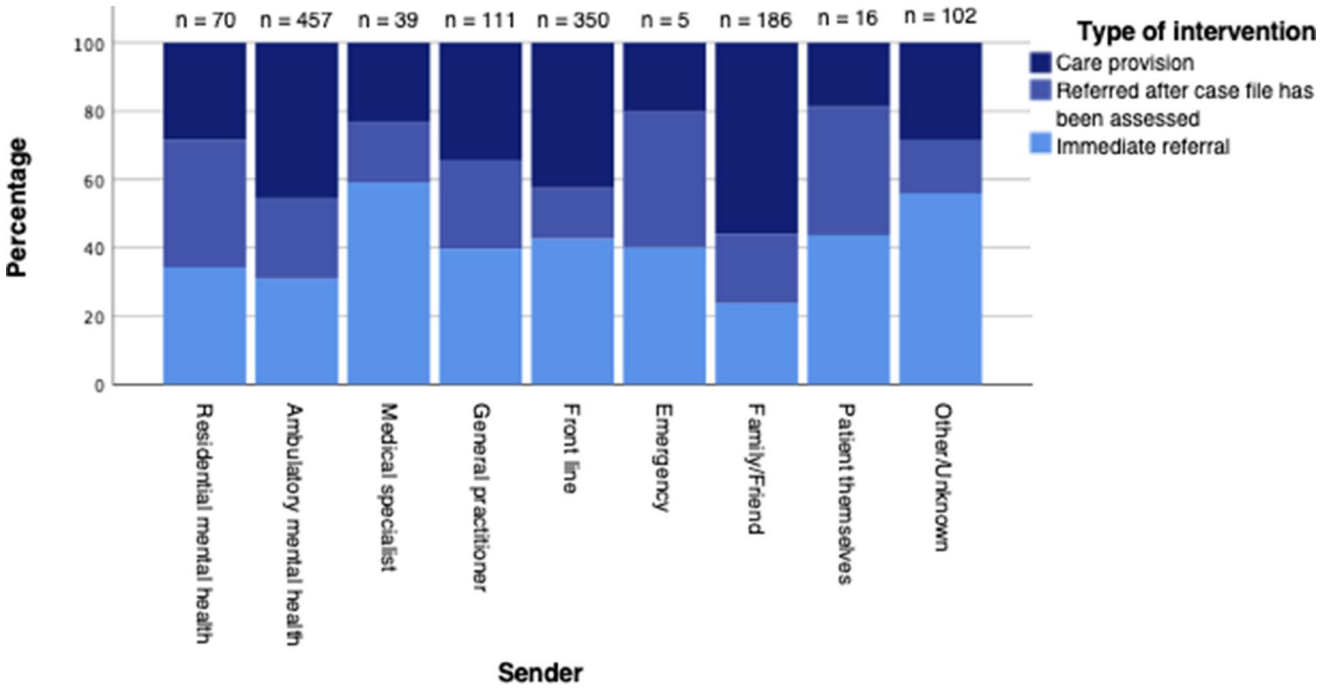

Fig. 1 Type of intervention according to the sender

[5] As the researcher points out, the period studied contains a significant bias, given that it corresponds to a lockdown period following the Covid-19 pandemic. As the mental health services which took part in the study confirm, this period is marked by a reduced number of requests. The results pertaining to the saturation of services is thus underestimated in comparison with the situation when there was no lockdown in place.

[6] As a reminder: in the database the following figures are found: 40.3% provision of care, 23.6% requests referred after the case file has been assessed and 36.1% for immediate referrals.

to indicate differences in rationales and practices in terms of referral in the care network, which would not be without consequences regarding access to it. The data does not however allow possible reasons for this to be identified, and it would consequently be very valuable to investigate them in a more detailed manner.

Short-Term Ambulatory Care… and Next?

Besides this secondary function of referring patients across the Brussels healthcare system, the MCT's primary function is to rapidly provide ambulatory mental healthcare. At the request of a third party, and after a team discussion on whether the situation conforms with its care provision criteria, it travels to patients undergoing a crisis and who are said to be a priori refusing care, and for whom no other alternative exists, to provide care for them temporarily, until the crisis has 'passed' and a new care plan has been established over the longer term. With this in mind, the MCT provides ambulatory care in serious situations for which no other appropriate alternative exists. Through this function, it therefore plays an unprecedented role which seems to address a shortcoming in access to healthcare (Deschietere et al., 2019) and thus meets the expectations which motivated their creation (Service Soins De Santé Psychosociaux, 2010). The interventions it carries out are thus relatively short in comparison with therapeutic pathways and intercede rather as a turning point within these pathways. In other words, the care provided by the mobile crisis team of course constitutes a brief episode in a care pathway, but it also has the function of establishing medical support which will have an aim over the much longer term. Consequently, by analysing the transfer of care to another actor at the end of each of the MCT's interventions it is possible to examine the role played by ambulatory structures in the follow-up to the situations addressed (cfr. Table 1). The data indicates that, after the care intervention of the mobile crisis team, 30.2% of patients are referred to the ambulatory sector and 28.9% are hospitalised (12.1% voluntarily and enforced for 16.8%[7]). For 24.7% of them, a non-identified clinical handover or no transfer of care is established following the MCT providing care. Finally, the other users are referred to another frontline service (medical or otherwise) in 13% of cases and to their usual network in 3.2%.

It can thus be observed that ambulatory services play an important role in the care pathways of the users for whom the MCT is requested, but the data also indicates that hospitalisations remain used to a large extent. According to the reform, they should be restricted to situations where they are 'indispensable', in other words when the patient finds themselves "in a phase so serious that aid in the life environment or at home is temporarily inappropriate" (Service Soins De Santé Psychosociaux, 2010). Without specific clarification as to the realities or parameters which cover this instruction, one might thus suppose that they are essentially of a medical order. Yet, several research studies, carried out in Belgium (Walker et al., 2019) and in similar contexts (for France, see in particular: Sicot, 2019), have revealed hospital stay situations which might not match with the indispensable character, as understood by the reform, and have opened up avenues to explain the still relatively central role played by hospitalisations in psychiatry. The data provided by the mobile crisis team for its part allows one in particular to be discussed: the one which concerns the temporality of access to and/or the use of care. In fact, it is noted that despite a relatively short period of time to assess the case file (the median is 5 days), for 11.7% of the requests made of the MCT and which in the end do not lead to it carrying out a care intervention, this has occurred because the patient has been hospitalised in the meantime. Given this sizable percentage, it could be apposite to study the circumstances governing these situations in such a way as to shed light on the reasons for these hospitalisations, and to establish to what extent they could have (or not) been avoided by the early provision of care. This interrogation is

Table 1 Proportions of the transfer of care established after the mobile crisis team provides car

Support handover after mobile crisis team intervention	%	(n)
Ambulatory Mental Health Care Service	30,27 %	(211)
Voluntary hospitalisation	12,05 %	(84)
Enforced hospitalisation	16,79 %	(117)
Frontline, GP, social worker	13,06 %	(91)
Usual network	3,16 %	(22)
None/other	24,68 %	(172)

[7] Of these enforced hospitalisations, 62.6% were at the request of the MCT's care providers and 23.1% at the request of third parties (other than the patients' family and friends).

all the more relevant, for other reasons as well, owing to the saturation of mental health services in Brussels. In fact, as the difficulties in accessing mental healthcare delay the provision of care, a higher number of situations are managed in a crisis and/or emergency situation. Yet, these acute situations are those which more often than not require intensive treatment, such as hospital stays. This interrogation moreover pertains to the specificity of mental disorders, whose symptoms could impede care being sought, in the same way as the unreadability of the existing offer across the territory. These issues rightly constitute a focal point in Reform 107, which through its primary function encourages more prevention and rapid and early interventions. Access to and the use of care thus indeed seem to constitute possible levers by which to reduce hospitalisations, but they must nevertheless be appropriately established in accordance with the context in ways to be able to react fully and effectively within it.

An Accumulation of Acute Care Interventions

In one of its reports, another mobile crisis team[8] makes a surprising observation as regards institutional stays and their role within therapeutic pathways. In fact, 60% of the patients cared for have already been hospitalised in psychiatry in their lifetime, and for 46% of them this hospitalisation had taken place within the past six months (Janssens & Wauters, 2020). The existence of such a short period of time between two acute interventions is striking and questions the (dis-)continuity of mental healthcare. In Brussels, the coordination of care would at the present time thus appear to remain an obstacle, in particular following hospitalisation. It is all the more so in the case where the patient's situation involves difficulties of several types and requires collaboration between actors from different sectors (Walker et al., 2019). Becoming increasingly common, the combination of social and psychological problems– and their entanglement– is challenging care providers and social workers, who come from different disciplines and do not always have the same perspective as to where the problem lies and what is hoped/advisable for the patient, and who must nevertheless provide care jointly (Borelle, 2017). At the present time, even if the collaboration and the coordination of the various support services are encouraged by the reform and are the subject of discussions during meetings between professionals, they are struggling to genuinely become fully integrated within effective practices. It is therefore not unusual to observe shortcomings in the provision of care or in the continuity of care, where in such cases hospitalisation becomes the 'backup' solution. For example, for certain patients, it can serve as a temporary solution, either in extending the stay until accommodation can be found, or by accumulating stays in one hospital and then another (Walker et al., 2019).

[8] Its mission is similar to the MCT whose data we have analysed, and its conclusion is based on an analysis of seven years of activity (from 2013 to 2019).

On the *Personalisation* of Healthcare

The Definition Given by the Reform

As has already been noted, the 'Reform 107' encourages not only the privileging of ambulatory mental healthcare, but also urges that it is more organised around the patient and with the patient (Service Soins De Santé Psychosociaux, 2010). More specifically, it attributes more agency to the patient than previously in the decisions concerning their care pathway and it encourages care providers to personalise the provision of care. As is true of the ambulatory nature of care, it proves valuable to question the operationalisation of this ambition and to identify how, concretely, the mobile crisis team's care providers 'personalise' the management of care, and what factors are used to base this on.

Beforehand, it is necessary to return to the content of the 'Reform107' and find within it the definition of the personalisation and individualisation of care. This concept occupies a prominent place as its objective, cited in its introduction, targets the 'establishment of individualised therapeutic pathways' (Service Soins De Santé Psychosociaux, 2010). On reading the guide to the reform, it appears that it is the 'appropriate' character of care which truly motivates the importance granted to the patient, to their situation and to their preferences, and leads to the talk of the personalisation of care provision: this must be appropriate to the medical characteristics of the patient, their social environment, and more generally to their capacities/needs for autonomy when social and professional reintegration services are involved. The reasons cited to justify this new consideration of healthcare are multiple. They are based on a rather negative assessment of mental healthcare in Belgium, before the reform and in comparison with the situations of other countries: the requests for mental healthcare are increasing considerably and are becoming more complex, given the entanglement of psychopathological and social problems. Despite the existence of innovative initiatives, in particular in the Brussels region, the capacity of frontline services to accommodate patients remains limited and their referral of patients to specialised bodies remains difficult given their saturation. In addition, Belgium is endowed with a very large number of psychiatric hospital beds, often occupied on a long-term basis by patients only very partially reintegrated into society. Conversely, other European countries, which have already implemented de-institutionalisation procedures and where mental healthcare treatment is essentially

carried out in the community, are seeing good results. The intention expressed in Belgium is thus to initiate these changes in ways which 'optimise' mental healthcare (Service Soins De Santé Psychosociaux, 2010). Therefore, mandating individualised healthcare means that these problems of intake and the organisation of mental healthcare, which do not (or no longer) correspond to the existing demand and must therefore be rethought, can be perfectly addressed. But the personalisation of healthcare can also be considered as the extension of de-hospitalisation, because it is no longer a question of integrating care within the patients' life environment, but of also integrating it within their environment in the broadest sense of the term, within their social situation.

How can a Mobile Crisis Team Personalise the Provision of Care?

Invested in this new vision of care, the mobile crisis teams, such as the one studied in this article, are fully involved and committed to its personalisation. That said, whilst the memorandum issued by the mobile teams working group allows us to round out and more fully specify the role and the missions of these teams, it appears that the conditions and the components of the provision of care which may be personalisable remain not clearly defined. One might therefore wonder what concrete form the individualisation of care actually takes. What are the possible levers available to the care providers to personalise care and, conversely, what are the immutable aspects? Such are the questions which have guided the next part of the analyses and which have enabled a demonstration of how and in what ways the mobile crisis teams constitute a personalised and personalisable measure.

The Mobile Crisis Team: A Personalised Measure

The creation of mobile crisis teams already in itself constitutes an adaptation of the system of mental healthcare in Brussels to the needs of the patients, and more specifically to certain of them, those for whom no alternative exists and for whom seeking care is impeded by the severe psychiatric disorders they suffer from. Faced with these situations, mobility, which characterises these teams, makes possible an in-depth assessment of the patient's material and social environment, as well as the contact with their entourage, and facilitates the personalisation of healthcare. Their mission thus undeniably calls for individualised care provision. Not only because they aim to 'work the request' of the patient in crisis, but also because this is done in collaboration with the local and preexisting healthcare network this patient is in. Consequently, it can be observed that the mobile teams service is perfectly in line with the trend for the personalisation and subjectification of public action described by Cantelli and Genard (2007): "this personalization is, of course, in a certain way rendered possible by the process of the formalisation and proceduralisation of the norm which opens up room for interpretation, which allows for differentiated implementations of a norm. Nonetheless, […], what is striking here, is both that this incursion of subjectivity within public action is claimed and assumed as such, not solely as method or functional requirement (for example, to make possible the application of a norm), but as condition and purpose of the action" (p.30). With this in mind, the adaptable character of these mobile crisis teams underpins not only their structure but also their mission. This in fact aims to provide care for patients in crisis and/or emergency situations, with a particular view to 'working the request' (since the patient is a priori refusing care) and to the patients' social and material environment (Demailly & Dembinski, 2014).

The question which is thus raised concerns the operationalisation of this adaptability and aims to understand, as far as possible, the factors on which it may be brought to bear. If we look more specifically to the provision of care in itself, we thus note that its duration seems to constitute a component of care which is completely suitable for personalisation. In fact, the working group given responsibility for clarifying the mission of the mobile teams points out the following:

> "It is neither possible nor desirable that the mobile teams, from the first contact, stay involved with the users until the end. In this context, it is crucial to refer users to regular care. In the absence of referral, there will never be enough mobile teams. The treatment provided by the mobile team must thus be as short as possible, but as long as necessary. Certain patients of the target demographic require very long support provision, sometimes for life" (Service Soins De Santé Psychosociaux, 2017, p.2).

Expressed in these terms, the duration of the care provision seems to be more dependent on the characteristics related to the situation in which it is given than on strict and predefined criteria. It could, consequently, be subject to individualisation. In its explanation, this adaptable character covers two distinct principles, which are fully discovered in the results presented further on. It concerns, on the one hand, a moral principle which demands the availability of mental healthcare for the users who need it and for whom no other alternative exists, as well as greater attention paid to the patient, their situation and their request (as long as necessary). The reality principle, on the other hand, however obliges the mobile teams to not only distinguish between crisis and chronic situations (in such a way as to divide the interventions and organise their work) but also to rapidly

establish the handover of care, without which they risk no longer being capable of responding to other requests for intervention (as short as possible).

The starting point for the statistical analysis of the MCT's data thus leans on the duration of the care provision, which is encoded for 685 interventions out of the 703 which make up the database. This duration can vary considerably as it ranges from 0 to 379 days, and its mean is of 54 days.[9] Given the presence of extreme values, it is nevertheless preferable to focus on the median, which is established at 40 days. That indicates that half of the care interventions last 40 days or less. More specifically, 25% of the interventions lasts less than 18 days and 75% of the interventions less than 72 days (cfr. Figure 2).

The Personalised Duration of the Mobile Crisis Team's Interventions

Do any of the variables in the database help to explain this wide variation of the care duration? The statistical analyses[10] have demonstrated that six are statistically correlated to the duration of the care intervention and thus influence it significantly (cfr. Figures 3 and 4).

The MCT's care interventions in effect seem longer when the patient suffers from physical comorbidities: the median of their care provision is 49 days, against 35 days for the others, who do not have comorbidities. Furthermore, the data also indicates longer care interventions for patients who live with their parents (median = 47 days) in comparison with the ones who do not (median = 38 days). In addition, the condition of the patient also plays a role in the duration of their care provision. This is shorter when the patient finds themselves in a psychiatric decompensation situation (median = 25 days), in comparison with those in a crisis situation or where the two are combined (both situation have a median of 44 days). This first series of determinants, relative to the situation the patient is in, constitute indicators of its seriousness and urgency. The leeway the mobile crisis team enjoys therefore allows it to adjust the care provision to the situation and the needs of the patient.

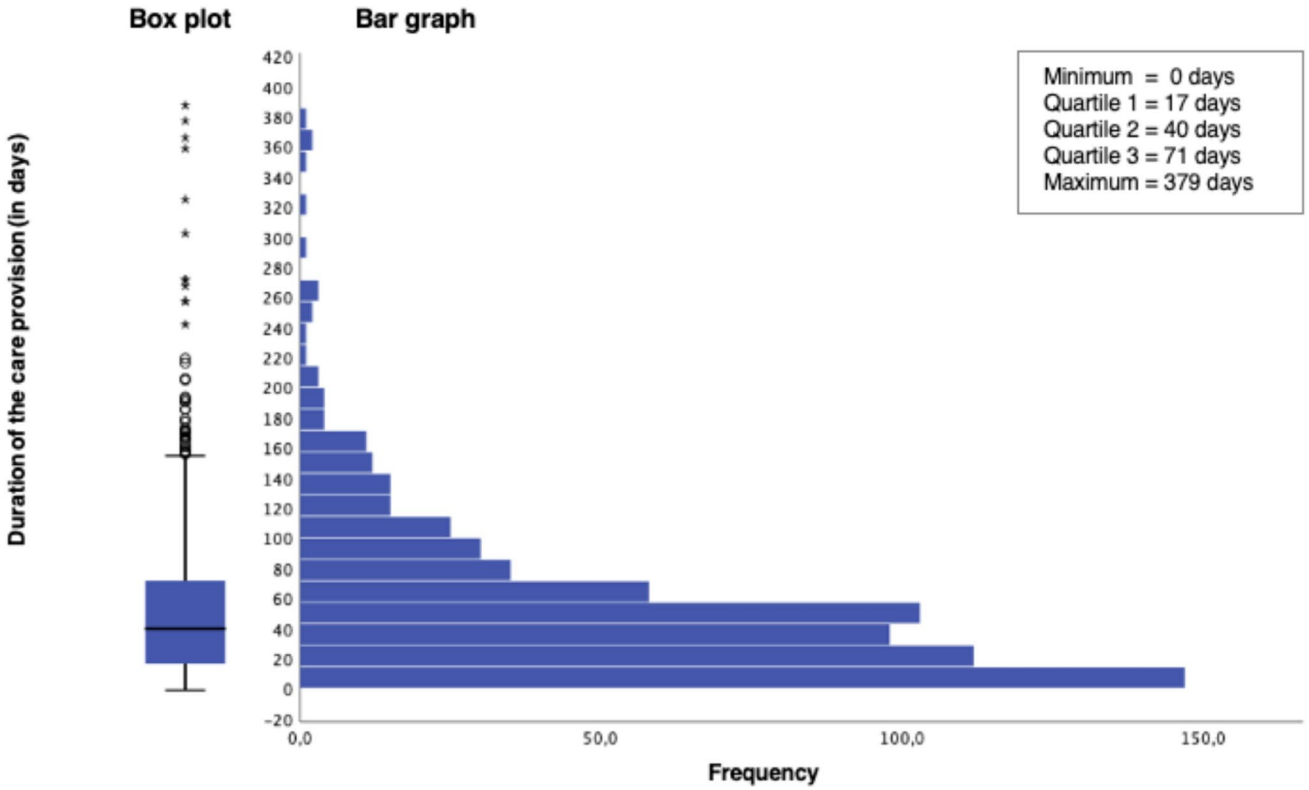

Fig. 2 Duration of the mobile crisis team's care interventions (with indication of the quartiles)

[9] The occasions where care provision lasts for less than a day are few in number (6 out of the 685), and involve situations which are very urgent and/or not very suitable for the MCT, as the data indicates that in the end the patient is hospitalised in two-thirds of the cases (4 situations out of 6).

[10] These statistical analyses are Kruskall-Wallis tests. For each of them the confidence level is established at 95%.

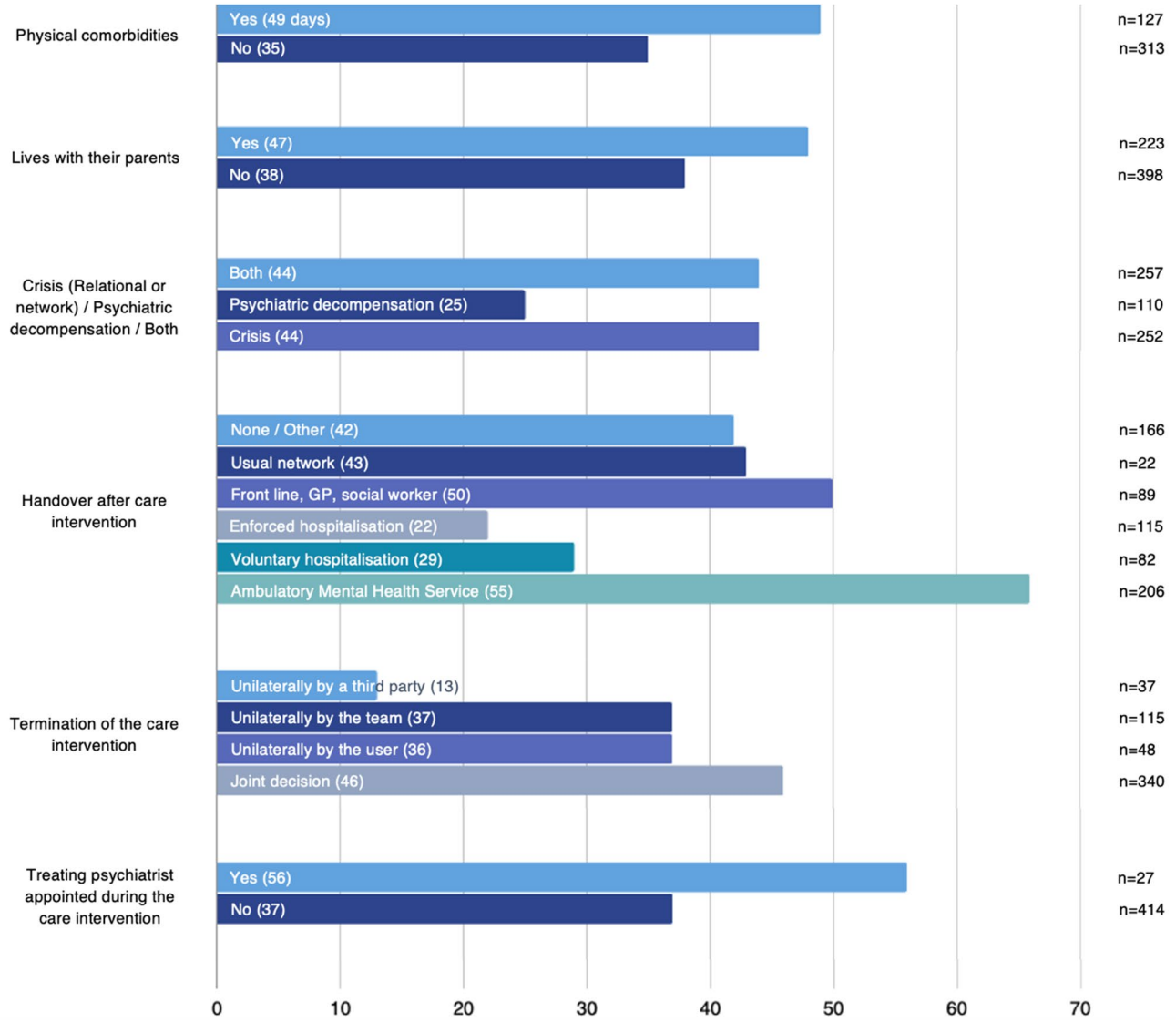

Fig. 3 Median duration of the mobile crisis team's care interventions (in days), depending on certain characteristics connected to the patient and their situation

But if the duration of the interventions could be perceived as a personalisable dimension of care, it must nevertheless be stressed that it at times covers very different realities. In fact, a short provision of care could, on the face of it and in certain cases, indicate a situation dealt with in timely manner and rapidly stabilised, but it could also point to a situation for which care provision more intensive than that given by the mobile crisis team has proven necessary and has thus been implemented as soon as possible. In the same vein, a longer provision of care could reflect a more severe situation, involving sustained intensive care, but it could also result from a care intervention extended owing to difficulties arranging appropriate care handover.

Thus, the variability in the length of the care intervention naturally encourages personalising and ensuring the appropriateness of care to the patients' situation, but it remains undeniably subject to circumstantial constraints, as the following determinants testify. In fact, the data indicates shorter duration of care provided by the MCT when it leads to an enforced hospitalisation (median = 22 days) or voluntary hospitalisation (median = 29 days). On the other hand, it is slightly longer when there is no established handover after the MCT care intervention, or when the handover is the patient's usual network (medians of 42 and 43 days respectively). The longest care interventions were recorded when the handover was a front line service, a general practitioner or a social worker (median = 50 days) or if it is a an ambulatory mental health service (median = 55 days)[11].

[11] For greater clarity, details of the results of the multiple comparisons of this variable are presented in the table in Fig. 4.

	None/Other	Usual network	Front line, GP, social worker	Enforced hospitalisation	Voluntary hospitalisation	Ambulatory Mental Health Service
None/Other						
Usual network	+1					
Front line, GP, social worker	+8	+7				
Enforced hospitalisation	-20 **	-21 *	-28 **			
Voluntary hospitalisation	-13 *	-14	-21 **	+7		
Ambulatory Mental Health Service	+13 **	+12	+5	+33 **	+26 **	

* indicates a 5% significance
** indicate a 5% significance after Bonferroni correction.

Fig. 4 Differences in the median duration of the MCT interventions according to the handover after the care they provide (in days) and significance level of these differences

Furthermore, there can be noted shorter care interventions when they are brought to a halt by a decision taken by a third party (median = 13 days). No significant difference nevertheless exists for the other situations, apart from when the termination is decided jointly, where the durations of the care provision are longer (median = 46 days) than those brought to a halt by a unilateral decision by the team (median = 37 days). Finally, the duration of the intervention provided by the MCT also appears correlated with the appointment of a treating psychiatrist over the course of it. If that is the case, the care provision is in fact longer (median = 56 days) than when it isn't (median = 37 days).

To summarise, the data indicates that the duration of the care provision can vary relatively significantly. Several variables, amongst those which are encoded,[12] lead to it fluctuating. The care interventions thus appear appropriate to the patient's medical situation (crisis and/or emergency condition; the presence or otherwise of comorbidities) and to their living environment (with their parents or otherwise). But it seems that external constraints also have an effect (decisions made by a third party to terminate the care ahead of time; a transfer of care put in place for the continuation of treatment; arranging follow-up by a treating psychiatrist). This finding completely reflects the objective which stipulated that "the treatment provided by the team must therefore be as short as possible but also as long as necessary" (Service Soins De Santé Psychosociaux, 2017, p.2). Thus the duration of an 'appropriate' provision of care is situated at the intersection of these parameters and its definition leans on the assessment and the experience of the care providers, who must thus work with this personalisation directive and its situational constraints. In a context where the healthcare provision available is complex and saturated, and where accessing it and referrals across it remain uncertain and arbitrary (as was outlined in the first part of the article), it seems important to interrogate the way these two conditions drive the care, are balanced and/or affect each other. Consequently, it appears there is justification for fears that the external constraints may have such an influence that they may jeopardise the hoped for objective of the individualisation of healthcare (in other words healthcare first and foremost adapted to the needs and the situation of the patient).

Conclusion

Clearly set forth in the reform's principal objective, the wish to render healthcare ambulatory and personalised has been incorporated in the daily work of the mobile crisis team whose data has been drawn on in this article. The analyses carried out on its basis has first of all enabled an assessment of the role of ambulatory services, on two levels: in the mental healthcare network on the one hand, and within therapeutic pathways on the other. In fact, the number of

[12] It is important to here underline that the list of variables which can lead to significant variations in the durations of the MCT's care interventions is probably not exhaustive, given that they are sourced from data encoded at the request of SPF Santé.

requests which are referred (either immediately or after the case file has been examined) by the mobile crisis team confirms its important work in referring patients across the healthcare network. These results corroborate a finding shared by many: in Brussels, the provision of mental healthcare is scarcely readable and difficult to access. In addition, the data also casts light on the role of the ambulatory sector (and, by extension, that of institutional stays) within therapeutic pathways. Given that we do not have longitudinal data available, only a very short-term analysis is possible (before, during and after the care intervention of a mobile crisis team). Combined with the reading of other studies carried out across Belgium, the results obtained underline the diversity and the important role of ambulatory services in the care pathways of patients, but they also support the hypothesis that a certain number of hospitalisations are the outcome of late access to healthcare or the discontinuity in the assistance and the care, thereby aggravating the situation of the most vulnerable.

Secondly, it is more specifically the individualisation of care which has been questioned in this article, on the basis of the reform's texts, and then the data concerning the mobile crisis team. Emerging from new moral considerations of 'good care' and the role of the patient in it, it seems that this personalisation in addition enables an appropriate response to the evolution of the needs and requests for care in mental health which has been ongoing for several years now (a rise in the requests for interventions, an expanding of the field of psychiatry to mental health, complexification and entanglement of social and mental problems, etc.). More concretely, in the context of mobile crisis teams, we can first of all suggest that the measure in itself embodies this desire for the individualisation of the provision of care, given that its conception and its organisation have been thought through so as to provide care at home, for patients who find themselves in relatively heterogenous situations (medical and social). Furthermore, the analyses produced on the basis of the data encoded by the mobile crisis team indicate that the duration of care interventions seems to constitute a dimension which is completely suitable for personalisation. This duration proves to be shaped on the one hand by the personal characteristics of the patient, and on the other by situational constraints. It is nonetheless important to underline the limited scope of these results, taking into account the multiple and complex realities they cover. The duration of the provision of care, it is true, seems to be a tangible indicator of the personalization of care, enabling the bringing to light of correlations with certain characteristics for which the MCT encodes data and the duration of interventions, but it does not for all that provide an exhaustive picture. We would in fact require more variables (quantitative and qualitative) to be able to identify the ensemble of dimensions care providers could refer to as a means of personalising their interventions.

These results are mainly in line with research carried out in other European countries on the establishment of mobile crisis teams: they contribute to deinstitutionalisation by avoiding a series of hospitalisations thanks to the acute care they provide (Killaspy et al., 2018). However, while cost-effectiveness analyses focus mainly on evaluating the care interventions as such, the relational context in which these teams are deployed should not be ignored. Their work relies heavily on the network, whether in terms of patients referred to them by colleagues in other services or by relatives who have no other alternative in the area, or in terms of coordinating the actors in the patient's care network who are mobilised to ensure that the patient receives long-term care in the community. In Brussels, the diversity and the plurality of healthcare measures, principally ambulatory, constitute a rich resource for the smooth implementation of the reform and of its objectives. Nonetheless, the fact that they exist in a context consisting of a lack of general awareness and the issues of gaining access to them may produce several adverse effects, similar to those which several researchers have observed in comparable contexts. As Sicot (2019) has pointed out: "To describe a local care provision system, you need to take into account the characteristics of the actors operating within this system: their missions, the accreditations, the geographical zones they cover, their funding models, etc. But the system is above all relational practices: it is therefore less about the supply strictly speaking, but the uses which are made of the services available by the ensemble of actors. It is conventions, informal agreements, habits of collaborative working, turf wars, practices related to the referral, selecting and screening of patients; a 'system of exchange', of gift/counter-gift, reputations, 'care provider networks', etc" (p.22). In this conclusion, it therefore seems important to first emphasize the need to take into account and value the contexts of implementation when developing and studying this type of reform, in order to gain a better understanding of the possible discrepancy between the normative ideals conveyed by the reform and its actual effects. With this in mind, the analysis of the mobile crisis team's data has enabled an evaluation of the operationalisation of the reform's two central pillars and, thanks to the important role this service has in the referral of patients across the Brussels health network, it has also enabled these results to be connected to those of other research studies carried out on the same territory. In this way, this article hopes to be able to contribute fully to the preliminary sketches of the outline of Brussels mental healthcare system (emergency and crisis) and to open up several avenues of questions concerning the ways certain actors could make full use of it (late recourse to care, complex referrals in the healthcare

offer, more or less clear patient referral rationales, etc.). Without however being able to claim an exhaustive description of mental healthcare practices in Belgium, nor even in Brussels, so vast and complex is this field, the second aim of this conclusion is to encourage the development of more valid and relevant data collection tools to support more in-depth research on this topic.

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Declarations

Ethics Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Ethics approval for this retrospective study has been given by the Ethics Committee of UCLouvain. Exemption of informed consent has been authorized regarding the potential risk of remembering traumatic event in psychiatric patients and their relatives, and the format of the data collected. This article does not contain any studies with animals.

Competing Interests The author has no competing interests to declare that are relevant to the content of this article.

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