Mental Healthcare Reform in Belgium: a qualitative study with mobile teams

by

Eleni Alevanti

PhD Thesis

Faculty of Health, Education and Life Sciences
Birmingham City University

March 2020

[This page intentionally left blank]

Abstract

The Belgian mental healthcare reform is located between the current mostly residential models of delivery, and the first line care as well as ‘ambulatory’ mental healthcare. The implementation of a novel function through new community mobile services and interventions aims to bridge the gap, while also offering care alternatives.

The presented research is a qualitative study of four such new mobile projects, each with one participating “2A” team and one “2B” team i.e. for acute and long-term care respectively. Their main goal is to maintain people in their home environment and within their social fabric, offering supportive, individual and flexible therapeutic interventions through multi-disciplinary networks.

After an initial observation of the teams, a set of intensive semi-structured interviews were carried out, followed by a second observation period. Drawing upon and developing critical social theories, the interviews and observations were analysed using a constructivist grounded theory method. This was underlined by a methodology using a Foucauldian and social justice lens, including experiential knowledge literature to examine mental healthcare constructs. Concepts of confluence and social navigation allowed this analysis to focus on the way different contested categories in mental health are shared; on how they are part of the same field and in effect are confluent through their differences.

The analysis presented reflects the process of inquiry. Firstly, a presentation of the data collected through the interviews uses three levels: (i) team working, (ii) working with other services and (iii) working within a wider context. Using those levels and taking into consideration the second observation with the teams four subcategories are explored: existing in ‘time’, making use(s) of ‘space’, carrying ‘memory’ and (up)holding (on to) ‘value(s)’. These in turn, set the basis for two central categories: forming ‘relationships’ as well as borrowing words and diffusing ‘language’.

The analysis reveals a series of emerging paradoxes through the subcategories and central categories, borne out of the disparities in the content between the interviews and the direct observations. In an original way these paradoxes reflect contested meanings present within the wider field of mental health and psychiatry. Located on social justice principles, a set of possibilities is examined at the end of this work, further exploring these paradoxes in practice, which may in fact prove to be important opportunities for navigating the future of mental healthcare.

[This page intentionally left blank]

Acknowledgements

It is difficult to know when this piece of work started and where to begin giving thanks for the support that made it possible. To be exhaustive would be impossible since it would mean to include all the personal and intellectual encounters from the very beginning of my life.
The content of this thesis has been nourished by innumerable and ephemeral moments. I therefore humbly ask to be excused for the absence of numerous mentions that would have been justified.

In any case, I give thanks

To my father, for setting me on this path to thinking critically, always alert yet unassuming, for all his help, both practical and intellectual
To my mother, ever present in her own, unique way
To my sister, Angeliki, always welcoming regardless of the chaos
To my brothers, Manoli and Giorgo, whom despite circumstance, I always carry with me
To Vanessa, my sister, my own
To Raphaël, my red sun, my promise

To Dafni Kioussi, for her presence, her strong ethics, for her daring hope
To Hara Kaminara, for her patience, her trust, her few words
To Vaggelis Papastefanou, for those moments of needed respite, for the sounds and the drinks
To Joachim Ben Yakoub, for the motion and emotion
To Jonathan Gadsby, without whom this work would not have been and to the Gadsby family, whose home was always open

To Patrick Van der Jeugt, for the history, for the ideals
To the translators and interpreters, Jolien Smet and Julie de Smet, for making this work complete
To the participants of this study, for their time and the insights they gifted me
To the service-users I met, who opened their homes, who shared their time and their stories
To Sarah Ben Yakoub, for her voice, ever louder, even when there were no words
To Charly Sibille, who listened even when it became hard to hear

To Nikos Petridis, to whom only silence could do justice

To Mervyn Morris, for every single step of this journey
for your unequivocal faith, your unyielding trust, your patient serenity, your gentle guidance
for holding space, for the freedom and for possibility, always

In all, there were three things:
the certainty one is always beginning
the certainty one must go further
and the certainty that one will be interrupted before finishing.

From the interruptions, to make a new path,
from falling, a dance step,
from fear, a ladder,
from dream, a bridge,
from search,…the encounter

Fernando Pessoa

Contents

Abstract 3

Acknowledgements 5

Contents 7

Prologue 15

Part I: Setting the Scene 19

- Chapter 1: Introduction to the study 21
  - Introduction to Chapter 1 21
  - Belgium’s history 21
    - Population 22
    - Economic and social changes 23
    - Language(s) 24
  - Health and Social Care 25
  - Mental Healthcare 26
    - History 26
    - Regional Differences 27
    - Reforming Mental Healthcare Internationally 28
    - International Evidence and Fidelity Criteria 30
  - The ‘107’ Mental Healthcare Reform 31
    - The ‘107’ Five Function Model 33
    - Mobile Team Guidelines 36
  - The Research 37
    - Participating projects 39
      - Brussels: HERMESplus 39
      - Wallonia: Région du Centre 41
      - Ghent: PAKT 41
      - Central-West Flanders: PRIT 42
    - Research Questions 42
      - Beyond ‘evidence-based practice’ 44
- Chapter 2: Methodology 47
  - Introduction to Chapter 2 47
  - Constructivism 47
  - Foucault: Power and Knowledge in Mental Health 49
    - Archaeology and Genealogy 50

    From Biopower to Governmentality ... 50
    Biopolitics ... 51
    Governmentality and Pastoral Power ... 52
    Neoliberal Governmentality ... 53
    History of Madness ... 54
  Social Justice in Mental Health ... 55
    Social Justice and Constructivist Grounded Theory ... 56
  Confluence and Social Navigation ... 58
    Social Navigation ... 59
  ‘Knowledge(s)’ in mental health ... 60
    Biopsychosocial model ... 60
    Diagnostic Systems ... 61
    Experiential Knowledge ... 62
  De-institutionalisation ... 64
  Terminology ... 65
  Grounded Theory ... 65
    Constructivist Grounded Theory ... 67
    Rationale and Selection ... 68
    Grounded Theory Ethnography ... 69
  The Researcher ... 69
    Locating the Self as the Researcher ... 70
Chapter 3: Method ... 73
  Introduction to Chapter 3 ... 73
  Project selection ... 74
  Ethical Considerations and Approval ... 74
  Witnessing: Observations ... 75
  Federal and In-project Outcome Data ... 77
  ‘Expert’ Involvement and Intervention ... 77
  The Interviews ... 78
    The Questionnaire ... 79
    The Participants ... 79
    Intensive Interview Structure ... 82
    The language(s) ... 87
  Constructivist Grounded Theory Analysis ... 88
Chapter 4: The Projects ... 93
  Introduction to Chapter 4 ... 93

Witnessing: First observation 93
The Projects 94
  Brussels: HERMESplus 94
    2A team: TANDEMplus 94
    2B team: Antonin Artaud 96
  Wallonia: Région du Centre 98
    2A Team: Emc² 99
    2A/2B Collaboration 100
  Ghent: PAKT 102
    2A team: Mobiele Crisis Team (MCT) 102
    2B Team: MOBiLteam North 104
  Central-West Flanders: PRIT 105
    2A/2B Collaboration 105
    2A: MTA 106
    2B: MTL 107
Part II: Analysis 109
Chapter 5: Categorical Levels – Presenting the Data 111
Introduction to Chapter 5 111
Level I: Working in a Team - Team Work 112
  Working With/For a Population: 112
  Working in a Particular Way - Intervention Models and Organisation 113
  Working in a Team - Disciplines and Hierarchies, Working Together 115
  2A/2B/PZT-SPAD differentiation and collaboration 117
  Ideal 118
Level II: Working with other services 120
  Working with mental health services 120
  Working with Hospital 121
  Ambulatory Teams and Other Mental Health Services 124
  Working with Other (Non-Mental Health) Services: 125
  Working Within Professional (107) Networks 126
  Ideal 128
Level III: Working Within a Wider Context 132
  Geo-Political Area 133
  107 context 134
  Comparing with Other Contexts 135
  Wider Socio-Political Context 135

    - Ideal 137
  - The interviewing process: transient, personal views 138
  - Language and Linguistic Differences: French and Dutch/Flemish 139
    - French Glossary of Terms 139
    - Dutch/Flemish Glossary of Terms 140
  - Conclusion 141
- Chapter 6: Subcategories – Making sense of the data 143
  - Introduction to Chapter 6 143
  - Witnessing: Second Observation Period 144
    - Second Observation Method 146
  - Subcategories 148
    - Existing in time 148
      - Level I: Team work 148
      - Level II: Working with other services 151
      - Level III: Working within a wider context 152
    - Making use(s) of space 153
      - Level I: Team work 153
      - Level II: Working with other services 156
      - Level III: Working within a wider context 157
    - Carrying memory 158
      - Level I: Team work 158
      - Level II: Working with other services 160
      - Level III: Working within a wider context 161
    - (Up)holding (on) to value(s) 162
      - Level I: Team work 162
      - Level II: Working with other services 167
      - Level III: Working within a wider context 170
  - Conclusion 172
- Chapter 7: Central Categories – Theory Building 173
  - Introduction to Chapter 7 173
  - (Being a) witness(ing) 174
    - Two Stories 176
  - Forming relationships 179
    - Level I: Team work 180
    - Level II: Working with other services 185
    - Level III: Working within a wider context 188

Borrowing Words and Diffusing Language 189
Level I: Team work 190
Level II: Working with other services 197
Level III: Working within a wider context 201
Conclusion 203
Part III: Navigating Paradox 207
Chapter 8: Discussion - Emerging Paradoxes 209
Introduction to Chapter 8 209
The 107 paradox(es) 210
Social fact 210
Social control practices 212
Deinstitutionalisation 215
‘New’ practices, same paradoxes 216
(Re)established hierarchies 219
(Re)creating the “other” 221
Confluence 222
Social Navigation 223
Politics and possibilities 225
Chapter 9: Paradoxical Possibilities 227
Introduction to Chapter 9 227
Dissensus 229
Narratives 230
Recovery 231
Person-Centred Care 235
Peer Support 237
‘Madness’ in the community 239
Values in practice 240
Rights-based approach 242
Resistance 245
Epilogue 249
References 253
Appendices 273
Appendix A: Legal procedures used in mental health 275
Appendix A.1: Treating Medical Bodies 275
Appendix A.2: ‘Professional Secret’ 275
Appendix A.3: Administrative Trustee 276

  - Appendix A.4: ‘Placement under Observation’ (Forced Admission Procedure) 276
  - Appendix A.5: ‘Retention Measure’ 278
  - Appendix A.6: European Models 278
  - Appendix A.7: The ‘107’ Five Function Model 281
- Appendix B: Statistics 283
- Appendix C: First Observation Checklist 285
- Appendix D: Interview Questions 286
- Appendix E: Participant Information and Consent Forms 289
  - Appendix E.1: French Participant Information and Consent Form 289
  - Appendix E.2: Dutch/Flemish Participant Information and Consent Form 295
- Appendix F: BCU Ethical Approval 301
- Appendix G: UGent Ethical Approval 302

List of Tables and Figures

Table 1. Number of Participants Interviewed for Each Project, Including Interview Duration 81

Figure 1. ‘107’ Five Function Map (Service Soins de Santé Psychosociaux, 2010 35
Figure 2. Map of Belgium with Projects’ Locations 40
Figure 3.1 The Analytical Process 91
Figure 3.2 The Analytical Process: Categorical Levels 112
Figure 3.3 The Analytical Process: Subcategories 148
Figure 3.4 The Analytical Process: Central Categories 174

List of Acronyms and Abbreviations

***“A” beds*:**	Beds for short term hospital stays established in Belgium in the 1970s
ACT/AOT:	Assertive Outreach Teams and/or Assertive Community Teams (UK model; appendix A.6)
“Bemoeizorg”:	Meddling, ‘intrusive’, interfering care, part of the FACT-model of care (appendix A.6).
CAW:	Centre for General Welfare Work (Centrum Algemeen Welzijnswerk)
CGG:	Mental Health Centres (Centrum Geestelijke Gezondheidszorg)
CMHT:	Community Mental Health Teams (UK model; appendix A.6)
CRHT:	Crisis Resolution Home Treatment Teams (UK model; see appendix A.6)
CTOs:	Community Treatment Orders used in the UK (see appendix A.5)
DSM-5:	Diagnostic and Statistical Manual.
FACT:	Netherlands Flexible Assertive Community Treatment (appendix A.6)
***FACT board*:**	People assigned to the board are deemed to require intensive care (appendix A.6)
FG:	Focus group
Guidance Centres:	Walloon ambulatory structures, later become mental health services/centres
ICD-10:	International Classification of Diseases.
INAMI/RIZIV:	Belgian National Institute of Disability Health Insurance or Institut national d’assurance maladie-invalidité for French-speaking regions and Rijksinstituut voor ziekte-en invaliditeitsverzekering for Flemish-speaking territories (p24).
***107 reform (one-o-seven)*:**	Belgian mental health care reform born out of ‘article 107’ (see p29)
***PZT*:**	Psychiatric Care teams At Home, Psychiatrische Zorg Thuis for Flemish speakers (SPAD is the French-speaking equivalent)
***SPAD*:**	Psychiatric Care teams At Home Soins Psychiatriques pour personnes séjournant A Domicile for French speakers (PZT for Flemish speakers)
SSM/CSM:	Mental Health Services (Services de Santé Mentale) and Mental Health Centres (Centre de Santé Mentale)
***“T” beds*:**	Beds for long term hospital stays established in Belgium in the 1970s
2A teams:	Short-term intervention multidisciplinary teams for people experiencing a ‘crisis’
***2B teams*:**	Long term intervention multidisciplinary teams for people presenting “chronic mental difficulties” and/or “severe psychiatric illness”, with complex needs.
UPSIE:	University Hospital Psychiatric Rapid Response Unit or Universitaire Psychiatrische Spoed Interventie Eenheid, a closed short-term ward

[This page intentionally left blank]

Prologue

This work started as a piece of critical exploration which was to concentrate on the different ways community mental healthcare models were adapted and adopted by mobile teams as part of a deinstitutionalisation reform process in Belgium (generally known as the “107 reform”). However, this type of research inevitably tends to omit the broader social and political questions concerning the context in which a study is being undertaken. Many explanations have been given to the processes of mental healthcare reform from the point of view of social policy changes, new drugs and economic theories amongst others (Prior, 1993). However, all these explanations omit any substantial reference to movements within psychiatry itself and, in particular, to the ways in which psychiatric professionals such as nurses, social workers, occupational therapists and psychologists as well as psychiatrists, essentially (re)define, or not, the social construction of ‘mental illness’ in their given structures. The main focus of this work became what that (re)definition involved, how it occurred and how it was represented through the work of psychiatric professionals in mobile community teams.

It has been suggested that people wishing to undertake doctoral study need to find a topic which ‘inspires’ them (Birks and Mills, 2011). In my case, this research was a revelation, as much about methodology and the ways we choose to look at and study our world, as it was about the Belgian mental healthcare reform. This study is not a neutral act, nor did I set out on this PhD journey ‘uninitiated’ (Charmaz, 2005:510). In fact, I don’t pretend, nor aim for neutrality or objectivity. In this way, there could have been many ways to look at mobile community work and the ways in which mental healthcare systems operate. However, I chose various yet particular tools (as much as they chose me) in order to construct a specific lens which was used for this study.

As a freshly graduated mental health professional, with some experience within services, I found out very quickly how certain paradoxes were inevitable in practice. Throughout my years in services on both sides of the fence (between professional and ‘beneficiary’; p69) and in different (albeit mainly low) levels of professional practice, I became aware of the well-established hierarchies that were in place. Although omnipresent, they were seldom discussed and I repeatedly became a witness to the (often devastating) results. A few months before embarking on this PhD journey, whilst still working as a mental health professional, a service-user I intermittently had encountered killed themselves. This person had ‘passed’ all the protocols, including the manualised semi-structured interviews measuring suicidal risk. They had been offered an evaluated and ‘evidenced based care’ with different teams and professionals supporting them. Through this exercise of ‘care’, little to no signs of risk were detected; the service-user was said to have strong “protecting factors” despite their complicated experiences both personally and within their context. Yet despite access to professional input, despite the “resources” and “expertise” provided, they were found dead around midday in their home in the most ordinary of settings, if one may go so far to say under such circumstances.

This event was a shock to the system, it was a shock to my system and increased my disillusionment of a care practice that was paradoxical in ways I had not expected. This incident, which followed others (perhaps less shocking) before it, served as yet another example and made my frustrations and the culmination of unanswered questions difficult to ignore any longer. Why had such a tightly knit system, based on supposed ‘evidence-based models’, practiced by experienced professionals failed so lethally? All those boxes checked, models and their fidelity criteria evaluated, clinical notes carefully coded, thoughts and opinions shared during team meetings, structured home visits and interventions offered, yet here we all were, my colleagues and I, sharing our disbelief and our condolences.

The idea of bearing witness became central throughout this PhD journey, including in hindsight of previous experiences within the field of mental healthcare (as seen in the example above). As Charmaz writes “a journey begins before the travellers depart” (2006:1). I didn’t start out as a neutral witness: based on past experiences and interactions I had come into contact with the field of study in various settings and from different positions and angles. Nor did I become one during the research process, since being a researcher itself is (as argued above) far from neutral. Rather, my own position was questioned, reflected on and challenged, constantly re-evaluated and further ‘amplified’ by the studied ground. As a researcher, I took on the position of ‘witness’ and far from a static act I became part of the process of ‘witness-ing’.

Whilst nearing the end of this PhD, somebody asked me how the experience was of “going down the rabbit hole”. I found their question difficult to answer realising that even the initial convictions I perhaps held about practice had all been systematically deconstructed. When starting on this journey, my previous experience in the mental health field, both personally and professionally, had made me feel fragmented. This PhD was an opportunity to navigate those fragments, put the pieces back together, without the need for a given, established and constraining certainty. In the end, I found no single, liberating and fixed reality but rather different ways in which we construct our world and in turn (try to) navigate it. Ultimately, we become complicit to and with a system, even if we choose to renounce it. Acts and positions exist in relation to others; views are always dependent on where one is standing.

The word ‘thesis’ can be defined as a ‘sustained argument’ (Birks and Mills, 2011). However, I hope that this thesis and resulting argument does not become a given and final interpretation but rather an invitation for dialogue. The essence of this work has been its process of deconstructing customary notions, much like Aristotle's 'endoxa' (accepted wisdoms), to show that they are in fact 'paradoxa' (Smith and Lewis, 2011). Just as the Occupy Wall Street activists replied when asked what their demands were, here too, "the process is the message" (Sheridan, 2011 quoted by Hoffman, 2011). Through this process, the reader is invited to critique established constructs within western society and specifically surrounding mental health and illness, to question hierarchies and systems of knowledge and how they can be changed, to reflect on ways in which social justice can be promoted and applied, all while trusting and navigating the process itself.

The idea of studying the process of deinstitutionalisation while it was being implemented was introduced in the early stages of the reform by some of the people involved in its shaping. With models and tools developed in other countries, the Belgian context was an opportunity to use an academic and qualitative lens to explore such a process as it was happening. Evidenced models of intervention were offered as the main basis for the reform and the study originally aimed to examine their implementation within the Belgian context. The scope of the study widened however, to include the contextual elements and wider socio-political aspects incremental in grasping such a complex process as a deinstitutionalisation reform. Moving beyond customary notions of "evidence-based practice", questions arose about the roles of professionals and their interaction with the fundamental but also practical approaches within their work and the larger mental health system.

The thesis is formulated in three main parts. The first includes the introduction, followed by the methodology constructed for the study and its method. A brief overview to the four participating projects is then presented. The second part of this work concentrates on the analysis of the data gathered through direct observations with mobile community teams and interviews with the professionals. The third and final part includes a discussion of the analysis, followed by the last chapter of this work which take a reflective look at existing possibilities for change.

> Any real change implies the breakup of the world as one has always known it, the loss of all that gave one an identity, the end of safety. And at such a moment, unable to see and not daring to imagine what the future will now bring forth, one clings to what one knew, or dreamed that one possessed. Yet, it is only when a man is able, without bitterness or self-pity, to surrender a dream he has long cherished or a privilege he has long possessed that he is set free — he has set himself free — for higher dreams, for greater privileges (Baldwin, 1961/1993:82).

[This page intentionally left blank]

Part I: Setting the Scene

[This page intentionally left blank]

Chapter 1:
Introduction to the study

Introduction to Chapter 1

This first chapter will set the context of the mental healthcare reform as well as of the present study of it. Firstly, Belgium's history is presented followed by an explanation of modern-day Belgium including its health, social and mental healthcare institutions. The mental health reform currently under way is presented as well as how it is situated within the international movement towards care in the community (WHO, 2001; 2002; 2008), including the European Community models which became important in its shaping. The reform's most novel function ('function 2'), which will also be the main focus of this study and involves the development of mobile mental healthcare teams, is introduced followed by the participating projects and their contexts. Finally, the questions and aims as well as the emerging methodological framework in which this study was conceptualised and carried out are introduced. This chapter will therefore present the socio-political context for this study. As such it is somewhat different from the content that follows but nonetheless imperative in describing the setting in which this research took place.

Belgium's history

"What people do and say, […] is always circumscribed by time, place and socio-historical context" (Prior 1993:2) and, as will be seen throughout this work, "a historical consideration, an appreciation of the temporal" became an important focus (Joseph, 2015:17). A country that has always been polarised on matters of politics, Belgium has in recent decades faced new divisions due to its differences in language and the unequal economic development across its regions, factors which impacted the mental health reform and this study (Witte, Craeybeckx and Meynen, 2010).

Belgium is made up of three separate regions Brussels-Capital, Flanders and Wallonia, and three communities, based on its three national languages: French, Dutch (Flemish) and German. The Flanders region is situated in the north of the country and is Dutch-speaking while Wallonia in the south is French-speaking. The Brussels-Capital region is bilingual. As for the German community, it is rather small and exists in the eastern part of Wallonia, near Germany. Belgium's linguistic diversity and related political conflicts are reflected in its political history and complex system of governance.

The following brief presentation of Belgium is based on a thematic approach. The themes include the *economic and social changes,* the *population* and the *language(s)* divide. Each is analysed through the concepts of politics and power, both of which became central during this study (as will be explored in the following chapter). The premise is that political events are closely associated with the impact of power. This account of history is deliberately presented in this way, in order to connect with the contents of the whole thesis, which, as will be explored, is heavily based on Foucauldian notions of power and knowledge as well as social justice ideas (p47-56). This chapter is therefore a way of 'setting the scene' for the present study.

Population

Throughout history, Belgium has been both a cosmopolitan centre of trade and culture as well as a major battleground between the main European powers. The Belgian Revolution in 1830 gave rise to an independent, French-speaking Belgium mainly formed by catholic powers and the bourgeois class. It sought to be neutral after historically being invaded by its powerful neighbours. Belgium is a constitutional monarchy and parliamentary democracy, with a laicist constitution based on the Napoleonic code (Cook, 2002).

Today, the Belgian territory is still divided in three Regions (Service Public Fédéral Belge, 2019a). The total population of Belgium is a little over 11 million (Eurostat, 2018) with more than 95% located in urban areas. Around 6% of the population are citizens of the European Union Member States, while nearly 13% originate from non-EU countries. It is estimated that around 25% of the total population are descendants or people with a foreign background, most from European ancestry and many from Morocco, Turkey and the Democratic Republic of Congo (Myria, 2015). The diversity in population reflects the economic and social changes, heavily influenced by the country's colonial past as well as its recent industrial power, which saw massive waves of migration from its colonies to Belgium. Furthermore, many Europeans made the capital their home, following the establishment of European institutions in Brussels (although they do not always adopt the Belgian nationality; Myria, 2015).

Throughout this work I met many different people, from policy makers to professionals and service-users. Each represented different aspects and layers of Belgium's complex and decentralised regional system within a federalist social reality. For example, in Flanders, I visited a house with animal-skin rugs and ornaments, the residents of which each owned a car. In Ghent, I visited a cul-de-sac with small terraced houses, previously inhabited by working class families, now home to young alternative communities. In Brussels, I met people who were homeless, Congolese and North African immigrants as well as university graduates, now employees of multinational companies. In Wallonia, I came across people living below the breadline, often lacking the bare necessities as well as many first and second-generation workers from various European, eastern European and African countries, all carrying symbols of the past.

Economic and social changes

The Industrial Revolution hit Belgium in the early 19th century, ahead of its European neighbours. The Walloon region rapidly developed its mining and steelmaking industries which thrived well until the mid-20th century while the Flanders textile industry underwent a severe crisis further deepened by famine. With the end of World War II, the Flemish cities of Ghent and Antwerp expanded their industries. The 1970s oil crises caused the country's economy to go into recession which was particularly lengthy in Wallonia, its steel industry in severe decline by then. The country's economy continued to shift northwards and it is now concentrated in the so-called "Flemish Diamond area" which includes the cities of Antwerp, Brussels, Ghent and Leuven and is one of the wealthiest regions in Europe (Witte, et al., 2010).

Belgium's history as well as its economy is very much associated with its colonies, the most important of which was the Congo. Originally, the "Free Congo" was entirely conceded to King Leopold II and was recognised as his private possession, which he used primarily as a source of revenue. As a result, concern grew internationally due to the extreme and savage treatment of the Congolese population. An estimated 10 million people were killed (Cook, 2002; Witte, et al., 2010). Today's Belgian population very much reflects its colonial past. However, the collective and national memory, despite many movements by academics and concerned citizens, frequently omits the important and tragic details of this past (De Witte, 2002).

Due to its geographical position, Belgium has a policy of mediation and has been an advocate of European integration with the aim historically to avoid being subjugated to more powerful neighbours. As a result, the country played an important role in both World Wars and went on to become one of the founding members of the European Union. Today, the capital hosts major institutions, including the European Commission, the Council of the European Union and the European Parliament as well as the NATO headquarters (Witte, et al., 2010). Although an important player in European and international affairs, Belgium is also a haven for tax, foreign holdings and arms deals (Duquet, 2015; Meers, 2018).

Being in the centre of a highly industrialised region Belgium has become one the largest trading nations trading raw materials, chemicals, raw diamonds and pharmaceuticals amongst others. However, the economy has been and continues to be very unequal across and within its regions. At present, unemployment rates in Wallonia are over double those in Flanders (Statbel, 2018). This divide has contributed in tensions between the regions which have further fed into the existing language divide (Witte, et al., 2010). As a result, pro-independence movements have gained in popularity in

Flanders, with the nationalist and separatist N-VA currently standing as one of the largest parties in the region (along with the Flemish Christian-Democratic Party; RTBF, 2018).

Language(s)

As mentioned, Belgium has three official languages: Dutch, French and German. There is no official data regarding distribution or usage of the official languages or their dialects (de Witte, 1992). An estimated 60% of the Belgian population speaks Dutch (over 6 million) and is mainly concentrated in the north of Belgium, while French is spoken by 40% of the population (over 3 million) and is based in Wallonia. Just under a million French-speakers are based in the bilingual Brussels-Capital region. Both Belgian Flemish and Belgian French have minor differences in vocabulary and semantic nuances from the varieties spoken in the Netherlands and France, respectively. Many Flemish people still speak dialects of Dutch within their local environments. The Walloon French dialects are now only understood and spoken occasionally; they are seldom used in public and have largely been replaced by modern French (Witte and Mares, 2001).

The linguistic conflict is central to the Belgian political landscape. Historically, the economic power of the industrial south meant that French was the dominating language, including the French speaking nobility and the bourgeoisie that made up most of the ruling class. As a result, people from Flemish regions who could only speak Dutch were effectively second-class citizens. The Flemish population refused to adopt French as their official language and strongly reacted by creating Flemish movements and a separate identity. By raising awareness about its culture and history, Dutch became more and more accepted until it was officially recognised, in the 60s and 70s, as a national language making it equal in the education system (Witte, et al., 2010). The formerly unitary Belgian state became a federal one and repeated governmental crises finally divided it into its three regions.

Belgium’s political power is organised to meet demands in representing the main linguistic and cultural communities, making it a complex institutional system. The largest Belgian political parties have separated into distinctive components to represent those political and linguistic interests of each community (Witte, et al., 2010). The Federal State affairs include justice, defence, federal police and social security amongst other aspects of public finances, while it also controls substantial parts of public health. Regions have authority on matters of territory such as the economy, employment, agriculture etc. Communities originally dealt with matters of culture, education and the use of their respective language within their linguistically determined geographical boundaries. They now also deal with more personal matters, indirectly associated with language, such as health policy and assistance to individuals (protection of youth, social welfare, family aid, immigration assistance services and so on; Service Public Fédéral Belge, 2019a).

Peoples’ origins, their class and gender along with the regional realities and the linguistic conflict so central for the Belgian landscape, shaped the context in which this study took place. The federal state’s organisation was not therefore a mere supra structure, but actually mirrored people’s everyday life. The paradoxes intertwined in the regional differences directly affected service-users’ situation, including their distress and how it was presented and represented within the psychiatric system as well as the possibilities offered to alleviate it.

Health and Social Care

Similar to Belgium’s governmental system, its healthcare is composed of several parts and/or levels. The federal government organises and regulates a primarily publicly-funded healthcare and social security service. Healthcare insurance coverage, known as “mutuelle”, is compulsory and provided for everybody. A system of independent medical practitioners as well as public, university and semi-private hospitals and public or private institutions deliver care. They are mainly paid by the patients themselves and later reimbursed (an average of 75%) by the different health insurance institutions. For services involving extended care, there is a complementary system of health insurance offered by those agencies and/or private insurances. Medications are generally partly paid by patients, while the supplier gets paid a supplement by the social security services. For hospitalisations most costs are directly invoiced to insurance agencies and the patient’s personal part is to be paid directly by them (except if they have complementary insurance; Corens, 2007).

Healthcare is organised in three layers. First-line care is mainly provided by general practitioners (GPs) and emergency services as well as polyclinics for non-urgent care and involves primary care functions. Second-line care includes acute and immediate care provided by hospitals. Rehab-clinics, old-age and home-care services are provided by long-term care. Patients usually contact their GPs for common health problems. For specialised care, most doctors combine private practice with hospital work (this includes psychiatrists). There are two distinct types of hospitals: general hospitals and psychiatric hospitals, while certain general hospitals include psychiatric wards. Most hospitals are publicly funded and are independent units or part of larger organisations. They receive funding from the public health service based on the activities they deploy, number of beds operated, specialist knowledge etc. (Corens, 2007).

Much in the same way that healthcare is organised, every Belgian citizen also has the right to social assistance and social integration. To ensure this, each municipality has Public Centres for Social Welfare (Openbaar centrum voor maatschappelijk welzijn or OCMW for Dutch-speakers, Centre public d'action sociale or CPAS for French-speakers and Öffentliches Sozialhilfezentrum or ÖSHZ for German-speakers). Social services provide financial help, medical help, housing and legal advice. People who may not have sufficient means to live receive a minimum income (Service Public Fédéral Belge, 2019b).

The Belgian health and social service structures are based on a system of equity and choice by which at first glance every citizen is offered the same opportunities across the country; every patient has access to any doctor in any region they may wish to. It is a system most frequently based on reimbursement, with each sum paid upfront at the end of a doctor's visit partly reimbursed by a health insurance provider later. Nevertheless, it is also an extremely complex system that is difficult to navigate at times, especially since it demands the 'patient' to be actively engaged in their choices. Moreover, the inequality in wealth across the regions considerably limits certain parts of the population whereas others are offered more possibilities (Corens, 2007).

Mental Healthcare

Mental healthcare in Belgium operates in part under the same rules as general healthcare. The insurance system still applies for consultations in private practices or for hospital in-stays (except for psychologists/psychotherapists). As is the case for many countries (as will be discussed later; p28-29; appendix A.6), mental healthcare in Belgium has seen some considerable shifts concluding with a general mental healthcare reform in which the current study is focused (specifically on 'function 2'). The following paragraphs offer an overview of how the '107 reform' (as it became known) was historicised, how it was interpreted and is presently represented given its historical context and introduced based on the formal guide *Towards Better Mental Healthcare*. One such guide was published for each of the three regions in 2010 by the federal public service for health due to their differences (Service Soins de Santé Psychosociaux, 2010).

History

Care was originally provided mainly within psychiatric hospitals, while in the 1970s two types of beds for adults were established. "A" beds were used for short-term stays while "T" beds represented longer term care. At the same time, the creation of the Belgian National Institute of Disability Health Insurance (INAMI/RIZIV) and the development of community care through the creation of mental health centres and other institutes for medico-pedagogical support or rehabilitation allowed people to avoid hospital care and favour "ambulatory" care instead (Corens, 2007; Service Soins de Santé Psychosociaux, 2010).

In the 1980s awareness and understanding further grew around the fact that the residential offer of care does not always fulfil people's needs. An agreement was put in place by which a fixed number of hospital beds was set, limiting the possibility to create more. Patient associations started raising awareness both among politicians and in the general public. By the end of the decade, a new form of residential care for people who no longer needed hospital was introduced and it took the form of sheltered housing (IHP/ibw), including houses for psychiatric care (MSP/pvt) aimed specifically at people suffering from 'mental health issues'. Both those residential structures exist today where residents live individually or in small groups and can participate in daily activities: they are encouraged to live autonomously and actions are undertaken for their 'social reintegration' (Corens, 2007; Service Soins de Santé Psychosociaux, 2010). Other forms of care were also introduced in the community in the 1990s. Most notable are the Psychiatric Care teams for people At Home (SPAD/PZT), teams which still offer care at home through a coaching and psycho-educational approach, including support and supervision for mental health professionals (Corens, 2007; Service Soins de Santé Psychosociaux, 2010).

Although those changes saw an increase in the awareness surrounding mental health issues, they further widened the gap between the residential and community sectors. Since regulatory frameworks differ between the regional and federal levels, including how structures are financed across different forms of healthcare, these changes promoted the development of fragmented services which increasingly worked separately rather than as part of an integrated system. The deinstitutionalisation reform, as will be shown later in this chapter, aimed to close that gap between different mental health structures towards a more cohesive care model (Service Soins de Santé Psychosociaux, 2010).

Regional Differences

Projects developed differently for each region. In Flanders, the 1960s saw the creation of "dispensaries for mental health" which emphasised prevention work and the early detection of psychological distress. These dispensaries evolved into mental health centres (CGG) by 1975 and were given an important place in the landscape of mental healthcare as they partly took over service-users' care. The underlying philosophy of those centres was, and remains today, that mental and psychiatric problems require a wider approach than a purely medical one. These centres developed exponentially and have now become multidisciplinary teams offering support within a psychiatric and psychotherapeutic approach (Service Soins de Santé Psychosociaux, 2010).

Wallonia also had some particularities with the creation of "guidance centres" in 1975. Those were ambulatory structures, developed locally throughout the Walloon territory, if and where professionals wished to set them up. A decree reinforced the orientation of mental health by redefining its funding, control and evaluation in a more global manner. Much like Flanders, mental health centres and services (Centre de Santé Mentale or CSM and Service de Santé Mentale or SSM) were established in Wallonia as a result (Service Soins de Santé Psychosociaux, 2010).

The Brussels region remains a particular example within the wider Belgian structure, since the number of hospital beds has always remained low and in constant decrease while it hosts a high number of mental health centres. This difficulty in bed capacity proved a challenge for the reallocation of funds, which was the reform's main basis (shown later). With the complex socio-economic background of a city and the specific social frames of Brussels, the capital has always presented itself as a very different region compared to the others. As a result, Brussels has a long experience of formal and informal collaborations in 'extra-mural' care (outside of the hospital setting) and indicates how much of care work transpires through networks. Finally, both the main linguistic communities operate within the region, each with its own institutions of care (Service Soins de Santé Psychosociaux, 2010).

As will be explored throughout this work, the regional differences presented diverse challenges for the participating projects as well as for the service-users. People's social realities and the care possibilities they were offered were both shaped, and in turn themselves shaped the way in which mobile teams developed and operated within their communities.

Reforming Mental Healthcare Internationally

Given the 40-year developments (presented above) and looking to reforms internationally, mental healthcare in Belgium further changed orientation towards community care, offering services within the home environment as opposed to treatment within a residential setting. Looking at the presented evidence of countries where mental healthcare was already community based, reports suggested that treating people at home had better success rates and better results than residential care. As a result, residential care was said to have become a circumstantial necessity marked by intensive treatment (WHO, 2001).

In order to draft and later implement the reform, Belgium turned to those presented evidence-based models of their European neighbouring countries with fewer beds, in order to develop a strategy and support its implementation (Service Soins de Santé Psychosociaux, 2010). Presented below are some summaries of the mental health systems across Europe that were used as inspiration and in particular the aspects which were dominant to this reform. This is not an exhaustive list but rather includes models that seem to be mentioned or referenced most frequently in Belgian reform guides and manuals (more information for each model can be found in appendix A.6).

The UK model is a clear reference for the Belgian 107 reform, especially the way in which community mental health teams are organised. The main models referenced are the Crisis Home Treatment Teams (CRHT) for the «2A teams», the Community Mental Health Teams (CMHTs) and the Assertive Outreach Teams for the «2B teams» (see later p28-29; appendix A.6; Service Soins de Santé Psychosociaux, 2010; Natalis and Pieters, 2016). Note that the UK's National Health Service (NHS) has a secondary care that is boosted while its tertiary care (or equivalent of «Function 4» in the Belgian system) is smaller (National Collaborating Centre for Mental Health, 2011).

The Netherlands Flexible Assertive Community Treatment (FACT; Veldhuizen and Bähler, 2013) was mainly adopted and adapted in Flanders. It was developed in the Netherlands and aims to combine the ACT and CMHT models into one team. To combine care for these two groups, the FACT team employs a flexible 'switching' system. This flexibility to switch between the two modes of service delivery within the same team is said to enhance continuity of care and reduces drop-out rates. For service-users who are at risk of recurring episodes of psychosis and/or hospitalisation stays, the same team immediately switches to intensive ACT support. This combination of flexibility and continuity ties in well with the "natural" course of people who may present chronic difficulties, recurring episodes and relapses (Veldhuizen and Bähler, 2013; Sood, Owen, Onyon, Sharma, Nigriello, Markham and Seabrook, 2017).

Trieste in Italy has long been a source of inspiration for other European countries that seek ways to organise mental healthcare differently with mainly community and neighbourhood-oriented care along with a minimum number of beds. The city became famous for its model of "democratic psychiatry" in the 1970s. The hospitals were closed and replaced by ambulatory care, focusing on people's 'socialisation'. With the hospital no longer active, attention was given to establish support and care in the neighbourhoods. Based on this history, the services in Trieste have developed a few guiding principles. The team focuses on the whole person taking on a holistic approach, they include the network and social group that the person is part of with the aim to include as many actors as possible. Finally, the teams have a rights-based approach with an emphasis on the civil rights of people (Dell'Acqua, 1995; Mezzina, 2014).

The model from the city of Lille, in the North of France, was also referenced in the 107 reform practices. This model is based on a system of integrated care with different services acting as partners from primary care to specialised services (Roelandt, Daumerie, Defromont, Caria, Bastow and Kishore, 2014). In particular, the Community Mental Health Mobile teams in Lille offer home hospitalisation services in the form of intensive care with the help of other professionals either in health, mental health, the social or the justice sectors (EPSM Lille-Metropole, 2019; Roelandt, et al, 2014). A continuous link with primary care through the GP is put in place while there is an emergency response at any time provided by the mobile team. Their main aim is to avoid situations escalating, based on a system of accessibility, coordination and networking. As a result, hospital bed numbers have decreased and those that remain are on open wards (EPSM Lille-Metropole, 2019; Roelandt, et al., 2014).

The Lausanne model in Switzerland was also important for the Belgian reform. This model was based on a plan of action aiming to reinforce psychiatry in terms of liaison and coordination. The main goal was to improve continuity of care between the different institutions as well as to find better solutions for the population's expectations. As part of the solution to this, a mobile team was developed with the aim to ensure interventions within the community loosely based on an ACT model. The mobile team therefore reinforces coordination and liaison between services through the practice of case management (Bonsack, Ferrari, Gibellini, Gebel, Jaunin, Besse and Morandi, 2013).

International Evidence and Fidelity Criteria

Each of the models was a source of inspiration in developing specific guidelines for the Belgian reform and more specifically as guidance for the new mobile community teams (explored later). As can be quickly noticed in the descriptions of those European models, each country and region have their own context within a broader health and social care system with a different history, therefore different drivers. Furthermore, the resources and implementation strategies for each were also very different to how the 107 reform was conceptualised, agreed upon and applied. Each model used was therefore linked to particular geopolitical and socioeconomic factors giving it a particular contextual character.

There were two major arguments for the Belgian reform: one concerned the high numbers of psychiatric beds and the other the increased suicide rates compared to other countries (Service Soins de Santé Psychosociaux, 2010). The development of community teams within different European contexts were all part of the supporting evidence that the Belgian government used as inspiration for what became the 107 mental health reform (of which more later). Each model attempted to offer accessible mental health services based on "sound evidence of best practice" (Department of Health, 2001:6). However, there is little research or evidence on the implementation of these models in these countries and where there is, it does not always present as successful (National Audit Office, 2007).

In terms of the number of beds, Belgian policy-makers looked to the ways in which they could decrease them. For example, in the UK, CRHTs and AOTs developed exponentially in number since 2000 (Department of Health, 2001; National Audit Office, 2007). However, a national audit report concerning CRHTs across the country showed that despite this introduction to the mental healthcare system on a national scale, wide regional variations existed, often with a lack of dedicated input from key social and care professionals. As a result, teams could not provide the intended multi-disciplinary and/or comprehensive care. Furthermore, only half the proposed admissions to hospital were screened by crisis teams and successfully avoided. This evidence suggested that the stipulations set by the original CRHT model were not always implemented or maximised (National Audit Office, 2007).

Another major incentive for the Belgian reform was the high suicide rate (WHO, 2014). The Belgian reform guide suggested that evidence from the UK showed the number of suicides to have decreased, leaving mental healthcare professionals convinced that the direct reason for this decrease was the change in the organisation of care services (Service Soins de Santé Psychosociaux, 2010). Conversely, studies have suggested that in countries with national policies, programs, legislations and more funding for mental health suicide rates may increase (Burgess, Pirkis, Jolley, Whiteford and Saxena, 2004; Shah, Bhandarkar and Bhatia, 2010; Rajkumar, Brinda, Duba and Thangadurai, 2013).

The Belgian mental health reform attempted to re-organise mental healthcare towards an integrated system, yet integrated care itself is often a poorly defined concept while its implementation is far from simple. This has particular implications with a wide gap between policy discourse and practice (England and Lester, 2005). There is little evidence to show the successful implementation of community mental healthcare models and paradoxical results are produced in terms of their effects. Questions arise not only about whether those models are/have been implemented, but also about the evidence those models are based on, about how they are implemented and with what results. Although specific characteristics of fidelity criteria were developed as part of the community mental healthcare models presented above, the Belgian reform was based on the suggested models and alleged results rather than on their successful implementation, for which available evidence was limited.

The '107' Mental Healthcare Reform

Belgian citizens with mental health difficulties have usually turned to their GPs as a first port of call for psychosocial issues. Different providers, from mental healthcare to education and social services, as well as housing, have also acted as first line care. Depending on the severity of the presentation, people can be redirected for a more specialised assistance towards mental healthcare centres, psychiatric hospitals, general hospitals and private psychiatrists and psychotherapists. This referral or redirection technique, however, has not always happened harmoniously, mainly due to a lack of knowledge of available resources which effectively blocks people from being directly and quickly referred to the best available service (Service Soins de Santé Psychosociaux, 2010). This has been further prevented due to the taboo which surrounds the mental health field (Sartorius, 2007; Thornicroft, Rose, Kassam and Sartorius, 2007). To add to this, once people are referred, the waiting lists for services have usually been very long, adding to the time lag (Service Soins de Santé Psychosociaux, 2010).

Following the 2001 WHO (2001) report and subsequent reports that identified an urgent need to widen structures and a better organisation of care, Belgium started actively promoting a different offer of care, based on people’s needs. Already late compared to other countries, Belgium’s reform took a more concrete shape between 2002 and 2009 (Service Soins de Santé Psychosociaux, 2010). In 2002 a law was approved recognising patients’ rights (‘Loi relative aux droits du patient’, 2002:3341). It stipulates that individual rights are determined by the quality of services, free choice of mental healthcare services, access to medical notes, the protection of privacy and assures mediation in case of complaint. 2007 saw the introduction of “therapeutic projects”. With the WHO data in 2008 showing a striking difference in the number of beds between Belgium compared to other countries (for example, Italy or the UK; WHO, 2008), Belgian officials turned to the examples explored above as support to implement a mental health reform. Finally, in 2009 Belgium’s federal, community and/or regional public health ministers agreed to re-organise mental healthcare from a residential system into a community one, constructed of circuits and networks of care for both ‘acute’ and ‘chronic’ needs. The agreement stated that a circuit of care included all concerned structures within mental healthcare and their purpose was to answer to the needs of a target group. Each circuit was to be organised as a collaboration between care providers. Furthermore, hospital admissions were to be avoided as much as possible. If, however, an admission proved inevitable, considerable efforts were to be made to shorten it as much as possible. By 2010, given the diversification in mental healthcare, a specific plan was put in place to reallocate existing funds from residential care into other structures of care, as well as to introduce complementary investment funds, that would allow these circuits of care to take shape. This was done through “article 107” which was subsequently adopted as the name of the reform (Service Soins de Santé Psychosociaux, 2010).

Respecting the older order of existing care, the reform was put in place in a way that would allow for its progressive adaptation within conditions that were deemed acceptable for professionals. Its aim was to avoid services and institutions competing but rather it was intended for them to amplify and complement each other’s action for the benefit of service-users. Five main goals were identified: (i) deinstitutionalisation by boosting intensified and specialised ambulatory care as an alternative to hospitalisation; (ii) inclusion for rehabilitation within an indispensable collaboration with other sectors, such as education, culture, work and social housing; (iii) ‘de-categorisation’ put in place through circuits and networks of care and in collaboration with other care sectors; (iv) intensification of care within hospitals and (v) consolidation, by regulating different projects at a federal level, as well as within the communities and regions within a globalised vision of mental healthcare (Service Soins de Santé Psychosociaux, 2010).

By 2009, based on previous reports and aiming at a reorganisation of mental healthcare the application of article 107 was finally put in place moving funds from hospitals towards other care modalities (about 10% to start with). This article also stipulated specific funding arrangements from the federal government for a limited time allowing those circuits and networks of care to be initiated as pilot projects until formally established. In other words, ‘article 107’ was a financial technique that permitted reallocating some of the funds aimed at hospital care. Those funds were used as resources and personnel allowing them to be moved towards a needs-adapted form of care. This was done by “freezing” funds allocated for ‘T’ (long-term; p24) beds but, at least during the first steps of the reform, no actual beds were put out of use. Note also that there was no set number given concerning the number of beds to be “frozen”. The funds were based on the hypothesis that hospitals had surplus resources available for “other” purposes which would be restructured and directed towards the new projects. The development of new care functions would provoke a different activity for hospital beds which would be used less or not at all as a result, thus allowing for the actual closure of beds. All the successive Belgian governments engaged themselves to “open up” the current service of care in order to intensify cooperation between institutions within and outside the hospital walls. They also launched the creation of new mobile teams that offered intensive care for ‘acute’ situations as well as long-term care (the main focus of this work). Rehabilitation teams within hospital were also created that worked specifically towards social reintegration. Finally, intensive units in residential care were formed for both ‘acute’ and ‘chronic problems’ when a hospitalisation is thought to be indispensable (Service Soins de Santé Psychosociaux, 2010).

The ‘107’ Five Function Model

As mentioned, Belgium’s mental health reform has as its main objective to maintain people in their home environment and within their social fabric, by offering supportive, individual and flexible therapeutic interventions through multidisciplinary networks. The goal of the final model put in place is to associate in a global way all the structures available, by integrating all the resources of residential and community care. The organisation, therefore, aims to include all actors present within a territory and aims at creating strategies to answer to a needs-based care approach for the target population within that area. The organisational aspects of care were to evolve progressively to make way for a network of alternative services distributed across the given areas. This implied an adaptation of each of the resources available, so as to allow each function to develop within a complementary model based on the actors’ creativity and originality within their area, but at the same time always based on the global philosophy of the reform (Service Soins de Santé Psychosociaux, 2010).

To construct this new model a few main functions were proposed, functions that were to be progressively organised into a network of alternative services distributed within a given zone. A low threshold first line care would facilitate accessibility towards care, which until recently was riddled with stigma. The model is further presented through 5 key functions: (i) prevention, mental healthcare promotion, early intervention, screening and diagnosis, (ii) mobile teams for acute and chronic psychosocial problems, (iii) rehabilitation teams, (iv) intensive residential treatment units when admission is necessary and (v) specific residences (for more details see appendix A.7; Service Soins de Santé Psychosociaux, 2010).

Those functions were proposed as possibilities and were always prospective rather than actual, in the same way that the European models were used as inspiration (Van der Jeugt, 2015). Although the initial proposition included a deinstitutionalisation process (through the reduction in the number of hospital beds and the development of a mobile community function), throughout the reform, the idea of a “balanced care model” prevailed (Natalis and Pieters, 2016). This model proposes that a mental health system that is comprehensive should include both community and hospital-based care, rather than one largely or solely provided by one of these functions (Thornicroft and Tansella, 2013). In this way, the reform’s guide has often been used to propagate different opinions about the reform’s main aim with contradicting positions, from ideas linked to deinstitutionalisation and the reduction of hospital beds (Van der Jeugt, 2015) to ‘balanced care model’ propositions defending hospital structures (Natalis and Pieters, 2016).

The model’s second function concerns teams that are mobile and visit people at home or elsewhere. They will be the main focus of this study. One type of team can support people in acute or sub-acute situations, and another can support people who present chronic difficulties. This new function was designed to explore a new form of care that is quicker and more accessible, as well as adapted to the home or live-in situation. As an alternative to hospital, the offer of care is one that is mobile, with an immediate and intensive intervention for ‘acute’ situations. Intensity and duration of care is also adapted for people in ‘chronic’ situations since those may vary greatly. Care is organised based on resources and as a complement to the first function, but with a mobile approach and ‘expertise’. The partnership is structured using a holistic approach by considering the person’s environment and general health, as well as ensuring continuity in care. Resources from other functions are used in an individual manner according to service-user need (Service Soins de Santé Psychosociaux, 2010).

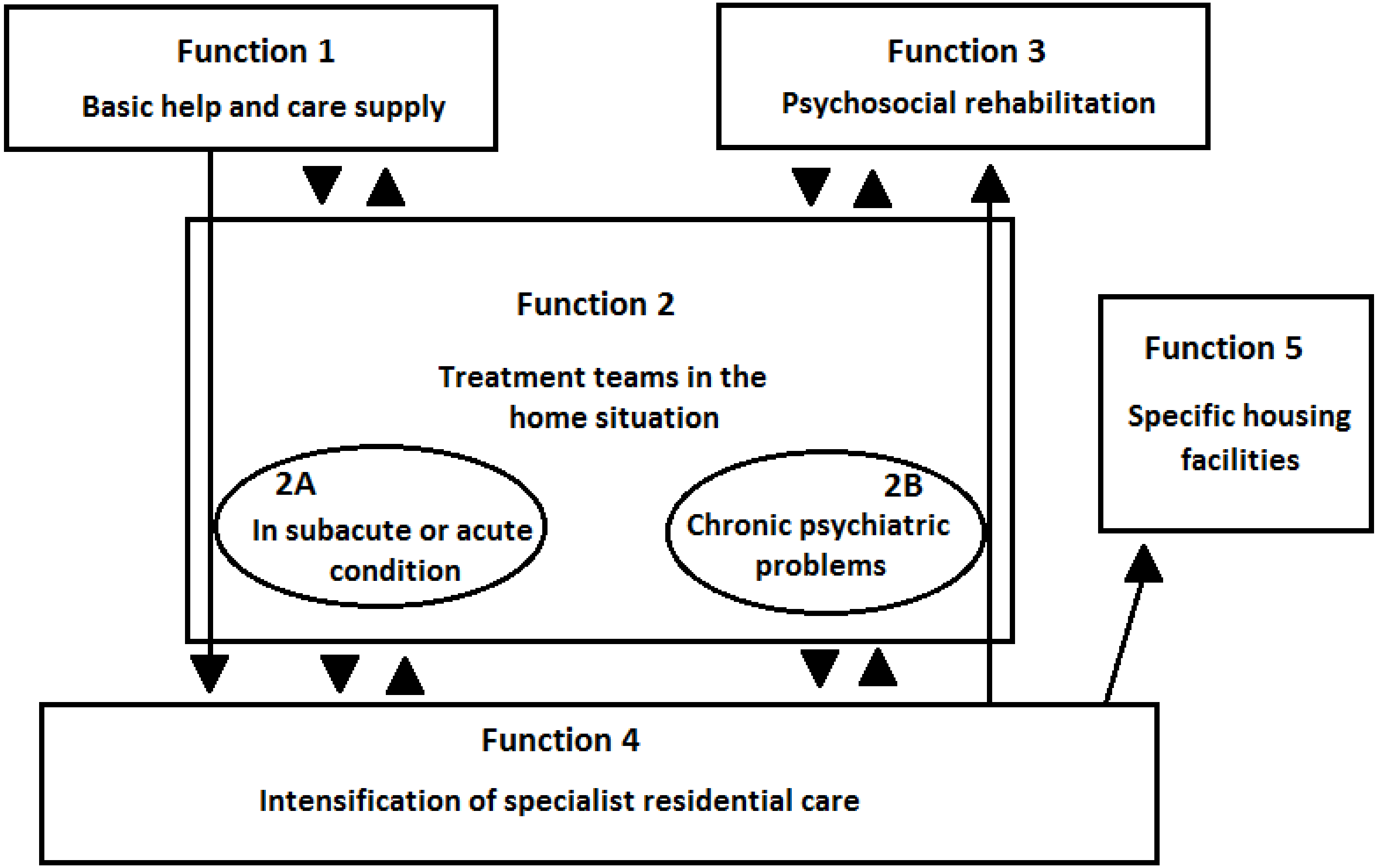


Figure 1. '107' Five Function Map (Service Soins de Santé Psychosociaux, 2010

Mobile Team Guidelines

The reform called for a better organisation of the existing care structures, by respecting the older order but with a progressive adaptation towards a new care system, with each function complementing rather than competing. The second function, although to some extent and in most cases informally carried out by the ambulatory sector, was to be financed by the hospital sector, while formally developed and implemented based on European evidence-based models (presented above). In effect, it was the main function to be developed through the advancement (for the most part) of new mobile teams, promoted by psychiatric hospitals. The second function gave the reform a novel service of care and was regarded as key in restructuring and integrating care networks (as seen in Figure 1).

Two types of mobile teams were established early on to be included as ‘Function 2’ on the five-function map (Figure 1), broadly based on the evidence-based models presented above. One was concerned with ‘crisis’ and aimed at offering intensive support as an alternative to hospitalisation. The other involved longer-term care for users needing support in several areas of daily life. Using a multidisciplinary approach, both these models were said to be grounded on “evidence-based” interventions, centred on the person and based on recovery as complementary facets of a necessary professional expertise. The teams were generally to operate within the same catchment areas. Although these teams were both set up as community care initiatives, their target population significantly differed and so did their intervention times (Natalis and Pieters, 2016).

Mobile crisis teams or 2A teams aimed at preventing or shortening psychiatric admissions. Comprising several workers from different disciplines offering intensive psychiatric care at home for a short period (usually between four to six weeks), their main objective was to offer short-term support before referring towards other care solutions. The idea was also for 2A teams to offer a first diagnosis that would define future care paths. For people who are already supported by services, the objective was to ensure a continuity in care, through consultation and collaborative practices between the 2A team and the existing professionals. 2A teams were to work flexibly with a permanent access (24/7). Several teams were also to have the possibility to refer to a few psychiatric crisis beds available at all times when needed (Natalis and Pieters, 2016).

2B team guidelines were aimed at people presenting “chronic mental difficulties” and/or “severe psychiatric illness”, with complex needs that needed more support than ambulatory care could offer. In order to avoid hospitalisations and especially frequent readmissions as well as to shorten admission periods, an intervention at home was deemed essential. Offering better access to adapted care according to the needs of people presenting a “severe psychiatric illness” was seen as more beneficial in the community in comparison with traditional hospital structures, while also allowing for a better continuity of care and flexibility in care delivery. Particularly, the idea was to use a "case management" approach by which each full-time equivalent worker would have a caseload of ten users. Furthermore, the service was to be accessed in the evenings and weekends. Working within the person environment, at home or elsewhere, while assertively engaging with them was seen as core. Finally, in-reaching and outreaching practices with hospital, were seen as important aspects of 2B team work (Natalis and Pieters, 2016).

Although these guidelines and available models were used as starting points, candidates within different terrains each submitted specific 107 project proposals describing their intent within their given context. Each selected project was organised and developed following local negotiations, both in terms of their funding but also their position within their area's mental health structure. Fidelity criteria from the EU models and function guidelines presented above were not followed in the strict sense but were rather abstract guidelines which the teams interpreted in parallel with their diverse realities. While there were some expectations from the federal government on the teams' development, there was no strict model imposed, nor any specific implementation strategy (Van der Jeugt, 2015).

Mental healthcare networks were set up as pilots and continue to operate as such. During the starting period, several mental health professionals (mainly from the second function) from each project had the opportunity to visit teams abroad in order to experience first-hand different systems and ways of working within those teams. Specifically, most workers within the newly developed mobile teams had previously been employed by the residential setting of their promoting hospitals. Furthermore, experts from other countries were also invited to visit the new Belgian mobile teams as well as meet with network partners, in an effort to exchange knowledge about community work (Van der Jeugt, 2015).

The Research

This study was conceptualised and set up through these exchanges between Belgian mental health professionals and experts from abroad focused on the reform's second function. Specifically, the director of studies for this study was an active participant as an expert of the Birmingham mental health community care model. As a result, this study focused on the reform's second function which concerns mobile community teams and which gave a novel aspect to Belgian mental healthcare, one based on evidence-based models aimed at reducing hospital beds yet financed primarily by those same hospitals. Focusing on the Function 2 teams was an opportunity to capture evidence-based models being adopted and adapted between different contexts through a process of knowledge exchange (Collins, 2010).

Similar reforms had been underway and taken place in other countries with models produced as a result. With the reform coming late, compared to other countries, this meant that models and tools used in Belgium had, in theory, already been tested and implemented elsewhere. However, as seen earlier (p28-29) a wide gap exists between policy discourse and practice (England and Lester, 2005). With little evidence showing the successful implementation of community mental healthcare models and where available showing paradoxical results produced in terms of their effects (National Audit Office, 2007), this study changed course. Questions arose not only about whether those supposed evidence-based models had been implemented but also about the evidence those models were based on, about how they were implemented and with what results. Although specific characteristics of fidelity criteria were developed as part of the community mental healthcare models (p26-28; appendix A.6), the Belgian reform was based on the suggested models and alleged results rather than on their successful implementation, for which available evidence was limited. Finally, although much of the literature in this work may be considered dated, this reflects both how the 107 reform was introduced later than its European neighbours. Implementation studies dating back to 15 years as well as sociological and anthropological works on deinstitutionalisation from the 1990s were used as references throughout this study, showing both the limits of implementation as well as how it is still relevant in this current context.

As mentioned, the idea of studying the process of a reform taking place *in vivo* was introduced in the early stages of the reform by some of the people involved in those. Personally, this study was an opportunity to delve into frustrations that arose from having worked as a professional within community teams as well as in research in the field. Furthermore, it was a unique opportunity to do this in a country that was interlinked with my personal history. Finally, coming in from a university outside the Belgian context, gave me the possibility and the tools to witness this contested reform from a particular angle, as will be explored in the following chapter.

The Belgian context presented a new challenge, especially given the country's particularities and socio-political idiosyncrasies. Looking at this reform using an academic and qualitative lens, was a prospect worth exploring, especially since such a study had not been conducted before, particularly within such a complex environment. Furthermore, Belgium and its context presented a unique opportunity to study the wider field of mental health and psychiatry within a very particular environment, permeated by particularities in language, culture and politics. Specifically, the creation of the function 2 mobile teams was perhaps the most concrete expression of the reform and had the potential to be an important facet in changing the approach to mental healthcare.

Participating projects

Four 107 reform function 2 projects were selected for this study to be presented as case studies: HERMESplus in Brussels (point 1 on the map below), Manage in Wallonia (point 2), PAKT in Gent (East Flanders; point 3) and PRIT in West Flanders (point 4). The teams were recruited in such a way that each represents Belgium's main areas/regions and their population respectively: two projects are from Flanders; one is located in Brussels and another in Wallonia. Two of those serve a rural population (West Flanders and Manage) while the two remaining are in urban areas (Gent and Brussels). Each project includes two teams a 2A team and a 2B team (or 2B function).

Federal guidelines (presented above) were used as basic instructions on how these projects were organised and divided (Natalis and Pieters, 2016; Service Soins de Santé Psychosociaux, 2010). Nevertheless, the way in which each team evolved differed widely across and within projects. In this sense, although this thesis is perhaps superficially presented using a traditional quantitative structure, it is nevertheless qualitative and heavily influenced by the ongoing methodological exploration that occurred throughout the study. In effect, the way the participating projects were selected and in turn the ways the data was collected and analysed does not account for generalizable results, nor are they presented chronologically. Instead this is a study built on a more subjective temporality, as will be further explored in the following chapter.

Brussels: HERMESplus

The Brussels Region, which is the capital of Belgium, is relatively small compared to other European cities. The centre has a population of 1.2 million while the metropolitan area counts over 2.1 million. As a major international centre and the host of a number of EU institutions, it also hosts a large number of migrants and expatriates that speak many languages, including Arabic, Spanish, German and Italian. The population of Brussels is younger than the national average. The gap between the rich and poor is wider, with the latter often living under the poverty line, including an increased level of homelessness (Englert, Luyten, Mazina and Missinne, 2017). These particularities in the population very much reflect both the mobile team service-users as well as their needs.

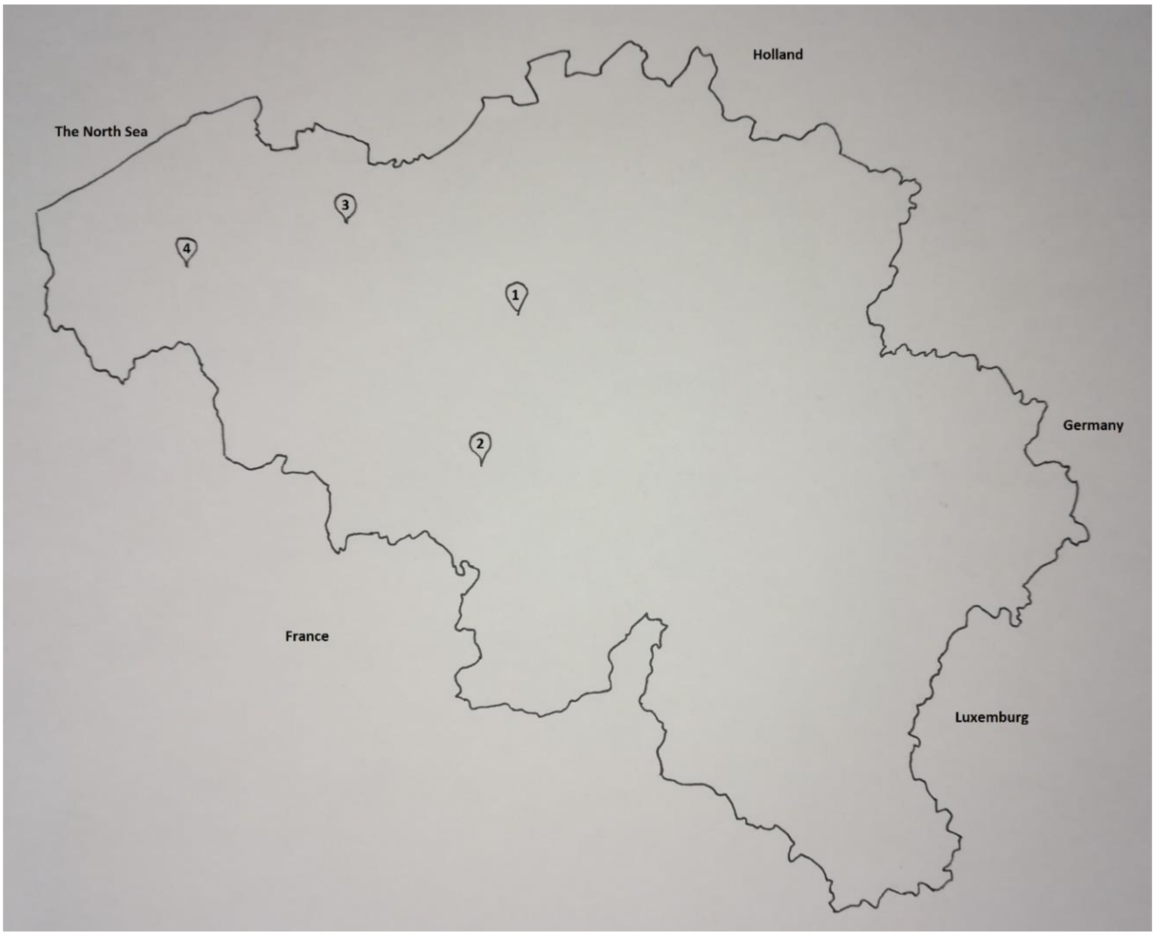


Figure 2. Map of Belgium with Projects' Locations

As mentioned, the Brussels region presents a few differences compared with the rest of the 107 projects due to the relative lack of psychiatric beds as well as an already boosted community network of care. Specifically, the HERMESplus project, which was selected for this study, is not attached to a hospital and therefore was not set up in the traditional way by reducing beds to fund it. Conversely, it was developed solely using governmental funds. It is also the only bilingual project to reflect its territory. The HERMESplus includes the five functions as drafted by the federal government and also includes service-user and carer organisations. In terms of the second function of the reform model and unlike other projects, only one 2A team was created while for the equivalent 2B team a network was established of already existing community teams within the area.

A direct product of the 107 reform (unlike the rest of the teams within the project), the 2A team operates from the city centre and covers a large area including the centre and most of the municipalities in the north, east and south of the region. For the purpose of this study, the Antonin Artaud mental health centre was deemed closest to the 2B function, serving a chronic, long-term population within the centre of Brussels. The team was also closest to the other 2B teams across the country in terms of target population while it also provided an interesting picture in its relationship with the hospital function (function four). Unlike other projects Antonin Artaud is originally an 'ambulatory' sector centre and has been operating for over 40 years. It is not funded by a hospital and operates in part as an ASBL (Association Sans But Lucrative – non-profit association).

Wallonia: Région du Centre

The Centre or Central Region is an Hainaut province in the Walloon region of Belgium. It was at its highest economic position due to its coal industry and later its steel as well as glass, railway, textile and iron industries. As a result, it welcomed large successive waves of immigrants who worked in the mines, with the largest coming from Italy and later Poland. Workers from Turkey, Morocco, Algeria and Greece as well as the Congo and other African countries also immigrated and were integrated progressively, forming a multicultural landscape across the region. With the successive closing of the coal mines, the Central Region was hit hard, with disastrous consequences that the population still experiences today (Caestecker, 2000).

The '107' project included the cooperation and participation of service-user and carer organisations. The function 2 involved a 2A and a 2B team with funding from two hospitals in the region: Saint Bernard and Jolimont. Project members were originally employed by the hospitals and were hired to work for the teams through a "sliding" process i.e. by moving personnel from one structure to the other, using the same funding, contract and hierarchy used by the "host" hospital. The 2A team was formed six months ahead of the 2B team, with many team members moving from the former to the latter. Both teams were based in the administrative buildings of the Saint Bernard Hospital, a psychiatric facility in operation since the 1930s (CP Saint-Bernard, 2019). Access to both is ensured through a shared telephone line.

Ghent: PAKT

Ghent is a city and port in the Flemish Region of Belgium and the second largest municipality by number of inhabitants in Belgium. It is a strong economic and cultural hub with a high employment rate. The city centre hosts a multicultural population as a result of a big wave of immigration in the late 1990s, while the suburbs are mostly inhabited by Flemish families (Caestecker, 2000).

The PAKT project includes the city of Ghent, its suburbs and the region of Eeklo. At the beginning of this research there was one large 2A team which, during the course of this study, in the spring of 2015, was split into two teams one for the north and another for the south of the area. The south team was followed after the split due to its more urban character. The 2B function was shared between four different teams and the north team was selected for this study, again due to its more urban population. The funding for the PAKT project has been ensured through the collaboration between four hospitals in the region.

Central-West Flanders: PRIT

West Flanders is the most western province of the Flemish Region of Belgium. It borders the Netherlands in the north as well as France and the Walloon region in the South, while it also overlooks the North Sea. It is an area with a historically rich industry and hosts two important ports (Caesteker, 2000).

The Central-West Flanders project operates in the middle of the West Flanders area and serves for the most part rural zones. Its name “PRIT” stands for the major cities of its area: Roeselare, Izegem and Tielt as well as the municipality of Pittem where the “host” or promoting hospital is based.

The PRIT mobile teams share an office and are situated in a renovated house in the centre of Roeselare, a town in West-Flanders. They also share the same central telephone number. All workers come from the hospital which means they had previous experience of working in a residential setting although a few workers had also worked in ambulatory settings. The teams also shared a psychiatrist. During this study the psychiatrist was replaced.

Research Questions

Through the process of reform three main questions came into focus: How do new, community services link with and shape existing services? How are models of working in the community ‘adopted and adapted’? How do professionals working in these new services experience their work and professional role? This study therefore had three main aims. First, to describe the new services within the existing wider system. This was to be done looking at service design in three levels: team (‘collaborative working’), intro-organisation (‘co-ordinated working’) and inter-agency (‘co-operated/co-operative working’). Secondly, the aim was to analyse the models of working and how those are ‘adopted and adapted’ at a local level describing what the services become, based on the people implementing those models in practice. Lastly, the aim was to investigate the impact of the existing culture and beliefs about the role and function of those new mental health services.

Evidenced models of intervention in the community were offered as basis for this reform and this study originally aimed to explore which of those were used (if any) by understanding knowledge transfer techniques. Each evidence-based model used was specific to a broader health and social care system with different drivers, differently resourced and with different implementation strategies, each with their own history. How this evidence and knowledge was exchanged, adopted and adapted for the differing Belgian contexts was the original focus of this research. Knowledge was classified as ‘explicit’ and ‘tacit’ and this understanding was important in the early stages of the reform process. While 'explicit knowledge' is offered through descriptive and manualised means, there remains the question of 'tacit knowledge’, which cannot be as easily transferred (Collins, 2010). In other words, models are adequately described and manualised to ensure that they are transferable. However, allowing for teams to interact with 'experts' of said models was hypothesised to enhance knowledge about those models by offering direct experience of their use (Polanyi, 1967).

The roles of professionals could therefore be understood as being developed through interaction within practical contexts (Prior, 1993). Those were to provide insights into practices which cannot simply be obtained from explicit knowledge (Collins, 2010). Professionals may have an array of literature on offer which prescribes and describes how a service should be organised and how practice should unfold. However, those cannot capture the detail of the practical process of mental health interventions (Prior, 1993). As a result, examining and reflecting on professionals’ specific culture, their assumptions, their beliefs and their attitudes, offered an important insight into their practice.

The question surrounding how professionals working in new mobile community mental health services experience their work and professional role has been explored before. Only one qualitative study at the start of this research was found which aimed to answer this question. Conducted in Norway, it sampled six professionals from three community mental health teams who were interviewed twice through focus groups. Four central themes arose. Firstly, the professionals saw their roles as varied from consultants to supporters and carers in all aspects of their service-users’ daily life. Secondly, all the workers aspired to meet individuals within their social fabric while trying to assist them. Thirdly, the experience of working in those new community teams was compared to previous employment mostly in residential settings. Professionals’ new-found role was characterised as ‘liberating’ compared to their previous work, which allowed their relationships with individuals to be more egalitarian and person-centred. Finally, the professionals commented on the expectations other mental health services had of them. Expectations could be high when the need arose for the new professionals to solve a problem, but low in how they were regarded for their knowledge and experience. It is important to note that the study was limited in its region and sample. While it looked at teams, it failed to provide an insight into the individuals making up those teams, as well as the mental healthcare structures outside those which were not accurately described. However, the study did add some interesting and alternative insight to the knowledge base of mental health work and specifically the changing culture of professional roles within the community setting (Elstad and Hellzen, 2010). More explicitly for this study, it provided an important focus on professionals’ experience, most notably in the shift between working within the residential sector compared to the community.

Due to Belgium's intricate cultural, social, economic and political make-up, implementation of this reform has included many facets which need to be taken into consideration. With a system that had already been established, mobile community teams were seen as a potential change to the mental health landscape both in terms of organisational structures, but also in terms of mental health cultures and beliefs. Creative and original actors within those specific teams and localities proved paramount, as they accounted for this mental health community culture shift. Providing a descriptive narrative of that process quickly became a goal, including everyday working tasks such as face to face therapeutic interventions to service functionality within the wider system. This narrative provided an insight into theories of knowledge transfer, but also so much more, within a mental health culture and the actors within it, their meanings and social constructs. After all, "it is by studying what people do and say about what is commonly called mental illness, that we may best come to understand what it is" (Prior 1993:1). With mental health reforms unfolding across the world, this study may point out the need to consider specific as well as wider social and cultural factors. Ultimately the de-institutionalisation process and the field of contested mental health at large may be a matter of their particular but also broader socio-political context.

Beyond 'evidence-based practice'

As examined above, the 107 reform came into focus during a global movement towards community-oriented care (WHO, 2001; 2002). Data concerning long-term residential care became a driver with a stark contrast between countries with a low number of beds and Belgium's increased number, signifying that the political complexity in implementing a reform had to be solved (WHO 2008; Service Soins de Santé Psychosociaux, 2010). This reform was said to be partly established on evidence models and expertise developed and implemented abroad, especially when it came to the mobile team function. However, such evidence does not detail (or at least not fully) successful implementations of such models.

The customary notion of 'evidence-based practice' is often described as being the foundation of mental healthcare. Although the idea is indeed to provide people with the best care based on the best evidence, careful examination shows this evidence to be both limited (as shown above) but also limiting. More specifically, through time, research has become increasingly restricted, with specific paradigms regarded as valid such as Randomised Controlled Trials (RCTs). This, however, is a very specific type of evidence-based research, which limits the possibilities of other types of research to be used. It is also imperative to question the decision-making procedures within this research: not just what the research is about or how it is carried through, but also by whom it is done and who is left behind (Morgan, Felton, Fulford, Kalathil and Stacey, 2016). Of course, the most notable exclusions to this type of ‘evidence-based’ study is experientially led research, which is a growing but often disregarded in mental health (Wallcraft, Schrank and Amering, 2009).

The 107 reform’s second function was firmly grounded in this limited/limiting evidence-based value system, as seen above, with its specific but limited view on ‘best care’. In a time when the service-user and survivor movement became increasingly important internationally, with people proclaiming “nothing about us, without us”, the lack of a critical experiential voice in the 107 reform proved problematic. Moreover, the way in which the mental health care reform was developed and later historicised omitted radical care alternatives which were developed and had existed in Belgium. The most notable example was the town of Geel, which as early as the 13th century took on the early adoption of de-institutionalisation and community care, based on the practice of ‘host families’ allowing former in-patients access to family life (Goldstein and Godemont, 2003). It was evident from the start of the reform that the service-user voice was uncritical and un-politicised if not entirely absent, in the same way that the rest of the reform was presented as adhering to an evidence-based positivist ‘neutrality’ in terms of its politics. When examining the new ‘evidence-based’ driven mobile teams, this research aimed to deconstruct the fundamental notions beneath that evidence, while also considering this growing body of experiential work. Focusing on the individuals at the receiving end of the care experience, the idea was to go beyond the established ‘evidence-base’. With a growing movement of experiential and survivor knowledge, driven by people experiencing mental health distress and receiving care, this body of work was not only important to consider but impossible to ignore any longer.

[This page intentionally left blank]

Chapter 2: Methodology

Introduction to Chapter 2

Moving on from the history and context of the study explored in the previous chapter, this chapter will examine the central ideas which were used to understand it. A specific methodology was developed for this work, which moved beyond the '107 reform' itself and came to encompass wider notions within the field of psychiatry and mental health. A Constructivist Grounded Theory approach underpinned this research while using a Foucauldian lens proved important when thinking about the wider field of mental health. This chapter therefore moves from the descriptive contextual elements presented in the introduction to examine the philosophical position used as the basis upon which this study was conceptualised.

As such, a brief summary of the constructivist elements supporting this study's methods and an introduction to the main texts by Foucault are explored. Foucault has been an important figure in the deconstruction of prevailing notions in mental health, offering a methodology to examine established and imposed power and knowledge hierarchies (Rabinow, 1984; Gutting, 2005; Oksala, 2013). As a result, emergent ideas of social justice became central and brought many of the different elements of this methodology together, including a lens through which the different 'knowledges' surrounding mental health were understood and critically evaluated. A rationale for the selection of Constructivist Grounded Theory, which is ideologically linked and underpinned by social-justice ideas, is followed by a detailed explanation of what such a selection entailed in understanding the specific subject. The chapter ends with a note on the researcher and the subjective positioning inherent both in the methodology but also the studied context.

Constructivism

Constructivism maintains that science explains experience in the natural world through mental constructs. Knowing the world is thus dependent on the mind, since knowledge of the world is always subject to social construction (Crotty, 1998). Constructivism, thus, opposes the philosophy of objectivism and positivism by which theory is constructed through hypothesis testing using empirical measurement (Charmaz, 2006). In contrast, constructivists use a diversity of useful methods, as no particular methodology in science is more valid than another (Clarke, 2005). For this study, a Constructivist Grounded Theory methodology was selected allowing for meaning to be generated through the examination of interpretations people give to their experiences as well as by exploring how they interact with each other (Holloway, 2008). The purpose of Grounded Theory is therefore to generate new theory rather than to test existing theory using social processes and field work. Its main methodological aspect is the constant comparisons linking theory construction to raw data. Furthermore, using a constructivist approach to Grounded Theory (of which more later; p65-66) also acknowledges that the resulting theory itself is an interpretation (Charmaz, 2006).

According to Thomas Kuhn's seminal text The Structure of Scientific Revolutions (1962), constructivism as an epistemology urges social sciences researchers to reflect upon the "paradigms" that may be underpinning research and then consider other ways in which results could be interpreted. With social relationships and interactions at the forefront of the researcher's world of which they cannot be exempt, categories of knowledge, and in turn reality, are therefore dynamically shaped. Ultimately, these relationships and interactions also alter the way in which science is organised. Social constructionism therefore presupposes that human beings exist within shared constructs of life, making up social activity. Social structures and institutions are shaped and in turn reflect shared meanings. Research must present its results with a focus on the wealth of accessible and possible social constructs rather than aiming to "represent" social realities (Charmaz, 2006). In this regard, 'mental illness' is not a scientific fact which is 'out there' ready and waiting to be revealed. Rather, as will be explored later in this chapter, it is constructed in accordance with the dominant beliefs and theoretical structures of the age (Prior, 1993).

More specifically, pathologies are portrayed as "natural processes", understood as a sum of symptoms which add up to a recognisable disease. In other words, they are understood as natural manifestations and regarded as ontologically real entities. However, in practice this system of classification has proven elusive since no commonly agreed somatic pathology could be established for specific forms of insanity (Kupfer, First and Regier, 2002; Pierre, 2008; Davies, 2013). This inevitably leads to questions about the reality of those disease categories. In other words, many object that the problem with categorising mental illness is not solely linked to the (dis)agreement amongst 'psy' disciplines. Rather, it reflects the wider nature of human reality and how it is puzzling and elusive (Sedgwick, 1982/2015).

It is evident that what has been designated as 'mental illness' is a multi-faceted, polymorphic phenomenon and, in that sense, it is perhaps impossible to have any single definition of it. Indeed, it has been specified, applied and classified by the definition of a psychiatric treatment rather than any commonly held set of signs and symptoms. In other words, it is defined more by what psychiatry does, rather than what it says it is (Prior, 1993). Its empirical base is in the treatment itself rather than the sum of symptoms. This is perhaps most evident when applied to people who are classified within the same diagnostic group, when in fact they may not present as such. In effect, it is suggested that mental illness is first and foremost the result of social and political practice, rather than the expression of naturally occurring phenomena (Prior, 1993; Sedgwick, 1982/2015); the presence of illness only becomes apparent when reflected through the specialised language and practices of professional mental health workers, as they are the ones who define and shape the features and create patterns of ‘mental illnesses’ (Prior, 1993). This, however, is in no way meant to deny or discredit the very serious distress and daily suffering with which people deemed ‘mentally ill’ are faced with.

Foucault: Power and Knowledge in Mental Health

If the world can be understood through constructs, how does one decide which ones ought to be adopted to form a specific world view? The risk with assuming a solely constructivist view is that it may lead to a relativist vacuum, where any interpretation has the possibility of being valid (Frank, 2010). In this way, certain constructs (such as those used in mental health) can have damaging effects on people who are deemed ‘mentally ill’. A position that is only relative to the next creates the illusion of neutrality where all positions can co-exist under different prisms. In relation to a mental health reform for example, the idea of deinstitutionalisation becomes one that is celebrated in comparison to a residential based system. However, upon closer inspection any position becomes permeated by its own bias, especially in its comparison to other positions, with its language reflecting particular forms of knowledge. Readings of Foucault were referenced to answer this so called ‘neutral relativism’ by looking at notions of power and knowledge (Rabinow, 1984; Gutting, 2005; Oksala, 2013).

> My point is not that everything is bad but that everything is dangerous. If everything is dangerous, then we always have something to do. So my position leads not to apathy but to a hyper- and pessimistic activism. I think that the ethico-political choice we have to make every day is to determine which is the main danger (Foucault, 1983:231-232).

There are three parts of Foucault’s writings that became important in this work. One concerns the way in which he develops a methodology to look at social structures (Rabinow, 1984). The second is the way in which he deconstructs notions of power and knowledge using this methodology (Oksala, 2013). Finally, it was of particular interest to understand how Foucault uses the above in his extensive history of madness, which offers an important elaboration, orientation and direction into how the process of deinstitutionalisation as well as reform can be understood in this study of mobile teams (Foucault, 1972; Gutting, 2005). In fact, the following paragraphs argue that going beyond the residential institution and into community care may not so much liberate persons but may instead propagate an established neoliberal rationalism which is imposed on the individual though the reformed psychiatric system. In this way, services become part of the institution by being more focused on their own success than on reforming an established structure.

Archaeology and Genealogy

Foucault considered himself a historian, although different from others in his methodology. Throughout his different 'histories' he employed two distinctive terms: 'archaeology' of thought and later on 'genealogy' (Gutting, 2005). Foucauldian 'archaeology' of thought proposes that language is a source of thought, not just an instrument of expression (Gutting, 2005). As a result, language constrains individuals in how they are able to think (implicit rules in language restrict their range of thought). 'Genealogy' on the other hand considers the historical causal explanation in a critical way. Foucault presents genealogy as a "history of the present" (Foucault, 1977/1995:30-31), so that present rules are understood and evaluated through history (Gutting, 2005).

Foucault shows that ultimately there is a very close link between the knowledge we hold and established power. This is a crucial idea throughout his analyses and one that is revisited throughout this work (Rabinow, 1984; Gutting, 2005; Oksala, 2013). Changes in thought are caused by social forces that control behaviour, rather than changes in thought itself. With power and knowledge closely intertwined Foucault shows that power established institutions such as schools, hospitals and prisons constitute subjects rather than particular knowledge bases. Those institutions in turn incite, provoke and produce forms of knowledge which educate, care for and punish. Therefore, knowledge actualises, modifies, redistributes and stabilises categories of power. Foucault regards power as having the potential for a positive epistemic role; instead of constraining or eliminating knowledge, power can also produce it and in turn transform power structures that give rise to it (Oksala, 2013). For the present study, understanding the processes in which power and knowledge coexist and reinforce particular hierarchies of thought, as well as relationships was central in understanding the mobile teams' work, including their link with service users but also their position within the wider mental health system and society at large.

From Biopower to Governmentality

In order to fully appreciate Foucault's views on power, it is important to consider his later texts and especially his lecture courses at the Collège de France, in which he presents different types of powers valid across the ages (Foucault, 1979/2004). An introduction to those is crucial to form a picture about the social order which defined 'madness' and which is important in this study of mental health structures.

> I try to carry out the most precise and discriminative analyses I can in order to show in what ways things change, are transformed, are displaced. When I study the mechanisms of power,

> I try to study their specificity [...] I set out to grasp the mechanisms of the effective exercise of power; and I do this because those who are inserted in these relations of power, who are implicated therein, may, through their actions, their resistance, and their rebellion, escape them, transform them—in short, no longer submit to them. And if I do not say what ought to be done, it is not because I believe there is nothing to be done. Quite on the contrary, I think there are a thousand things to be done, to be invented, to be forged, by those who, recognizing the relations of power in which they are implicated, have decided to resist or escape them. From this point of view, my entire research rests upon the postulate of an absolute optimism. I do not undertake my analyses to say: look how things are, you are all trapped. I do not say such things except insofar as I consider this to permit some transformation of things. Everything I do, I do in order that it may be of use (Foucault, 1978/1994:91).

Biopolitics

Foucault first defined ‘sovereign power’ which was created on violence and the right to kill. In other words, the sovereign was powerful since he had the right to kill or refrain from killing. This ‘sovereign power’ transformed, especially in the West, throughout the 17th century to become what Foucault calls ‘biopower’. Contrary to ‘sovereign power’, ‘biopower’ has a positive influence on life “that endeavours to administer, optimise and multiply it, subjecting it to precise controls and comprehensive regulations” (Foucault, 1976/1990:137). The idea is not to kill anymore but rather to “invest in life through and through” (Foucault, 1976/1990:139). Biopower and biopolitics are reflected in a number of techniques to control bodies and populations. This includes medical care and the normalisation of behaviours amongst others. Mechanisms of power and knowledge assume responsibility with individuals now taking charge of their own life (Oksala, 2013). Using this lens, understanding notions of choice, self-determination and independent living all become central in community mental health services and are frequent themes when engaging with service-users (as will be shown later in this work; Morgan, et al., 2016).

Biopolitical techniques are further legitimised by expert knowledge which works on continuous regulatory and corrective mechanisms. Biopower infiltrates political power through the use of experts, interpreters and administrators. In the present study mental health professionals and policy makers become the vehicles for biopower. As for violence, biopolitical societies are obviously violent but make attempts to exclude its use or at least hide it. As a result, violence becomes harder to discern not only because it is hidden but because it is mediated. It is filtered and given scientific legitimacy in order to be compatible with the aims of a biopolitical society (Oksala, 2013). From ‘cruel compassion’ when designating someone as ‘mentally ill’ and in need of help by taking away their agency and marginalising them (Szasz, 1973) to the threat of coercion and forced admissions, violence in mental health is very present yet often covert (Chan, 2002; Morgan, et al., 2016).

It is important to note that Foucault's analysis of biopower has also foreshadowed the growing criticism of medical intervention in today's society, since many areas of life are increasingly medicalised and brought under bio-scientific control (Lupton, 1997). Although, he does not make explicit judgments about these processes of medicalisation, he gives a strong theoretical basis and historical processes that explain how its development was made possible (Oksala, 2013). As will be seen later in this work, the study of madness is an example of such a medicalising process, with often detrimental and harmful effects on mental healthcare service-users and their distress often understood and explained mainly in psychiatric terms (Davies, 2013; Frances, 2013).

Governmentality and Pastoral Power

Foucault confirms that his work, his 'histories', were concerned with showing not how objects were natural to be discovered through valid scientific methods, nor how they were products of a certain ideology. Rather, his work aimed to show how they became scientific objects through the use of practises that formed part of the experience of reality. Foucault called this process 'governmental' power or 'government' functions, and this became one of his main theoretical tools for analysing 'rationality' and the techniques and procedures which form the social order. As he explained "I have proposed to call governmentality […] the way in which one conducts the conduct of men […] a proposed analytical grid for […] relations of power" (Foucault, 1979/2008:186), later adding that "the state is a practice […] inseparable from the set of practices by which the state actually became a way of governing, a way of doing things" (Foucault, 1978/2007:277). As will be explored below, psychiatry and the mental health system are facets of the state; vehicles that have come to propagate a set of governmental practices directed at the individual.

For Foucault, in order to understand the genealogy of the state as a political form of centralised power, it is important to also understand its tendency towards individualisation. He calls this 'pastoral power' and it is orientated towards individuals with the intent to rule them continuously and permanently. "Pastoral power is a power of care" (Foucault, 1978/2007:127). In other words, modern political power regulates a population in an individualised manner. The idea is to normalise people's conduct by continuous care and compulsory forms of knowledge whilst in doing so ensuring obedience. The modern state becomes a space in which individuals are to be integrated but only under very specific conditions: their subjectivity is shaped in the form of a particular type of individualised knowledge and normalisation to which they comply and obey. By doing this, the state subjects its population to continuous care, control and guidance in the name of its wellbeing (Oksala, 2013). As a result, one cannot deviate much from the formulated norm before being considered 'abnormal'. Perhaps, this may explain why more and more people are diagnosed with a mental illness (Whitaker, 2010). As mentioned, statistics show that one in four Belgians suffered from mental health problems and a third was unable to continue work for long periods of time (Demarest, et al., 2004). In this way, the specific conditions shaping subjectivity set out by the modern state, become increasingly restricted whilst deviation and disobedience becomes a personal responsibility.

Neoliberal Governmentality

Liberalism is seen by Foucault as the main determinant for the birth of 'biopolitics' in Western societies through the use of power and knowledge. It can be traced to the conception of economics as an autonomous and neutral object of scientific knowledge. This new 'regime of truth' meant that the laws of economics were brought to the forefront and notions of social justice or political right were no longer important (Foucault, 1979/2007). The emergence of neoliberal governmentality further redefines the limits between economics and politics (Foucault, 1978/1994; Oksala, 2013). Economic rationality affects the whole of human action through politics and the state. Social conditions ensure and encourage natural competitiveness and self-interest, so much so that they also produce them. Competitive free markets function within the knowledge that such an order is superior economically but also morally and politically, since it is the most advantageous in securing freedom and happiness for its members (Oksala, 2013).

The individual reflects this larger social order; they become themselves a permanent multifaceted enterprise. Foucault explains that neoliberal governmentality produces a specific type of subjectivity. Different from the political or legal citizen of a disciplinary society, the economic subject has other tendencies, preferences and motivations (Geekie and Read, 2009). Subjects are understood as having a natural self-interest and their tendency for competition is nurtured and enhanced. As such they are assumed to be rational persons, who will navigate this social order based on an economic knowledge, where the necessary costs and desired benefits are constantly considered for maximum economic returns. In effect, to understand who we are (and who we are not) requires exposing this neoliberal governmentality which dominates us and our societies (Oksala, 2013).

Inevitably, neoliberal governmentality hits harder those who are easily deemed 'irrational', who may not be able to navigate this order and whose 'costs' are bigger than their 'benefits' with no returns. People who may not manage themselves as a permanent multifaceted enterprise cannot become economic subjects as demanded by neoliberal governmentality. Closely interlinked with the domination of neoliberal states are therefore the developments in welfare, which have been saturated in recent years by austerity politics and policies. People with mental health problems have been shown to be disproportionately affected by cuts in support services (Spandler, Anderson and Sapey, 2015; Thomas, 2016). What is considered 'irrational' becomes central in understanding the societal frame in which a mental healthcare reform takes place. Questions inevitably arise on how such a reform comes to reflect the wider complexities in which it exists in terms of both the political context and the power structures borne out of it.

History of Madness

Foucault did extensive work on his 'history of madness', in which he takes a position that goes against the established perceptions where notions of 'normality' do not allow for any meaningful alternatives and deviant behaviours placed outside of it. In Foucault's view, madness can be a commendable challenge to that of normality, even if normality would be a welcomed relief for many people (Foucault, 1972; Gutting, 2005).

In his work on madness, Foucault explains that in the past madness played an important role in our understanding of human possibilities. However, during the 'classical age' (what the French call the end of the renaissance period which began in the middle of the 17th century) madness was seen as the opposite to reason, also taking a physical form. People who were deemed 'mad' were isolated and confined from ordinary life. Furthermore, this condemnation had a moral tone. The 'mad' were seen as dominated by passions, in a constant delirium which reflected their inability to distinguish the real from the unreal. They were understood as taking a radical choice in rejecting humanity and the community in its totality. (Foucault, 1972; Gutting, 2005). Although, this view somewhat changed with the mad returning to the human community throughout the 19th century, they were still seen as moral offenders of social norms. They were guilty of their situation and the aim was to change their attitudes and behaviours. The 'mad' remained isolated but were now subject to a 'moralising therapy' within a 'therapeutic asylum' (Foucault, 1972; Rabinow, 1984; Gutting, 2005).

Modern views of madness further shifted towards medical notions. Although they could at first be seen as neutral treatments moving beyond personal responsibility, Foucault digs deeper. He explains that the moral domination seen in the asylum is based on "the apotheosis of the medical personage" (Foucault, 1972:269). With people deemed 'mentally ill', doctors inevitably are requested to control their care (Davies, 2013; Frances, 2013). However, this rule is not based on a medical authority but rather a moral one. In other words, doctors do not hold a knowledge that can cure; their knowledge is arbitrary at best. Instead, they represent the moral demands of a society. This in turn legitimises 'mental illness' as a condition based on an objective scientific discovery itself the product of an ideal of objective, value-free knowledge. This in turn, gives little room for other systems of knowledge such as moral therapies which were value-led (Foucault, 1972). As a result, 'mental illness' is not in fact based on a scientific truth or successful cure but was rather introduced mainly to justify a medical authority, amongst others (Foucault, 1972; Rabinow, 1984; Read and Dillon, 2013; Gutting, 2005).

Aside from the structure of the asylum, Foucault also commented on the psychoanalytic therapeutic relationship between the doctor and 'patient'. He regarded it as the principal reflection in the domination of the 'mad'. The 'medical personage', sitting behind the couch becomes "an absolute Observation, a pure and circumspect Silence, a Judge who punishes and rewards in a judgment that does not even condescend to language". For Foucault, psychoanalysis not only fails to build a meaningful interaction but instead "has not been able, will not be able, to hear the voices of unreason". Perhaps effective in some cases, it "remains a stranger to the sovereign enterprise of unreason" (Foucault, 1972:278).

> There is no common language: or rather, it no longer exists; the constitution of madness as mental illness, […] bears witness to a rupture in dialogue, gives the separation as already enacted and expels from the memory all those imperfect words, of no fixed syntax, spoken falteringly, in which the exchange between madness and reason was carried out. The language of psychiatry, which is a monologue by reason about madness could only have come into existence in such a silence (Foucault, 1961/2006:xxviii).

Foucault regarded his work as subjective. He was not just showing how the mad were perceived by the sane, but he was also taking the position of a 'mad' person himself. He was criticised for it insofar as a genealogy of madness presupposed it to be a singular category rather than a variety of experiences (Russo and Shulkes, 2015). However, it is perhaps exactly this point which makes his work interesting especially in terms of his methodological analytical tools, rather than to have claimed a so-called singular 'objective' category. All in all, Foucault saw 'reason', which was originally regarded as the key to liberation, as the primary tool used to dominate us. In the same way that the concept of truth has been used systematically to justify actions until they turn out to be false, so the idea of madness should be used with caution. What is regarded as rational may someday turn out to be irrational and where established constructs are seen as socially just (and justified), perhaps they are merely the most powerful within a society that further perpetuates them.

Social Justice in Mental Health

Based on Foucault's texts and constructivist theories it can be asserted that mental health or illness is socially constructed. It reflects an experience that is greatly altered by social inequalities while the concepts themselves are constructed and altered by social narratives, specific discourses, power structures and norms (Foucault, 1972; Read and Dillon, 2013). As such, the 'mental illness' construct asserts that it is a particular social order which led society to consider a difference between mentally ill and mentally healthy. This difference becomes significant enough to assign people to what becomes their social group, where the line between them is all but arbitrary. This line results in a process of marginalisation by assigning negative labels to the “illness” group through the use of negative stereotypes and by considering its members to be inferior to those without a mental illness. Through stereotypes and perceived inferiority, discrimination is justified against members of the subordinated group while privileges are awarded to dominant group members (Holley, Stromwall and Bashor, 2012).

This raises ethical and social justice considerations. Research has mainly dealt with mental health oppression through stigma, which is primarily seen as an individual oppressive label (Stuart, 2008). Using a critical approach, the scope for research broadens, moving from individuals to groups, with questions arising not only about the oppressed social groups but also the privileged ones, including how those interlink through established power and knowledge structures (Corrigan, Watson, Byrne and Davis, 2005). Given the process of mental healthcare reform it seems important to observe whether there is a shift in the established power/knowledge narrative and its resulting oppressive mental health constructs or whether those are maintained but in different settings. After all, “when we can identify and understand how people can create and sustain such an oppressive world we have gained important tools we can use to change it” (Aguinaldo, 2007:94). More importantly by tracing the (re)produced power relations and positions of subjects within those new settings we can look at a common project of “one historically created system” (Collins, 1991). By focusing on the interdependencies within this system and being attentive to the practices and processes that “secure” it and order it hierarchically, we can better advance a position of social justice for recognition, redistribution or reconciliation (Razack, 1998; Joseph, 2015).

Social Justice and Constructivist Grounded Theory

The constructivist approach to Grounded Theory has been built on theories of social justice. Inquiry in this area assumes focusing on and “furthering equitable distribution of resources, fairness and eradication of oppression” (Charmaz, 2005:203). As employed for this study, Grounded Theory methods consist of simultaneous data collection and analysis, with each informing and focusing on the other throughout the research process. Analysis begins early, focusing on further data collection while emerging analyses are refined. Grounded Theory entails developing increasingly abstract ideas about participants’ meanings, action and worlds and seeking specific data to fill out, refine and check the emerging conceptual categories. This work results in an analytic interpretation of participants’ worlds and of the processes constituting how these worlds are structured. Thus, Charmaz’s “processual” emphasis (2006) can be used in Grounded Theory to analyse relationships between human agency and the social structure in which it exists. This in turn poses emergent theoretical and practical concerns in social justice studies. The critical stance in social justice in combination with the analytic forces of Grounded Theory broadens and sharpens the scope of inquiry. Such efforts locate subjective and collective experience in larger structures and increase understanding of how these structures work as well as to how they can be bettered (Charmaz, 2005).

A major strength of Grounded Theory methods is that they provide tools for analysing processes and these tools hold much potential for studying social justice issues. A Grounded Theory approach encourages researchers to remain close to their studied worlds and to develop an integrated set of theoretical concepts from their empirical material that not only synthesise and interpret them but also show those "processual" relationships. Novel aspects of experience give rise to new interpretations and actions. This view of emergence can sensitise researchers to study change in new ways, and Grounded Theory methods can give them the tools for studying with implications for social justice and democratic process (Charmaz, 2005). As Charmaz writes:

> An interest in social justice means attentiveness to ideas and actions concerning fairness, equity, democratic process, status, hierarchy and individual and collective rights and obligations. It signifies thinking about being human and about creating good societies and a better world. It prompts reassessment of our roles and national and world citizens. It means exploring tensions between complicity and consciousness, choice and constraint, indifference and compassion, inclusion and exclusion, poverty and privilege and barriers and opportunities. It also means taking a critical stance towards actions, organisations and social institutions. Social justice studies require looking at both realities and ideals. Thus, contested meanings of "shoulds" and "oughts" come into play. Unlike positivists of the past, social justice researchers openly bring their shoulds and oughts into the discourse or inquiry (Charmaz, 2005:510).

Based on these ideas of social justice the methods employed, including how the interviews were developed, reflect this difference between the current mode of working and people's idealistic view. However, the question remained, how can one establish which interpretations are the most "socially just" i.e. which contested meanings of "shoulds" and "oughts" reflect a socially just world view? Aside from personal representations of the researcher's "shoulds" and "oughts", the conversation can be expanded by including the participants' ideals too. These not only concerned the work between service-users and professionals but were inclusive of the organisational and social systems in which those relations were set up, encouraged and/or constrained. Furthermore, those ideals were never static but transient and part of the wider process of research; continuously under exploration, alteration before becoming temporarily visible.

The aim of this study was not to identify interpretations in a fixed and simplified way so as not to limit critiques of power by assuming stable pre-existing objective and knowable patterns. Rather, it was about understanding how the processes of differentiation and 'systems of domination' interrelate and interact, how they are produced, reproduced and effectively resist change by multiple interactions across time, space and the different hierarchical levels (Joseph, 2015). In this way the process of identifying ideas that would be deemed 'ethical' and 'socially just' becomes somewhat elusive but valid, nonetheless. Those concepts are at the same time extremely abstract, urgently practical and never simple but complex and challenging (Adorno, 2000). It is a practise allowing for more dialogical possibilities, going against a monologue of the established power/knowledge structure and asking questions about life, from the individual to the community. "Shoulds" and "oughts" of a more socially just system are themselves not static or stable nor pre-existing or objective and knowable patterns. Rather, they are processes that allow differences and possibilities, without straightforward answers but legitimately diverse, thus shaking established and closed models of power/knowledge.

Confluence and Social Navigation

This research could initially be seen as a study of intersectionality examining different identities from 'professional' to 'service-user' or 'psychiatry', 'madness' and 'mental health'. Intersectional methodologies are said to study "the relationships among multiple dimensions and modalities of social relations and subject formations" (McCall, 2005:1771). In this way, the identities studied throughout this work could be conceptualised as forms of oppression and privilege where bio-morality becomes key: healthy people are seen as morally superior and 'reasonable' compared to those deemed unhealthy ('health-ism'; Metzl, 2010), in the same way that 'sane' people view people deemed as 'mad' or mentally ill in a discriminatory or stigmatising way ('sane-ism'; LeFrançois, Menzies and Reaume, 2013). Using a Foucauldian perspective, however, one quickly realises that those sections may perhaps not be so separate after all. Although those categories could be explored as separate yet mutually constitutive, this would mean relying on predetermined analytical systems of oppression. In other words, intersectional approaches rely on established aspects of identity and difference. In contrast, an 'analysis of confluence' (Joseph, 2015) presents the opportunity to consider the effects of oppression without presupposing the mechanics of difference as a means to advance positions of social justice (as will be shown later).

As opposed to intersectional approaches, confluence is offered as an alternative way of examining systems of oppression and specifically psychiatry and mental healthcare. All categories and systems of difference are suspect and complicit with a focus on how they are common, including in their resulting fields of knowledge and practices (Joseph, 2015). In this way, social and community psychiatry can only exist because of residential psychiatry. Even though they appear to be separate modalities of care they are in fact ‘interlocked’, in the same way that ‘professionals’ and ‘service-users’ are part of the same hierarchical system.

“An analysis of confluence also acknowledges identity qua difference as complicit within and a product of historically perpetrated violence rendering positions of ‘anti-(racist, oppressive, [or psychiatric] etc.)’ impossible” (Joseph, 2015:15). As will be seen later in this work, the difference between service-users and professionals, between hierarchical systems within teams as well as the wider relation between higher financial and political structures, are finally perpetuating the same systems of power. It is a methodology with a respect for complexity, for historical productions of representations and interpretations. “Interlocking systems need one another […] they help to secure one another” (Razack, 1998:13). In other words, an analysis of confluence allows to study the (re)creation of hierarchical powers within a historical continuum rather than as exclusive positions based on differences.

> To study a confluence is to trace how more than one idea, system, factor, or influence run or merge together at a similar point or junction, just as two or more bodies of water run together and affect the composition and trajectory via their contributing sources. The study of confluence is never static, no part is completely distinct from another, and there are multiple perspectives from which one can examine or trace the same idea, system, factor, or influence. Confluence demands a historical consideration, an appreciation of the temporal. It must also attend to complexity by engaging with the terrain as it is, with its many contributors of differing composition. Imagine that no cubes of a matrix, spheres of intersecting difference, or systems that interlock can remain static. Imagine that their relations are fluid and therefore time must always be an aspect for consideration (Joseph, 2015:29).

Social Navigation

Within these fluid relations, this study focuses primarily on locating the service-users and professionals within a wider hierarchical structure of mental healthcare. The concept of ‘navigation’ is often used to describe the way people move within situations of social volatility and in uncertain circumstances, to how they act when in difficult situations, under the influence of multiple forces or in the way they seek to escape confining structures. The term ‘navigate’ literally means ‘to sail’ and in this way it defines a special kind of movement within a moving environment. Instead of the movement across solid surfaces, ‘navigation’ highlights motions within a fluid and changeable matter. In other words, it highlights the concept of 'motion within motion'. When used to illuminate social life it directs the attention to the fact that people move in social environments of actors and actants (or individuals and institutions respectively), that engage and move them as much as they also move along. Usually, social structures and agents within them are studied as if motionless but using the concept of 'navigation' allows to see the interactivity or 'intermorphology' of motion between the two (Vigh, 2009).

With the concept of 'social navigation' the emphasis is on the fact that the reform was set in a moving environment. The image of this changing process was seen as that of a "convergence of waves and currents" (Lefebre, 1991:91-2). As a methodological lens the concept of 'social navigation', designating 'motion within motion', examines how people act in and shape their social environments in constant dialogue with the way the social environment moves and shapes the circumstances of their lives as well. It therefore also entails a rethinking of the setting in which a life is configured and reconfigured, constrained or free. Rather than understanding positions and movements on a stable social setting, navigation moves the analytical gaze toward the way people not just act but also interact with their social environment and adjust their lives to the constant influence of social forces and change (Vigh, 2009). Service-users, professionals and mobile teams were seen not just as a static part of a deinstitutionalisation reform, but were rather actively part of a changing process, which they shaped but which also shaped them.

'Knowledge(s)' in mental health

In order to delve deeper into the different articulations of 'mental illness', 'madness' and distress, it is important to examine the different existing discourses as well as how they compare and are confluent within the field. Although different constructs and modes of thinking about mental health do exist, some prevail and become more established and widespread while others, although less powerful, open up possibilities and disturb established powerful models of understanding experience (Thomas, 2014). Those take an active position against powerful constructs but exist because of those. This can be understood in the Foucauldian sense, with ideas that are more established reflecting the social order, i.e. just being the most powerful and not necessarily the best suited to a democratic and socially just model of many co-existing possibilities.

Biopsychosocial model

The current mental health system can be mostly understood through a "bio-psycho-social" model, first coined and proposed by Engel (1977). This model is used in care, either within the hospital or the community. Until recent decades the traditional approach towards health and specifically mental health was a medical or biological one. As a result, illness and disease were exclusively treated by medical means. Research in psychology and social sciences challenged this approach and sought to create a wider model of health. Based on this approach psychosocial notions to disease are included, without letting go of the original biomedical model, so that individual 'lifestyles' can also be considered (Read and Dillon, 2013; McInerney, 2018).

This new biopsychosocial model appears to be a balanced one that reflects all the possible relevant factors of health and illness. However, in practice, this is a mere "illusion of balance" so that for example 'vulnerability' is translated as a series of social stressors or 'triggers' which only work on those by implying pre-existing biological or genetic predisposition (rather than a social vulnerability). In other words, critics of this model point to the fact that there is no real integration of models but instead we are seeing "a colonisation of the psychological and social by the biological" (Read, Mosher and Bentall, 2004). Those medicalised models of mental illness are exported onto other disciplines which "overshadow" different understandings of the experience of madness (Beresford, 2013:ix):

> The colonisation has involved the ignoring, or vilification of research showing the role of contextual factors such as stress, trauma (inside and beyond the family), poverty, racism, sexism, and so on in the aetiology of madness. The colonisation even went so far as to invent the euphemism 'psycho-education' for programmes promulgating the illness ideology to individuals and families (Read, et al. 2004).

In this perfect example of a Foucauldian power/knowledge regime, the 'biopower' has in fact produced an extension of its knowledge which continues to propagate it rather than discredit it. Inevitably, the biopsychosocial model is very much present in Belgium's mental healthcare field and was reflected both in the conceptual frameworks of the reform as well as the evidence-based models recreated by the mobile teams (p26-28; appendix A.6). As will be explored in the interviews, constructs surrounding the biological foundations of 'mental illness', as well as the psychological and social aspects, were often models employed by the teams.

Diagnostic Systems

There are two systems of classification for 'mental disorders' (the International Classification of Diseases or ICD-10; WHO, 1994 and the Diagnostic and Statistical Manual or DSM-5; APA, 2013), each with multiple editions. This fact demonstrates that categorisation in psychiatry is often subject to revision, dispute and contestations, with many ethical considerations surrounding those debates (Greenberg, 2013). Aside from the older versions, the efficacy and validity of the current constructs of mental disorder have been worked on extensively, with specially working groups set up to study diagnoses (Pierre, 2008). It has also been concluded that existing psychiatric categories have no objective validity, in that "no one laboratory marker has been found to be specific in identifying any of the DSM-defined syndromes” (Kupfer, et al., 2002: xviii). There is also a lack of reliability due to an inability to distinguish between major ‘syndromes’, leading to “extremely high rates of comorbidities” and “short-term diagnostic instability” (Kupfer, et al., 2002: xviiii). Finally, the lack of treatment specificity is a “rule”. The introductions of the DSM-IV-TR (APA, 2000) and DSM-5 (APA, 2013) state that “since a complete description of the underlying pathological processes is not possible for most mental disorders, it is important to emphasize that the current diagnostic criteria are the best available description of how mental disorders are expressed…” (APA, 2013:xli). Both introductions are cautious, claiming that “a diagnosis does not carry any necessary implications regarding the aetiology or causes of the individual’s mental disorder…” (APA, 2013:25). With no objective markers for psychosis (schizophrenia, bipolar disorder and schizoaffective disorder) it becomes impossible to demarcate the boundaries of the different disorders adequately and accurately to clearly diagnose on assessment and match pharmacology in a straightforward manner. This leads to the conclusion that the classifications used are just a way to order and capture varieties of mental distress. In this way, they are not diseases but constructs which are never stable (Kupfer, et al., 2002; Pierre, 2008; Davies, 2013).

Other critics of the classification systems debate ideas of “diagnostic inflation” and “medicalising normality” (Frances 2013; Greenberg, 2013). By increasingly creating disorders, psychiatry has led more people into the world of mental health and as a result to be treated with medication. After all, the DSM has exponentially grown in size throughout its various editions (APA, 2013). This debate is complex as it is very much predicated on the attitudes one has towards normality and suffering, as well as larger philosophical, cultural and ethical considerations (Davies, 2013). As argued throughout this chapter, the diagnostic systems are another reflection of the fact that ‘mental illness’ invokes large questions about power and knowledge systems currently in place.

Diagnostic systems and the biopsychosocial model of ‘mental illness’ are undoubtedly powerful knowledge systems that propagate much of mental healthcare (APA, 2013; National Institute for Mental Health, 2018). Those models were employed both in the policies that were developed as a result of this reform, as well as in the conceptual bases of the mobile teams (Service Soins de Santé Psychosociaux, 2010). As such, this study was an opportunity to explore the change in setting from a primarily residential to the community sector, including whether those models became pervasive within the new practice of mobile teams.

Experiential Knowledge

In the past decades and as a direct response to an increased sense of disillusion towards previous models, a growing movement of ‘experiential’, ‘survivor’ knowledge and radical mental health politics has developed, which brings forward different sets of ideas, notions and understandings to the mental health field. In some ways it has ran parallel to established notions in mental health but in most ways, it goes unambiguously against what the survivor movements explicitly argue is an oppressive system for service-users of mental healthcare services. This 'experiential', 'survivor' or 'consumer' knowledge is made up of people who experience, and in many cases survive, mental health 'care' (survivors do not consider they have been cared for) as well as of professionals and/or academics allying themselves with this view (e.g. LeFrançois, et al., 2013; Spandler, et al., 2015; Morgan, et al., 2016; Russo and Sweeney, 2016).

There are several such movements, each reflecting a diversity of understandings and positions based on similar but also different value systems. Such movements include the Peer Recovery Movement, which aims at transforming mental health services with more user-driven and recovery-orientated approaches (Davidson, Bellamy, Guy and Miller, 2012). The Hearing Voices Movement challenge the notion that to hear voices is characteristic of mental illness but instead it regards the experience as meaningful and part of human variation (Longden, Corstens and Dillon, 2013). Other movements are concerned with human rights violations carried by psychiatry amongst others and aim at raising awareness of such interventions and banning non-consensual treatments (e.g. World Network of Users and Survivors of Psychiatry).

In recent years, there has been a resurgence of more radical mental health politics and social movements. 'Mad Studies' emanated from the anti-psychiatry and Mad Pride movements and other identity-based struggles, such as black feminism (Collins, 1991). It is a movement that regards psychiatry as a branch of medicine and constructs an identity based on the experience of 'madness' (e.g. LeFrançois, et al., 2013). Other radical movements have focused on wider issues of the 'madness' experience such as welfare difficulties, social inequalities and the politics of alliance between users and professionals (Cresswell and Spandler, 2016). Although the two above movements are presented as distinct, they are not necessarily so, nor are they mutually exclusive, with many key figures active in both.

> […] all these present struggles revolve around the question: Who are we? They are a refusal of these abstractions, of economic and ideological state violence which ignore who we are individually, and also a refusal of a scientific or administrative inquisition which determines who one is (Foucault, 1983:212).

These movements were important references throughout this work, specifically as means to deconstruct the powerful biopsychosocial and diagnostic systems of knowledge but also as practical implementations of novel and more socially just practices (see later). Using a Constructivist Grounded

Theory approach with an interest towards ideas of social justice was an opportunity to analyse and reflect on the mobile teams' practice in relation to these survivor and experiential movements. Furthermore, these understandings offered a strong yet fluid platform on which service-users could take a more central position within the work. In other words, since this study was primarily focused on professional representations, this literature was a much-needed invitation to service-users' voices.

De-institutionalisation

Practice holds much of 'mental illness' constructs together, and as such it is practice that became the object of study. Assuming 'psychiatric disease' as such does not exist, professional practice certainly does. As a result, what is studied is not just abstract ideas but organisational arrangement of everyday life. It is an organisation that discusses, describes, 'treats', 'cares' and ultimately organises real human beings by use of paradigmatic assumptions, frameworks, concepts/constructs, terms, ideologies and systems (Prior, 1993). To examine the process of deinstitutionalisation and the transition of care from hospital to the community, it is necessary to also understand the way in which 'mental illness' has been structured and represented in the social world.

It is often argued that reformers and legislators are at the centre of changes in the organisation of care and that those are a direct and conscious product of specific actions and desires (Prior, 1993). However, it has also been argued that such organisational changes in social life often begin as the result of unintentional consequences and of unintended actions rather than of designed movements (Merton, 1967). More importantly, the policy-oriented view of social life also tends to overlook the fact that change always occurs within a discursive context, and that human interests are always to be transformed and in turn occur within the conceptual and theoretical structures of the age (Prior, 1993).

The 107 mental healthcare reform in Belgium was introduced based on a set of federal government guidelines (p29-35) which were based on a wider international movement towards community care. Strengthened financially by promoting psychiatric hospitals, mobile mental healthcare teams inevitably were to hold certain characteristics linked to their organisational backgrounds. In this regard, this study on de-institutionalisation paid close attention to the governmental policies and structural hierarchies and how those were reflected within mobile team work and practice. The reform also took place during a time when 'experiential' movements linked to ideas promoting social justice are increasingly at the forefront of policy, with co-production between policy makers, professionals and service-users becoming standard practice (e.g. NICE, 2013; Psytoyens, 2014). It was therefore important to examine whether this was a reform of its time, consistent with the different accessible knowledges, or a reflection of established power structures.

Terminology

In many ways, these different discourses that surround the mental healthcare field and notions around mental illness, madness and distress are reflected in the many labels, the language and accompanying constructs used to describe people and their situations. This variety of positions become even more complex by the fact that the meanings assigned to these labels vary and alter over time depending on the particular circumstances in which they are used. This is not only true for diagnostic criteria or meanings assigned to descriptions of extreme states but carries on through to the wording used to claim an identity. Although the word ‘patient’ or ‘client’ may be assigned to the biomedical and/or even biopsychosocial model, other denominations are as complex and contested, with ‘consumer’, ‘survivor’ and/or ‘user’ used interchangeably by some, while carefully rejected by others (e.g. Burstow, 2013; Morgan, et al., 2016).

Throughout this work, the word ‘service-user’ will mostly be used, as well as ‘survivor’, to refer to the actual people with lived experience of mental distress and users of the mobile teams. There can be no one language that is universally acceptable to this heterogeneous group of people and each term has its usefulness and problems (Pembroke, 2009; Burstow, 2013). This study concerns services, so ‘service-user’ was perhaps the most explicit term possible for this specific piece of work. However, even here this term is used with caution as it still poses a real problem in terms of the limits of its representation. For example, throughout the study, people who were not consensual to a mobile team intervention were often included in the services and discussed by the teams. In general, I have tried, however, to use terms that have come from the mental health user/survivor movement and avoided terms that represent purely medical ways of thinking about mental distress (Kalathil and Perry, 2014).

Grounded Theory

Based on the above deconstruction of ‘mental illness’ constructs, as well as the specificity of this research in terms of its qualitative features surrounding the professionals within mobile teams, Grounded Theory methods were employed to make sense of practice (Charmaz, 2006). The following paragraphs will give an overview of Grounded Theory and more specifically the constructivist elements which became important for this study.

Grounded Theory is based on Pragmatism and Symbolic Interactionism. Pragmatism puts forward the notion that debating ideas and beliefs about the world may produce practical answers and actions, which in turn assign meaning to those original ideas or beliefs (Corbin and Strauss, 2008). Symbolic Interactionism is based on symbols and how they are used to make meaning, produce communication and allow experiences to be shared. People create symbols to represent their world and construct meaning. To understand our shared world is to look at how people make sense of it (Stern and Porr, 2011).

With its basis in symbolic interactionism, meaning can be generated by examining interpretations people give to their experiences and exploring how they interact with each other (Holloway, 2008). The purpose of Grounded Theory is to generate new theory rather than test existing theory using social processes and field work. Its main methodological aspect is the constant comparisons linking theory construction to raw data. Thus, it controls for internal validity while challenging the researcher's interpretation and analysis (Birks and Mills, 2011). Although there are diverse explanations about the essence and conduct of Grounded Theory, there are some key characteristics which include open or initial coding, focused coding, axial and theoretical coding, categorisation of data, concurrent data generation and analysis, memo writing, theoretical sampling, constant comparative analysis using theoretical sensitivity, theoretical saturation and sorting to finally (re)constructing theory (Charmaz, 2006). Through these actions, theory is based in data which is systematically collected and analysed (Myers, 2013). Practical theories specific to people and place are studied, while simultaneously formal theory, abstract and generalizable to a wider population, is generated (Glaser, 1992).

It is important to make the distinction between the objectivist origins of Grounded Theory and the constructivist approaches developed later. As Charmaz explains "an objectivist approach resides in positivist tradition and thus regards data as real in and of themselves and does not attend to the processes of their production" (Charmaz, 2006: 131). As a result, no attention is paid to the social context, the researcher, the participants and their interactions. Therefore, an objectivist stance assumes that data represents "objective facts about a knowable world" (Charmaz, 2006:131). On the contrary, a constructivist approach "places priority on the phenomena of study and sees both data and analysis as created from shared experiences and relationships with participants" (Charmaz, 2006:129). It is a study on how (and sometimes why) participants construct meanings and actions in particular social contexts. However, the theory produced is not only based on the participants' interpretation of their given context but a constructivist approach also acknowledges that the resulting theory itself is an interpretation (Charmaz, 2006).

In the classic use of Grounded Theory given by Glaser and Strauss (1967), theory is sought to be discovered as emergent from the data and separate from its observer. However, later on Kathy Charmaz assumed a different, constructivist position which is the one employed for this study (2006). The constructivist approach is based in the same ideas of Grounded Theory which allow one to learn about the world studied using a specific method with the aim of establishing theories of understanding. However, neither data nor theory is discovered but rather are part of the studied world and the data collected. In other words, grounded theories are constructed by “past and present involvements and interactions with people, perspectives and research practices” (Charmaz, 2006:10). Unlike a mirrored reflection, one gives an “interpretative portrayal” of the world.

Constructivist Grounded Theory

Constructivist Grounded Theory is therefore built on constructivist elements rather than objectivist learnings while it belongs within the interpretative tradition. Theoretical understanding is based on the theorist’s abstract interpretation of the studied phenomenon showing patterns of causality and connections that can be unspecific rather than linear. Theory thus adopts evolving, multiple realities where facts and values are intricately interconnected. As Charmaz put it “truth [is] provisional; and social life [is] processual” (2006:127). Thus, Constructivist Grounded Theory goes full circle to its symbolic interactionism roots whereby action paves the way for analysis (Mead, 1932; Charmaz, 2006).

Building on constructivist elements, Grounded Theory challenges earlier assumptions about “objectivity, the world as an external reality, relations between the viewer and the viewed, the nature of data and the author’s representations of research participants” (Charmaz, 2005:509). Instead, constructivism allows one to view positivist principles as social constructions to query and revise. If, however, positivist principles are adopted they are done so knowingly with rationales made explicit. Constructivists ask: What do people assume is real? How do they construct and act on their view of reality? Practices and actions are therefore at the core of constructivist research emphasising and interpreting multiple realities which in turn inform theories (Clarke, 2005; Charmaz, 2005; 2006).

A constructivist approach gives priority to the studied phenomena with both data and analysis created from shared experiences and relationships with participants and/or other sources. Constructivists study how – and sometimes why – participants act and construct meaning in specific situations. As mentioned, a constructivist approach goes beyond the way participants view their situation but builds theories on the interpretations participants make by acknowledging in turn that the resulting theory is an interpretation itself. The theory is thus interlinked with the researcher’s view as it cannot exist separately of it. The constructivist approach means learning how, when and to what extent a studied experience is embedded in larger and often hidden positions, networks, situations and relationships. Subsequently, differences and distinctions between people become visible as well as the hierarchies of power, communication and opportunity that maintain and perpetuate such differences and distinctions. A constructivist approach means being alert to conditions under which such differences and distinctions arise and are maintained. In this view, any analysis is contextually situated in time, place, culture, situation and persons (Charmaz, 2006).

Rationale and Selection

Grounded Theory was suggested as a possible avenue of qualitative method by my director of studies. Reticent at first, I considered other methodologies; at first glance Grounded Theory aims to be presented as an objective method based on positivist traditions. However, after exploring it further, Charmaz provided solid answers to questions I had about objectivity (as explored in the previous section; 2005; 2006). Based on subjective understandings, Constructivist Grounded Theory proved to be the best fit for the current study. With little qualitative research in the field of mental healthcare reforms across the world, a qualitative approach that gave meaning to, rather than measure participants' views, seemed important and appropriate (Holloway and Wheeler, 2009). After all, qualitative research is concerned with just that: understanding experience and investigating meanings people give to this (Holloway, 2008).

Five different approaches were considered and although Grounded Theory was chosen, many facets of some ethnographic and case study approaches can be found within the final method. Narrative and Phenomenological approaches were also considered but given that their investigation is focused on individual identities and personal experiences, they were thought to be inappropriate for the current study which is more concerned with the professionals as a system including their social (and) work context (Birks and Mills, 2011; Denzin and Lincoln, 2017).

Grounded Theory investigates shared meaning and actions (Holloway, 2008). It aims to explore "what's going on" (Glaser, 1992:41) and it is appropriate for investigating an area where little is known (Corbin and Strauss, 2008). It proved suitable for this study because it allowed forming an explanatory framework while also producing theories which offer practical actions and consequences. An ethnographic approach was also considered as it investigates culture sharing of a particular group within their "natural surroundings" (Harris, 1968). It aims to study a group's norms, values and behaviours from the group's perspective (Wolcott, 2008). It is therefore appropriate to explain common social processes in a cohesive group (Fetterman, 2010). Certain aspects of ethnography were used, especially in the observation periods with each team, but within a Grounded Theory approach as argued by Charmaz (2006) and explored in this chapter. Finally, this study presents a series of case studies as particular units within a culture (Yin, 2009). In this way, it is an investigation of study norms, values and behaviours from the perspective of those chosen cases (Cresswell, 2013). Studying those was of specific interest since they were chosen to represent different contexts.

Grounded Theory Ethnography

Unlike ethnographic research which has the potential of “seeing data everywhere and nowhere” (Charmaz 2006:23), Grounded Theory ethnography is focused and allows the researcher to concentrate on fundamental social process. Grounded Theory ethnography gives a more complete picture of the whole rather than a chaotic general approach. It is then possible to compare the data with emerging categories in order to demonstrate relations between concepts and said categories. Grounded Theory strategies can increase ethnographers’ involvement in their research inquiry, despite pressures they might face to be full participants in their research settings. In this sense, Grounded Theory dispels the positivist notion of passive observers who merely absorb their surrounding scenes. Instead, grounded theorists select the scenes they observe and direct their gaze within them. This method provides systemic guidelines for “probing beneath the surface and digging into the scene” (Charmaz, 2006:23). It also allows to maintain control over the research because it assists the researcher in focusing, structuring and organising the study.

Understanding derives most directly from the immediacy in one’s participation in the shared world of social actors (Prus, 1996). In practical terms, this means the researcher needs to share some experiences, but not necessarily all viewpoints with those being studied. Henri Bergson states: “Philosophers agree in making a deep distinction between two ways of knowing a thing. The first implies going all around it, the second entering into it” (Bergson, 1903/1999:1). The Grounded Theory ethnographer’s job is to explore the second way. By moving around an object, qualitative methods tend to generate a map of the object of study from the outside but may not enter it. Such studies may look at phenomena from a variety of locations and standpoints, yet Grounded Theory ethnographers can go deep into experience to make an interpretative rendering (Charmaz, 2006).

The Researcher

A constructivist approach emphasises the studied phenomenon rather than the methods of study. Theorists therefore take a reflective position on the different ways of knowing and representing studied life, by paying attention to the observed realities and their collected renderings. Further, researchers aim to locate their own self within these realities. This means that they do not assume that data waits to be discovered in the external world or that methodological procedures will correct limited views of the studied world. Nor does it assume impartial observers entering the research scene without an interpretative frame of reference. Instead, what a researcher might experience depends upon their prior interpretative frames, biographies and interests as well as the research context, their relationships with research participants, concrete field experiences and modes of generating and recording empirical materials. Qualitative methods cannot be based on pure induction – the question rests on the frame of knowledge that is available. Data is therefore defined by shared constructs. Similarly, conceptual categories arise through one's own interpretations of the data rather than stemming from them or from particular methodological applications. Thus, a theoretical analysis is merely an interpretation of a given reality, not an objective reporting of it (Charmaz, 2006).

Locating the Self as the Researcher

> Do not ask who I am and do not ask me to remain the same: leave it to our bureaucrats and our police to see that our papers are in order. At least spare us their morality when we write (Foucault, 1969/1972:17).

Michel Foucault wrote in order to escape from a fixed identity and was quite proud that he was difficult to be classified. Differing yet equally plausible versions of his life have been written but no definitive picture can be drawn, which is just what he wanted. Ultimately, much of his existence was the writing of his books and these tell us more about him than any collected fragments of his private life (Gutting, 2005). This chapter has been an exercise in deconstructing what appears, at first, to be fixed constructs. In the same way, as a subjective researcher, I am less interested in constructing a specific and fixed identity. My position was confluent throughout this work, while socially navigating a conflicting and contested field. In this regard, I do not claim to be a grounded theorist, nor a constructivist but rather I am aiming to use a methodology: the best available lens through which I can do justice to this study and more importantly to the people involved. Were I to have a different set of participants, operating within a different strata of so-called 'mental health', my approach and process would have been somewhat, if not entirely, different.

Undoubtedly, past experiences, knowledge and biases all become drawn into the research process, but rather than objectifying, they can enhance sensitivity (Denzin and Lincoln, 2011). After all, "objectivity in research is a myth" (Corbin and Strauss, 2008:32). Furthermore, the researcher's abilities, identity, theoretical orientation, self-understanding, reference-group attachments, demographic characteristics and other personal factors influence the research process (Junker, 1960). From this perspective, having insight into the area to be studied, through my experience as a Belgian born European citizen, a background as a mental health professional and a mental health recipient as well as a French speaker with a 'foreign' identity, gave me an interesting advantage. This, however, was also a potential bias. Firstly, I am a French speaker but not a Flemish one and this fact could somewhat impair aspects of this study. I am also aware I have a particular accent: Greek although not always discernible. As a woman in my late 20s, this was also perceived in different ways depending on the interlocutor: either as young and inexperienced, too critical or even naïve, but sometimes also relatable. Furthermore, having worked in the field may have given me an understanding but a professionalised one. Although unimportant to me personally, I was often asked to situate myself based on my disciplinary background. Openly acknowledging my own pre-existing knowledge, beliefs and biases guided me to reflect on the preconceived ideas I may have had about the data, whilst also giving transparency to the study. This could assist readers in judging my ability to tune in and interpret participant's voices.

As mentioned, I use an extensive list of 'experiential knowledge' and my sources are definitely, to some extent, 'survivor' led. However, I do not claim that title. I may have been a customary user of mental health services for a period; nevertheless, I was a beneficiary of this system rather than a 'survivor' of it (most probably due to my privileged background). I do not wish to appropriate the important and eye-opening efforts done by the people who call themselves 'survivors' and/or activists within this field, for whom so much is owed, with (more often than not) little restitution.

Starting this research journey was a challenge in trusting its process. What was important for me was clear, but I didn't necessarily know how or where I was going. Still, basing decisions on the things that mattered to me meant that I was going to end up where I needed to go. Of course, I could not have predicted how this work was to end when I set off on this journey, but its start and its end are sort of similar in a spirit of temporal subjectivity that is the ultimate thread running through all this labyrinthine work. This nuance is central for me as a subjective researcher and allows my work not just to be an opinion piece, a static hypothesis I am proving or disproving, but a study based on a particular methodology as a means for critical evaluation.

> I don't feel that it is necessary to know exactly what I am. The main interest in life and work is to become someone else that you were not in the beginning. If you knew when you began a book what you would say at the end, do you think that you would have the courage to write it? What is true for writing and for a love relationship is true also for life. The game is worthwhile insofar as we don't know what will be the end. My field is the history of thought. Man is a thinking being. The way he thinks is related to society, politics, economic, and history… (Foucault, 1982/1988:9-10).

[This page intentionally left blank]

Chapter 3: Method

Introduction to Chapter 3

The method proposed involved four 107 reform projects. As mentioned in the introduction chapter (p37-40) those were: PRIT in West Flanders; the Central Region project in Wallonia; PAKT in Gent; HERMESplus in Brussels. The teams were recruited in such a way that each represents Belgium's main areas/regions and their population: two projects were from Flanders, one was located in Brussels and one in Wallonia; two of those served a rural population (West Flanders and Wallonia) while the two remaining were in urban areas (Gent and Brussels). Each project included two teams: 2A teams dealt with 'acute' distress and 'crises' while 2B teams served service-users presenting with 'chronic' difficulties, based on the formal reform guides (p34-35).

Data was collected in several ways. A first observation period was carried out averaging two to three days with each team (four to six days with each project) that aimed to paint a picture of each team's practice, their daily organisational structure and their role within their existing systems and contexts (appendix C). During that time the projects' own data and federal government data were also collected (appendix B). Particular attention was given to the models of working or therapeutic frameworks that each team adopted and adapted within their contextual development. Based on these observations, a questionnaire was developed which was used to return to the teams and interview their members (appendix D). An analysis of those interviews gave way to a second, longer observation of a total of eight days per project (four days for each team) that focused mainly on the teams' practice and interventions.

The questionnaire was used to direct the interviews. It was developed in a way that would allow interviewees to describe three levels of collaboration in their (i) work as a team, (ii) with other mental health services and (iii) with agencies or services outside mental health (p79-84). Based on the constructivist elements of this study, all three levels were examined from a realist perspective, exploring present circumstances and an idealistic perspective questioning how teams *ought* or *should* work (p55-56). In order to create the final draft that was used to interview the teams, ground rules were first set up. The structure for the final questions was also developed through some pilot interviews. Furthermore, specific attention had to be given to the language difficulties in translating the questions in both French and Flemish in order to conduct the interviews in the interviewees' mother tongue (p85-86). The Flemish-speaking interviews created a particular set of problems given that I do not speak the language as opposed to French, which I speak fluently. Several routes were considered and others tested before concluding with the final approach that answered and controlled the inconsistency of my language abilities in the best way possible.

Project selection

The selection process for each project was a collaborative action based on an invitation to participate. The PRIT project was already to be included in the study before I became involved with it, based on the ongoing involvement of my director of studies through the Formation Programme for Belgian Mobile Teams (p75-76). The Brussels project was my choice, suggested by my affinity with the city I grew up and lived for many years. For the Wallonia region, two projects were considered. I met both the teams and presented my proposal and in turn was introduced to each context. The Centre Region was chosen given its contextual particularities, as well as its rural position which would match with the PRIT project. Finally, Ghent was included both as a balance to the Brussels project in terms of its urban character as well as due to the links established with its university.

Given the particularities of the Belgian reform process as well as the time constraints, this way of selecting the projects was not necessarily entirely based on Grounded Theory methods and specifically did not involve much theoretical sampling (strategic decisions on new samples chosen in order to obtain more information and continue the comparative process; Charmaz, 2006; Birks and Mills, 2011). However, certain practical aspects had to be thought of in advance, so as to have access to projects and in turn set the groundwork for interviewing. It was important to have a good representation of both Flemish and French speaking projects as well as a picture of both urban and rural populations in each. This is hoped to have been achieved in the current selection procedure.

Ethical Considerations and Approval

As with any research study, it was necessary to meet the standards for ethical conduct and in turn consider the potential harm to participants. Glaser's (1994) and Strauss (1987) ethical considerations of Grounded Theory were used to structure the research framework. First, it was essential to recognise and establish a relationship with participants that would be mutually *beneficial* (Birks and Mills, 2011). In the aim to allow for a more equal position of power between the participants and me, the interviews were presented as a space for a reflective process to unfold. This was a unique debriefing opportunity for participants and specific care was given to create a detached environment for them to share and reflect on their work. Furthermore, *justice* and *non-maleficence* was ensured by treating all the participants fairly, equitably and appropriately, while also encouraging autonomy by allowing individuals to make a free choice regarding their participation by preserving their anonymity and assuring they had the right to withdraw at any time. Consent was sought to record participants, transcribe the interview content and use extracts in their data, while arrangements were made to keep that data secure, protecting confidentiality. As directed by Birmingham City University’s Faculty of Health, Education and Life Sciences policy, the data will be destroyed five years after the study has been completed. Given the Grounded Theory bases, *fidelity* considerations were achieved through systematic supervision, record keeping, field notes and memos (Glaser, 1992; Corbin and Strauss, 2008; Charmaz, 2006).

After the study’s design was approximately set up, ethical approval was sought from Birmingham City University, based on the ethical considerations mentioned above. Given that the study did not include participants with a high risk of “physical or psychological” harm, seeking and receiving ethical approval was relatively straightforward. However, particular attention was given to the disclosure of information that could raise issues regarding services and people receiving care. For such eventualities, supervision and in turn the appropriate service management were used as sources of help. Furthermore, written consent was sought and information was given both through the projects’ own ethical panels for the complete course of the study as well as from individual participants themselves prior to each interview. The interviews were videotaped since many were focus groups, to ensure each participant speaking could be recognised when the content was transcribed.

Consent was sought with each project stating their agreement to take part in the study. As the study progressed, ethical clearance had to also be sought with each of the projects for the interviews. A collaboration with Ghent University was set up for this ethical clearance process to take place in Belgium. Each project is overseen by several scientific committees and in turn, ethical panels depending on the number of “promoting” hospitals behind their financing. Through the agreement made with Ghent University all four ethical panels involved were contacted and clearance was sought and accepted. This process took a considerable amount of time; a total of six months (appendix G).

Witnessing: Observations

Based on Charmaz’s Grounded Theory ethnography (2006) already discussed (p67), a first observation period was carried out with each team for a period of two to three days per team (four to six for each project). This was achieved in order to get a first picture of each team as well as for me to get to know the team members and vice versa. Following the interviewing process, I revisited the teams and sought to observe their practice and interventions more closely by accompanying workers on visits to service-users. This was for a period of four days with each team (eight for each project).

To practically implement Charmaz’s Grounded Theory ethnography (2006) and to witness the teams’ work first hand, Adler and Adler’s definitions of participant-as-observer and observer-as-participant methods were used (1987), in line with the Chicago School of thought and in turn with the constructivist Grounded Theory approach. The term Chicago School refers to the "researchers' ability to know and understand the broad range of social meanings by which members of a social scene organize their attitudes, behaviour, and, ultimately, their social world as 'verstehen', a process of interpretive understanding" (Adler and Adler, 1987:12). In order to gain understanding of the teams, I was to study their perspectives and to do so it felt necessary to venture, firsthand, into the place where their activity was organised, in order to observe them "in situ" (Hughes, 1971). Only by observing their everyday work and by talking with them could I start to understand their interpretations of their work and the meaning they assigned to it.

As a field researcher and based on the Chicago School methods, I was explicit and overt about my role and made my intentions known as I began to meet and know the different team members. I started my observations in a Grounded Theory fashion by asking "What is going on?" (Adler and Adler, 1987; Strauss and Corbin, 1998). As opposed to roles of complete observer or complete participant (Junker, 1960), I oscillated between the observer-as-participant and participant-as-observer roles. At first, I tended toward an observer-as-participant mode as I was rather detached but overt and interactions with members were brief and relatively formal. I entered each setting as a rather passive observer, watching individuals from a safe and reclusive point while saying 'little'. However, as the days progressed and I got to know a few members and actively interacting with them, my role started to shift and I found myself adopting a more participant-as-observer role. This was due to team members being increasingly accepting while I was able to form a series of relationships. As a result, some members became key respondents and informants allowing me to gain further insight into the teams' setting. This gave me an increasingly "insider status" from which I could gather data better. All in all, this progressive evolution of stages reflects the increasing acceptance I felt with each team, so that my role shifted from a "provisional" or "marginal" to a "categorical" or "involved" membership status (Adler and Adler, 1987).

Junker (1960) identified specific factors to the functions researchers take in their settings, such as the fact that conditions already established within the setting could affect the observation while the researcher's abilities, identity, theoretical orientation, self-understanding, reference-group attachments, demographic characteristics and other personal factors influence the observation process. This of course, includes the prior knowledge and involvement the researcher has with the setting, including the level of comfort with practices within it. Finally, Junker explained that changes within the setting, as well as undergone by the researcher throughout the research process are also important aspects of the data collection. Not only my background within mental health but also and specifically my prior involvement with the teams in setting up the study were focal points in the unfolding of the study process. Furthermore, both members of my supervising team had prior involvement with workers. This impacted upon how I was introduced and how my presence was understood by team members. Furthermore, my language abilities, my professional background in mental health services and my preconceived ideas about the work as well as my demographic characteristics also played a role as already established in the methodology chapter of this work (p68-69; Junker, 1960).

Federal and In-project Outcome Data

Any data collected from the teams such as project proposals, outcome measures, assessment and intervention tools as well as federal data were treated as what Charmaz calls “extant texts” (2006). “Extant texts” are different from “elicited texts” such as interviews, in that as a researcher I did not have any effect on their construction. However, they were used as they complement the interviews and observations while they also give a certain perspective for each project. It was also apparent that federal data collected during the time of this study were not developed based on the projects’ own choice and as such reflected the federal level rather than the teams’ everyday work (appendix B).

It is important to note that this data may be presented as to “mirror reality” since they look as reports of “facts” (Charmaz, 2006). However, they also reflect a shared definition of outcome measures and in turn serve to enforce such definitions. To some extent and for the first part of this study such definitions won’t be altered or contradicted but will be presented as they were discovered, mainly in the form of demographic data which serves as a backdrop for each team. However, following on from the interview analysis and looking at them from a constructivist and “survivor knowledge” perspective, some of the data are put into perspective by exploring the purposes and objectives of such outcomes. As a result, definitions are altered or contradicted, reviewing some seemingly concrete categories, such as diagnoses for example. One may find sharp differences between those in-project or federal reports and the observations as well as the interviews. It is those differences that steered both the analysis and the subsequent observations.

‘Expert’ Involvement and Intervention

Around the time of the first observation the teams were visited by an “expert” for a set period. This was part of the “Formation Programme for Belgian Mobile Teams”, financed by the public federal health service (SPF, FPS; Van der Jeugt, 2015), with the aim to offer education, training, coaching and support for members of the newly founded projects. This came into effect by the end of 2012 and carried on for several years until 2015. Specifically, for the Function 2 of the reform, a two-way exchange was put in place by which project members travelled abroad with the opportunity to work with different mental healthcare services. The ‘Formation Programme’ also involved experts who came from abroad and offered support in the starting up and continuing needs of the teams. This offered opportunities for different members such as team workers and leaders as well as coordinators to work with, learn and exchange experiences and knowledge with mental health professionals from other countries. Feedback from this ‘Formation Programme’ was collected which was structured around a number of themes with the theme of “starting up and further development/deployment of mobile teams” most referenced as a learning experience (Van der Jeugt, 2015).

Many participants in this study had the opportunity to be part of this ‘Formation Programme’. Furthermore, and in conjunction with the present work, the director of studies for the research acted as “expert” and was invited to spend a period of four days with each team (eight days per project). The teams set what would be interesting and important to share and in turn, a dialogue ensued at the end of the four days, which allowed for an exchange of thoughts. The teams were generally appreciative of this exchange. Furthermore, experiences from the ‘Formation Programme’ were definitely referenced and reflected upon during the interviews.

Originally, this “expert” involvement was thought that, to some degree, would orientate the study in understanding the projects’ development. It was hypothesised that the ways in which projects adopted certain models from abroad and in turn adapted them to their context would be heavily influenced by the knowledge and experiences exchanged during these encounters. Although this is certainly true and was reflected in the interviews, the content produced both by the observations and interviews, showed a broader spectrum of subjects with the knowledge exchange theme being one component amongst others.

The Interviews

Given the Grounded Theory approach and based on the first observation with each team, a questionnaire for a semi-structured interview was developed (appendix D). Driven by the themes collected during the first observation with the teams, a structure reflecting three levels of service design was established. Each level also included several prompts to be used if needed, thus allowing for the interviewees’ own interpretations of the chosen themes. Furthermore, each level covered two sub-levels, one where participants were asked to explore how things are and the other exploring their ideals in how things should be. The questionnaire was then used to complete a series of intensive interviews in the form of one-to-one conversations or focus groups together with a few team members. Finally, the interviews were both audio and video recorded given the number of participants to allow for each team member to be differentiated when speaking. Those were then transcribed and translated where applicable and finally analysed using a constructivist Grounded Theory approach.

The Questionnaire

Originally, the questions were much more specific, structured and directive but given the chosen Grounded Theory analysis, they were changed to become more open ended yet directed. There was considerable exploration into how the levels should be divided. Finally, great reflection was spent into how the interview approach and the specific questions set a particular tone for the ensuing conversation and how controllable that would be or even how much need there was to control this altogether.

In order to test out the questionnaire, three pilot interviews were organised with a team leader and two psychiatrists from a different project. This allowed me to think upon the questions and their clarity, on the time needed to complete each level and the interview as a whole. It was also an opportunity to hear the interviewees' feedback, on whether the questions seemed clear and relevant to their work. For example, I was told that some questions, especially those that were concerned with language, were too abstract and needed more orientation. Conversely, for other questions, it became apparent that those were too directive. Instead, allowing the participants to develop their ideas within a more relaxed framework of questioning produced interesting ideas worth exploring. In general, however, the questions were said to reflect mobile teams' work and practice.

The questionnaire was somewhat "boosted" as the interviewing process for each project was completed. Based on Grounded Theory ideas, certain categories started to form, especially as themes were repeated from one project to the next. However, the original structure was kept mainly because I wasn't interviewing the same people but rather different teams within different contexts. Prompts were added as the interviews progressed. Developing themes that came up in subsequent interviews were explored to advance emerging categories.

Consent was sought before each interview, while some ground rules for the focus groups were set. These were mainly involved with facilitating a discussion, allowing for different opinions to be expressed and recorded as well as time-keeping guidelines to move the interview along. It was specified that the participants were the experts making each of their answers valid and important. Finally, after each interview feedback was taken by asking participants to consider whether the questions were pertinent to their work.

The Participants

Interviews were conducted with three proposed groups: the team leaders, the team members and the psychiatrists. The psychiatrists from both 2A and 2B teams were interviewed together (where applicable) but each team leader was interviewed separately (as will be explored later). Team members from each team were also interviewed as separate groups in the form of focus groups. The interview with the psychiatrists and team leaders took roughly an hour while the aim for the focus groups with team members was two hours. This was calculated based on the pilot interviews. However, due to particularities in each project these differentiations between participants was not always possible, either because some psychiatrists or team leaders were present during their team's focus group or because some teams did not have team leaders or finally because the teams' psychiatrist was not very involved with "on the ground" work. A total number of 12 participants was set for the focus group and, later during the Flemish-speaking ones, a total of six to allow time for the interpretation process. Finally, it was asked of the focus groups to include a representation of the teams' different disciplines. Table 1 provides an overview of the participant numbers for each project including the interview durations.

There were several reasons why three different interview groups were set up and teams were differentiated, many based on the first observations with the teams. Firstly, although the projects represent one function, each team operates different facets of this function. This meant that 2A and 2B teams had to be interviewed separately given that they serve different populations and follow different models. It was decided to interview the team leaders separately, since their function within and outside the team was different to the other workers, especially given their access to higher structures within the network. Each team leader was therefore interviewed separately to allow those differences in themes to emerge, but also to see how they overlap and how the function fits in within the network and the wider mental health system. The team leaders' role came to represent this link between the higher hierarchies and the practical and organisational aspects of working, as well as providing an overview of team dynamics and decision-making.

Separating the psychiatrists from the teams and team leaders was a more difficult decision. It was felt that by doing so it would reinforce the problematic idea that because psychiatry operates a separate and thus higher or more important role, psychiatrists require a separate interview. However, after the first observation with the teams it became clear that in the same way that team leaders had a different role than the rest of the workers, so did the psychiatrists. Although this was a difficult decision, separate interviews were planned. The reasoning behind this was that given the reform, psychiatry's role is also by default changing through this new community function. In order to capture this potential shift, the interest was to see how psychiatrists experienced this change in their own respective roles. Interviewing the other workers separately proved to give them more space to express certain points that they certainly would not have done, or perhaps not in the same way, had the psychiatrists' been present.

Table 1.

Number of Participants Interviewed for Each Project, Including Interview Duration

Projects (in the chronological order they were interviewed)	**Participants (in chronological order)**	**Number of participants**	**Duration**
HERMESplus (Brussels)	2A team (FG)	6	2h
	2B team (FG)	10	2h
	2A assistant psychiatrist	1*	1h
	2B psychiatrists (FG)	2	1h
Region du Centre (Wallonia)	2B team leader	1	1h
	2A team leader	1	1h
	Psychiatrists (FG)	2*	1h
	2B team members (FG)	11	2h
	2A team members (FG)	10	2h
PAKT (Ghent)	2B team leader	1	1h
	2B psychiatrist	1	1h
	2A team members (FG)	5	2h (3h)***
	2B team members (FG)	3	2h (3h)***
PRIT (Central West Flanders)	Psychiatrist**	1	1h
	2A team leader	1	1h
	2B team members (FG)	6	2h (3h)***
	2A team members (FG)	6	2h (3h)***
	2B team leader	1	1h
Total:	**17 interviews (10 FG)**	**67***	**26h (30h)*****

***Some participants took part in more than one interview;**

****One psychiatrist for both 2A and 2B teams;**

*****Duration excluding interpretation (duration including interpretation)**

There is, as Charmaz writes, a “hierarchy of credibility” by which “different weight is given to the word of people or organisations with different status” (2006:137). With people at the top of a hierarchy seen as more credible it was important to try and remain open to “theoretical possibilities”. As such, it was central to allow space for all the participants to be able to express themselves as freely as possible, without deflecting certain meanings, opinions or ‘voices’ already at the forefront of this mental healthcare reform discussion.

Intensive Interview Structure

Charmaz’s *intensive interviewing* was used as it fits with the Grounded Theory method particularly well: “Both Grounded Theory methods and intensive interviewing are open-ended yet directed, shaped yet emergent and paced yet unrestricted” (Charmaz, 2006:28). An intensive interview approach was also complementary with the observations. Although the structure of an intensive interview may range widely, a semi-structured questionnaire was used in this instance to focus the questions. As Charmaz notes, an intensive interview can be conversational. However, it does follow a different “etiquette”:

> The researcher should express interest and want to know more. What might be rude to ask or be glossed over in friendly agreement in ordinary conversation becomes grist for exploration. Research participants often expect their interviewers to ask questions that invite reflection about the topic. The interviewer therefore asks participants to articulate their intentions and meanings. As the interview proceeds, details will be asked to be clarified in order to obtain accurate information and learn about the participants’ experiences and reflections (Charmaz, 2006:28).

The interview questions were presented in three parts reflecting the three levels of service design (see also appendix D). The first level focused on the team and ‘collaborative working’. The second explored intro-organisation or ‘co-ordinated working’ encompassing the larger organisational structure that provides mental health services, including other teams, departments, both in hospital and the community. The third level examined inter-agency or ‘co-operated working’ which involves other statutory agencies separate from mental health organisations, such as primary care, general healthcare, social care/welfare as well as agencies who provide supporting resources for mental health service-users in the community e.g. housing, employment, cultural needs, leisure, education amongst others. Finally, based on the social justice methodological underpinnings of this study, all three levels were explored from two perspectives: a realist perspective (what is happening now, how things are) and an idealistic perspective (what ought to happen, how each of the respondent thought things should be; p54-56).

An overview of the questions was introduced at the start of the interview and then each level was reintroduced when the previous one was completed. The prompts were only used when necessary. As mentioned, several prompts were added in the course of the interviewing process but those were only used if somebody mentioned them. Particular attention was given to themes of time, space, memory, values, language and relationships as the interviews unfolded and as will be explored in the analysis.

The **first part of the interview** focused on the experience of working as members of a team. This concerned team members specifically. Questions explored why the team came to be, the principal elements that made up the service and the persons the team work with. It was also an opportunity to explore the differences of individual and team work. Participants were asked to define their current or target population, the principal organisational and distinct features of the service, the origins of the model used and the way it was implemented. We also explored clinical roles as shared or distinct functions, as well as the general and new experience (in most cases) of working in a mobile team. Finally, I questioned people's ideas of how all these things should be in an ideal world.

This first level was an opportunity to have an overview, in the participants' words, of who the team is, who they work with, how and why. Here, I was particularly interested in how the team organises for the specific population they are trying to reach. For that purpose, I often started by asking about the population. This was an excellent opportunity to also hear how team members described the people they see in their daily work. This usually led to the models i.e. the ways in which the team organises for that specific population, especially in the context of the community. For example, a 2A team that primarily offers support during crises may opt to work for longer hours, perhaps also during weekends, since a crisis can happen anytime. This is not true for all the 2A teams that were interviewed and finding out why and how they implement a certain model was of interest. A 2B team on the other hand may prefer working in pairs with the rationale that having a one-to-one relationship presents a higher risk of experiencing it as too intense and strenuous on both sides (professional and user). Others may prefer a one-to-one relationship as it can be of particular strength and may also make other team members more available. The discussion on models would also involve specific interventions used by the team such as psychological or educational/occupational ones amongst others.

During the interviewing process a prompt was added mentioning modalities and specificities of the service. Modalities concern the setting which sets the tone for the models of care that will be used (modalities of care in the community are different to the ones used in residential setting). Specificities on the other hand focus on the specific therapeutic interventions. Those organisational aspects also include various roles and disciplines that may be determined by people's or the service's specificities. The different roles and disciplines were also explored, concerning all the team members. Here the psychiatrist's role was of particular interest. Particular attention was paid in exploring the hierarchies that may exist in a hospital setting and which perhaps are similar or different in a community setting. This was also, as mentioned, a reason to interview the psychiatrists separately, also in view of capturing any change in their role from hospital to the community. Given the context of community work the role of a psychiatrist may prove to be less 'hands-on' since a lot of the information gathering and intervention is done with other workers acting as mediators. Both the roles of the psychiatrists and the team leaders are always a little separated from the rest of the team for reasons of medical responsibility or organisational structures respectively. How those differences were experienced and understood offered an important picture of team dynamics. More specifically, analysing these dynamics would show whether hospital models were employed in the community or whether new models were developed and adopted.

As mentioned, each level included a question on how the team members thought things should be in order to catch a glimpse into the participants' ideal world (how it would look, who they thought their service should be for and how they thought they should organise to achieve this). Again, their ideals on what their and others' roles should be was also of interest. Specifically, this was a way to understand what participants understood their new role to be and what it could be for them. This was linked to the methodological underpinnings of this study based on ideas of social justice.

The **second part of the interview** focused on the team's work as part of an organisation. The focus was on the "intra-agency level" which includes other mental healthcare structures with which the team were in collaboration. These could include partners within the network of care established by the project, and usually did, but it was also open to other separate services. As a result, services included ranged from other mental health teams and departments within the community but also residential settings such as psychiatric inpatient units within psychiatric or general hospitals. The focus of the questions was mainly about how the team works with other mental health services, how their target population populations may compare or whether unexpected differences arose. It was also a prompt to question possible interfaces in the work between services or how the focus and purpose of contact was different. At this point, the hierarchy of the "promoting" or funding hospital was also examined inasmuch as it imposed definition, categories and descriptions or whether the team had room to explore those within their new community setting. Finally, this was also the opportunity to comment directly on the use of particular terminology and question its specificity, if any. For example, explore the meaning behind the use of psychiatric categories and diagnoses, if used, and if not, question this choice, as well as words such as "user" or "patient". This level was an exploration of the team’s collaboration with other mental healthcare services, but it was also a way to understand whether the team worked and saw themselves as alternatives, where possible, to those existing services.

The teams were asked to describe the population they served and how comparable it was with other services. The hypothesis was that residential and community services would have the same target population. However, the work would take different shapes depending on the setting. If populations were thought to be comparable between the mobile teams and the other settings, I further questioned how the team’s work was different in comparison with what other services offered. Of course, the comparison with hospital and its role or purpose for team members was central. Moving on from the idea that the reform is a process of de-institutionalisation, hospital populations would be comparable to that of the teams, given that the latter offer an alternative to institutional care. Conversely, there may also have been an entirely “new” population given the teams’ mobility and in turn access and reach towards people that would had not access to care before. In Ghent, for example, the teams got to meet members of the Turkish community who until then had not had access to residential care. With new mobile teams visiting at home, they were introduced to a different form of care.

Since the setting and in turn the work in the community is different, the suggestion was that the language used by the team would also by default be different. For example, in the hospital there may be a wider use of diagnostic terms while in the community descriptions of the home environment or family relationships may have become more important. This was a very important aspect of what I aimed to capture and asking directly about language differences between those settings was an opening to do so. The general interest lay in how the teams work with community structures, but the main focus was on the collaboration and differences with the hospital setting since this held the clue to understanding whether a de-institutionalisation reform is actually happening or not. If the teams stated that they did not need to collaborate with the hospital because they were reaching an entirely different and incomparable population, then the hypothesis would be that the reform was not a process of de-institutionalisation. Conversely, if the teams were involved with the same population as the hospital but used the same language and intervention models as the residential setting then the hypothesis would point towards a de-hospitalisation process rather than one of de-institutionalisation (Prior, 1993). If a team, however, did present as providing a different service but for the same population, this could mean that they perhaps have an indirect impact on hospital admissions. In that case how a collaboration is maintained and what terms are used to communicate between two very different settings was worth reflecting upon. Furthermore, in instances where a mobile team service-user may feel the need to be hospitalised, the decision-making and collaboration process, as well as the function the hospital would serve becomes central. Considering that in Belgium, the residential system is very much established, quite large and as such a dominant structure within mental healthcare, exploring ways in which this reform and specifically the mobile teams may be shifting the hospital system (or not) was of explored.

In terms of ideals, the teams were asked about how they would want their collaboration to be with community structures and the hospital. However, they were also challenged to think about the ideal function of those other structures. Most specifically, the role of a hospital structure and its function was questioned, whether it was necessary and in what instances; what other structures could or should exist instead, if at all. The questions were not just a so-called neutral open-ended exploration of participants' ideas but were rather aimed to focus on the specificity and need for certain structures. Prior to the reform and the de-institutionalisation idea, those structures would have for the most part remained unquestioned. Asking people about their ideals aided in further unravelling the meanings assigned to different fields of care.

The **third part of the interview** focused on the team's work as part of a mental health agency. The inter-agency level included other statutory agencies separate from mental health organisations, such as primary care, general healthcare, social care/welfare, and agencies who provide supporting resources for mental health service-users in the community (e.g. housing, employment, cultural needs, leisure, and education amongst others). It was also an opportunity for participants to give more general statements on the 107 mental health reform, in terms of its ideology versus its practice, as well as a broader reflection of society and the possible change in culture.

The question aimed to explore how service-users' differing needs could be addressed and the role of the team and services outside mental healthcare in doing so. GPs were of interest as well as welfare services and social care. Mobile teams are also frequently in contact with these social services/agencies since their populations may often be similar. Again, some aspects of the work of the mobile teams may overlap with those services and where they are similar but also where they differ and why was explored.

Again, the aspect of language was of particular interest in how it may differ within those structures and why. It was expected that the teams would employ a more "specialised" language while their affinity and "skills" developed with the service-users would present an opportunity to strengthen collaborative projects with social care structures. This level was also of significant since the first line of care could be invaluable in terms of the mobile teams' accessibility as well as for giving the option to potential service-users to avoid residential care. How the team built links with those agencies and how they communicated effectively or how they influenced each other was brought into focus.

The teams were also asked about their ideals for this level. Again, the interest mainly lay in the collaboration with agencies and ways in which it could be better. It was also an opportunity for participants to explore themes regarding mental health within the wider society. Subjects such as stigma and the culture linked to it were explored at this point. These reflections were especially welcomed and were also a good way to close the interviews, usually because ideas became too abstract and were not necessarily ones that were possible to explore further.

The language(s)

The interviews were conducted in the participants' mother tongue, with a few exceptions. For the French-speaking interviews this was easily done by translating the questionnaire and carrying on with the interviewing process in French. The transcription was then done in French again, as was the initial coding analysis. However, the Flemish-speaking teams presented a challenge given that I do not speak the language. A series of trials were investigated before coming up with the final interviews which involved Flemish to English simultaneous interpreting. A brief summary of those trials is explained in the following paragraphs.

It was important to allow Flemish-speaking teams to be able to express themselves in their mother tongue as had been the case for the French-speaking teams. After appraising a few ideas, it was thought best to involve another Flemish-speaking PhD Student from Ghent University who could carry on with the interviewing in my place, while I was present. After an introduction to the study and its methodology, as well as some coaching with the questionnaire and interviewing technique, the student carried on with three separate interviews with the PAKT project. Unfortunately, these did not prove to be successful for several reasons. First, given my previous encounters with several projects and the specific participants, I had a tacit understanding of the context that was difficult to impart, mainly based on my previous involvement with the teams (first observations). Secondly, having developed the questionnaire and subsequently used it several times, I had built an experience in conducting the interviews, including an intensive style fed by the previous data. Thirdly, the data collected from previous interviews had only gone through initial coding but an understanding of it had started forming. Specifically, different themes and subcategories had started to form but those were still unclear and abstract. Again, those were difficult to transmit in a way that did their content justice. Finally, in line with the subjective elements of both the first observation based upon ethnographic techniques, as well as the development of the methodology used, it became clear that the interviews should be conducted by me, rather than somebody else (even if their knowledge had been greater).

In order to conduct the interview myself it was thought best to involve interpreters that would translate the content *in vivo*. This way, I would be able to follow the interview as it was taking place and direct it as appropriate. After a first interview with a certified interviewer, the financial aspect of involving a certified professional, as well as the fact that he had no background in mental health proved to produce poor results. Finally, in a last attempt to find a better solution, the department of translation and interpreting of Ghent University was contacted. Two students referred by a professor were involved for the remaining Flemish interviews and subsequent transcription and translation of those.

Having the same persons involved throughout this process proved invaluable both because they developed an expertise in the subjects discussed, while they also became familiar with the process and the people involved in it. Furthermore, given the affiliation with the university the students were also well equipped with the necessary interpreting tools to carry on with the interviews with minimal interference. The questions were asked in English and where participants did not understand the interpreters would step in. Moreover, in order to keep the process as simple as possible, one-to-one interviews were translated by consecutive interpreting, meaning that a translation was provided after a short speech. For the focus groups, the two interpreters were involved in simultaneous mode by which they translated directly, as participants spoke. Considerable time was reserved to allow for the interpreters to switch during the interviews but also for them and the team to have breaks.

Constructivist Grounded Theory Analysis

All the interviews were first transcribed in the original language in which they were conducted. The French interviews were coded in French and subsequent codes and categories were then translated. The Flemish transcripts were translated word for word by the same interpreters present during the interviews. The translations were then verified by my Flemish-speaking supervisor who mainly advised on linguistic particularities of the mental healthcare field, as well as more specifically of the Belgian reform. For both languages, specific attention was given to particularities in the wording and language used, especially in the mental health field. Words that may be used daily, but which are difficult to translate and/or are unique to each language, were thought to reflect specific meanings and cultures surrounding the teams and their context. Those words were collected and reflected on as part of the analytic process (p137-139).

The transcriptions were analysed using a Constructivist Grounded Theory approach. A list based on different readings of this method were compiled to make sense of this method. There were ten hallmarks of Constructivist Grounded Theory, which will be visited and revisited throughout the analytical process:

1. **Open or initial coding:** Grounded Theory starts with “open coding” involving a close examination of words or phrases (Charmaz, 2006; Birks and Mills, 2011).

2. **Focused and theoretical coding:** Existing significant codes direct subsequent analysis so that new codes are focused around an identified core. In turn, theoretical coding further advances coding with codes drawn from existing theories to assist in the final theoretical integration. Those prove important because they offer explanations in relation to a theoretical body of knowledge (Charmaz, 2006; Birks and Mills, 2011).

3. **Axial Coding:** As open codes are collected and the study progresses, axial coding also starts to take place on several levels simultaneously (Corbin and Strauss, 2008).

4. **Memo writing:** This is a continuous process (Glaser, 1992) described as a ‘conversation with the self’ and it offers a way of tracking the analytic process (Corbin and Strauss, 2008)

5. **Categorisation of data:** Significant data is then assigned relevant labels and conceptual groups and in turn sub-categories and further macro-categories are created with a label assigned to each (Myers, 2013).

6. **Concurrent data generation, constant comparative analysis and theoretical sampling:** Data is constantly collected and analysed, with new data being compared to older data. As a result, categories develop (Birks and Mills, 2011). Comparing new data with older data allows for constant examination of their similarities and differences as well as the absence and presence of data all the while testing and refining conclusions (Corbin and Strauss, 2008). Theoretical sampling allows for the comparative process to continue while new samples are chosen (Birks and Mills, 2011).
7. **Theoretical sensitivity:** The concluding theory must echo the data by recognising its meaning (Otkay, 2012). At this point, personal subjectivity must be considered to maintain internal validity and reliability and move away from personal bias (Morse, Stern, Corbin, Bowers, Charmaz and Clarke, 2009) thus seeing data in an innovative and original way (Urquhart, 2013).

8. **Theoretical Saturation:** This constantly occurs until no new understanding is arising from the data and a central theme has been developed allowing for theoretical sampling to finally be stopped (Birks and Mills, 2011).

9. **Theoretical Integration:** Causal and correlational links are formed between categories while also explaining any variation in the data (Myers, 2013).

10. **Central Category:** Encompassing and drawing together all categories identifies a central category which fits closely to the original data. It is accurate yet abstract but most importantly it is based on the previous coding steps and represents the participant's voices. Thus, a central category carries the main explanation on which all other categories can be based (Birks and Mills, 2011).

The diagram (next page) shows the basic steps of the analytical process for this study. This is not necessarily a chronological timeline since I had to go back and forth between different steps, but it is a representation of the main analytical building blocks on which the theory was built. This diagram will be revisited throughout the rest of this work.

Note that during data collection there were aspects of the experience with the teams which go beyond the meaningful or the relevant within this particular piece of work. Given that qualitative work is always permeated by many variables that lie outside the field of study, those aspects were certainly recorded but have only been briefly discussed, if at all. However, this is not to say that they were not paid attention to and reflected upon.

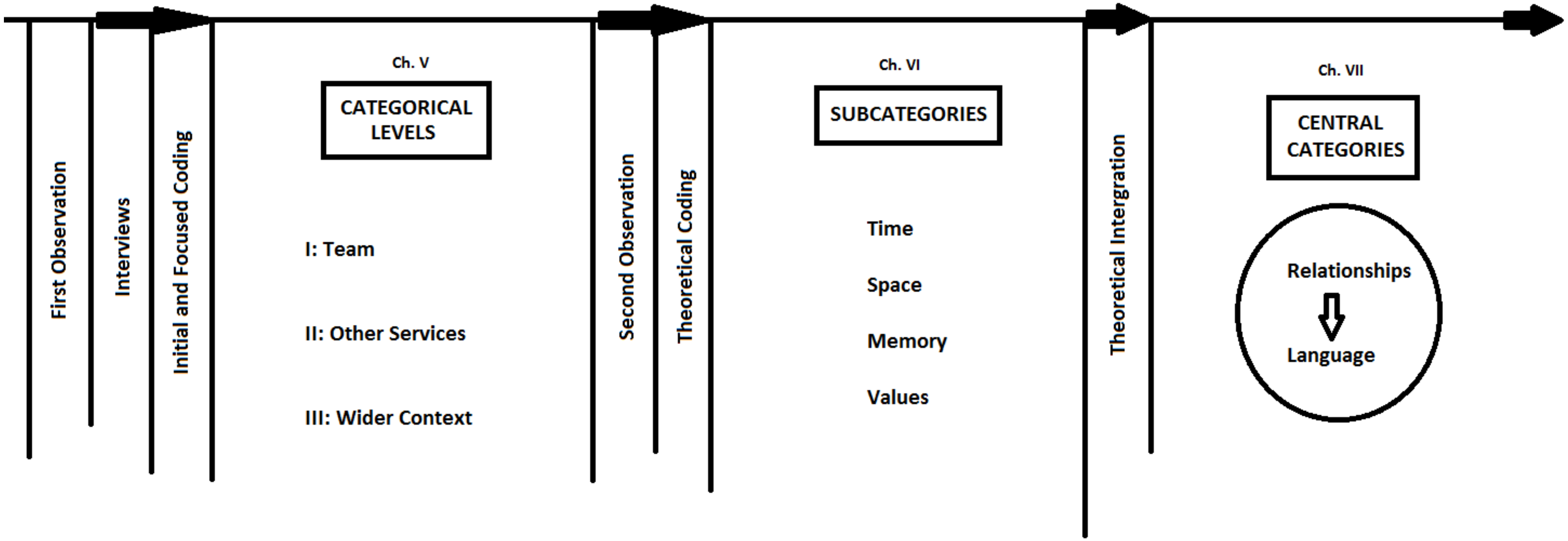


Figure 3.1 The Analytical Process

[This page intentionally left blank]

Chapter 4:
The Projects

Introduction to Chapter 4

During the first observation period which lasted between four and six days with each project (two to three days with each 2A and 2B team/function), each team offered an introductory overview of their practice, their daily organisational structure and their role within their existing systems and contexts using a check list that was developed for this purpose (appendix C). Here is an introduction to all four projects based on those first observations. It is presented in the chronological order the teams were visited, to reflect the process in which they were observed. Each observation was used as an example for the next by comparing and contrasting how the different teams made sense of the federal guidelines (p34-35).

Witnessing: First observation

A list with several points was proposed as a blueprint for observations which gave them a specific focus (appendix C). This was done in order not to get lost in data but rather to have specific research answers in order to carry out the interviews (Charmaz, 2006). The list included organisational aspects of the teams such as opening times, discussions and meetings, telephone access, referral procedures (including inclusion and exclusion criteria) and access to the team (e.g. waiting lists), as well as intervention models. I also questioned members about their information sharing and information keeping techniques, who their closest partners were, their assessment tools, their resources. I also began to form a picture of who worked in the teams, their disciplines, where they came from (residential or community settings), how long they had been there and what hierarchical positions they took in the decision-making processes. Finally, it was also an opportunity to find out more about the language they used in their everyday activity, i.e. how they talked of their work and the people they saw.

During this first observation, it was decided for me not to attend any visits to service-users with the team, since the focus was on the teams’ organisation. I mostly stayed at the teams’ headquarters, was present during their meetings and formal and informal debriefing sessions, telephone referrals or follow ups. This was also the first opportunity I had to talk to individual team members to present myself and get to know them too. There were a few instances where I was invited to take part in conversations as well as to be present in some visits. This was done purely at the team members’ insistence and ultimately reflects the ethnographic approach to the study.

Quantitative data was also collected for each project, during that first observation period. This included outcome measures the teams collected as well as on-paper tools they may have been using. Also, many provided me with their project proposals based on the reform guide. Furthermore, federal data was also collected although that proved less detailed than originally expected (appendix B). There is little homogeneity between projects as each collects information according to their own references and definitions. The data collected during the observation is presented here as it was shared, reflecting each team's own renderings.

The Projects

Brussels: HERMESplus

Since this Brussels project was not attached to a hospital and the 2B team representation was actually an ambulatory centre, this first observation proved to be quite different from the others. More specifically, the 2A team had been developed using the governmental funds since no promoting hospital was involved and in effect no beds were "frozen" to finance the team. Furthermore, it was the only project that was bilingual. In any case, this was my first introduction to 107 mobile teams.

2A team: TANDEMplus

The 2A team had been operating for the last two and a half years as a direct product of the 107 reform. The team was based in the city centre and covered a large area including the north, west and south of the Brussels region. Team members always visited people either at home or elsewhere. Generally speaking, service-users represented the Brussels population. They were from poorer socio-economic areas and lived in highly precarious conditions whether in terms of earnings, education, employment or housing.

When I first met the team it comprised four professionals, two of which worked four days a week. Most of the members had come directly from working in a hospital setting while others had worked in the community and in ambulatory mental health centres. For others this was their first job in the mental health field while one member came with a social services background. There were two nurses, a social worker and a psychologist while an assistant psychiatrist had also just started his placement there. However, they all presented themselves as "psycho-social workers" of equal standing; their disciplinary background was only revealed if and when needed. A consultant psychiatrist attended the weekly team meetings as well as two "function referrers" fulfilling consulting and supervisory roles. The team did not use an active psychiatric function within the team. They took an actively critical stance towards psychiatry, avoided prescribing medication or diagnosing but instead preferred to refer to external psychiatrists, based on service-users' requests.

Three part-time staff operated the phone line from the TANDEMplus offices, taking in referrals for both the 2A team, as well as re-orienting people towards the rest of the HERMESplus network and project. These three persons were considered "experts by experience" although they were not formally employed as such. It was unclear why this was the case. Originally, the team only accepted referrals from other professionals, but quickly started accepting them from anybody who called, including self-referrals, even if rare. The team explained that family members were the most frequent callers. Officially, the ages ranged between 16 and 65 years. However, the team avoided supporting people under 18, given the legal limits, especially related to young people's parents, which apply for underage users in Belgium.

The team did not operate in the evenings or weekends, as they regarded 'crises' different from emergencies. Crises were defined as long-term situations, usually involving the person's network, which was no longer able to handle an increasingly complex situation. Many service-users were presented as having "psychosocial problems" with a "psychiatric profile". Emergencies, where people presented with urgent suicidal ideas or where violence was an issue, were directly redirected to an Accident and Emergency (A&E) department. Service-users were usually people who had not yet had contact with the HERMESplus network or other out-of-hospital mental healthcare, while others had often "disengaged". The team (re)referred them towards the professional network of care, including ambulatory mental health centres and private professionals, medical centres, schools or community services amongst others. The team's intervention model was based on psychosocial theories, which meant that the workers usually preferred to refer people towards ambulatory or even non-mental healthcare structures. This could be an indication of the gap that exists, especially in the Brussels region, between the ambulatory mental health sector and hospital care. Furthermore, this transpired to be a big difference compared with other projects where the main referrers were psychiatric care providers and where the collaboration with residential care was much more important and close.

Each new referral was evaluated by a team member and an intervention officially took place between four and six weeks, although in practice this was often longer. Continuity in a person's care was ensured as much as possible by having the same worker involved throughout an intervention. Although all team members were informed of every situation, each user had a person of reference (unlike other 2A teams). People were visited as often as three times or at least once a week. The team took decisions together in a 'horizontal' manner and frequently met to hand over important information. Although time consuming, the team travelled by public transport or by bike around their very large catchment area. This created a considerable time limitation on the number of visits they were able to do. The first observation period happened a few days after the Paris November attacks, during which most of the public transport in Brussels was inactive. This inability to travel as easily showed how important the aspect of mobility was for this team.

The team had to be flexible and creative especially for people who did not want them involved. This was mainly due to Belgium's strict confidentiality law, called 'professional secret' (appendix A.2). Based on this law, a service-user must explicitly give their consent for any information to be shared between professionals. Workers took particular attention when they introduced themselves and often gave people time to decide whether they wanted support. This was revealed not to always be as important for other teams. All in all, this team did not appear to be a standard 2A team.

2B team: Antonin Artaud

As mentioned, given that the HERMESplus was funded solely with governmental funds and Brussels already had a large array of mental health services within the community, it was deemed more optimal to create a network of partners made up from those services that would all serve the function 2B without creating a new and separate team. For the purpose of this study, Antonin Artaud, an ambulatory mental health centre and an ASBL (Association Sans But Lucrative – non-profit association) funded mainly through regional funding, was deemed closest to this function, serving a chronic, long-term population within the centre of Brussels.

Firstly, a brief note on the team's chosen name: Antonin Artaud was a French literary figure of the twentieth-century avant-garde theatre. His most noted contribution to drama theory has been his "theatre of cruelty", an intense theatrical experience that combined elaborate props, magic tricks, special lighting, primitive gestures and articulations, themes of rape, torture and murder to shock the audience into confronting the basic elements of life. Artaud's creative abilities were developed, in part, as a means of "therapy" during the artist's many hospitalisations for mental illness. While being treated in hospital by Edouard Toulouse (a French psychiatrist who developed ambulatory teams), Artaud was encouraged to express himself through poetry. His life and work very much reflected his mental states (Morfee, 2002).

The Antonin Artaud service was therefore a product of the development of ambulatory mental healthcare. The team had been active for the last 40 years, occupying the same location in the centre of Brussels. Originally, the service started as a day centre based on the ideas of the anti-psychiatry movement of the 60s and 70s coming from Italy (Corbascio Fox, 2006). It quickly developed other functions such as protected housing facilities and a mental health centre. The latter that also had a mobile function (when needed) was similar to the 2B function.

There were nine professionals with different disciplinary backgrounds including psychiatric nurses, psychologists, social workers and psychiatrists working at the centre when I first visited. Although the team explained that they operated in a horizontal way, in practice psychiatric nurses and social workers were the main case managers, while psychologists only got involved if requested. The psychiatrists operated somewhat separately from the rest of the team and met with people independently, in their consultation room. The whole team was said to know of every situation and decisions were taken at a team level. However, this was not always the case in practice. Rather than resembling multi-disciplinary discussion, team meetings were very much directed towards the psychiatrists.

The centre was mainly a drop-in centre for service-users with or without appointments. The team's "welcoming" function ("accueil", p138) was very important for them since it was seen as the main way for them to keep a low threshold while also being able to re-orient towards other services, when possible. In other words, anybody could drop in or call at any moment and in this way the centre was regarded as accessible. There was a first come, first served policy and when the team's maximum capacity had been reached no new users were taken on. Instead, they were re-orientated towards other services. The team organised their shifts in such a way for a member to always be present in order to receive people who came to visit, answer the phone or deal with emergencies. This "permanence" function was carried out by all members of the team except the psychiatrists. People who dropped in were not always users but often came to ask questions, find out about referral procedures or just had a cup of coffee. At the back of the centre was a small garden where a lot of people met and socialised. This was a space the team members seldom visited. In fact, I found out about this garden later on during my involvement with the team, after spending some time with service-users.

People who used the service lived in the centre of Brussels and were presented as having a "severe psychiatric disorder". Most had long standing links with mental health services, often with intermittent hospital stays. Since there was no intervention time limit, many service-users had been involved with the centre for over 20 years. The active caseload ranged between 150 and 230 service-users at any given moment. Each team member had an individual caseload of around 20 people, while each user was assigned one of the two psychiatrists. Interventions were usually of a 'social' nature such as finances and housing, reflecting the needs of the target population. Nevertheless, the team often had a very 'psychiatric' function too i.e. linked to symptomatology and medication. Note that in Belgium, there is only one treating psychiatrist who holds medical responsibility and who can be associated with a service or entirely private. However, people can also visit other psychiatrists if they wish. In the Antonin Artaud team the psychiatrist tried to always act as the "treating psychiatrist" and as such aimed to see people at least once a month. People were therefore prescribed medication or depot injections administered by the team's nurses. This was very different from the other projects I visited.

Given that service-users were often seen for decades, interventions around physical and somatic problems linked to these ageing populations also had become relevant. Furthermore, a person's continuously changing context was also considered, although the team mainly worked on individualised interventions, based on psychodynamic theories focusing on the service-users. According to the team's motto "we are present and we are continuous", service-users were said to be supported as much as needed. In terms of mobility, the team was not as mobile compared with other/classic 2B teams, but only did so when necessary. For people who disengaged, their file was kept "dormant" but they were seldom discharged. The team was very close to a protected housing service which operated next door to the centre. Service-users were sometimes admitted to hospital. The team saw this as a necessity in certain cases. There was a general philosophy that long-term admissions were better, while short stays were seen as a risk for (more) crises during discharge. There was also frustration that, although the hospitals were aware of the team, they did not always alert them when a person was either admitted or discharged.

During this first visit, the frequency at which service-users were seen by the psychiatrist was being discussed. It was felt that once a month was too often and service-users were getting too "attached". Originally, there were two psychiatrists involved, both of whom had been with the team since its formation. One of the two had recently passed away and this resulted in a great sense of grief for both the team and the service-users. As an established service that presented as very committed to its service-users, the notion of "getting old together" was particularly felt at that moment. The team saw themselves as professionals who had a "caring" role, pushing for "therapeutic choices".

All in all, this was to become an example of ambulatory mental health centres, especially in terms of its similarities but also its differences with mobile teams. The most important difference was the gap between the centre and hospital structures, which was proven to be smaller for other projects. Nevertheless, there was a sense in which the Antonin Artaud team and other mobile teams were similar in terms of their understanding of people's distress, their values and interventions. This became even more apparent during the interviews, as will be shown in later chapters.

Wallonia: Région du Centre

I first met with the two team leaders for this project during the selection procedure for the Walloon teams. Both teams were based in the administrative buildings of the Saint Bernard Hospital, a psychiatric facility, but operated from separate offices. As mentioned, the workers were originally employed by the hospitals and were hired to work for the teams through a "sliding" process on a voluntary basis (by moving personnel from one structure to the other, but using the same funding, contract and hierarchy used by the "host" hospital). The 2A team was formed six months ahead of the 2B team, with many team members moving from the former to the latter.

2A Team: Emc²

There were 15 people working in the 2A team including one psychiatrist, when I first met the team. The team leader was a social worker while the other professionals ranged from nurses, social nurses, psychologists and assistant psychologists as well as special educators (occupational therapists; OTs). Shifts were based on those of the hospital while nurses and OTs worked the out of hours' shifts. At night, callers left a message and were called back within 15 minutes. This system was later transformed with night callers being redirected to the hospital phone line. This was done based on statistics that showed very few calls during the night.

The team met often to handover between shifts. Decisions on referrals, inclusions and discharges were also taken during those times with the psychiatrist acting as the ultimate decision maker. Anybody could refer to the service including self-refer. Interventions were usually four weeks long, but if necessary were shortened. Sometimes, the team worked solely with the referrer or the family and social network if the person in question was refusing to have them involved. The team's caseload ranged from as low as seven people to 30 (average of 20 to 25). Every service-user was visited by a pair of workers while the caseload was shared by the whole team.

The team described the service-users they saw as presenting with a crisis of a "psychosocial" nature that may or may not be accompanied by a "psychiatric profile". A diagnosis was therefore not essential and in fact the team explained that the medical model was rarely used and even avoided. Taking into account that the area the team operated in is one of the poorest socioeconomically in the country, many users presented with psychosocial problems given this context. The team leader had a background in social work and the psychiatrist had systemic training, so the inclusion criteria were developed based on these models. Moreover, the psychiatrist had a consulting and supervisory role within the team. Nevertheless, team workers most of whom had previously been employed by the hospital did not always agree with the psychiatrist's model. Other models were also applied depending on the situation and the professionals involved.

All in all, the team did not present themselves as a 'hospitalisation at home' service. Instead, their intervention was mainly based on strengthening a person's network. They worked towards finding other professional partners to support the user in the long-term. This involved services such as the SPAD (ambulatory psychiatric teams) or the 2B team. The team avoided increasing the time limit because they wanted to avoid becoming "too needed" by a service-user. They hoped instead for the person to form links with long-term services. In other words, the team did not just aim at providing an individualised service according to the person's need but mainly worked towards strengthening the user's professional and personal network.

2A/2B Collaboration

The teams used the same computer system which is based on a hospital software. As a result, several problems linked to continuity, confidentiality and transfer/referrals were experienced by the teams. In other words, it was felt that files were created in a way that fragmented people's everyday life and situation. Furthermore, the teams shared the same phone line. Each team was responsible for it on a rotational basis and referred to the other when appropriate. For people who were referred but whose situation was unclear, a "mixed assessment" was organised with a worker from each team. In practice, this created a few problems, most notably on the information obtained, how relevant it was and on the decision-making process for inclusion. Workers felt that referrals were often biased depending on who was responsible when the calls came through.

2B Team

There were seven people working for the 2B team with a part-time psychiatrist who was also working in the forced admissions ward (for people involuntarily admitted). The funding for the 2B team was linked to the local SPAD team (ambulatory team at home) although their target population differed considerably, with the 2B team seeing people that were deemed more "severe" and needing a more intensive intervention. This multidisciplinary 2B team worked in a different way according to their disciplinary background, as well as their personal perspectives but in all they were said to do the same work. Furthermore, the psychiatrist's double function in the team and within the hospital was seen as an important step in allowing a decrease in the number of forced admissions.

Service-users could be referred by anybody, including self-refer. In general, the team aimed to meet with the referrer to increase their visibility but also to explain the criteria for inclusion. Those usually included people who were said to be "revolving door" hospital users, people who had difficulty engaging with services, who presented as "chronic" and "disengaging". It was also important for the team to be able to offer options and possibilities to re-orient people towards other services within the area's professional network. However, given that there were many disparities in service provision across the area, the team did include service-users that may not have fitted these criteria. In other words, the team felt that if they didn't get involved, people could find themselves without any support. Most referrals were said to come from the Saint Bernard hospital where the team was based. The team explained that this could have been due to the hospital being the main “host” in terms of their budget, while hospital workers were also more aware of the mobile team’s work.

Two workers were assigned to each service-user. The team met regularly to exchange information and to set precise objectives for people. Users were said to be seen “as short as possible, as long as necessary”. This could be daily to once a fortnight. The psychiatrist visited service-users at least once a year or more if deemed necessary. Usually, the 2B team would support people during a crisis without the involvement of the 2A team, except for weekends. In general, the team did not have a clear model. There was considerable resistance to concepts such as “psycho-education” as well as attitudes of “social control” (see also p128). Conversely, “confidentiality” was very important for the team (appendix A.2). Workers did not share everything either with the team’s psychiatrist or with other services. Their main interest was to form a connection and a relationship with service-users. This relationship was believed to be “therapeutic”. It allowed a secure platform on which the person could express their wishes for the future. The team and the person were said to work together in achieving these wishes. The idea was to see people’s strengths as well as their limits, while “distress” and “suffering” were understood to be more important than “symptoms”. The team discharged people from their service when they found their presence no longer necessary. They explained that this did not necessarily mean that someone was “symptom free” but rather that the network around them could support them in their daily life. In any case, any former service-user could be re-referred to the team.

The team explained that they referred people to hospital if necessary. In other words, hospital was not a place to avoid rather the question was whether it was necessary. Although the threshold for “risk” had decreased considerably since the team’s creation, hospital was still seen as an important and positive option to have in certain situations. Several examples were explored, such as people who had been in hospital for a very long time and who as a result struggled to live in the community. For others, it was said to be too costly to pay for a house as well as a hospitalisation to the extent that people chose to be admitted. It is important to mention that during my first visit with the team, the workers explained that the region had seen an increase in so called “pirate houses”. Those are private houses that resemble psychiatric hospitals but there are no formal records for their residents and practices as they operate outside the law. Moreover, there is no control in how care is provided with increasing revelations of abusive practices and severe human rights violations (Giot and Mann, 2016). For the team, it was therefore important to have controlled, long-term hospital environments that would shelter and “treat” people who were said to have “chronic problems”. In conclusion, the team did not always avoid referrals to hospital but was said to be more present as a post-hospitalisation service rather than a pre-admission one. In general, the team aimed to create links with other services including GPs, service-user groups in the area, as well as local A&E departments in general hospitals. However, it became obvious that A&E doctors preferred to discharge people without offering any support, let alone referring to the 2B team.

The most striking revelation during my visit was the way in which the team members narrated their experience of having worked in hospital for years and suddenly getting to know people in the community, in many instances people they had known as in-patients too. One worker explained that for the first six months as a new 2B team member, she would return to visit her previous in-patient ward in order to feel “secure”. However, when asked whether she would go back to her previous work after two years of working in a mobile team she was adamant that she wouldn’t. Members also explained that visiting people within their home/own environments helped workers to also understand situations better. However, the team also felt it very important to not become active agents of “social control”. Conversely, the team’s hope was instead that mental illness should be seen as a part of human experience. “We are all a little mad” explained the team leader.

Ghent: PAKT

As mentioned in the introduction, at the time of my first visit there was one large 2A team which, during this study, in the spring of 2015, was split into two teams one for the north and another for the south of the area. My first observation with the team was before the split. I then followed the south team after the split. The 2B function was shared between four different teams and I mainly worked with the north team. This choice was based on the fact that the north team served a more urban population, which was an important characteristic when this project was selected. The funding for the PAKT project had been ensured through the collaboration of four hospitals in the region.

2A team: Mobiele Crisis Team (MCT)

There were 19 professionals working with the 2A team during the first observation. The team operated in the whole territory of Ghent and was based in two locations. One was at Dok Noord, a building overlooking the Handelsdok (trade dock) canal and the other was at the University Hospital Psychiatric Rapid Response Unit (UPSIE) ward (part of the Ghent University Hospital, UZGent). Specifically, the UPSIE is a small closed ward which accommodates people who are in crisis for a period of three days of observation, assessment, medication and reorientation to an appropriate service or discharge. Most 2A members were former hospital employees, including some from the UPSIE.

Referrals were only accepted from other professionals and were all assessed for inclusion. Calls were generally re-referrals or concerned people needing support while on waiting lists for long-term services. Referrals that came from hospital were usually for people wanting to be discharged earlier as well as for beds to be freed for new admissions. Service-users were therefore understood to be part of the “severe psychiatric population” (people who had past admissions). They usually presented with a “severe crisis”. The team explained that they preferred to include people with a “psychiatric” profile rather than a “psychosocial” one. However, a psychiatric diagnosis was not part of the inclusion criteria. The team assessed people on how acute their situation was, on the duration of their crisis and the network available (both professional and personal). Finally, they also questioned whether the team’s involvement would prove beneficial. For re-referrals, the team included people for whom there was a new difficulty in their situation.

The team intervened on average for four weeks, but this was shorter if necessary or as long as six weeks. People were seen as much as every day or as infrequently as once a week. The team managed “risk” through their direct engagement and clinical judgement while safety, support and a clear plan was also ensured. However, people who self-harmed, abused alcohol or were deemed too “floridly psychotic” were usually referred to hospital. Once discharged from the team, service-users were usually referred back to their GP, their psychologist or psychiatrist or sometimes to a day hospital.

Generally speaking, the team did not adopt any particular model for their work, although different members were trained in different approaches. Each presented themselves with their personality and experience which they exchanged with other members. Many also went on training courses, such as for Dialectic Behavioural Therapy, motivational work and suicide prevention techniques amongst others, which they then fed back to the rest of the team. Their interventions were said to be based on forming a “therapeutic relationship”: talking and engaging with service-users in order to build a meaningful connection. The team valued the fact that they could rely on their “clinical judgement” as they believed it was important for them to take the most effective decision for people’s care.

Workers explained that they felt “free” to explore new ways of doing things without being restricted by the precise rules of the hospital within their new role. They presented themselves first as care workers and only used their disciplinary backgrounds and training if needed. There were two psychiatrists working for the team, each with their own caseload. After the split, a psychiatrist was assigned to each team. The team worked in shifts, with a “dispatch” person always available to answer calls. Visits were done in pairs and the whole team met regularly during the day to debrief on their activities. Many different members were involved with each service-user. A psychiatrist was always on call but only did visits when booked in advance while the hospital crisis unit psychiatrist was on call for weekend nights. All in all, the psychiatrists were felt to be absent in practice but only present during some team meetings where discussions were solely directed at them. Team members felt that they spoke more as a team when the psychiatrists were absent. The psychiatrists' involvement was an issue that was raised repeatedly during my time with the team (including the interviews).

2B Team: MOBiLteam North

All four 2B PAKT teams cooperated and worked together mainly in terms of their referrals system. However, each had their own target area and developed their own model and philosophy. The 2B North team operated within the city centre which was also the main reason for its participation in this study. There were 12 professionals working for this multidisciplinary team during my first visit, including two volunteer experts by experience and a psychiatrist. Most workers had not directly been employed by hospital and some had little or no experience within the residential setting. At the time of my first visit there was some confusion on the expert by experience role within the team, both in terms of specificity as well as on what information was collected within that role, how it was stored and shared. The team worked with caseloads and each worker supported up to 18 people. They generally followed the FACT model (p27; appendix A.6). All in all, team members felt that it was difficult to balance both the ACT and CMHT functions which presupposed different approaches.

An assessment and screening team had been set up between all 2B PAKT teams, with one member from each team assigned to it, while the team leaders and psychiatrists joined on a rotational basis. Anybody could refer, including potential service-users themselves for whom a lower threshold was set. Ultimately however, the decision on who was included was left up to the psychiatrist. An important number of referrals came from one of the promoting hospitals, based on an agreement for a fast-tracking referral pathway for "very vulnerable" people. The team leader expressed dissatisfaction with this agreement, especially since it was felt that the same was not true for referrals coming from the team towards hospital. It was also explained that referrals from hospital were not always of a 2B "profile" but had to be included regardless. Moreover, service-users were sometimes unaware of such referrals between the hospital and the mobile team. As a result, they had not always had the opportunity to give their consent for the involvement of the 2B team.

Service-users supported by the teams often presented as "acute", with a "double diagnosis". They were said to be "psychiatric patients" who were "chronic". The team mostly supported service-users before an admission to hospital, while they saw the local PZT team (ambulatory team at home) as a post-hospital service. Given that the team was mobile and operated within the community, the question inevitably arose as to whether the team acted as an alternative to hospital or whether they also offered support to people who would not have had any connection with a hospital but were "new" to the mental health system.

Given the team’s FACT model, workers employed three different approaches depending on people’s needs: AOT, CMHT and “bemoeizorg” (“meddling” or intrusive care for people who actively disengage with services and are difficult to establish contact with; p139). The team met regularly, more often to discuss service-users on the “FACT board” (people who were said to be in “crisis”). The team’s aim was to always have a concrete plan of action for service-users. Each person’s engagement with the team was dependent on their needs. The team often acted as a safety net, with “dormant” files for people with whom the team was not actively involved with but who were not discharged from the service. However, this approach often prevented new inclusions.

In general, the team aimed to work closely with other services but often found it challenging to do so. This was mostly due to difficulties in the sharing of information between services. Collecting information appeared to be very time consuming and a lot of it had to be collected manually (mainly by telephone to specific professionals). It was also interesting to see that in this project the 2A and 2B teams did not work closely together. This was also due to the fact that the 2B team supported service-users through their crises and seldom referred them to the 2A team.

Central-West Flanders: PRIT

The PRIT project was a ‘typical’ 107 project, which included a 2A and 2B team with its members all employed directly from its promoting hospital. The teams operated and organised closely together, along with the local PZT service. All in all, this project was perhaps the most financially comfortable in comparison with the other three participating in this study.

2A/2B Collaboration

The teams shared the same resources (office, computer system etc.) as well as the same central telephone number. Any professional could refer people to the mobile teams, but self-referrals were not accepted (people were advised to go through their GPs). It was felt that professionals knew the target group better and therefore had better judgement when referring. A referral was first assessed by phone by two social workers and if appropriate was forwarded to the teams. Both teams were multidisciplinary. However, psychiatric nurses were the only ones to hold caseloads while the psychologists had a consultancy role and saw service-users if it was stipulated as a need (although this was not always clear when). The teams’ psychologists were also important actors in the development of the service model. The social workers who mainly answered the phone could also be consulted when needed. The teams also shared a psychiatrist who was the main decision maker when present. Conversely with most other teams, the psychiatrist aimed to be the “treating psychiatrist” but this rarely was the case in practice, due to opposition from other professionals. In general, any service-user had to have a GP who acted as a reference throughout an intervention and ensured continuity of care for the future.

Both teams used the same personal recovery plan which was filled in with the service-user during an intervention. The plan included an overview of the situation and the reasons for seeking help as well as the goals expected. It also included a genogram and sociogram (a map of people's interpersonal relationships) as well as a short history and context description. Service-users shared their daily living situation and activities by filling in a weekly activity diary. The recovery plan also included information on a person's medication. Furthermore, vulnerabilities and resources were discussed. The plan also included psychometric tests, such as depression and anxiety questionnaires, as well as some basic neuro-psychometric tests. Finally, service-users were also asked to complete Cognitive Behavioural Schemas (specific events that trigger certain thoughts, feelings and behaviours with the resulting consequences), as well as a signalling plan to use as future reference. Once completed, a copy of the personal recovery plan was given to the service-user to keep and use as needed. If they were re-referred to the service, their old plan was recovered and amended as appropriate.

2A: MTA

Inclusion criteria for the 2A team included people who were experiencing a 'crisis' considered acute and accompanied by a "psychiatric" problem. However, a diagnosis was not needed and whilst symptoms had to clearly be acute those were sometimes said to be of a psychosocial nature. When a person was included in the service, the team were involved for an average of four to six weeks. The first week workers assessed the person's situation by visiting daily and collecting information so as to set up an intervention plan. Generally, the team adopted a collective approach: nobody held a caseload, but all members visited service-users in pairs. The caseload ranged from around 22 to 25 service-users on average. The team met regularly including during the day to discuss people on the "FACT board" (crisis situations) focusing on interventions and planning, have a handover for the next shift and organise visits.

The team mainly used a FACT model approach (p27; appendix A.6) but adapted it for everyday work, using different parts from different models. At its basis, the intervention was centred on the recovery plan the team used, to which other relevant intervention techniques had been added. During the first observation, the team explained that they aimed to include more risk management to their intervention using a phased model approach. Generally speaking, most people were referred to a psychologist or other ambulatory or community service. Particular attention was given to ensure continuity of care both as follow up to the 2A team's work but also during the intervention period itself. When people were said to need a hospital admission the 2A team generally referred them to the general hospital because there were more acute care beds available. For more specialised care people were referred to the psychiatric hospital. About 10% of people were referred to the 2B team.

As was the case with other teams, during my first visit it was explained that there was uncertainty about the impact the mobile teams were having on hospital admissions and whether they presented an alternative. For this 2A team (as for others) the A&E department's priority remained to admit people who were said to be in crisis, mainly in order to keep beds occupied. Once the beds were full, the 2A team was called. The team also explained that A&E doctors were often not trained in 'matters of mental health'. Furthermore, team members often found it difficult to work closely with other services, mainly because information on service-users was not freely shared. Continuity in care could not always be ensured due to the lack of transparency.

2B: MTL

As mentioned, the 2B team worked very closely with the 2A team but given the difference in their target populations there were also a few differences in the way they organised. The 2B team offered longer term support by building and maintaining support networks. People included were said to have "a psychiatric problem with complications or impairments that have an impact in a person's everyday life". The team explained that their threshold remained low and that they only offered support for a maximum of 2 years. For more severe situations or complex presentations, people were referred to inpatient services.

Service-users were first placed on a waiting list. They were then visited for an intake period, where they were seen four times in a period of two weeks, including a visit by a psychologist and if possibly by the psychiatrist too. The team generally paid attention to the service-user's context in order to get to know them and their situation. After those two weeks, the situation was discussed by the team and, if included, a case manager was assigned. Case managers were responsible for people's support but if the need for more intensive care arose (e.g. increased frequency of visits) then the situation automatically became shared with other members of the team. Service-users who were going through a crisis or were potentially at risk of one were put on the "FACT board" and daily meetings allowed for team members to discuss those situations. People who were admitted in hospital were also included on the board and the team worked towards shortening their stay.

Service-users saw the psychiatrist once or more if needed. The treating psychiatrist still held the responsibility for important aspects of people's care such as medication. The 2B team's psychiatrist only changed medication after discussing it with the treating psychiatrist. Furthermore, as in most projects, nurses within the team never administered medication. The team explained that they generally avoided using diagnoses. If used, they were mainly seen as hypotheses. However, workers did some work with service-users and their assigned diagnoses especially in order to explore the stigmas attached to such labels. It also became apparent that the team was not always in agreement with other services or professionals on the subject of diagnoses. The team generally tried to have an open line of communication with other professionals involved. As mentioned, the 2B team intervened for a maximum period of two years. Service-users were mainly referred to private psychologists, mental health centres (CGG) or psychosocial rehabilitation centres as well as the PZT, since those services also operated for the long-term. Given the long waiting lists for those, the 2B team often had to refer ahead of discharge to ensure continuity.

Unlike the 2A team, the 2B team felt that they had an impact on the number of hospital admissions. Services in the areas referred people to the 2B team in order to avoid admissions. The team also explained that their threshold for risk had decreased considerably and with that the rate of admissions. However, when asked, the concept of risk remained unquantified and was said to depend strongly on clinical intuitive judgement. Usually, communication was said to be quite open with hospital. In general, however, the team valued their independence. In contrast with other 2B teams, it appeared that this team worked with service-users who had given consent and agreed to an intervention with all its facets. In this regard, it could be assumed that service-users' situations were perhaps less 'chronic' than in other areas, where often consent had to be actively sought and was not always guaranteed. Furthermore, the team mainly worked on subjects surrounding mental health while problems of a social nature were redirected towards other structures. This was possible given the efficiency of social care within the area, unlike urban or socio-economically precarious contexts where services were often saturated by social care demands.

Part II: Analysis

[This page intentionally left blank]

Chapter 5:
Categorical Levels – Presenting the Data

Introduction to Chapter 5

The following three chapters will explore the analysis that was done on the basis of the interviews and the second observation period with the teams. Based on the Grounded Theory methods (chapter 3) open coding quickly made apparent levels which were descriptive of the data and which became increasingly obvious throughout the interviews. Those levels and ensuing sub-levels will be discussed in this chapter which will in turn pave the way for the relevant analyses, subsequent sub-themes (chapter 6) and categories that transpired (chapter 7).

All eight teams described their work focusing on two aspects: one concerned their daily direct work with service-users at a team level while the other referred to the way in which they collaborated and compared themselves with other services. Those collaborations comprised agents within the mental healthcare sector including the residential sector and the already existing ambulatory (or community) care sector. Other collaborations concerned first line (or Function 1; p31-32; appendix A.7) and social care services as well as wider services such as the police, schools, private employers and others. Finally, the participants also described their work within the wider geographic, societal and political context. According to the questions developed for the study at each level (p80-85), participants also provided their "ideals" i.e. ways in which they would like to see their work and collaborations change.

The three categorical levels presented were based on initial coding technique, which with time became more focused to produce conceptual groupings and categorical levels. "Categories explicate ideas, events or processes in […] data, and do so in telling words" (Charmaz, 2006:91). Groups of those "telling words" or focused codes are shown in *italics* throughout the text, with clusters of codes <u>*underlined*</u>. Those make up the conceptual groupings and in turn categorical levels that reflect the interview levels presented in the methods chapter (p80-85). Those levels are therefore made up of concepts that are perhaps sometimes abstract but consistent with the raw data to reflect what people are saying, are doing and/or what is happening (Charmaz, 2006; Birks and Mills, 2011). It is through those levels, the field notes taken during the observations and interviewing process, as well as the memos throughout the data collection, that a series of theoretical concepts and categories were born which will be explored in the following chapters (Corbin and Strauss, 2008; Morse, et al., 2009; Birks and Mills, 2011).

As mentioned, this chapter will explore the initial categorical levels that came out of the interview data based on open coding techniques and concurrent data generation, as well as constant comparative analysis (Birks and Mills, 2011). While those were emerging from the first sets of interviews, new samples were taken from the next projects' interviews and so on, which further boosted the initial and new data. Some initial theoretical sampling was used as a technique in this interview process as new interviewees and new projects were included (Charmaz, 2006; Corbin and Strauss, 2008; Birks and Mills, 2011).

Figure 3.2 below, as first shown in chapter 3 of this work (p89), shows this process with the highlighted level representing the processes and results produced and explored in this chapter in relation to the following chapters.

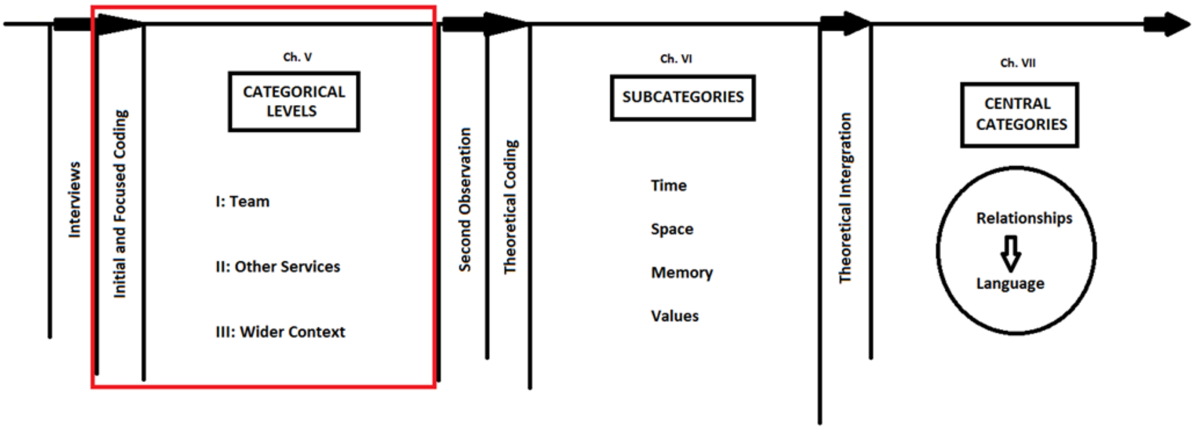


Figure 3.2 The Analytical Process: Categorical Levels

Level I: Working in a Team - Team Work

Working With/For a Population:

The teams described working with and for a *specific or target population*. Description ranged from "*crisis*" situations for most 2A teams to people needing long-term support and described as "*chronic*" for 2B teams, also based on the original 107 reform guidelines (p34-35; Service Soins de Santé Psychosociaux, 2010; Natalis and Pieters, 2016). For service-users who may have had previous contact with mental health services, participants described where they had been *cared for before*, if at all.

More specifically, 2A teams described populations that had been cared for by psychiatric or mental health services before (*known population*) but also populations that would not have been in contact with services prior to the mobile teams' creation (*new population*). Most participants made the distinction between "*crisis*" and "*urgency*". Although "crisis" situations were the main inclusion criteria for 2A teams, a standard, fixed and strict definition did not exist. Many participants interlinked the term with notions of burden and destabilising elements within a situation. Others, described a "crisis" as an opportunity or a "necessary passage" which "introduces possibilities". In general, understandings of crisis were close to established models of crisis theory, which participants often referenced back to their experiences with European 'experts' (p75-76; MacDonald, 2016).

For 2B teams' population, most people were described as "*revolving door in-patients*" (people with many admissions in hospital due to 'chronic relapses', complex living situations and increased "*vulnerabilities*"; Joyce, Khan and Jones, 1981). Participants described *inclusion criteria* for their service such as age and geographical area, while some used psychiatric diagnoses and/or symptoms. All teams presented their respective populations as vulnerable, although it was not always clear what was meant by this, and *"diverse",* representing different socio-economic and cultural levels. The chosen population reflected the teams' function and context as shown in the next sub-category. However, even if a population was key to the teams' organisation, it was very difficult for participants to actually ascribe clear definitions to those populations.

Working in a Particular Way - Intervention Models and Organisation

<u>*Models and values:*</u> Participants described the way in which they worked in order to serve their target population(s). This was mainly done in two ways, by referring to specific ('evidence-based') *models* (p26-28; appendix A.6) and through the agreement on *common values*. The Flemish teams were more concerned with using 'evidence-based' models while the French-speaking teams presented their work mainly through shared values. All presented their interventions as *person-centred* with notions about empowerment, independence and self-reliance (revisited throughout this work). From the team's point of view notions of *flexibility and transparency* towards the service-user were deemed important, while *perseverance* to offer care for people not wishing to have the team involved was also mentioned, always taking into account users' wishes as seen through the FACT model (p24-25; Veldhuizen and Bähler, 2013). *Community and the home setting*, *time frame*, *intensity and frequency* of visits as well as the *context* of users' situations were all mentioned as ways in which mobile team work was structured. Family, personal networks and working with a *person's personal context* were also important and something the teams aimed to work with more. Many alluded to the *relationship and bond of trust* that had been set up as the basic foundation for any successful intervention with people (Shea, et al., 1992; Thomas, 2014).

> *So, the idea is to meet the person in their suffering, to look at the suffering rather than the symptoms. The team acts focused on the suffering. We are very aware that we go to patients that sometimes do not want us to be present. So, there is the question of time: to really let ourselves have time to create a connection, create a transfer/transference, to address the issues, to allow the needs to come out for this patient, starting from what they have, the resources they already have. So really move below what was broken in order to, finally, rely on what they have still; to try and create other needs so as to develop other resources. I would say that that's one thing: flexibility. So, we really try to be very flexible. So, we can go 5 times before they open the door; we go. Sometimes visits happen with the door half opened. As long as they don't refuse that, we go, we continue going; refuse clearly, and even then we think about how we can do things. So, time, flexibility and the fact that our first input may not be care. We are clear that we are a care team, but our first introduction could be something else. If the patient tells us "I need to do some activities" we will start from there. We make a bet […] that he knows what it is he needs better than us, while we stay vigilant […] and also propose things, and take the time to do them. […] Really support him where he lacks going. It's about leaving our own frames of reference to be able to move within his representations* (2B team leader).

For Flemish teams, the model of "*recovery*" was at the forefront of their work (Anthony, 1996; Bonney and Stickley, 2008), with most of them also employing a *solution-focused* model (O'Connell, 2005). All teams were concerned with *avoiding medicalization and categorisation* in their work. They described their work as based on *care and social responsibility* with the hope to *prevent relapses* and in turn *avoid or shorten hospitalisations* (based on the original 107 reform guidelines, p31-35; Soins de Santé Psychosociaux, 2010). Finally, it was important for many participants *not to formalise* their work too much but to allow for *possibilities*.

<u>Mobility and the home setting:</u> Offering the possibility for care at home was an obvious particularity of the intervention models, also based on how the teams were developed. The mobile aspect of the work was therefore important in what the teams understood their work to be, how they made use of it and how they organised around it (e.g. by using pairs to organise visits). The way in which workers were organised differed across teams, with some employing an individual case management approach, usually for longer term support (2B teams), while others working in pairs mainly for short-time support work (2A teams).

> *Because you are going to a person's home, you expect to meet that person, and then that day you will also meet the neighbour, then the grandson, the dog who is barking, the workman*

> *who came to do a meter reading. It is often very lively. And for that reason, I come back to the idea of pair work – but for that reason pair work becomes a useful tool, not only necessary but useful, […] because you are not faced with all this alone; dealing with all this is a little complicated* (2A team leader).

Organisation: The teams described how they organised to be able to provide the necessary resources, time and personnel in a way that fitted with their intervention model and/or values. This included *tools* they would be using such as recovery or treatment plans, social maps, case files etc. Also, the teams mentioned the methods used for their service to be made *visible and accessible*, such as *referrals* to and from the service ensuring a certain *continuity* in the work. For example, the participants having developed and using a “recovery plan” (p103) explained this process in this way:

> *The intention is twofold. It’s a document which must be given back to the client, because we fill it in together with the client, to give back to them, with the intention of containing an added value for the client. The client, well - he knows his story - but he gains a bit more ‘insight’ about it; about how a crisis might be associated with a few themes of the past for example. That insight comes back and gives meaning to somebody. So it’s a document for the client and for us, which we project daily, well not daily, but which we project on team meetings and on which we base our decision policy* (2A team member).

> *In some cases, this plan is kind of left out and it’s rather conceived as an official tool which has been used. But in other cases, it’s actually actively being used as a working tool, you know, and it offers other tools which [workers] can effectively use. […] Some assistants will be more inclined to use these tools, others will be more inclined to draw on direct experience and gut feeling and won’t be strictly using this plan* (2B team leader).

Working in a Team - Disciplines and Hierarchies, Working Together

All teams presented themselves as being *multi-disciplinary,* as stipulated by the 107 reform guidelines although the use of disciplines differed amongst them. Most workers presented as doing the *same work*, except for team leaders and psychiatrists, except for one project, where a clear hierarchy was in place based on workers’ disciplines. One team did not have a team leader or a psychiatrist. Participants went on to explain that they had a *shared identity* and that they did the *same work but in different ways*, taking on different roles within the clinical setting (such as “bad cop, good cop”), or by paying attention to different elements grounded both on their disciplinary background but also their personalities. There was a sense in which participants could not make a clear distinction between *discipline* and *personality*. In most teams, team members had been working together for a couple of years and in most cases knew each other from before (since they were employed directly from their promoting hospital). Familiarity with colleagues seemed to be an important part of working effectively together as a team and allowing for *complementarity*. Workers presented as having different views but the same objectives, allowing for a *homogenous team approach*.

> *P1: From the perception, I think, from the training I've had, I think, we have a different perception; while still being the same but we differ a little. For example, I am an educator (OT) so the treatment, it shouldn't interest me. But having worked in hospital for 34 years, it is something that comes to me directly. I suppose that each person, depending on their training, has perceptions that can be different while still remaining homogenous enough for the rest. But everybody can defend their own way of looking at things or experiencing them. This way we have several views and we have the habit of going in pairs but varying those. I think different views are taken.*
> *P2: It allows, perhaps, to have a global view of a situation.*
> *P3: It really allows for complementarity within the team* (2A team members).

Participants actively *compared their work within the mobile team and hospital*. There was a dynamic period during which a lot of notions and habits learned in hospital had to be deconstructed. Some found it hard at first, while some still find it hard to adapt to this new way of working. This was sometimes *linked to their disciplinary background*, with social workers finding themselves more suited to the mobile setting based on their work, which always had an outreaching focus outside the hospital walls while nurses were left feeling a certain loss linked to their training and functions within the walls (Prior, 1993). All shared a *preference for mobile work*, however, even if the change had proven challenging.

> *At first, I was asking myself: "What are we doing here? What is the use to talk?" […] There were moments when a patient was telling me that he had to phone somewhere and I wanted to tell him to take my phone [or] ask him if he wanted me to do it. And then I told myself that it is not how we should be working, and then, I realised other things. So, before I die, I will have seen other things which are good also!* (2A team member)

Team leaders and psychiatrist(s) were somewhat distinct from the rest of the team workers (Prior, 1993; Hall, 2005; Iqbal, Rees & Backer, 2013; Morgan, et al., 2016). They represented different functions both within and outside the teams, including coordinating, training, consulting, coaching and managerial roles. This gave way to a particular *hierarchy* in the way the decision-making process regarding clinical matters, such as who was included in the service and who not, what the decided course of action would be etc., as well as regarding organisational questions (shifts, diaries, meetings etc.). This hierarchy was especially true for psychiatrists who were thought to have a different and greater knowledge of the work (based on 'medical models'; Read, et al., 2004), while their position was also widely linked to the question of *medical responsibility,* generally held by the psychiatrist (appendix A.1) and then vested and shared by the team members. Many psychiatrists were the main persons communicating with other doctors.

> *I think it's first of all a matter of position, considering the fact that [they are] a doctor, you know. We still believe that this is someone with an even greater knowledge, or with more knowledge and skills as far as these matters are concerned, and also because in the end [they are] the ones who are responsible for the clients' treatment, for the clients' support. Because it's also important that [they] fully [support] the goals that are being pursued since [they are] also [helping in] supporting these objectives. Because very often we do have to ask for the doctor's help, from time to time, to establish contact with a client's treating doctor, to discuss certain matters. Sometimes doctors can understand each other better or can communicate better with each other, whereas we sometimes [can't]. So, it's of the utmost importance that [the psychiatrist is] on the same page as our team concerning our wishes, but we can definitely engage in dialogue with [them], [they are] very open and don't mind you saying. If [the psychiatrist] says something, we're allowed to go against [their] point of view: [they] can deal with opposition and you're allowed to go against certain things. [They] can take that. So, it's definitely not the case that [they don't] tolerate any opposition, it's allowed, but there remains a general feeling that the doctor should give his or her consent, and definitely with regard to certain decisions. Taking an involuntary admission into account, for instance, then it's actually up to the doctor to take that decision, because we're talking about a medical decision* (2B team leader).

One team rejected having a psychiatrist function within their team, opting instead to work without one. However, the need for one, especially in matters of collaborations was not always clear.

> *P1: […] it's more in regard to our exterior that [having a psychiatrist] has resonance.*
> *P2: I don't think so. I think that we have a big enough mouth to say: "it's not because we don't have a psychiatrist that you shouldn't listen to us"* (2A team members).

2A/2B/PZT-SPAD differentiation and collaboration

As seen in Chapter 4, for urban projects, the 2A, 2B teams and PZT/SPAD teams worked as *separate partners* within a wider mental health network. In Brussels and Wallonia, the PZT/SPAD teams continued their work separately and/or in parallel with mobile teams. This was mainly because funding for those teams came from the sheltered housing sector while mobile teams were formed using mental health and residential care funding. In Ghent, however, the PZT (SPAD) function was *integrated* within the 2B team, while in West Flanders, the PZT team operated within the same space as the mobile teams, thus facilitating in the continuity of care for 2B team service-users. In addition, the 2A and 2B teams for both rural projects *worked closely* together, some even sharing office space and employing one psychiatrist for both teams. Access for both teams was made through the *same telephone line*. The question of *inter-communication* because of this joint access for both the teams was a central theme in how they organised and collaborated.

> *For us the joint/communal telephone line is one of the realities that precisely, obliges us to communicate, to make it so that patients are sometimes known by both teams. This can be important since some patients change teams, which involves everyone* (2A/2B team psychiatrist).

In some cases, the collaboration between teams had a competitive characteristic that appeared to be linked to the difficulty in assigning clear definitions to target populations (as seen earlier in this chapter, p110-111)

> *It is sometimes very random, since we have a tendency to see a crisis when we hear a referral, like they have a tendency to see that it concerns them more because there is something more for the long-term* (2A team member).

Ideal

Participants presented a wide range of different ideal scenarios for how they would like to work in their respective teams. Many were concerned with having a *different target population*, either by making it wider or including people with a *more "vulnerable" and/or "severe" presentation*, including people who may not wish or agree to be cared for, at least in the beginning (as also stipulated by the FACT model; p27; appendix A.6). This was translated in the wish to have a *lower threshold* and increase the mobile team's *visibility* for people to be able to access the service more easily. However, this was not an idea shared by all the participants with some actively disagreeing and instead preferring to offer more *specialised care*. The idea of a low threshold was therefore twofold with some seeing it as a way to be more specialised and others as a barrier for people needing care.

Many participants wished for more *flexibility* in their work and hoped to avoid it becoming too *formal and/or bureaucratic* with more *transparency* towards others and especially service-users. Having the *freedom of content* in their work was definitely important. They also aimed to keep *spontaneity, creativity and time*, with many mentioning the need for *"fluidity"* in their daily work. Keeping a *person-centred approach* was also considered central, including taking particular care of *service-users' own goals*.

> *To be able to keep time; that we don't become teams based on "industrial" models in big quotation marks, where we do a lot of procedures, filling in papers, signing documents. I think we are very, very flexible; it is what qualifies us, we are very flexible and very transparent with the patient, but all this in a lot of informal ways. My worry would be that we'd have to formalise based on the number of patients, for the powers that pressure for results, numbers, Personally, I see results, qualitative ones, but it's difficult to express those. [So] to keep time for the unpredictable* (2B team leader).

Team members discussed the use of *time across disciplines*, with some having more available time compared to others, most notably the psychiatrists. Some participants hoped for psychiatrists to be more available, including the need for guidance, especially in these early years of mobile work, where others alluded to the need for more "horizontal" work practices.

> *It's complicated to ask for self-management when on the contrary we are always in co-management* (2A team leader).

Many teams called to increase the teams' *efficiency* in order to be able to receive more demands and discharge in a better way, so as to also avoid waiting lists. Furthermore, participants wished for their work and function to be made clearer as well as *setting a frame* with specific goals. Some mentioned their aspiration to become *treatment teams* rather than counselling or "accompanying"/supporting ones. In order to do this, many teams expressed the need for more guidance in their work, as well as *training.* All teams actively wished for *external supervision*. In turn, the need for *more resources* and personnel was also discussed.

One project operated from within hospital grounds and some members explained that they would prefer to have their own *distinct space*. However, others welcomed their offices within residential spaces, arguing that this pushed them to be more mobile as well as to keep links with hospital wards or personnel when needed.

> *Mobile teams should be distinct from hospital. […] I visited other teams […] and it's true that the models or the spaces were completely distinct from hospital. I found that good, because it avoids confusion, it facilitates the idea of a new care setting a new care mode and inevitably being within the psychiatric hospital walls gives different connotations* (2A team leader).

Some teams wished for a *clearer 2A/2B differentiation* with separate phone lines where only one existed. However, others preferred to make the already imposed differentiation smaller, some even arguing that one large mobile team should exist which would include different roles and functions within it.

Most teams agreed that a *small cost* could be good for the service to impose on their service-users, in parallel with how the Belgian health system operates as a whole (p23-24; Corens, 2007). This would also in turn help collect funds and increase services' resources, as well as keep waiting lists somewhat at bay.

Finally, one participant expressed the very clear wish to have more of an expert-by-experience or peer support worker role and function, explicitly involved within the mobile teams, either by employing directly or by building links and relationships with the existing and growing peer network structures available throughout the country (such as Psytoyens for French speakers and UilenSpeigel for Flemish speakers).

> *In multidisciplinary teams we could also imagine experts by experience. I was asking myself if it would be good to have them in mobile teams […]. Even though we already do this, we could really lean on the service-user's capacities, to anticipate a new, or in any case eventual crises and "what do I do in that case? What can I put in place for the day when..?" Because it is good to avoid crises, but we also need to anticipate/foresee. Because sometimes some will come back. Personally, I realise that there is a network which is becoming more and more important. It's the peer network, so peer support. I think, it is because there are more and more connections made between people who have psychic problems, more and more spaces where they can find themselves and at that moment there is a real mutual aid that happens. And the moment we are not well, we can call on each other. Yes, we systematically avoid hospitalisations, systematically. Because it's true that family is not always the best, I mean, those are always complicated relationships that will not always be especially supportive, friends not always either. […] Whereas people who live a little of the same thing or who have lived through the same things, yes, that can help a lot* (2A team member).

Level II: Working with other services

Working with mental health services

Participants presented their work with other mental health services in two main ways. First, by describing their *collaboration* with mental health services i.e. the way in which they worked together when users were referred to the teams from other structures or when mobile teams referred people to others. The second way in which participants presented their work with hospitals was by *comparison* i.e. by comparing their function and setting to that of other structures, based on the notion that mobile teams exist as an alternative to existing possibilities and/or as substitutes within the mental healthcare system.

Working with Hospital

Collaborating: Participants presented their collaborations with hospitals in specific ways compared to other mental health structures. Given the context of the 107 reform (p29-35) their work was interrelated first with what they called their 'promoting hospital' and the rest of the hospitals within their area and beyond. This also reflected the fact that most teams were created by former hospital workers. Furthermore, the teams presented as an *alternative to hospitalisation* admission either by shortening the admission period or by avoiding admissions altogether (as stipulated by the 107 reform guidelines; p34-35). However how much that was true or effective was not always clear.

> *One of our goals is to prevent, or shorten, admissions. But to work towards shortening admissions, still remains a shady notion, because the intention is not to install aftercare for people in admission within psychiatric hospitals or other hospitals. Regarding that, we still have not found what that is exactly – shortening admissions. It's still a grey area, where I have the impression also that, on a higher level, things are not what they should be yet* (2A team member).

As teams repeatedly mentioned, hospitals differ in *function* and *time periods*, with psychiatric hospitals working on longer admissions and psychiatric wards within general hospitals focusing on short-term stays. Most, if not all teams, had several differing opinions on hospitals, explaining that *collaboration depended on the particular hospitals,* their populations and methods including the particular wards within those hospitals.

Most participants agreed that *communication, transparency and exchange of information* with hospital professionals was not always easy but became easier once certain *"key persons"* or "persons of reference" became involved. Those "key persons" were people the team worked with before and with whom a certain personal rapport had been formed, upon which a working relationship was built. The professionals mentioned the difficulties they faced in the lack of *transparency* with hospital structures, sometimes referring to the "high walls" between structures and professionals. Examples ranged from late notices or even lack of notification of people being discharged, supposedly within the care of the mobile team, which proved to be a major obstacle in providing *continuity of care* for service-users.

Most participants agreed that hospitals were at times *necessary.* However, *hospitalisation habits* were set in a 'culture' directed at occupying beds. Referrals to mobile teams were made only when no more beds were available. This reflected the way in which *decision-making procedures* within hospitals were presented by the mobile teams.

> *I know to what extent hospital is important. But it is also important in people's way of thinking. When care is needed [that means] hospital care. We do not think that there may be an accumulation of different types of care which will perhaps bring about the same well-being as a hospital service* (2A team leader).
>
> *The beds must be occupied. That's what it's about!* (2A team member)
>
> *The psychiatrists […] are paid per admission, so the faster they send people home, the sooner new ones can be admitted. And then they refer to us* (2A team member).

The teams also mentioned the fact that hospital referrers usually had *specific expectations* of the mobile teams, mainly in the form of out-patient hospital interventions. Participants did not always align with this view, since hospitals have outpatient departments specifically aimed at providing care for people's return to their home. The teams saw their role as a separate function concerned with support at home regardless of hospital stays. Nevertheless, most teams spoke specifically of *in- and out-reaching practises*.

Finally, most teams spoke of a feeling of *competition* with certain hospitals, since much of the population in question was comparable for both hospitals and the mobile teams.

> *Sometimes, psychiatrists see us as psychiatrists who take away their patients, because their beds are not occupied yet. When do they rely or appeal to us? When their clients are discharged, because there are other patients waiting to be admitted* (2A team member).

Comparing: Teams were not always clear about how hospital populations and users of mobile teams were comparable or not. For 2B teams most service-users had past hospitalisations but not all, while for 2A teams many people seen were first time mental health service-users. Participants also questioned the presentations they were brought to see and the time during which they were called to offer support. They compared their work to hospital work by paying particular attention to the differences between the hospital *setting* and people's home setting.

In line with this, they also emphasised the possibility for the *involvement of a person's personal network*. Participants explained that involving the personal context is very different depending on the setting. Within residential treatment structures a person's context is perhaps less involved than in the home environment where they occupy the same space as the service-user.

> *The fact that you work in the context is of course also very different than in the hospital. In the hospital you come as an identified patient, while now, we go to the client and that immediately*

> *gives us a view on the residence, social contacts, context. That's not a new public, but a totally new approach, a different approach at least* (2A team member).

The teams also reflected on the process of their *changing roles* (Elstad and Hellzen, 2010). This was true both for professionals from hospital moving to the community as well as for users now visited in their homes and private settings instead of hospital. This, in turn, was reflected in how participants referred to the difference in the *relationships* formed between professionals and service-users depending on the setting (Prior, 1993; Gilburt, Rose and Slade, 2008; Morgan, et al., 2016). Finally, workers explicitly compared their own experiences of hospital versus community work, with many clearly stating their preference for mobile work.

> *We all come from hospital. […] I think we deconstructed all this. I find that there really was a reframing on the level of our intervention models. […] So when we were in hospital, we had the patient within our walls, with our models and we had an easier, well, we imposed something more readily. [Now] we go to their homes, we are invited to their homes, so already it's a completely different approach/action* (2B team member).

Another category which was often mentioned was the difference in how *time* was organised in hospital in comparison to the home environment. This was different for 2A and 2B teams, with 2A teams offering short-term but intense interventions with longer lasting results and 2B teams taking longer to effect change within the home environment.

Mobile team professionals explained that hospital workers had a different *view* of their in-patients which made for a very different *vision, mind-set and/or model and philosophy* to their way of work in comparison with mobile team work. For example, many participants mentioned that hospital only saw a "snapshot" or "photograph" of a user from the time they were inpatients, while professionals in mobile teams got to see a more *global picture* within the home environment.

In addition, participants were adamant that although there could be similarities in the function both structures served, all in all hospitals operated within a different function than mobile teams. One particular example was the notion that hospital is often used for a *"hotel" function*, something which the teams were unable to provide for their service-users. Finally, participants mentioned the difference in *cost* since hospitals are a paid service (including for compulsory treatment and forced admissions), which can sometimes be expensive for inpatients while the teams offer a service free of charge.

Ambulatory Teams and Other Mental Health Services

<u>*Collaborating*</u>: Many participants regarded their collaboration with ambulatory teams and other mental health teams in a *competitive* manner but were clear that their functions differed, even though the populations where somewhat comparable. Many team members explained that closer collaborations became possible through specific relationships and personal links with “key persons” as was the case with hospital professionals. In other words, ‘networking’ practices often boosted collaborative work.

However, *expectations* from ambulatory or other mental health teams were often specific. Participants mentioned that given the *unfamiliarity* of ambulatory teams with mobile team work, certain *attitudes* sometimes arose, which were not always aligned with mobile team work. It has to be acknowledged, that the ambulatory sector, which has been practising for over 40 years in the community, were somewhat cautious of the ‘107’ reform, especially since the hospital structures were heavily involved in its development (especially in terms of funding).

The question of *confidentiality* (linked to medical responsibility; appendix A.2) was also more of a focus when talking about the collaboration between mobile teams and the ambulatory and existing community sector (which was not as much a focus when talking about collaborations with hospital). Teams often answered such problems with regular meetings, concrete agreements aiming at *complementarity* and *parallel working* practices.

The most important point that was raised concerning the question of collaborative practices between mobile teams and ambulatory services, however, was centred on the *long waiting lists* that are making access to these services very difficult.

> *In Belgium we always bump into the same thing: waiting lists. This really slows down things and it’s really difficult for clients, because if you’re convinced that your client shouldn’t get help from an outreaching service, and can simply go to a [mental health centre] instead, but then he has to wait for 6 months, 8 months, even a year- It rather has the opposite effect* (2B team member).

> *You lose people because of the waiting lists, definitely, that’s a common fact, if you send someone for example to [an ambulatory mental health centre], at that moment in time he wants to, or he’s motivated, but there is a waiting list and meanwhile, [our] support has stopped. Say that he can start up [with the mental health centre] within five months, maybe he doesn’t want to anymore then. [But] no one is going to stimulate him or something, like*

> *'why are you not going?' And that is not followed up […] we don't know whether people get there or not* (2A team member).

<u>*Comparing*</u>: As mentioned, many teams regarded their work with ambulatory teams as *competitive* although they explained that their *functions* and *insights* differed. In other words, they pointed towards different *approaches and visions* with the ambulatory sector operating from a *prescriptive* and *therapeutic* base (Service Soins de Santé Psychosociaux, 2010) while mobile work aims to be *person-centred* (Rogers, 1961; Morgan, et al., 2016), *demand-oriented* (mostly valid for the Flemish community inspired by the Netherlands; Rijckmans, Garretsen, van de Goor and Bongers, 2007), in many cases solution focused (O'Connell, 2005) and concerned with the *"here and now"*. This was not true for all teams: some said to also work on a "therapeutic" level as their ambulatory counterparts.

> *I told myself: if I had seen this patient in my psychotherapy practice, I would have done that, that and that because he told me this, this and this. Now, I'm at his home and I observed this, this and this. If I hadn't been to his home, I wouldn't have seen this. But now, I saw home so my way of working on the psychotherapeutic level will be fundamentally different, more of a systemic one which I would have missed with a psychotherapeutic framework which is more restricted if you like* (2A team psychiatrist).

Finally, ambulatory teams or community mental healthcare services (including private psychologists and psychiatrists) came with a *cost* which differed from the free of charge services offered by mobile teams.

Working with Other (Non-Mental Health) Services:

The teams described working with other services outside the mental healthcare sector such as with General Practitioners (GPs) and "medical houses" (GP offices including other first line care ranging from physiotherapy to psychological therapy) as well as social services, housing, cultural spaces, private employers or schools and universities. Here, participants were less prone to compare their work with other services but talked at length about their collaborations.

<u>*Collaboration:*</u> Many participants spoke of collaborations as dependant on the persons they worked with from other services and the possibilities for *personal links* that could eventually be formed with such persons. However, many also explained that several constraints arose due to matters of *confidentiality* and the "*professional secret*" (appendix A.2). However, non-mental health services were presented as *important partners,* with some more *distant* than others, that were often regarded to have a significant *facilitating role* for mobile team interventions. Conversely, many

participants spoke of the *expectations and attitudes* of such services differing widely from mental health services. Those *mentality differences* as well as *differing sensibilities* made for a sometimes difficult collaboration.

> *I think the only way is to go to these settings and search for people who have the same mind-set as you and who can exercise a certain influence to set things in motion. I think it's the only possible way: search for close associates* (2B team member).

GPs were often used by services as the key reference person, providing a continuous line in a person's path. GPs were often used as a "*continuity of care*" guarantor (Corens, 2007). However, GPs were not all easy to work with and *collaborations differed* widely depending on *personal values, visions and sensibilities*. Mobile team work was *not always known* to the GPs in the specific areas. Some teams aimed to meet with them others leaned on "*word-of-mouth*" techniques. Given that GPs can also be *prescribers* (Corens, 2007), this often presented the teams with problems of medical treatment change or two different treatments being prescribed or administered without communication between them. The question of who held *medical responsibility* was always in focus but not always answered clearly (appendix A.1).

Social services were also an important partner for mobile teams. Workers described their work as "*accompanying" and facilitating* users towards social structures. However, participants often complained about the *unfamiliarity in mental health* matters in such structures. This lack of knowledge often resulted in the difficulty of "working together". Some teams offered *support, training and education* to social services workers. However, due to those structures being very large, especially in cities, as well as persons working within them often moving around, it was felt that it was very difficult to form ties with specific "*key persons*" in order to form effective collaborations. Finally, those structures are under *strict policies,* something that doesn't always allow for the *flexibility* required for mobile team service-users.

> *Administrative procedures are very, very heavy, sometimes already for us to make our way through, so for the person directly concerned, it is sometimes very difficult, so they don't always do what is asked of them* (2B team leader).

Working Within Professional (107) Networks

For some teams working within a professional 107 network (p32-33) had a certain significance and as a result it was mentioned during the interviews. Although at first, it was planned to be something that would be explicitly asked, it became apparent that it was a subject important for some but not others. Therefore, it was left to the participants to actively bring it up in order to pursue it during the interviews. Here, the different subgroupings of those who mentioned the networks will be explored, however those were perhaps not pertinent for all the teams and maybe the teams that did bring it up, did so more out of frustration rather than successful collaborations.

For some teams working in a network was important and made for a very large part of their understanding of the 107 reform (p32-33; Service Soins de Santé Psychosociaux, 2010).

> *We shouldn't forget that the mobile teams are an emergence of the network. They are only a little link. The project idea, the 107 reform is the work in a network* (2A team leader).

In general, however, many participants expressed *uncertainty* about the purpose of their respective 107 networks and which services were active and participating within them. They regarded them as something *abstract* which did not necessarily push for *dynamic collaborative work practices*. There was a sense in which participants were feeling split between their hospital promoters and their community work.

> *P1: We are adrift.*
> *P2: And actually, we compete with each other, with our employer that is* (2A team members).

It was felt that partners within the networks were the same as others outside them and that whether they were partners or not did not change the way in which services operated, especially in comparison to before the networks were set up. Some were closer than others although that was not dictated by the setting up of the 107 network but rather by the *needs for effective collaborations* depending on the service-users' situations. An interesting example is the collaborations with social services, with the latter not presented as active partners within 107 networks. However, they were important actors in people's care and often became close partners for community interventions.

> *We work with the patient's network. That is not 'the' network. Well, I think [the project coordinator] is doing more of all that work on the formal network. We are not [involved] in that. […] We are more [involved] in the spaces. So we don't have a lot of things formalised. There are very clear relationships according to patients, with the social services' social workers, with the family assistant, with the nurse, with home help, with the general practitioner, with the treating psychiatrist - that could be even more - with the family of course, the carers - that could be even more. […] We are not yet in a clear formalisation. So, [the project coordinator] is working on plans towards integrated care, individualised care plans rather, so that there is something more formal at the partner level, of those who work around a situation. But now, it happens a lot in an informal way* (2B team leader).

Ideal

There was an interesting debate on the *need or not for hospital structures*. Some participants questioned the 107 reform's goal of gradually decreasing hospital beds to boost mobile care in the community (as originally stipulated by the reform guide, p29-35; Service Soins de Santé Psychosociaux, 2010). They wished instead to explore more possibilities with more distinguishable care modalities but less specialised teams. Other participants questioned the need for hospital structures and whether they should exist at all, also making reference to the Italian system of mental healthcare which operates with no residential long-term treatment (p27; appendix A.6; Mezzina, 2014).

> *A pure and simple suppression of psychiatric hospital does not only do good. Because sometimes it's more violent to keep people in the community rather than to shelter them for a few days, I mean, even if actually a hospitalisation always comprises a certain violence. Sometimes, the simplest fact of leaving people in the community is violent. I mean, society can be violent towards people who are suffering* (2A team member).

> *I think also that as a society you have to dare say "actually […] we are here for you, not hospital* (2A team member).

In general, there was consensus that the hospital function should certainly be reduced with some still deeming an intense residential treatment as a form of specific care necessary. Furthermore, the wish was for mobile, ambulatory and community mental healthcare structures to be boosted with a *better alignment and integration of care*.

> *[In my ideal] the hospital is always there but differently to the way it happens concretely, provided that there are alternatives in the ambulatory sector or other forms of residential care setting. But the hospital for a crisis is always there, different in its framework. It's always the same thing. I mean, Basaglia who says that "the hospital is ill and we have to tear it down" and institutional therapy which says "the hospital is ill, we need to treat/care for the hospital". I think that a bit of both is needed. […] I think hospital needs to be reduced to a strict minimum and at the same time be conscious of the fact what if we treat/care for hospital, it can do amazing things and be a link in care that is fundamental. So, does the hospital exist? For me yes, differently and to a minimum. Do the mobile teams exist? For me yes, because they have this specificity as a tertiary team and a practice in the community. For me the mobile function would clearly be inflated compared to the miniscule thing that exists now. Do mental health services exist? Yes, I think yes, because again [they have] a different temporality. And I think*

> *that there is nothing that will outright replace a psychotherapeutic relationship, […] it is precious to have a psychotherapeutic time, outside the home sometimes* (2A team psychiatrist)

> *Personally, I always say that in a care system you need "and", you don't need "or". You shouldn't imagine that one structure will compensate for all the others. There needs to be several types of units and one must above all avoid iatrogenic situations. And the psychiatric hospital is a prime example of an iatrogenic space* (2A team psychiatrist).

> *We can always hope for a better collaboration, a better comprehension between one service and another. It could be with hospital as with other services […] we could also hope that at some point we manage to really function in a completely complementary way, with all the people that are around. […] It's clear that I could imagine something where we are in a hyper-complementarity with [everybody]* (2A team member).

Some 2A teams could see their *function* as one of "*gatekeeping*" for hospital referrals (National Audit Office, 2007). For most 2B teams the wish was for a *better collaboration* and "alliance" with hospital, with some bringing up notions of "cross-pollination" from both sides in order to build bridges.

> *If there are harmonious interactions, […] I hope that there could be a reciprocal spill over/contagion effect* (2A team psychiatrist).

> *So [for example] I will use certain elements from the residential settings to take on a stronger position in the home environment and to build a bridge between these two settings. I point out what exactly causes problems in a client's home environment so that hospitals, in turn, can take this information into account. You can actually call it cross-pollination* (2B team member).

An idea was also to have *joint decision-making* procedures through close collaborations which would allow for more *harmonious continuity of care*. Some participants, for example, mentioned the possibility to be able to visit people admitted to hospital more easily as well as be involved in hospital team meetings during that time.

> *I think if you turned ["Care Harmonisation Meetings"] for example into a habit, something we're doing too little right now, to say things like: "we'll come and visit you during the first week and we want to have a voice during the treatment period, the treatment itself", then you'll have a considerable influence in introducing external aspects inside the residential setting. And I believe it's a matter of adopting that kind of attitude* (2B team member).

Others expressed the need for mobile teams (especially 2B teams) to act as *treating teams* making them the main decision-makers of a person's care (including holding medical responsibility; appendix A.1). In this way, they argued, one would avoid repetition. Another way to do this was through the use of a shared case file, but this idea was not shared by all participants with some seeing it as a form of "social control"[1] (Bloomfield and McLean, 2003) and instead favouring 'gaps' between care structures, translating it as a way for service-users to enjoy (some) freedom.

Others wished for hospitals particularly to be more lenient, more aware and open-minded in order to *understand the context* of the home setting and for outreach and in-reaching work to take place in more efficient ways. This, participants argued would in turn allow for admissions to be shortened with more accessible intensive care structures for people or as some participants called it "time-outs". Of course, participants admitted that this would require a change in the hospital admission habits, as well as *transparency* between mental healthcare structures (overcoming potential problems arising from practices involving the professional secret; appendix A.2).

> *Right now, we're standing in the side lines and we do try to get in there (laughs) and to introduce our idea of looking at the bigger picture. But we still have a long way to go to make hospitals aware of the fact that they're not alone when treating someone. […] And of the fact that they should include these external aspects and that they should bear in mind to ensure a smooth transition, instead of an abrupt one, when a client is about to be discharged. […] We should work together. Because we need to know the reason of relapse. And we see where things aren't going well and which difficulties we come across. And if we can share this information with them, they can take this into account while treating the client to reduce chances of relapse by collaborating* (2B team member).

Some participants argued in favour of a *better articulation of professional networks* with the need for regular contacts in order to build closer collaborations based on shared views. In other words, they wished for their presence to be stronger and closer to the networks. By having multiple care players for a person's care, each player would need to make gradual adjustments in order to align their visions with those of others (a process otherwise known as 'circuits of care'; Service Soins de Santé Psychosociaux, 2010). Participants hoped to do this through training and by sharing insights, knowledge, expertise and understandings. By sharing the work and the support as well as the knowledge and expertise there would be less need for mediation while competitive work practices could be avoided.

---

[1] "Social Control": referring here to the set of social practices which produce and maintain individuals who conform to the norms of their social group (Herman and Chomsky, 1988)

> *That everyone becomes aware that there is a whole and that we each participate towards a little part of this whole; that everyone is as important; that we are not in a competition* (2A team leader).

Some deemed necessary that only *one point of entry* for all mental healthcare services should be developed which would help to obtain a better alignment by making referrals easier and in turn building a future plan on those (although evidence is mixed; Raine, Carter, Sensky and Black, 2006; Gask and Khanna, 2011). Furthermore, some hoped for the introduction of *extra specialised teams* that would come in where other teams would have a prevention and signalling role (Thornicroft and Tansella, 2004). However, most agreed that it would be important to be attentive not to invade the home setting with ambulatory and mobile teams, especially if ambulatory psychiatrists became involved.

All participants agreed that *better communication and collaboration* practices with hospital structures, ambulatory and community mental healthcare services as well as non-mental healthcare services, such as first line care and social services would certainly be beneficial, including more effective transfers and continuity of care for service-users. Most importantly, those practices should be organised around the person and with their needs and wishes in mind.

Some participants mentioned that having *privileged access* and/or *working agreements* could have a facilitating effect, especially for requests made towards oversaturated structures such as social services. All in all, they wished for better service "*harmonisation*". By avoiding competition and instead focusing on mutual comprehension, sharing thoughts, including those on differences would allow professionals from different structures to renew, reinforce and revisit their relationships (Thornicroft and Tansella, 2004; Gask and Khanna, 2011). This however would presuppose that clearly defined work practices would be expected from all parties involved, as well as major structural changes.

Some participants, especially those in more rural areas, expressed the need to collaborate more with *alternative services* offering "normalising" spaces for the service-users who were described as very lonely in the community setting (Warner, et al., 1998; Bhugra and Arya, 2005; Moriarty, et al., 2007). Professionals imagined the creation of collective and/or creative spaces or activity centres where social links and notions of citizenship would be supported. There was a sense of uncertainty however, about who should be at the forefront of setting up such structures with participants questioning whether it would be their role or that of service-users themselves. Moreover, existing support was mentioned as just as important and it was deemed essential to be attentive to it, keep on promoting and developing it.

> *More welcoming structures in the ambulatory sector as well as alternative services; more adapted work, more bosses that take risks with people who are ill, more spaces where people can just have a coffee and talk with others, more social conviviality* (2B team member).
>
> *If today I would want to put something in place in the mobile teams, it's a collective space. I mean people who find themselves alone at home, isolated from the world, with the mobile teams sometimes as their only contact with the world. So a project […] would be to try and create soup bars or places where they could come and eventually find themselves in. It's maybe one of those things that exist in hospital and that doesn't exist in the mobile team. In hospital, one of the therapeutic elements is the patients between themselves […] and that is lost when people are alone at home* (2A/2B team psychiatrist).

Some participants explained that they would like to have a *"steering" function* for non-mental healthcare structures in order to clarify, justify and determine possibilities for non-mental health professionals to understand and adjust their working practices (Meadows, Harvey, Jouber, Barton and Bedi, 2007; Gask and Khanna, 2011). This would be based on person-centred practices said to be employed by the teams. Services would therefore adapt to the team's language. However, they wished for the GPs to keep overseeing these processes. By boosting first line care through collaboration and cooperation, a better communication and an effective contact would prove more effective for successful continuity of care practices. One participant (a psychiatrist) went further by suggesting a creation of a "general psychiatrist" who would operate a mental healthcare function where GPs operate a general healthcare one.

> *Now, the residential care sits on top of everything and first line care is only a small piece; it should be the opposite. There [should be] a broad safety net of first line care: psychologists, society workers, nurses who are available and who guide care* (2A team member).

At the centre of those ideals, all participants reflected on the need for interventions to be person-centred, with more possibilities allowing a *person's best interests* to be considered. A person's goals, needs, their decisions and choices would have to be at the forefront of any collaboration. For participants, people's best interest run parallel with the concept of person-centred care (Rogers, 1951; Adams and Drake, 2006; Morgan, et al., 2016).

Level III: Working Within a Wider Context

The following subcategories are concerned with what participants mentioned that reflected the wider scope to their way own of working and collaborative practices. These include subjects such as the particular contexts within the *geographical areas* in which the teams worked (as seen throughout chapter 4), giving rise to certain particular problems which the populations they saw came head to head with. They also include the *107 context* and the different political issues which also made up for a specific context. Given the 'Formation Programme', many teams had had the opportunity to meet with other teams from other countries (p75-76). Many had also been able to learn about other teams in Belgium. Those differences and similarities with other teams and *other contexts* were sometimes brought up during the interviews, if only to make sense of workers' own way of working. Finally, many teams made statements regarding the *wider societal and political context* in which they found both themselves and the service-users.

Geo-Political Area

The geographic areas that the projects were set up within differed widely between each other and this contrast was also one of the reasons they were chosen. Aside from the fact that some were in urban *areas* and others in rural settings, the difference between the Flanders, Wallonia and Brussels *regions* was also important in how the projects developed (p25-26; Service Soins de Santé Psychosociaux, 2010). The areas' *economy* and subsequent available psychiatric beds for mobile team funds were substantially different and that could be felt in the teams' *resources*. Moreover, the areas' economic possibilities for service-users as well as the ensuing political landscape also made for a massive contrast in the *standard of living* between the regions (seen throughout chapter 4; Service Soins de Santé Psychosociaux, 2010). Finally, the possibilities, given specific economic backdrops was also felt, especially as mentioned in alternative spaces service-users could find themselves in, or the *possibilities* for employment or housing. Moreover, some regions had better *working social services* than others, with more structures available. A good example of this it the Flemish Centrum Algemeen Welzijnswerk (CAW) or Centre for General Welfare Work, a service offering first line psycho-social interventions and dealing with a wide range of matters from financial problems to family and relational difficulties, all related to a person's wellbeing. In areas where there was a heightened need for social care, social services often were overwhelmed which made teams take some of the workload in order to improve service-users' conditions, showing that those with greater resources had better mental health overall (Friedli, 2009). As a result, the presenting situations and the type of problems service-users faced in mental healthcare services in Flanders or in Brussels and Wallonia differed considerably. All these different contextual factors profoundly impacted on the work and set the tone for the ensuing interviews.

> *Without wanting to stigmatise, without wanting to be pejorative, I think we are a little bit odd. Well, there is nothing to be embarrassed about but in a different, particular type of functioning [while] they function like this or like that. We would say that [the same] is not possible [here] because we also have to take the people, their social identity, their education, their cultural*

> *level into account. All of this also interferes with the fact that everything is not possible with everybody* (2A team member).

107 context

Since teams were set up as part of the national 107 mental healthcare reform many participants made reference to the *guidelines* and the *interpretations* they made of those. The 107 guidelines were written in a somewhat *abstract* and non-prescriptive way and that was done on purpose in order to give each project the possibility to develop within its *own context*. As such, 107 called for an *integrated system of mental healthcare* but how each project made sense and interpreted that depended on the specific environment, available resources, persons involved and possibilities (as also explored in chapter 4; Service Soins de Santé Psychosociaux, 2010).

> *I sometimes have the impression that this reform happened upside down/backwards. First, something ideological was decided which is completely sustainable/endurable and then we told ourselves: "how can we put alternatives in place?" In addition, I find that there is no control on the alternative or a control that looks from the outside. There are holes everywhere within the alternative that create the problem of a lot of people who are forgotten. And this, this scares me, it scares me for people* (2A team member).

In the French speaking teams, there was a lot of reference to the fact that the 107 made an explicit difference between matters of "*mental health"* and other of *"psychiatry"* with some participants going as far as saying that 2A teams were concerned with "mental health" and 2B teams were focused on "psychiatry" (Barker and Buchanan-Barker, 2011).

Most participants however, were more or less in agreement about the fact that the 107 reform was *"hospital-centric"* as it was promoting hospitals providing the finances based on their bed occupancy (p29-35; Service Soins de Santé Psychosociaux, 2010). Given the financial necessity of hospitals, mobile teams were inevitably accountable to them.

> *I think the problem is that the hierarchies are imposed. I think that it is linked. I think that the problem, for our patients, between the hospital and the community is that the hospital finds that life starts when people are hospitalised and that before there was nothing and after that the mental health centres have to take care of them. But that is a culture, a model that is based at the central hospital level and I think that it should be thought completely in reverse. It's the hospital that is an accident in the journey* (2B team member).

> *It means you speak like the one who pays you. The power of money* (2A team member).

> *We have to tell ourselves that they, what will supply their salary at the end of the month, is that there are people who go into hospital. […] We could contemplate/consider something else but at the same time, it's their livelihood to put people in beds* (2A team member).

There was a certain unease concerning the fact that alternatives did not exist for people leaving hospital. With social services already saturated, especially in poorer areas, the reform was seen as sometimes too ideological with few practical structures to help users in the community.

> *In Belgium, we are in a hospital-centric system, let's put it like that. The problem is that sometimes, I personally have the impression that for the 107 reform – and it's very much a caricature – but that there was a point where an ideological position was taken which was to say that the birds' cage must be opened. So, they opened the birds' cage and they said "ah, this way the cage is open". But the problem is that there are birds that do not want to leave, there are birds that when they leave, they die. It's nice to open the birds' cage, I agree with that ideology. But, I think, that first you have to ensure/provide valid alternatives to hospitalisations, especially for long-term ones with the necessary conditions for the person's well-being, or rather the bird's* (2A team psychiatrist).

Comparing with Other Contexts

As mentioned, the teams would sometimes use other contexts they had had the chance of visiting, either to *compare* their current systems with both general as well as specific practices. As expected, Dutch-speaking teams reflected on British and Dutch systems while French-speaking teams often referred to *French,* especially the city of Lille, or *Swiss* teams. The latter also made extensive reference to the *Italian* systems, especially in the Brussels region where community mental health settings have been historically influenced by what became known as "anti-psychiatry" movements (p26-28; appendix A.6). Often, teams would also make reference to other ways of working when referring to how they regarded their ideals: both in things they would choose to do similarly or things they would actively avoid.

Wider Socio-Political Context

The wider context can be divided into two groups. One concerned the *wider Belgian system* and specific facets of it, such as the healthcare system etc. As mentioned above, the cost of services was often referenced when comparing the mobile teams with other mental health and general health structures. Given that the reform was not implemented through the national "health insurance" system, the teams found themselves operating within a different system than the rest of healthcare. This meant that they operated within specific geographic catchment areas rather than with people having the choice to be cared by any team they may have preferred. Furthermore, and as mentioned, the 107 reform was presented as a very hospital-centric system with promoting hospitals setting the tone by financing mobile teams. With a scenario where mobile teams were asked to answer to hospitals, a “typical Belgian story” ensued, which appeared fragmented with a lot of lost time spent in discussions between the different functions and their hierarchical levels.

> *I don’t like that this is organized by the hospitals and that the hospitals keep being the bosses of the different teams. And that you, on the one hand, you have to keep a kind of diversity, but on the other hand… It’s kind of a classical Belgian story in which you have a bunch of different parties and then you reach a compromise about organizing mobile […] teams. But actually, this is a typically Belgian solution: Wallonia and Brussels and Flanders, each make their own team and each add their own nuances and then you, well you make many indirect costs, which is a disadvantage at the expense of patient contact. So that, […] I sit together with my organization, I sit with other organizations; it’s so divided fragmented/crumbled that you lose so much time taking part in meetings in which all parties must defend their own opinions - and compromise - one way or another* (2B team psychiatrist).

The other concerns with wider context were mostly focused on the *societal aspects of a modern Western society* including its *stigmas and taboos* (Sartorius, 2007; Thornicroft, Rose, Kassam and Sartorius, 2007). Many participants mentioned the societal *demands* that were imposed on users of their service, such as having an occupation and a steady income, especially in the community setting (Corker, et al., 2013; Friedli and Stern, 2015). Very often service-users were unable to fit that profile and such demands could not be met.

> *Because finally, today’s society constantly searches for returns and there always needs to be results but, in psychiatry, it’s true that sometimes we have to accept that certain patients won’t progress, will stay in their situation. But just the fact that there is a relationship and the possibility to have a certain stability with them, have this trust, it’s already enormous* (2B team member).

For the participants this reflected a mentality which paved the way for stigmas and taboos towards service-users. Perhaps in certain areas more than others, team members explained that mental healthcare was still viewed as foreign and not something people would actively seek, even if distressed. Some participants mentioned that they saw this new function or new role they occupied as closer to one concerned with *citizenship* (Lister, 2004) as well as professional mental healthcare. They viewed their relationship with service-users as a ‘professional – user’ relationship, but also one of a citizen faced with another, in turn removing themselves from a mental healthcare role and into a social one (Chen, 2011; Clayton, O'Connell, Bellamy, Benedict and Rowe, 2013; Vervliet, Reynaert, Verelst, Vindevoger and Maeyer, 2017).

> *We have a broader role: we'll go for a walk with them on the streets, we'll go somewhere and in that particular moment you actually take on the role of a citizen rather than of a care worker. […] You know, you turn into a care worker the very moment you need to appeal to your expertise. So, I'm partly a citizen; that's when standing next to them when they're also a citizen. But when they're having a difficult time, then I'll take up my role as care worker in order to play a facilitating role* (2B team member).

> *I believe that some people also feel very uncomfortable sometimes when talking to clients or they feel comfortable when talking to them from their position as a care worker, but after a while [they] can't act normal anymore. Whereas having a normal conversation with someone and acting normal from time to time is so extremely important, but of course, if necessary, they should be able to take on their role again as a care worker. Actually […] even in residential settings, you can point out their citizenship and society's expectations too, you know. That's something we have to appeal to more often from our position as a third party, like: people simply won't accept this or that kind of behaviour. […] There are two sides, I guess: on the one hand you should slightly encourage society to be open-minded about different behaviour and psychic vulnerability, but on the other hand you should also make your client understand that particular behaviours are simply unacceptable: you just can't do this or that. Again, it's all about that citizenship. There are certain things we can't do either or we will be punished, and they should also know that. I think residential settings should also make them aware of this* (2B team member).

The *difference in the Flemish and French language* made for some interesting distinctions in how people understood both their respective socio-political and economic contexts as well as more specifically their professional fields. This point, however, is further explored at the end of this chapter as well as later on in this work.

Ideal

Participants expressed a specific need for more societal involvement and *de-stigmatisation* in matters of mental health (Thornicroft, et al., 2007; Gronholm, Henderson, Deb and Thornicroft, 2017). Many saw this happening through education, with some mentioning that different disciplines should be trained in different healthcare settings in order to understand the different realities of professionals and service-users. Some professionals made it clear that through their work they understood that they were no longer carrying the *expertise*.

> *The experts are not necessarily us, I think* (P2BTL:23).

> *We're talking about people who have been trained to help other people with a disability in their household activities and very often they're inclined to do everything themselves. And then they find it difficult to understand us when we say: "you may not take control, they have to collaborate with you". There's a difference between someone who's bedridden and isn't able to do it anymore, and someone with mental problems, who needs to be activated to do these kind of things. […] You definitely see that home care services really want to have some support in that* (2A team leader).

This in turn, could be used to change the current *unrealistic societal demands*, based on currently powerful (neoliberal) notions of profitability/cost effectiveness, which effectively regard people with "chronic" presentations as individually responsible for being economically non-viable and a financial burden on society (Friedli and Stern, 2015; Thomas, 2016). Most, if not all, participants agreed that any change in society and its mentality would happen by changing political and financial power structures currently in place.

> *I think there is a lot of work to be done on de-stigmatisation to review the question of society's perception of mental health. That seems to me relatively fundamental* (2A team psychiatrist).

Some participants questioned the place psychiatry has taken in society and called for a *mentality change*. Others called for more awareness raising, that would allow society to "cohabit" more harmoniously with psychiatry and in turn avoid the social exclusion of mental healthcare users (Friedli and Stern, 2015). In other words, as one participant put it, it would be about bringing "madness into society" (Adame, 2014). By doing so a *shared language* should be formed which would allow the reintegration of people currently at the margins of society. However, it was unclear from participants whether their wish was for psychiatric understandings of madness to be accepted or service-users' experiences of madness.

The interviewing process: transient, personal views

Although this subcategory is not part of the actual research conclusions it most certainly was and is part of the research process. Many participants mentioned their views on the interviewing process as well as the interview questions mainly towards the end of the interview, as feedback, or within the interviewing process, especially when people were *unsure of their answers*. All in all, participants were happy with the interviewing process and the questions which were presented to them seemed to be *related to their everyday work*. Many participants were, however, clear in the fact that those were their *personal views* and may not be shared with other members of the team. This was also very apparent in the focus group where very often entire discussions and debates would start on certain *disagreements* allowing a plurality of voices (Morgan, 1996; Kvale, 1996).

Many participants explained that their views were not set in time and as much as those had changed with time and with experience, especially the novel experience of working in a mobile team, so they were *prone to changing* again. Therefore, as it was important for participants to make it clear that views expressed were personal and *transient*, so it is presented here. In this view, the interviews could be said to have been 'human conversations' permeating the entire process of the study (Kvale, 1996). This approach was significant for the ensuing thematic analysis which will be explored in the following chapters.

Language and Linguistic Differences: French and Dutch/Flemish

During the transcription and ensuing translation, it became obvious that certain words/terms were difficult to translate or held a specific meaning connected to the spoken language and practice reflecting its ontology (Davidson, 1974). Specific attention was paid to those language particularities which were collected throughout the transcription, translation and ensuing analytical process. A few examples from both the French and Flemish interviews were selected and are presented below, including a brief explanation of their background and use. These explanations are based on the ethnographic elements of this study (conversations and texts with native speaking professionals both within and outside the teams) as well as through the use of online dictionaries (including bilingual; Collins, 2019; Larousse, 2019) and multiple sources, multilingual search engines (MagicSearch, Linguee, 2019 and Interactive Terminology for Europe-IATE)

French Glossary of Terms

- "Suivi": monitor, follow, follow-up (Larousse, 2012), aftercare. It is used in healthcare to mark the period during which a person is supported and/or receiving care, but also in terms of "follow-up" and "continuity".
- "Soin": care, treatment, attention (Collins, 2019). From the verb "soigner" meaning "to treat", it is an action with a finality, as opposed to care which is continuous. French speaking mental health professionals often use "care" in English to make the distinction with "soin" as treatment.
- "Temporalité": temporality, belonging to time, temporal value, relationship with time, use of time. Temporality is sometimes also used in the English language, but it is not an officially recognised word.
- "Maladie": disease, illness, sickness (Collins, 2019), disorder. In the French language there is no distinction between 'disease', 'illness' or 'disorder' as it exists in English. When exploring

its Latin roots “maladie” comes from the "male habitus" which translates into "ill-condition" (Larousse, 2012). However, the difference between objective structural abnormalities and subjective experience or response to a state is not made explicit (Helman, 1981).

- “Lien”: link, bond, connection, relationship (Collins, 2019). French-speaking professionals were very focused on what they called “travail du lien” (building relationships with service-users, building connections, working on relationships) which they often considered as the basis of their intervention.
- “Accompagnement”: accompanying, caring, support (Collins, 2019), escort, assist. French-speaking teams described their work as “accompagnement” which encompassed different specificities and functions and translated as both ‘care support’ but also the physical act of escorting someone (e.g. towards other services or services).
- “Accueil”: welcome, reception (Larousse, 2012; Collins, 2019), acceptance. From the verb “accueillir” to accommodate, receive, take in (Collins, 2019). This notion was a pivotal notion for French-speaking teams, both in how they received people but also their distress.
- “Accroche”: hook, ‘click’, hang on. From the verb “accrocher” meaning to hang on, to win over, to engage, to attract (Collins, 2019), to cling to, to stick at it (Larousse, 2012). French-speaking team spoke of “accroche” when describing ways in which they would develop relationships, links and bonds with service-users. Workers were very much interested in creating a first link (see the term “lien” above) to eventually form closer, longer-lasting relationships.
- Folie: madness, folly, insanity, extravagance (Collins, 2019), craziness, lunacy, derangement. Although at first glance “folie” directly translates as madness, it encompassed many different meanings during the interviews.
- “Mise en observation”: the equivalent of the mental healthcare act or the act of ‘sectioning’. The literal translation means to put ‘under observation’ (appendix A.4; Collins, 2019).
- “Etiquette”: label (Collins, 2019), used as a criticism around diagnostic labels (see later Burstow, 2013).
- “Tutoiement” and “vouvoiment”: use of familiar or polite form, respectively (Collins, 2019). This is a typically French difference with English (and Dutch/Flemish), with informal and formal forms of address made explicitly distinct.

Dutch/Flemish Glossary of Terms

- “Aandoening”: disease, illness, condition, state (Collins, 2019), cf. French term “maladie”. A professional pointed out that if/when professionals want to be ‘nicer’ they will use “psychologische problemen” instead, meaning ‘psychological problems’.

- “Aanhaken”: building connections, ‘hooking up’, cf. French term “accroche”. It can also mean shackling (Collins, 2019).
- “Afstemmen”: align with, lock on, tailor, match, adapt, fit, tuning (Collins, 2019). Flemish teams were active in regulating and adapting their views towards more effective communication and coordination with other teams and services.
- “Bemoeizorg”: meddling care, ‘intrusive’ care, interfering care (Collins, 2019). This is part of the FACT-model of care, which distinguishes situations or people’s presentations according to their care needs between CMHT, ACT and “bemoeizorg” (Veldhuizen and Bähler, 2013).
- “Aanklampende zorg”: ‘connecting’ care, care by connecting, hanging on, accosting care (Collins, 2019). This is similar to “bemoeizorg” (see above) but is considered less intrusive.
- “Zorgvraag”: care demand, request for care, appeal for care (Collins, 2019). Flemish teams were using this term specifically when they received referrals, including in whether and how they chose to intervene in situations.
- “Vermaatschappelijking”: bettering (Collins, 2019), socialisation, making something part of the community. Specifically for mental health teams, this term was linked to ideas around “citizenship” (p134-135; Lister, 2004) with workers actively engaged for service-users to take their place in society, while receiving the necessary support.
- “Zelfredzaamheid”: capacity to take care of one’s self, self-reliance (Collins, 2019). Professionals used this term to measure people’s independence and ability to function in terms of the support they needed.
- “Draagkracht”: capacity (Collins, 2019). Professionals used this in similar ways to “resilience” in English.
- “Begeleiding”: guidance (Collins, 2019), monitoring, cf. French term “accompagnement”.
- “Zorgwekkende zorgmijders”: ‘alarming’, worrying care avoiders (Collins, 2019). This term was usually linked with the FACT model, with people falling under this category deemed eligible for “bemoeizorg” (meddling care, see above; Veldhuizen and Bähler, 2013).
- “Schakelen”: to change gears, to switch (Collins, 2019). In mental healthcare this term was linked to referrals and was generally used to explain the “continuity of care” practices between teams and services.
- “Terugvalgroep”: fall-back group (Collins, 2019), relapse group. This is a term used for people who need long-term care and who may be considered ‘revolving door patients’.

Conclusion

Through the categorical levels presented above, several categories started to emerge around the concepts of time, space, memory and the values employed as well as the way in which they formed different types of relationships and how they communicated and collaborated within those through language. With those themes slowly emerging, I felt compelled to revisit the data and while exploring for components that ran through all the different levels (explored in this chapter). With the conceptual codes presented above, I was interested to see what the main elements were in connecting and interlinking the different levels.

With the initial and focused coding well underway the conceptual groupings and categorical levels presented here offered a first introduction to the data (Myers, 2013). Memos produced during this process show the emergence of a few themes, notably those of time and space as well as language differences between the teams and other structures (explored in the following chapter). As a result, the data was (re)coded using a more theoretical lens with theoretical sampling techniques enhancing that emerging theory. In later interviews theoretical codes which were emerging were used as prompts, especially when brought up spontaneously by participants. Workers who may have mentioned the way in which they organised their time for example were further questioned to delve deeper into the meaning of such notions and in turn to produce more rounded categories (Birks and Mills, 2011; Otkay, 2012). Theoretical concepts (or subcategories, explored in the following chapters) were held against the categorical levels (presented here) and vice versa, by constant comparative analysis (Corbin and Strauss, 2008). In the end the subcategories of ‘time’, ‘space’, ‘memory’ and ‘values’ as well as the central categories of ‘language’ and ‘relationships’ became increasingly crystallised with causal and correlational links formed between them (Myers, 2013).

Chapter 6:
Subcategories – Making sense of the data

Introduction to Chapter 6

This chapter will take up the categories presented in the previous chapter and explore them further, using data collected from a second observation with the teams (p73-75), in order to bring out the themes on which the final theory for this research will be built. The themes slowly appeared during the categorical level analysis (examined in the previous chapter) and were further explored during the second observation period with each team. The themes were: time, space, memory, values, relationships and language. In the following paragraphs, an exploration of the second observation will be presented, followed by the subthemes and theory.

As shown in the previous chapter, initial coding of the interviews quickly became more focused and produced a series of conceptual groupings which in turn produced the categorical levels (see Figure 3.3, p146). As more interviews were collected and theoretical sampling took effect, the more it allowed me to immerse myself into theoretical coding and integration for a more theoretical analysis of the interviews to start (Birks and Mills, 2011). As a result, I was able to produce and finalise the emerging theory based on concepts which run throughout the data (and not just confined to the aforementioned levels). Although the conceptual categories gave a clear presentation of the interview data, it is through theoretical coding that I was able to find relationships between and within those categories; relationships that ran through all of them and brought them together into one integrated theory (Birks and Mills, 2011; Myers, 2013). Through this theoretical analysis the methodology grounded in social justice theories was put into full effect (by specifically looking at the data through a social justice "lens"; p53-55).

Theoretical coding was key in transforming those initial concepts and categories into focused, axial codes to finally arrive to the central categories running through the whole of the data. As Charmaz explained "[t]heoretical coding is the constant comparison of previous and incoming data in order to integrate a theory (converge into a coherent construct). Theoretical codes therefore specify possible relationships between categories developed in focused coding" (Charmaz, 2006:63). The initial categorical levels showed how participants presented their work, but theoretical coding allowed to look at the underlying elements which were common across those presented categories.

Memos written during focused coding centred mostly on "language", especially the Flemish-French linguistic differences (p137-140) as well as the use of diagnostic and "psychiatric" language.

Those memos showed that focused coding started becoming more theoretical as more and more interviews were collected. Notions that had to do with context also started becoming important, with participants often considering their given contexts and how that contrasted with others' (e.g. p115-116, p132-134). Time was also central in how the teams understood their work and made use of it (p111-112, p116-117). As a result, I started paying attention to notions of "space" and "time" with participants talking about "context", "setting", "environment" as well as "time", "long and short-term", "temporalities", "fast" and "slow" etc. These notions became important in how participants presented their work within the teams but also in how they collaborated and compared, in their "relationships" with other structures. Those notions gave me a new way to look at the data as a whole, without fragmenting it into levels. It showed elements that ran through all those different categorical levels for the teams.

Witnessing: Second Observation Period

With the categorical levels that were brought forward during the initial analysis of the interview data and the new theoretical codes or themes that started to emerge I felt compelled to revisit the projects in order to re-explore the interviews through the lens of direct participant observation (p73-75; Adler and Adler, 1987; Charmaz, 2006). The aim was to boost the validity of the interview data while also exploring the difference between the first observation period and the interview content. In other words, the way in which workers presented their work and their daily practice differed to some extent. This was also reflected in the interviews: what was presented as work practices often carried ideal properties that hadn't always been visible in practice. Revisiting the teams aimed at assimilating theoretical sampling and integration grounded theory processes with the more ethnographic elements of the data collection (p67, p73-75; Charmaz, 2006; Birks and Mills, 2011; Myers, 2013).

In order to understand, this difference between practice and description Austin's Speech Act Theory proved useful (Austin, 1962; Oishi, 2006). Unlike his reductionist predecessors and colleagues, Austin warned against oversimplifying complexities of meaning by reducing it to its descriptive properties. More specifically, the focus was set upon the way in which associated conventions made certain meanings more valid than others but how practices could be interpreted as having different meanings to the ones originally presented. In practical terms, the objective set was to observe the points expressed in the interviews. The descriptions and ideas described were to be observed in vivo to see what form those took in everyday practice (Hughes, 1971). As Charmaz explains, "organisation rhetoric and reports may pale in the face of observed worlds" (2006:40). As a result, what was said in the interviews did not always “mirror organisational processes” but rather “aimed to shape public reputation” (Charmaz, 2006:40).

There were several reasons for adopting this approach. As mentioned, given the study’s ethnographic qualities a second observation period allowed to further build on and strengthen those qualities (p67, p73-75). The constructs or categories which were unearthed and explored through the interview data were given the possibility to be observed in action (Charmaz, 2006). Finally, it also allowed further examination of the social justice qualities of this research by studying the participants’ thoughts and actions using that specific lens (p54-56). For example, ideas around thresholds of risk, tolerance to symptoms and hospital admission procedures stimulated by the teams or person-centred care based on service-user’s wishes were all presented in the interviews as aspects of practice that had been considerably thought upon and changed since, over the course of the teams’ existence (already explored in the previous chapter). By revisiting the teams, such notions closely linked to the ethics of practice evoked in the interview data, could now be examined more closely while also placing them within their social context (Prus, 1996). It allowed to answer questions from the emergent analysis, as well as to consider how participants had invoked ideas and practices but also how they actually adapted their language and interpreted meanings (Charmaz, 2006).

Compared to the initial observation which was concerned mainly with the practical ways in which the teams had been set up and subsequently organised themselves, this second observation period went beyond, exploring both the teams’ day-to-day interventions as well as the way in which they collaborated with other organisational levels, within mental health and outside it. Practically, this was mainly done by following professionals on their visits and interventions, as well as other aspects of their ‘clinical’ work (notes, communication with other services and professionals, clinical meetings etc.). This was linked to the premature theory building which started coming out of the data collected thus far through the study’s methodology and my own involvement in it. At this point, the idea was to understand the context the teams were set up in, as well as the context they were themselves producing. This was done by paying attention to the themes which will be explored below. In other words, the interview data could be considered to show that participants were deconstructing understandings learned within the residential setting to adapt to their new context. The way in which they did so in practice was worth exploring.

The second observation became even more relevant due to its timing which coincided with the retraction of funds by the federal government towards mobile teams and the restructuring of both the geographical areas and the main criteria for the teams’ development (Service Soins de Santé Psychosociaux, 2010). With the teams and their members in a financial and something of an existential crisis, my observation of them in action at that time became even more relevant for the emerging paradoxes, which will be explored throughout these next two chapters. It became a time of ever-changing understandings of both the reform itself and of mental health services.

With those paradoxes interlinked with the emerging ‘mental health’ concepts, the question of social justice also came back into focus. The interviews explored the social justice implications of the reform and questioned the scope for implementing certain differing or re-constructed ideologies. ‘Person-centred care’, for example, was a widely used notion, said to be focal for practice. The original approach to person-centred care developed by Carl Rogers was very much concerned with the use of a non-directive approach (Rogers, 1951). However, how it was understood and implemented was from a professional point of view, with notions heavily influenced by psychiatric understandings of mental health distress (Morgan, et al., 2016).

The second observation period allowed me to ascertain the nature of this ‘reform’ which ran in parallel with a given status quo based on a profoundly institutional and hospital system of care (p29-35; Service Soins de Santé Psychosociaux, 2010). It was an exploration on whether participants’ ideals were being implemented, to what extent and the reality and practicality of implementing them further given the existing, established and powerful residential structures.

I was once again given the opportunity to witness and be part of the reform as it was unfolding. This gave me the possibility to understand first-hand the development of the teams’ (re)constructed language and relationships that were forming within the constraints of everyday practice as well as political and economic powers. As for the research itself, it was an opportunity to further build on the methodology’s subjective form. By adopting a reflective position and locating myself within the reality of the teams, emerging ideas and shared constructs could be interpreted and theorised whilst building on the interview data (Charmaz, 2006). It was also an interesting move from the position of observer into a more participatory one by actively engaging in the team’s journeys and their everyday work (p73-75; Adler and Adler, 1987).

Second Observation Method

Within the time frame available, a period of four days with each 2A and 2B team, amounting to eight days with each project was planned. The second round of observations had a different focus from the first one. As mentioned, attention was given to home visits and interventions involving other services with actors from the residential sector to social services, as presented in the interviews (p118-130), as well as practical multidisciplinary team tasks like briefings and meetings. The goal was therefore to get a sense of the people the teams met with and the interventions offered, including the way they organised.

To ensure continuity, the teams were sent their interviews, including the transcripts. This served as a reminder of our work together until then. It was also an opportunity for team members to consider and revisit notions they shared at the time of the interview. There was a considerable time difference of about one year between the interviews and the second observation period, during which a lot had changed, both in terms of the teams' "vision" and "mission" (their words), as well as their practical everyday work, including personnel changes and wider governmental implementations. The second observation period therefore allowed for this lapsed time to be somewhat accounted for. Furthermore, the visit to the teams was also an opportunity for team members to amend or revise anything said during the interview if they wished to. However, most people did not really revisit it, perhaps because they did not have the time. Of those who did, most did not express any need to change anything. Nevertheless, one participant made the exception; she was shocked with things that were said but preferred not to "formally" change anything, expressing instead faith in my research analysis. None of the participants expressed a wish to withdraw at this point (as stipulated by the ethical standards underpinning this research; p72-73).

As the interview data was analysed and certain themes began to arise from it, this second observation period was firmly based on Grounded Theory methods. Specifically, concurrent data generation and analysis for new data, which is based on the principle of collecting and analysing new data which in turn is to be compared with older data (Birks and Mills, 2011). Categories developed from the interviews could be further strengthened and shaped during the second observations by constant comparative analysis (Corbin and Strauss, 2008). For example, identifying ideas around 'space' and 'time' through in vivo observation made them even more central to the theory, while making sure those themes represented direct interpretations of participants' voices. Finally, by the end of the observation period, theoretical saturation and integration was achieved originally based on the interview data and further improved by the observations (Birks and Mills, 2011; Myers, 2013).

The categorical levels, explored in the previous chapter, somewhat directed the second observation period, while they also allowed for the final categories to arise. With the second observation leaning heavily on ethnographic qualities, theoretical sensitivity became essential (p86-88; Charmaz, 2006; Otkay, 2012). Categories constructed from the interviews were further established while particular care was given for themes to re-emerge. By revisiting the interviews, the participants themselves were also invited to take part in this process, and in this way mitigated the researcher's subjective account while allowing for dialogue and co-production (Charmaz, 2006).

Below, the diagram (figure 3.3) used throughout this work is highlighting the processes that brought up the subcategories which formed the basis for the central categories explored in the following chapter.

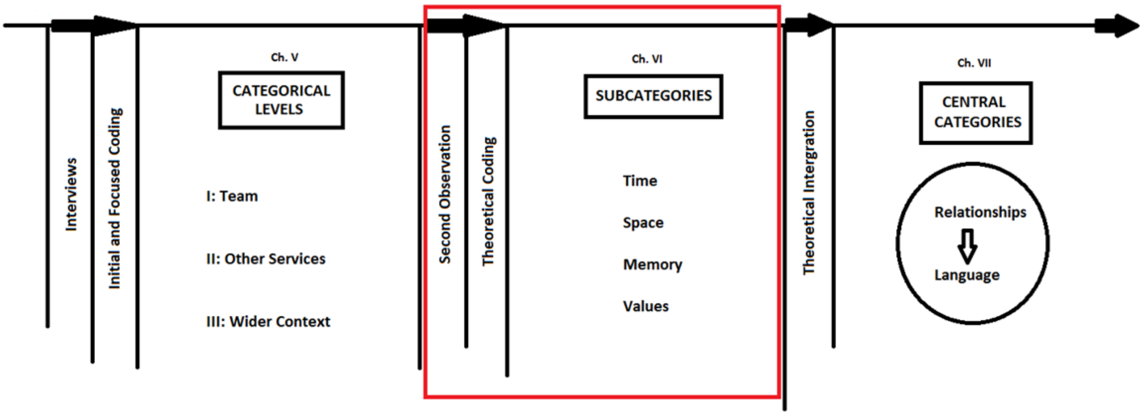


Figure 3.3 The Analytical Process: Subcategories

Subcategories

Existing in time

Time and temporality became important themes throughout this research. They reflected the work done by the teams, but also the research itself as well as the higher hierarchies in how the '107 reform' developed over the years. This theme therefore explores the different relationships with time or the temporalities at play throughout the different levels explored in the categorical analysis. Moreover, the time that ensued during this research meant that there were interesting developments from the changes in personnel within the teams to the restructuring in governmental structures with a direct effect on practice. Time was therefore an important notion in understanding the reform process at the teams' level but also the political landscape at large, as well as the researcher within the research process.

Level I: Team work

How time was used practically in interventions was key in understanding the difference between the 2A and 2B teams. With different temporalities to their work, one could also understand the populations they saw and in turn the models they followed to offer effective support. 2A teams worked within short-term periods but saw people with a high frequency (even up to once a day if and when necessary) during a period of “crisis” (broadly based on the CRHT model, p26-27; appendix A.6; Johnson and Thornicroft, 2008). This made their work short-term but intensive.

> *What is therapeutic? We know that there are people who go to see somebody for 20 years and nothing moves. Is that therapeutic? […] For me, I think through our style of work, which is in fact based on something subjective, there is an encounter/a meeting, which allows for something to change. Not a lot, but often there is something through that meeting that allows for things to happen a little bit differently, already during our intervention, if it’s just in the fact that people have the courage at last to go somewhere or talk a little about what is not going well. That for me is as therapeutic as someone who is working, following a person during 5, 6 years, which is also good* (2A team member).

For 2B teams, time was understood on a larger scale. As many participants mentioned the notion of having time on their hands gave them the opportunity to explore different possibilities during an intervention (Anthony, 1996; Moriarty, et al., 2007).

> *We have time to make errors* (2B team member).
>
> *It’s a process of falling and getting back up* (2B team member).

It was considered that there was time to build a relationship and get to know the person and their situation (Anthony, 1993). Some 2B team service-users were sometimes only seen once a month. However, even at that frequency, visits were considered important and valid.

> *We are in a society that demands objectives, to be able to arrive at something. Sometimes we are working with a patient for two years and we have the impression of never arriving somewhere. But when we reassess the situation, yes, there are things that have shifted. […] Already, s/he is receiving/hosting/welcoming us. S/he is able a little to put some words on certain things. We were able to refer to one service or another. Or simply, well, we chat with him a little. There is somebody in his situation* (2B team leader).

Interactions between service-users and professionals appeared to be fragmented yet ordered through allocated visits and appointments, with discussions often focused around people’s engagement (Bloomfield and McLean, 2003). Those times were generally organised and led by professionals rather than service-users (Moriarty, et al., 2007).

The services’ age (the period during which the teams had existed) impacted on who their target population was. Most teams existed as a direct result of the reform and were by default attached to hospital structures (Service Soins de Santé Psychosociaux, 2010). This meant that participants had undergone big and quick changes both in the way they understood their work and in turn their population. One team involved in this study had ambulatory sector qualities and had been in existence for the last forty years. By not imposing a time limit some of their service-users had been receiving support for over twenty years. This not only made time an important component to their long-term support, but it also meant that the service was faced with an ageing population. In turn, support was no longer solely focused on 'mental health' aspects but also on physical and somatic difficulties as well as cognitive ones that become more topical and central for older adults.

Participants repeatedly, both in the interviews and the ensuing observations, expressed the need to keep the "luxury of time". This was both in terms of the time available for them to see service-users and exchange with colleagues but also in terms of the period of interventions and, by default, the freedom of content in those.

> *I pray that despite all the reforms […] that we can keep this luxury [of time]. Why? Because, [of] this value which is important for me: to be able to keep/hold the other as a human and not within a (supported) care pathway* (2B team member).

For the 2B teams which had imposed a two-year maximum intervention period, all participants agreed that no time limit should be imposed (based on the FACT model p27; appendix A.6; Veldhuizen and Bähler, 2013).

> *There is a big difference in saying: "I am here for you for two years" for people for whom temporality is very different to saying "I am here for you, full stop"* (2B team member).

Most teams, if not all, wished for more time both in their clinical work as well as a part of a team. They hoped for more time for (re)consideration and exchanges in order to continue to evolve both as a team and in practice. In terms of the process of working in a team, some participants wished for a better multi-disciplinary approach. With workers presenting as doing the same work, some participants argued for the need for disciplines to be made more explicitly visible, as well as the workers' personalities, thus increasing complementarity in the team work. Many also wished for more involvement from the psychiatrists, including more available hours for the mobile teams. Moreover, through the increased involvement and available hours, many hoped to have the team psychiatrist also operate as the treating psychiatrist for all service-users followed by the teams. However, other participants questioned the need of a psychiatrist in a mobile team at all and also questioned the need for a specific hierarchy in decision-making processes.

Level II: Working with other services

In general, time was mostly used to intervene in a 'positive' way. Participants used time to their advantage both in building relationships as foundations of an intervention (Anthony, 1996), to refer people towards other structures of care and as a base to avoid 'relapses'. Many teams for example also mentioned "prevention" as part of their work (Snyder and Lopez, 2002).

> *The first objective will be not to have one and to really give ourselves time. So there, we do not put a time limit. The limit will come if the suffering decreased and we were able to find other persons to take on a signalling function based on objectives that we were able to build with the patient* (2B team member).

Depending on the time available however, certain interventions were consciously intense but not "too deep" with that work being left to teams offering long-term support, whether mobile 2B teams or the ambulatory sector as well as hospital.

Through the interview data, it became increasingly obvious that a strong comparison was made between the mobile teams and the temporalities within residential structures (Bloomfield and McLean, 2003). Those came into focus in understanding the intervention the teams were offering, including how they were presented as alternatives to hospitalisation. For example, it was said in the interviews that in-patients had to learn to "be (a) patient" (2A team member) in hospital, for example people had to wait around to be seen by the staff or to be discharged (Farnworth, Nikitin and Fossey, 2004). In contrast, with mobile team visits, there was a specific and agreed time for an intervention without one party waiting on the next. The time spent together between professionals and service-users was therefore focused and direct.

> *In the end, patients are seen more by a mobile team, in this work within the home setting, than when they are hospitalised. […] We move, we stay one hour, one hour and a quarter at people's homes, we take time. Maybe it's just 45 minutes, but it still is for them that we move, it's them that we listen to, it is positioned around them* (2A team member).

More specifically, 2A teams presented their work as short-term but intense with long-term results given the context and timing of their intervention. Since their intervention was confined to a crisis situation it was short-term but given the setting it was said to have long-term effects within the home environment (Johnson and Thornicroft, 2008). This was different to residential interventions that may be less intense but could not hold, once a person was discharged home (Bloomfield and McLean, 2003). For 2B teams, time was extended with interventions taking longer than in the hospital setting but again with longer lasting results. 2B team participants explained that changing a person's habits at home took longer than in hospital but those habits were then adopted by the person in their daily life (Anthony, 1996). Evidence of these longer-lasting results were however difficult to grasp, measure and render visible (England and Lester, 2005).

> *For me, working here, it's as if the patient is composed of two sides of the same coin and in hospital we only see one side and in the community, or in any case here, because we visit at home, we see the other side of the coin. And for me, really, I think when I arrived here, I had no idea of our patients' human distress. When I say human distress, it's about apartments in such a situation, we want to cry really. We want to cry. We tell ourselves that this is not possible. It is not human that people live like this, it's not possible. Yet, this is their daily life. So yes, in hospital we battle sometimes with patient hygiene; they need to wash themselves etc. but we manage. But us here we work for years with those patients that do not wash themselves and in hospital do every X days. Here we sometimes take months to make it happen, with patients who stink in the whole house* (2B team member).
>
> *Since we are in something for the long-term, we have time to make errors too. Hospital doesn't have this time. […] I think that hospital is taken in a completely different line of time. Everything just happens fast. They don't have time to check/verify* (2B team member).
>
> *In hospital everything is done quickly and under pressure, whereas in [the mobile team] there is a different rhythm, if only that. I mean, the temporalities are different* (2A team psychiatrist).
>
> *I would say that time is different between hospital and here. In hospital, I find that everything must happen quickly. The patient goes in on Monday and on Tuesday during the team meeting we are already discussing her/his discharge while putting in place a project which is suited for the team and not at all for the patient. Here, in the mobile team, time is ten times longer. We have time. And we saw it with people we followed in hospital and who had thirty hospitalisations and it was a catastrophe. Since they are with the mobile team, we really thought with them on how to improve their situation, their work etc. they weren't hospitalised any more. It really is a different way of working, a different way of seeing. I say, it is a new profession* (2B team member).

Level III: Working within a wider context

The regional contexts also dictated the particular goals the teams put in place based on peoples' socio-economic needs. For example, (and as mentioned in the previous chapter, p130-136) Flanders had a social care and first line care system that worked more efficiently than other areas where it was overworked. As a result, the teams could concentrate on matters of mental health in their intervention. However, teams in Brussels and Wallonia, had to first take care of peoples' social and financial situations as a way to also improve their mental health (Friedli, 2009). The workers' time was therefore spent very differently. This is also reflected in the way in which their collaborations with social structures or non-mental healthcare structures in the different regions was presented, with considerably more frustration where social and first line care systems were failing to answer to the population's needs. Many of those points will be explored in later themes.

This research has been a few years in the making, during which the reform changed and evolved. At first, the higher structures took a somewhat detached approach, offering the teams only abstract guidelines on how they should set up their work (p34-35). This was based on ideas of a bottom-up reform (Natalis and Pieters, 2016). However, times changed both the political landscape as well as the economic one. The second observation took place during a difficult time for the teams, since a political and financial crisis surrounding their practice was in full swing. As mentioned, the geographical catchment areas expanded while the governmental funds tightened. However, although this was true at a national level, the Flemish region projects felt it much less than Brussels and Wallonia, who have less finances due to the lower number of beds and higher number of service-users within their areas (p25-26; Service Soins de Santé Psychosociaux, 2010).

Making use(s) of space

The setting and frame in which the mobile teams worked, made use of different spaces that had perhaps not been actively used in mental healthcare until that point. Having the person's home environment play a part in a person' care was an important change, especially in terms of the reform's development and the way it shaped working practices of mental health services (Natalis and Pieters, 2016). The theme of "space" is very much interlinked and intertwined with the one of "time" previously presented (Bloomfield and McLean, 203). In many instances, concepts explored under the concept of "time" could well have been explored through notions of "space" and vice versa.

Level I: Team work

The concept of mobility and moving through space, was central to mobile teams (Natalis and Pieters, 2016). However, it was interpreted differently for each project (chapter 4). For example, for some, mobility meant home visits, where for others it also meant a physical support in the act of going to other structures, such as GP surgeries or social services. In some cases, mobility also meant the general philosophy of taking the person's environment and contextual setting into account.

> *It's de facto at their home, or in a place of their choice, because we have already had several situations where people do not wish for [the meeting/visit] to take place in their home. Because they want it to be outside, separate from the spouse etc. So, in any case, based on the*

> *fact that it is at home, or for a large part at home, we told ourselves that we should always pay attention to the household as a whole, so that all the persons living under that roof are informed of our passage* (2A team leader).

Although they all agreed that the home environment was a space to be invited in and visit, there was a sense in which visiting people at home was not always of added value. In some instances, it could even be regarded as a disservice or a way to perhaps further debilitate somebody, either by making them inactive or by the sense of intrusion (Moriarty, et al., 2007). Another interesting contrast (aligned with wider debates on the subject) was some projects' decision to include people who were homeless, while for others they became a specific target within their populations (Rogers and Pilgrim, 2014).

In general, the home environment, in comparison to the hospital, was seen as a space belonging to its resident (Mallet, 2004). As seen in the categorical analysis, home was where a service-user was in control, where they had more choice and more responsibility (Estroff, 1981). This was also generally true during the observations, although not always, with team members occupying the space not only physically but also verbally (Moriarty, et al., 2007). For example, team members did not always wait to be invited in or would speak at length without giving the space for service-users to express themselves. Team workers often adopted a directive and prescriptive style or manner usually based on behavioural aspects of everyday life (Bloomfield and McLean, 2003). Professionals appeared to be overly comfortable within service-users' spaces, perhaps masking their lack of comfort and control.

Each team's chosen headquarters was also an interesting point of reference in the context of space (Prior, 1993). Some teams, as mentioned, operated within the hospital grounds, one even within a closed acute ward, and although some participants hoped to become detached from it, others enjoyed the fact that they had closer links with the residential sector. Furthermore, in areas where there were relatively fewer possibilities to refer people towards other or alternative services, operating close to hospital meant that they could make use of residential structures such as day hospitals. Although perhaps unfortunate, this proved the only way to escape a difficult context but also avoid a deterioration and a hospital admission. This also appeared to be a good motivation for workers to be mobile as they didn't invite service-users to visit them. This meant that they were often associated with the hospital, with some referrers and/or users who believed that they (symbolically) represented the "key" to the hospital.

> *We are on a psychiatric centre site. Sometimes, the fact of making a call to a mobile team and seeing a psychiatrist for example [makes] people imagine that the psychiatrist will allow them in, will hospitalise them. There also, right away we need to put limits and inform that we don't*

> *have the keys. Because precisely, being on a psychiatric site does not facilitate things. Sometimes especially, we are with people that would like to be hospitalised* (2A team member).

In other cases, some teams enjoyed the luxury of large private spaces that they sometimes used to invite service-users to meet them instead of visiting them at home (Bloomfield and McLean, 2003). However, this was also seen as a good possibility, in order to offer people the choice to make their care separate from their home environment. They argued that this gave an opportunity for people to detach themselves from difficult environments but would also act as a self-motivation for their care (Moriarty, et al., 2007). The question however arose: if teams invited service-users to their office, what is the difference in function between a mobile team and an existing ambulatory/community team? For this reason, other teams actively avoided receiving people at their offices.

> *A particularity which we hold on to is to really stay mobile. So, we never receive people here. It is clearly an office for the team. I know that there are many mobile teams that slowly became [less mobile], to save time etc. Because, it's true, travelling/moving, eats up a lot of time and energy. So, they slowly started receiving people. We refuse to. Alternatively, we will become a guidance centre* (2A team leader).

A different approach to the theme of "space" can be explored through some of the teams' rejection in sharing spaces as per service-users' wishes. In other words, some teams offered to intervene in situations by coming into contact with people solely by phone or by mail. Workers actively chose not to visit people in order to respect their wishes (Moriarty, et al., 2007). In other instances, teams worked with a person's personal network without intervening directly with the person concerned. This was also a way not to invade their space but provide some support and guidance nonetheless (Natalis and Pieters, 2016).

In all these spaces, there was a very clear physical boundary between the professional space and the consultation space (Prior, 1993). There was even a sense in which workers would retreat to their offices, thus creating a "safe space" for themselves. In an interesting account, a team member remembered her first six months with the mobile team, during which she would revisit the ward which she previously worked in, in order to surround herself with in-patients. This, she explained, provided her with a sense of security she felt she lost when she started mobile work.

Level II: Working with other services

As shown repeatedly during the interviews, as well as above in the theme of "time", the teams were quick to compare their work to that of hospitals (Bloomfield and McLean, 2003). The main contrast, especially at first, was explained through the difference between the hospital or other mental health services and the home seen by mobile teams.

> *It's true that hospital framework is extremely, well often a little too rigid, often very regulated. We shouldn't forget also that the private consultation framework and how by simply having an office, a secretary, somebody that comes to you, a regular diary; those are all things that organise the therapeutic relationship a little and that you don't have at [the user's] home or perhaps less* (2A team psychiatrist).

This in turn brought about other notions linked to the space of the home environment, such as the involvement of the surrounding context, the need to work according to the person's wishes and control (Estroff, 1981; Moriarty, et al., 2007).

> *The fact that we visit at home, I think, that's already something that is really distinct. It's something you can't compare to anything else, I think, because you- well, you enter the home environment, you see so many things over there, and you will be more inclined to adapt yourself to, to the client you're visiting at that particular moment* (2B team member).

Furthermore, some teams, that had perhaps originally been closer to hospital work, started to become more involved with their neighbourhood and surrounding areas. In that sense they engaged with the social aspects of their work and actively promoted social links based on notions of 'citizenship', also explored in the categorical analysis (p134-135; Mezzina, 2014; Clayton, et al., 2013).

There were some ideas amongst team members in different projects about the possibility to set up spaces for service-users themselves. This was explored in the interviews and the categorical analysis (p129) but was also a subject during the observation. However, workers questioned whether it was their place and function to do so, or whether those spaces should be set up by service-users themselves or others (see Russo and Sweeney, 2016). In one project, a plan was put in place for a social event every fortnight for service-users.

By setting up spaces that were service-user led and occupied, existing possibilities for those service-users claiming their own spaces was also interesting in exploring this theme further. In one service for example, the waiting room and garden space assigned for service-users became a sort of meeting ground for them, resembling in some cases the "old asylum pavilion" (Prior, 1993). Others mentioned relationships they had kept from hospital admissions. However, this was not true for everybody with service-users disengaging from relationships they had formed in hospital and preferring to create their own separate spaces instead. Furthermore, many workers mentioned the increased experience of loneliness felt by many service-users, especially those that had many and long hospital admissions (Estroff, 1981). The possibility for users to form social relationships was also very much linked to their geographic areas and the possibilities offered within the region (Friedli, 2009). As mentioned, for areas where fewer options existed, teams expressed wishes to create such spaces (p129).

Level III: Working within a wider context

In general, teams aimed to "mirror" the spaces they occupied and that included the populations they saw. There was a stark contrast in how service-users' homes differed between projects depending on the areas they lived in, which also further reflected the difficulties they experienced (Friedli, 2009). As mentioned in the interviews, some hoped for more multi-cultural teams to represent their areas. However, this was not always the case, with a participant mentioning the risk of "colonising" different cultural spaces. As he explained, Western psychiatry had a past of colonising other countries and cultures with its interpretation of madness (Davar, 2016) and there was a sense in which this could happen more easily with mobile team work. For other areas, multi-cultural approaches were not as central because the population was more homogenous.

Teams made up of people who lived in the area were somewhat different to others to which people commuted. There was a sense of self-identification with the region and with people who had occupied the region, often for generations. They themselves represented the population they served, with migrants from the same home countries on both the professional and user side. For teams that were made up of people who commuted, there was a sense in which it was to some extent easier to "abandon a sinking ship", so to speak, once the financial crisis hit and the team's future became unknown (p143-144).

The idea of space also becomes relevant in the notion of "visibility" raised during the observations and interviews (p97; p116). Teams operated within catchment areas, each with their own context, and workers made specific choices in order to serve their given areas as effectively as possible (Natalis and Pieters, 2016). Paradoxically, in order to do so they also had to have certain resources to sustain those areas, something that was not always the case. For example, some teams who had large catchment areas with "vulnerable" populations, but few workers did not always have the necessary resources, especially given the greater amounts of time spent on travelling, in order to be able to sustain their working model. The teams' main criteria for their target populations (aside from that of age) was based on geography/territory (Service Soins de Santé Psychosociaux, 2010). As a result, the area and resources available to serve it, directly impacted on how teams made sense and developed or avoided their visibility. A good example of this was of a smaller team operating within a large city area: by actively avoiding becoming too visible, they also avoided receiving too many referrals that they wouldn’t be able to answer.

Furthermore, space is an interesting theme when thinking about regions and the possibilities they offer for service-users (Friedli, 2009). As mentioned, different regions have different services and some regions have a wealth of “normalising” spaces for mental health service-users while other regions prove very “poor” in that respect. For example, Brussels has many possibilities, from social cafes and restaurants to talking groups aimed for service-users (e.g. l’Autre «lieu», Le Pianocktail, Poco Loco). Nevertheless, those spaces remained for the most part the service-user’s personal responsibility often translated as ‘choice’, even if the health and social system was extremely complicated to navigate.

Moving up to higher levels, the concept of space was translated in how the federal government-imposed catchment areas on projects. As mentioned, aside from the political powers retracting a considerable amount of funds, they also made plans for all the geographic areas to be accounted for. This meant that new projects were to be put in place while existing ones were asked to expand their areas in order to cover ‘blind spots’. This presented several problems depending on where the teams were set up. For example, the Walloon region has a large geographic area which is mostly woodland and which had to be accounted for (south-eastern Luxembourg area). This is also closely linked with the previous point made on the need for time and resources to travel within large areas.

Carrying memory

Space and time are closely interlinked themes, but they cannot only exist in the present since they carry previous times and spaces that occurred before them. Those in turn, influence how present situations are interpreted. The theme of memory therefore came into focus, both in how participants specifically were influenced by their previous experience, but how psychiatry and mental health more widely was based on existing powerful systems of knowledge (see chapter 4).

Level I: Team work

An interesting phenomenon that transpired during time spent with the teams was the variability in the workers as well as their experiences. The importance of previous “knowledge” was very apparent in how they made sense of present situations. For most teams this involved knowledge they had amassed in hospital, through ‘specialisation’ (Wegner, 1987). For others, it was knowledge that was passed on through the process of sharing a team identity (Yank, Barber, Hargrove and Whitt, 1992).

> *A shared identity through values. […] Yes, I think that somewhere there is a whole ritual around this. There is [Mrs X] who has been working here for 40 years and often if there are students or new people who come to work here in the first days, well, we'll go see [Mrs X]. And we are invited into the whole story of the centre. I think that this also shows the extent to which we have built on values that we try to transmit every time […] in the style of a tribe. We don't have a clinic in which we will give definitions with words we found in books, but it happens through stories. […] It's just a side that is unseen* (2B team member).

Some of these participants noted from experience the fluidity in mental illness and in diagnostic categories including how those had moved and evolved with the times, even throughout their own working lives (Hacking, 1999). Some workers who had been working in the mental health system for over twenty years were important partners in this new way of working. Memory served as a tool for deconstructing current frameworks of thinking.

> *P6: We are talking of a system, a system where the doctor has a status, the illness has a history, psychiatry has a history. All of this is stronger than us. And so, people did whatever they could with this. At the time, a stupidity could be managed in a certain way, now we call the doctors, the fire fighters, the mobile team. I mean, we are also the reflection. The people who we visit are a reflection of the times and we are also a reflection of the times. We come with the tools of our time. Those won't be the same in 30 years and they aren't the same as 30 years ago.*
> *P1: My god no! At the time, we had two telephone lines: one in Dutch and one for the French-speaking institute. Two lines and patients were there for 20 years* (2A team member).

Although new ways of thinking about mental health have emerged, the theme of "memory" was very important in making sense of the mental healthcare services language today.

> *There were illnesses of the time and now we have our psychiatric illnesses that we may not have in 20 years anymore but there will be others. And we have to make do with all this. […] And the people to whom we go will make them an illness and will give meaning to this illness. Fibromyalgia, for example, […] it was recognised, it's a pain that found its place, which found its mediatisation[2] and all this plays. It plays because certain people see this, hear this [and think] "it resembles what I have" and here we go. Do we accept a diagnosis for us? […] Why does one have this diagnosis? Why do they present themselves like this? Why do we accept*

---

[2] Mediatisation: visibility, hype

> *this diagnosis? Because other colleagues said "[we accept] this diagnosis". All this is part of history, the history of a society. And what does one do with a diagnosis that falls on their head? Why do they like this diagnosis? Why do they not like it? It's from all this that we enter. In the end it's about all this that we discuss on our visits* (2A team member).

During this research, for example, and as will be seen in more detail below, diagnostic language was used quite readily. Many terms that are perhaps out of fashion in newer mental health circles were still used within the mobile teams, such as "melancholia" for example. Those were based on a professional collective memory, passed on through tacit experience (Wegner, 1986; Collins 2010). This theme of memory served as a reminder of how illnesses were in fact socially constructed and transient (Prior, 1993; Hacking, 1999)

Level II: Working with other services

As mentioned, in the theme of time interlinked with that of memory, the notion of 'target populations' was also connected with the collective memory of the area in which the service existed. For example, in new teams, service-users were sometimes known to professionals who had previously had contact with them within the residential setting.

There were a lot of comparisons between the work within the mobile team and that of hospital (Estroff, 1981; Prior, 1993; Bloomfied and McLean, 2003). This was also somewhat linked to workers' disciplines and the role they had previously occupied within the residential structures (Prior, 1993).

> *I think that for us, nurses, it's more complicated because we had to mourn many things. We either make it, or we don't, that's it. But there is still the mourning of technical acts, all this, the daily contact with patients. So yes, it's really very different and it's not always easy. For me at least, I really found it difficult at the start and then you find yourself* (2A team member).
>
> *There are things that I miss from hospital, others that I don't' miss at all. You have a little bit more proximity [in the hospital]. […] You are closer to the person because you live with them for 10 years* (2B team member).
>
> *For me, for example, I think it was easier based on my function [of social work], even if I worked for a long time in hospital: we [were] well on the outside, we [went] to patients, sometimes we [did] home visits etc. So, for me, it was something that corresponded. Besides, this was what I wanted to do, I really wanted to work in the home, I don't want to work in hospital anymore* (2A team member).
>
> *I was a little bit fed up with hospital!* (2A team member)

> *I find [our thinking] has moved a lot. The reflex to refer to hospital was more present at first, when we started working, but now we are asking "what can we do?" We are more tolerant. […] We wait. We are there, the end* (2B team member).

> *"P1: Well, I find that it is a plus that people come from hospital. […] There are clinical markers that we learn in hospital and that people who have not passed from hospital have less. For me, it is still more important that people have had experience. I think that it is a plus.*
> *P2: But it demanded construction.*
> *P1: Yes, it demanded some work. People shouldn't lose their hospital reflexes.*
> *P3: But on a clinical level, on a clinical maker level, fortunately it's there.*
> *P2: For many things I find, even treatment/medical management. When I look back on the last two year, the themes are not the same, the feeling, the relational aspect. We were focused on more pragmatic things: "he is not washing, hygiene is not great, what will we do? […] We were going to recreate the hospital setting at home with lots of things. Now we are more into "oh well, he is like this, we will see"* (2B team members).

In contrast, one of the chosen teams had existed for forty years with many service-users present for much longer than many professionals within the service (p93-95). Moreover, this team was rooted in the Basaglian anti-psychiatry and social psychiatry movements (Dell'Acqua, 1995; Mezzina, 2014). However, looking more closely, the service's daily work seemed to have shifted quite radically from its early days. With medical practices such as depot injections through 'retention' procedures (appendix A.5) as standard practice in everyday work, it seemed that perhaps their early "memory" had somewhat faded or perhaps this had always been usual practice.

Level III: Working within a wider context

The theme of memory is intertwined with the one of "space", since the teams worked within regions, each with their own history reflected upon the people that lived there (Friedli, 2009). In Wallonia for example, the population was very much a reflection of a post-industrial era. Furthermore, many people were second or third generation descendants from migrants who had come to work in the mining industry (p39; Caestecker, 2000). As a result, there was a lot of inter-generational hardship which could be understood to have become "chronic" (Bhugra and Arya, 2005; Sangalang and Wang, 2017). In rural Flanders, on the other hand, a different set of regional aspects were understood in the context of the culture towards mental health. Taboos and stigma were very much present and those proved to be difficult for people to take up the courage and seek help from services (Sartorius, 2007; Thornicroft, et al., 2007). Furthermore, although there weren't necessarily any particular financial difficulties for people, services with a cost were actively avoided. It could be argued that 'stigma' became important when there was 'something to lose'.

(Up)holding (on) to value(s)

As mentioned in the previous chapter as well as in the theme of memory the teams presented a system of values upon which their working practices were based. The teams' goals as presented by the 107 reform were to provide an alternative for people in order to avoid or shorten hospital admissions (p34-35; Service Soins de Santé Psychosociaux, 2010). This theme therefore is an exploration of those value systems and how they translated in everyday practice going beyond the evidence-based models presented as the basis of their work (p42-43). The idea of teams providing an added value towards the integration of the wider mental healthcare system was also examined. Furthermore, values are often contested by the time and space within which they exist, as shown in the previous theme of memory. It could be said that different frameworks use the same values, but each assign their own meaning, creating a "false consensus" (Pilgrim, 2008). The notion of recovery is a good example of this, with teams understanding it very differently. Furthermore, these differences in values were reflected in the difficulties the teams came across when communicating with other services leaving many workers with the feeling of "talking past each other" (see later p193). The question remains however: what possibilities exist for 'dissensus' i.e. the acknowledgement of the diversity in values, without suppressing different perspectives in established hierarchies of power (Pilgrim, 2008; Morgan, et al., 2016).

Level I: Team work

With each project separated into two teams, one could immediately see the similarities in both the team's values but also the difference in how they applied them in their everyday work, making up for different models directed at separate populations (Service Soins de Santé Psychosociaux, 2010; Natalis and Pieters, 2016). As a result, although all teams operated based on person-centred approaches (Rogers, 1951; Adams and Drake, 2006; Morgan, et al., 2016) they differed in their specific organisational traits which allowed them to work for their chosen populations (Natalis and Pieters, 2016).

Professionals often presented as being in a constant battle between their professional tasks and their values. For example, their main intention was for person-centred care, yet the service-user did not dictate their intervention. Rather, a value system based on the established professional knowledge and power hierarchies in place was apparent in practice. It was evident that professionals operated within a deontological framework, whereby actions were assessed based on moral grounds. Professionals had a moral duty of care and in doing so were pushed to take action based on service-users' motivation and incentive to change, rather than their possible needs or wishes (Morgan, et al., 2016).

Community care is inherently based on concepts of recovery and self-determination (Anthony, 1996) but examples of certain practices, the most extreme perhaps being 'retention' procedures in Belgium (appendix A.5; or the equivalent Community Treatment Orders-CTOs in the UK (Department of Health, 2008) prove that it can also be paradoxical regarding the violation of human rights and freedoms (Snow and Austin, 2009; Morgan, et al., 2016). In Belgium, there are some CTO equivalents such as "retention" "post-cure" (for drug and alcohol) practices which are implemented on people who are involuntarily admitted (appendix A.4) up to two years following their initial admission. This ensures they comply with their treatment which is usually a depot injection. Furthermore, during those two years there is also a "fast-track" admission procedure should somebody have to be re-admitted involuntarily (appendix A.5). Finally, in Belgium, people who are deemed 'incapable' to handle their own interests are often subject to an administrative/money trustee who manages their finances (appendix A.3).

Such practices were used by a few teams, with some even fulfilling the legal obligation of administering the treatment themselves (depot injection). This was especially true for one service which was said to be based on values of the anti-psychiatry and social psychiatry movement (Dell'Acqua, 1995; Mezzina, 2014). In practice however, it seemed that it centred its interventions mostly on "psychiatric consultations" with, as mentioned, practices of hospital 'post cures', depot injections and medication administration. It was also the main actor in people's finances as many received their weekly funds through the service. The question legitimately could be raised: was the team facilitating them or proving to be the face of social (and financial) control (Bloomfield and McLean, 2003). Furthermore, it failed to merge more modern notions such as the mobile aspect of other younger mobile teams. Although the teams were said to be mobile, they appeared to be seldom so.

The same teams were also very vocal about the "profitability" aspect in wider society and how it could be extremely detrimental to users of their service (Friedli and Stearn, 2015).

> *Those people are worth it and they have resources, and even if we need five years to do one thing, sometimes nothing but just keep the status quo, well, they are worth it. Psychosis shouldn't be bargained with. It's not possible. We are losers. Well, those patients are losers in this, because they are not profitable for anything. They cost in a certain way* (2B team member).

However, practice seemed to be very much anchored around ideas of "insight" and personal "responsibility" (Coles, et al., 2013). Yet, people would be presented as being "difficult" and "non-consenting" if they did not go along with professional interpretations (Burstow, 2013; Morgan, et al., 2016).

> *We must strive for the client gaining an insight, […] and that insight could then lead to change* (2B team leader).

Furthermore, the added value of the teams as alternative to hospitals was not always clear-cut given the value system employed by workers. There was often a lack of a clear plan in place even after years of working with a service-user, while concepts that were hospital-centred were very much in focus (Burstow, 2013). On the other hand, relationships of trust were well established and that was perhaps an important intervention aspect in itself (Shea, et al., 1992; Thomas, 2014).

The teams presented themselves as being especially invested in the person and repeatedly mentioned "person-centred" care (Rogers, 1951; Adams and Drake, 2006; Natalis and Pieters, 2016).

> *The patient is at the centre of the team the whole team, we are really in an inter-relation besides/according to the patient* (2B team psychiatrist).
>
> *We stand next to the client* (2A team member).
>
> *[We use] a humanist model that puts the subject in the middle. And a model that believes in the person's competences whatever they may be, if they are there. Rather an attempt to say that we don't retain the knowledge etc. But that there is a sharing to be had and a life experience, that sometimes is richer than whatever theory we could have* (2A team leader).

Yet, during the observations, assumptions and personal interpretations were made for people, without the possibility for them to make or give their own meaning to their situations. A classic yet simple example for this, was the assumptions professionals made on what a person was experiencing, based on their dress style. Those were further prescribed and directed towards service-users with many workers choosing a behavioural frame for their support (Coles, et al., 2013). In one instance, when challenged, the workers explained that they appreciated a "practical perspective". In others, when pressed, many workers were unable to give a clear plan of action and couldn't tell what the service-users wanted or needed out of their service and/or in general.

> *We don't guide clients to give them a good feeling. We guide clients so that they can get themselves in a better situation* (2A team member).

In terms of the person-centred value the teams chose to employ, it was interesting to see how meetings following visits ensued. As people fed back certain events and situations, it became clear that a lot of workers' reports were inevitably linked with the workers' own interpretations of events. This is also linked with their background in mental health services and the general collective rendering of mental health professionals (Prior, 1993). However, this was not always the case, with some employing direct quotes from service-users or by being aware of their own interpretation and representations making them explicit.

> *Our objectives are not necessarily theirs and so considerable work had to be done on ourselves so as to learn to differentiate ourselves from the patient and know what he wants and not what we want* (2B team member).

Most teams mentioned during their interviews that they actively chose to avoid taking a medical stance in their work but instead as mentioned chose to work in person-centred ways (Morgan, et al., 2016). An example of this for most teams was that they did not administer medication. However, they did often take it upon themselves to check whether somebody was complying with their pharmaceutical treatment.

> *We won't introduce ourselves with a medical framework. So, we can offer support, we support people even if we feel that a treatment could help. We will support people that do not wish to take it. So, we have a large part of our patients that do not want to take medication, that are completely delirious, with whom we will try to really work with the parts that are sane. […] When we start being very worried, we are obliged to put on our care caps on and negotiate for something with the patient; when those parts that are sane are invaded by the rest* (2B team leader).

Although this was true for most teams, some chose to still administer treatments. Furthermore, even those that didn't, were still seen as medical "enforcers" by way of 'medical responsibility' and the law (appendix A.1; Shimrat, 2013) as they did seek the information regarding pharmaceutical treatment. In one instance, the service-user visited chose to take their medication during the visit, which reflected their understanding of the team as one that was mainly medical.

During the interviews many participants alluded to the concept of "transparency" in their work towards service-users, especially by building on a relationship of trust (Thomas, 2014; Morgan, et al., 2016). This was also thought to be a way to avoid 'medicalisation', but in practice it didn't mean that the medical model was not present in the work (Read, et al., 2004; Pilgrim, 2009; Burstow, 2013; Shimrat, 2013).

> *[Users] have trust: they have trust in themselves, they trust us also. I think that trust is not only one way, it is shared and we are not alarmists. I think we have a large tolerance to symptoms and so that we really work in transparency. […] I think we are not going to their home to just chat for a bit. No, our missions are clear to them. [But] we will introduce ourselves from something else, we tell them that we have a nurse in the team, we have a psychiatrist. […[So the front door will not be medical care, but if it is specified, if at some point there is a need for it, we won't avoid it either. But that is done in a transparent way* (2B team leader).
>
> *If you start from their request and their wishes, then you can easily walk the same path together, instead of reinforcing something like "you need the doctor". It is not the first thing that is being discussed. We will first listen to their wishes and even when it's something that actually has no direct link to their vulnerability, we will still agree and follow them to make sure that we build a good bond, create trust, and later we'll deal with their vulnerabilities* (2B team member).

In practice there was somewhat a significant lack of this. For example, many service-users who were suffering from effects known to be directly caused by their medications, were told instead that those were of their own responsibility. People experiencing weight gain for example were told to exercise and eat healthily (Moncrieff, 2008). Furthermore, professionals kept their distance from people considered to be "risky" (often diagnosed with personality disorders; Felton, Repper and Avis, 2017) Professionals' apparent expertise was used to detract from the real reason and instead put the focus back onto personal responsibility.

A value raised repeatedly during the interviews was the wish to involve a person's personal context more closely into an intervention (also stipulated in reform guidelines; Natalis and Pieters, 2016). However, in practice this was not always actively sought. There could be several reasons for this, such as a lack of personnel to do this work, a lack of time and/or a lack of guidance on how to do so.

In general, different workers from different disciplines and with different personalities had inevitably different working styles (Hall, 2005). In some cases, this was celebrated and teams actively sought to use this wealth and variety in order to match professionals with service-users. However, in other teams, a certain protocol was more important to follow. For example, one project operated in a very manualised way by employing a "recovery plan" (p103; p113). It was said that some workers used it more rigidly than others, but it was important to use it, nonetheless. Variability in its use seemed to be more linked with service-users' engagement rather than with worker preferences. By using the recovery plan, individual workers present in a situation were not necessarily important to the extent that some teams did not actively try to have the same people involved in a situation but rather to have different workers visit the same service-user. This felt fragmented and some participants expressed the wish to provide more continuity in a service-users' care in that respect, by having the same workers involved where possible.

This last point may also explain the inability for peer support workers to find their place in professionalised teams (as will be further discussed in later chapters; Coy and Hedden, 2005; Walker and Bryant, 2013; Penney and Prescott, 2016). This difficulty could have been since peer support work is founded on a different and experientially-based value system than the supposed professional evidence-based knowledge of workers (Morgan, et al., 2016). Many professionals expressed fear for possible "relapses" by peer support workers and felt that such instances would clash with their deontological duty of care. This did happen or came close to happening in several teams, which resulted in team members' becoming even more uncomfortable with the idea of peer support work.

Level II: Working with other services

Participants expressed the wish to keep freedom of content in their work and avoid formalising it too much and/or be caught up in bureaucratic procedures of "care pathways" and prescribed networks, as partly stipulated by the reform guidelines (p29-35; Service Soins de Santé Psychosociaux, 2010; Natalis and Pieters, 2016).

> *So, it is an added value and a pitfall. Because the idea is not to work with care pathways. […] I think that there is no one good network for one patient. There is a good network depending on the patient's difficulties. […] But it is to ensure that there are enough zones where we do not speak, so that the patient feels free to bring what he wishes to one place or to another. We shouldn't be too much in this idea that there is a good network for all patients. No, there are networks that are interesting for each patient profile. Now, we have to coordinate ourselves a little not to redo the same work again and again, but [the patient] really stays in the centre* (2B team leader).

However, there were several ways in which this was not being implemented. For example, the use of a manualised 'suicide prevention plan' was implemented within all the mental health services in the Flemish region. Another example was the use of a "recovery plan" by one project, as mentioned (p103; p113). The idea that "one size fits all" proved to give little flexibility in the interventions with service-users. It begged the question as to whether the notion of providing the same and equal intervention for all was just enough in providing support for different needs. In other words, by making interventions the same for everybody and based on existing networks, peoples' differences were not accounted for and therefore support could be helpful for some but not others (hence not exactly person-centred). It was argued that the intervention style was also based on the disciplinary background as well as the worker's personality and experience. All in all, however, it felt very directive with an increased lack of dialogue.

The theme of "values" could also be extended to the value system employed in hospitals in comparison to that of the teams, as mentioned repeatedly in the interviews. With most mobile workers previously having been residential professionals, it was no surprise to see that many employed a similar value system (Wegner, 1986; Shimrat, 2013). However, it was the space and time, as mentioned previously, that by default created a different language around this value-system, which resulted in the deconstruction of notions made in the hospital time/space and a (re)construction for the mobile function.

> *This was a very big task, I think, that all care workers must do, but especially in mobile teams, where our representations were modelled by what we are, by where we previously worked, by our training. We made the bet to really deconstruct our representation and to go towards the representation of the other. To start from his representations of the world, of care, of illness, of his suffering to construct and go from there* (2B team leader).

Choice, responsibility and control were also interesting subcategories which were explored in the differences between mobile and hospital work. Service-users were presented as having more choice, control and in turn responsibility for themselves within their home environment than within the frame imposed in hospital (Estroff, 1981; Bloomfield and McLean, 2003; Moriarty, et al., 2007). Added to this, teams explained that consent was a notion approached differently in hospital than it was in the community with person-centred care taking a central role for mobile team work (Morgan, et al., 2016). These notions were also reflected in the different ways relationships formed between hospital and home settings.

> *Here we discuss and we try to resume certain things that people already have within them, their resources, which is not done in hospital; there we do it for them. And when they leave, since we did things for them, they leave and they're still there- they're dependent. Sometimes we even made them more dependent if it was a long hospitalisation. Whereas in their own environment, we go and we say "we should perhaps try to do this". Then some time later, we go back and ask "where are we at?". So, the person knows that they need to draw from their resources. I think this is very beneficial. Whereas in hospital people come and are told "listen, I'll do it and come back to you". We do this for three months, six months, a year, when they leave, everything has been done in their place* (2A team member).

> *They have been maternalised (infantilised). We move away from this paternalistic psychiatric hospital vision from before, when the doctor had an important place and the user effectively compensates for. Here we are trying to really mobilise what the person can do, their competences. That's the idea* (2A team member).
>
> *I think that the main difference is that we as care takers appeal much more to the feeling of responsibility for the client in comparison with hospital. I think that in hospital, the patient's responsibility is taken away quicker or the patient lets go of his responsibility* (2A team member).
>
> *At home, the client is the boss. He has control there. And we must adapt ourselves to the client's environment, where in admission the control lies with the care service. And that gets translated in the care treatment: we can give ten pieces of advice, but in the end the client decides what he will do and what he won't do. We have no power whatsoever against that. So that's a whole other approach. Also, towards the client: we won't start with giving him ten advices and guide him in what he has to do. We can only, yes, offer choices which might go next to his automatic choices, and that's a different perspective than an admission* (2A team member).

Multi-disciplinarity was also an important value raised by all participants during the interviews as also stipulated by the reform guidelines (Service Soins de Santé Psychosociaux, 2010). The disciplines represented were the same as those in hospital since most teams were directly employed by hospital structures with many professionals previously working there. In effect, mobile teams kept the same specificities and functions as their 'promoting' hospital. Moreover, there was a higher representation of nurses in most cases, with social workers, psychologists and special educators (equivalent of Occupational Therapists) usually in smaller numbers, although this was not true for all teams. Workers' shifts also represented the hospital system, with nurses working during out of hours, especially for 2A teams. Whereas in most projects, all workers (aside from their differences in shifts) presented as doing the same work, one project chose to instead use a similar hierarchy with the hospital with nurses holding caseloads and psychologists supervising. This raises questions linked to the multi-disciplinary aspects of the teams and how they are translated into practice (Prior, 1993).

With projects' funds coming directly from hospitals it became apparent that the teams were at risk of becoming 'buffers' for the residential sector. This was often explicitly mentioned during the interviews and the observations. Some teams actively sought not to adopt this function but instead wished to operate as clearly separate functions from the residential sector. Others wanted to have more of a 'gatekeeping' function in regard to hospital (broadly based on the CHRT model, p26-27;

appendix A.6; National Audit Office, 2007). Teams who served a public with a higher risk of admission, came into direct competition with their promoting hospital. Usually, those teams tried to stay away from becoming 'buffers' or from having a 'gatekeeping' function, whereas the opposite was true for teams whose population was widely different from their promoting hospital. This was highly dependent on the available number of beds available per area, with those needing to be filled first, before the mobile teams were called.

Level III: Working within a wider context

Mobile team values could be said to be further promoted through the possibilities made available to them, including by the existence (or not) of socio-cultural organisations within the projects' regions. Specifically, urban areas had alternatives spaces outside mental health and social care structures where people could find themselves in, such as social cafes and restaurants or cultural centres. For projects that existed in regions where the possibility to offer people alternatives was limited to (mainly) the regional day hospital, their values could not always be upheld given their limiting context. In general, however, there were many instances of teams working hard at opening up possibilities even where those were extremely limited. For example, one project employed an OT who set up a social event for service-users and worked at creating other such projects.

With the retraction of funds and resources becoming scarcer, the teams had to make quick choices on ways to re-structure their work. For example, workers visiting in pairs had to think about the sustainability of such a way of working. With less personnel and by default less time available there were fewer possibilities for joint work and teams reorganised for professionals to also work individually. They adapted their original model (presented in chapter 4) to their new situation. However, there were also clear ways in which teams actively sought to uphold their existing and constructed values, despite the contextual difficulties imposed. There was a sense in which they were loyal to their public and its needs as well as to the region. In practical terms, the teams did not want to limit their hours but instead were adamant about keeping their availability and aimed to keep their threshold for inclusion low.

People understood multi-disciplinarity in different ways especially in how it was implemented given the original often abstract reform guidelines (p34-35). For example, many professionals presented it in how their work was the same as that of their colleagues. For one team, who didn't have a coordinator, this was especially true, with some participants expressing that they would enjoy more guidance. In another team, members were unhappy with the coordinator's absence. With disciplines represented in the mobile teams heavily relying on the blueprints of hospital work, the political and financial restructuring at the time of the second observations, showed that the 107 reform provided no security, especially for disciplines historically outside hospital. Although, multi-diciplinarity was seen as an essential value in mobile work, it was not necessarily always easy to uphold given the wider organisational context (Prior, 1993).

Education was a category explored during the interviews, with many people hoping that through education would come the promotion of different types of care and understandings of mental health (Hall, 2005). The teams thus welcomed students from different disciplines, including psychiatry. It became very apparent that the students' training environment and educational framework was highly medicalised (Read, et al., 2004; Pilgrim, 2009). However, depending on their personality and/or personal background, but also the team members and the teams' hierarchies, the ways they were influenced by mobile team work differed significantly. Some student psychiatrists were given a semi-psychiatrist role and were therefore expected to perform standard medical duties whereas in other teams, student psychiatrists were made to work in the same way as the rest of the team members. The experiences between the two student roles differed significantly.

Some members of teams mentioned the need for a more multi-cultural approach to their work to reflect their regions' populations (p37-40 and chapter 4; p131). In many instances, especially in the Flemish regions, this became more relevant in mobile work, since it was the inauguration of contacts between mental health professionals and migrant populations. This proved problematic for the teams since they had no experience in working with those cultures and languages and there was a lack in guidance on how to do so effectively (for example through the use of interpreters). Sometimes, this was further aggravated by a lack of finances and time to set out effective working practices, such as for example inviting an interpreter to go over the obstacle of language differences. In one instance, it was felt that a potential service-user was turned away because of her situation being very "culturally charged" as well as the language and the ensuing communication difficulties.

Finally, and as already mentioned, values were also based on the possibilities available (Friedli, 2009). The value of offering help to people from lower socio-economic backgrounds was especially relevant for teams based in poorer socio-economic areas. It was important that the service was free of cost in order to make mobile team support possible and accessible due to the existing need, although this also somewhat put a certain pressure on the teams.

> *[We are] partly under pressure because we offer our services for free. So I also think that's one of the most important reasons why [clients] always look towards us, because we offer free care. Sometimes, when they need care from other agents or sectors, they are asked to give/pay a financial contribution, causing clients to drop out* (2B team member).

In areas with economic difficulties this was less of a problem, teams were more readily expressing ideas of including a minimal fee in the same way as the rest of the healthcare system (Corens, 2007).

Conclusion

With the thematic subcategories emerging, the context in which the teams were working in started unfolding, as defined by the themes explored in the chapter. Mentioned repeatedly during the interviews, participants were no longer snapping "photographs" of people's lives whilst in hospital, but they were now learning to see people within their home environments. Time was therefore experienced differently within those spaces. The residential setting was said to allow for short-term quick fixes, while interventions at home made a similar process lengthier but perhaps with longer lasting results. Space and time were therefore experienced differently, held on to a collective memory from previous mental healthcare structures. Values that perhaps existed within the residential setting were now remodelled for community conditions.

As a result of those different elements at play, a changing set of meanings around the context of mental healthcare suggested that an altered language and a different set of relationships were forming. Participants were learning to employ a language built around their new practice based on the new relationships they were now part of; perhaps a language they were in fact themselves producing. Influenced by the new uses of time and space, building on a collective memory and value system, their relationships with service-users and in turn their discourse was presented as changing, especially compared to the one employed previously within the residential setting. This was further reflected in their communication and collaboration with other structures such as hospital, social and first line care. Participants repeatedly described themselves as "translators" between the hospital, the social services and the people they saw at home. However, this 'new' language and these 'new' relationships were (as seen in this chapter) heavily reliant on previous experiences and established understandings of mental healthcare, which in effect also constrained them. Here also lies the paradox of this reform, which will be explored in later chapters. With a central category on the constructs of 'language' and 'relationships' slowly emerging, the question arose as to what made these any different or new, if at all.

Chapter 7:
Central Categories – Theory Building

Introduction to Chapter 7

Two central categories were born out of the subcategories explored in the previous chapter. Existing in different temporalities, understanding and making several uses of space, carrying a sector's and a region's memory, upholding and holding on to values within this 'new' context were all themes that pointed towards the process of forming different *relationships* through the use of a different *language*.

Participants were confronted with a different context within mobile community teams with 'new' functions and roles. As a result, they developed different ways to work with and within this context. This process was reflected in the way they formed relationships including how and what they shared and communicated, both amongst themselves but also with service-users and other services and structures. The importance of 'language' was also reflected in how workers compared and contrasted their own language with that of other structures. Workers actively sought to become interpreters between service-users and other structures. The language used by service-users, team members and other structures reflected the relationships and vice versa. This made the notion of 'language' as well as that of 'relationships' become increasingly important in the present work, through both the categorical levels (chapter 5) and ensuing subcategories (chapter 6) which was also reflected in the memos collected during the initial and focused phases of the work.

The figure below (figure 3.4) shows the final methodical stage of theoretical integration as the last step in the process to finally arrive to those central categories, built on previous phases (Birks and Mills, 2011; Myers, 2013). The central categories were developed as part of the analytical process, which was continuous, simultaneously encompassing the different stages presented below. The central categories of 'relationships' and 'language' are explored in the following paragraphs.

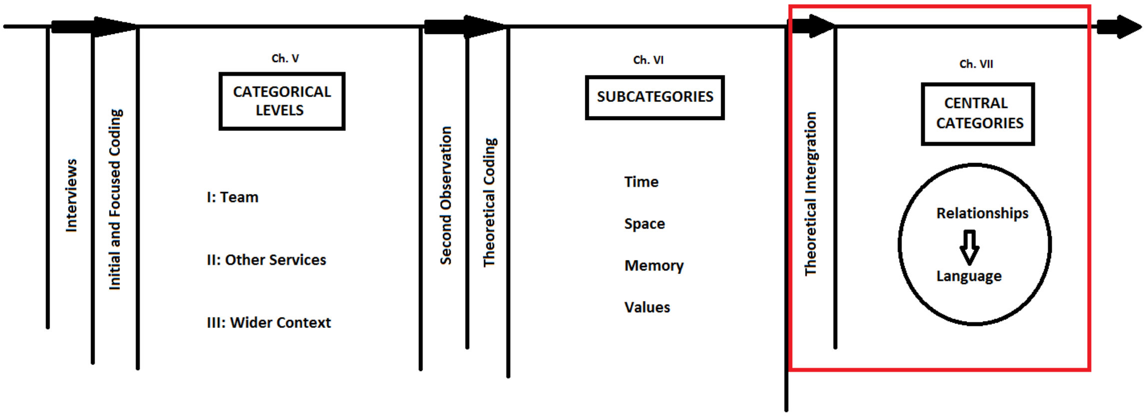


Figure 3.4 The Analytical Process: Central Categories

In this chapter, I will revisit the process of being a witness, with all its constraints and advantages, before delving into the central categories of the analysis. Observing the teams meant exploring the use of a 'new' language and of 'new' relationships within 'new' contexts, yet paradoxically, with the same established power and knowledge structures ever present. The themes of language and relationships both of which became central to this project, were understood through the lens of the 107 reform bringing into focus the teams' paradoxical position.

(Being a) witness(ing)

> I was to discover that the line which separates a witness from an actor is a very thin line indeed; nevertheless, the line is real. […] I was never in town to stay. [..] I had to accept, as time wore on, that part of my responsibility – as a witness – was to move as largely and as freely as possible, to write the story, and to get it out (Baldwin, 2017:31).

During the second observation with the teams some members believed that I was seeing only a specific part of service-users since only those that were 'well' enough agreed to my presence. In other services, team members aimed to invite me to meet with people who were in fact in extreme states. I cannot be sure about whether I experienced a biased view of the 'reform' but I can certainly say that I had the privilege of witnessing a wide array of insightful moments, which showed me why and how language and relationships are important when talking of mental healthcare.

It was humbling to have both professionals and service-users accommodate me into their everyday lives. For the most part, I felt entirely welcomed and even more so given that my presence also coincided with some difficult times for the teams when their future was uncertain and hanging in the balance. Perhaps even more dignifying was to be invited into service-users' homes, many of whom earnestly shared their stories with me, some while experiencing very difficult periods of their lives. It was some of these moments that proved extremely difficult to witness. The act of observation was hard to think of as a privilege, since it was so challenging to be present and not actively participate.

As much as I wanted to be present but not actively participate, there were instances when I was asked to give feedback on both my work and my thoughts on teams' practices (Adler and Adler, 1987). As a result, a wealth of interesting dialogues ensued, either formally during team meetings or informally during car trips to home visits, team lunches or in between breaths on bike rides. Those proved extremely important in making some of my work ethnographically driven (Charmaz, 2006). It was in some of those moments that I also felt to have overshared, mainly by being overly critical when it was not my place to be. For example, an interesting question asked of professionals was whether they would want to receive support by the mobile team they worked in, if they ever found themselves in such a position. Many categorically answered no and I was often in agreement with them. Based on this, on my last observations I asked the question while also mentioning this conclusion. Some professionals actively disagreed with me and were quick to defend their work.

This second period also occurred at the same time as political and economic reforms, during which my stance was certainly in alliance with the teams. This of course, was also an exercise in raising my own awareness into personal subjective biases (Charmaz, 2006). A good example of this was that throughout the study I became very conscious of my preference for 2B teams. This could be due to several reasons, such as a personal rapport with the work and its different and particular temporality. Or it could be linked to the workers' personalities. Finally, it could be that I have had more personal experience with this type of work. However, it was not only important to be aware of this fact but also careful not to ignite existing competitions.

Throughout the interviewing process, as well as the ensuing observations there was an obvious source of potential bias: my limitations with the Flemish language. As shown in the method chapter, I diligently tried to control this as much as possible, especially in conducting, transcribing and translating the interviews. However, for the second round of observations it was more difficult to do so, especially when it came to home visits. There were two patterns. Sometimes, people chose or had to carry on with their discussion in Flemish and I was then simply an observer. This was a big barrier for me to overcome and I felt like I was missing out on a lot of the nuances that I had been able to observe with French-speaking teams. In other instances, people very politely switched to English and I was then actively participating in their discussions since much of it was aimed and directed at me. This latter scenario felt as if I was losing my witness role entirely but as it transpired it also proved to be a new platform for participants to communicate their viewpoints with me. This was perhaps even more accurate for service-users who shared their stories with me possibly in a different way to how they had done with professionals till then.

Based on the methodological underpinnings for this research as well as my personal journey both before this study and while conducting it, I was already looking at the subject from the specific angle of social justice, 'experiential' politics and ideas of confluent positions (p53-62). Persistent questions about the validity of psychiatric and mental health services increasingly led to many different kinds of epistemic injustices (Fricker, 2007). These considerations were reflected both in how the interviews were designed, by asking people about their ideals but also in the way I critically engaged with the second observation period (p.142-143). I often felt as though I was somewhat an 'infiltrator' who was perhaps betraying professionals by being critical of their work. I aimed throughout the observations but also the interviews to hold a mirror to the teams, by allowing them the space to show me what they felt comfortable with and what they thought was important for me to see. It was an attempt at mirroring the participants' own subjective realities (Charmaz, 2006). This was, of course, something a paradox given that my position in holding that mirror was far from neutral. The purpose of this work is in no way to do a disservice to professionals but rather to offer them an honest view with an invitation for dialogue.

Two Stories

During this study and specifically during the second observation with the teams, I was invited to witness the mobile teams' work *in vivo*, as it was happening. This was an eye-opening experience to understand what was happening in practice. As was explored in the methodology chapter of this work (chapter 2), research is conducted in such a way that it cannot exist within a "social vacuum" (Charmaz, 2005). Research in its entirety becomes a process of past and current interactions and interests with the research, the empirical materials as well as the emerging ideas. Neither data nor ideas are mere objects that are passively observed and compiled. "No analysis is neutral" and a researcher does not spring up into their studies "uninitiated" (Charmaz, 2005:510). Existing knowledge develops without necessarily determining what will ultimately be theorised. Each stage of the inquiry is thus constructed through specific social processes. Social scientists are precise in defining what they record as data with those definitions outlining how a work is finally presented (Charmaz, 2006). As such, there were different ways to explore mobile work, but I constructed a specific lens to view and analyse it. This was not a neutral act, so I do not pretend or aim for neutrality.

Two stories became important during the research process that resonate with my experience, and show how my view and how this study with mobile teams ultimately became concerned with the emerging paradoxes explored in the analysis, which will be further discussed in this chapter. These paradoxes ultimately reflect wider ones that are linked to this reform specifically, but also to the wider politics of mental health and psychiatry. There is an ephemeral nature to the meeting between people, in this instance between professionals and services users as well as me, the researcher. It is difficult to define it. As a researcher, one attempts to make it visible but knows from the start that most of this meeting will probably be gone by the time it is written. Most of the possible interpretations will be lost to give rise to only the most powerful or meaningful narrative. A meeting can exist in the memories of its participants. These are people's stories; they are complex and there are only specific details that are shared in the following paragraphs. As such, it is impossible to explore all the nuances that exist and that certainly matter. Such moments are not quantifiable but tacit and fragile. However, the attempt here is not to challenge those stories' validity or the people involved. Instead, those are exchanges that convey the importance of being a witness, within a process, in this way and at that time. They are interpretations rather than definitive stories, based on an analysis that hopefully will allow dialogue on the emerging paradoxes.

The first story started with an invitation by a mobile team worker to witness a visit with a service-user, a woman who had been homeless for many years. As it happens sometimes with age, she was increasingly forgetful and her eyesight was also deteriorating. The team who were supporting her were concerned about her situation. Her professional network was starting to get worried about her and wanted an "administrative trustee" (appendix A.3) to be involved. They also wanted for this woman to be put in hospital and/or sheltered accommodation. This was especially complicated in this instance, given this woman's distrust and distress when it came to financial matters and the banking system; the worker knew that this woman would not be happy with the choices offered. The plan for the conversation was to try to find out what the service-user really wanted given the changes in her situation.

We met and she invited us to join her for a coffee in one of the main railway stations in the city. The conversation was difficult, not so much in content, but in the attempt at continuity. There wasn't always a sense of a shared reality between us. The woman talked in a fragmented manner but with sombre moments especially concerning the current frustrations with which she felt overwhelmed. She was nervous and constantly fidgeting. The worker was concerned not least because of this woman's situation but more so about the way in which her colleagues were thinking of proceeding. Therefore, throughout this exchange the worker attempted to convey what was being discussed and aimed to understand the service-users' preferences about procedures that were to be put in place. At a certain point and in the most ordinary manner, the worker put her hand on the woman's arm and said: "please tell me how I can help you". The lady stopped and looked up in tears. She didn't reply and nothing more was or had to be said for a few moments. It would be reassuring to think that there was a breakthrough; that the worker figured out what to do based on the woman's wishes. Unfortunately, this did not happen. But for those brief moments, there was a connection.

To me, such moments carry the purpose of this study. It is through these moments that I attempt to make some sense of what this 'reform' was or could be about. This story is amongst other things a best-case scenario about the professionals' intentions to care (Morgan, et al., 2016). It is about how many individuals involved in the mobile team are caring and do have the best intentions. Compassion was vital in this relationship and yet it was not a guarantee that this person would be offered alternative and suited choices to their predicaments.

The second story is very hard, perhaps the hardest I encountered during these last few years. It was on a visit with two workers to a woman they had been seeing for two years. When we arrived, we could already hear the screams coming from inside the house. Her partner answered the door and we went into a house that was in very bad shape - I learned later that there was no bathroom. These people lived in extreme poverty and in a very precarious environment, with limited resources. The workers explained that when the couple had been offered help, such as installing a bathroom or fixing broken tiles, they had refused explaining that they were on welfare and that they couldn't work, they weren't allowed to. It appeared that they had internalised their context to the extent that it dictated what they thought they were capable or allowed to do or have.

The woman finally came down the stairs barefoot and sat with us. I quickly noticed that half her nose was no longer there, from years of hitting it. She was hitting it repeatedly during the visit, each blow with such force she screamed and I couldn't help but wince. I learned that she heard voices who told her to hit herself. The workers attempted to have a conversation without acknowledging this behaviour. Unlike me, they did not seem very fazed by it. At some point, she started bleeding and when she made them notice the blood, they replied "if you hit it, that's what will happen". The woman pleaded us to help her continuously. She pleaded me to help her.

The workers offered for her to go to the local day hospital. When she agreed, they called then and there and put her on a waiting list (I think it was at least a month, if not two). We stayed there for about 20 minutes. When we were back in the car, the first thing we did was use some sanitary gel for our hands. I pointed to the fact that half her nose was gone and the workers explained that she did this in part also to 'provoke'.

Following on from the first story, this second story is about how professionals may have the best intentions, but they may just not be enough. Unfortunately, there are considerable constraints to their everyday work. The first is an organisational constraint. Instead of being constrained by hospital, this woman was now constrained by her home. Home, which is generally seen in reform manuals as a place of freedom, or people's "social fabric" etc. (Service Soins de Santé Psychosociaux, 2010) appears to have become exactly the opposite in this case. There were no alternative structures to support this woman in this area. Day hospital was the only solution that was offered to her which effectively meant that the only difference to a hospital admission was that now she would be sleeping at home, arguably with more pressures, more everyday struggles and more isolation. It could therefore be argued that this is de-hospitalisation process rather than de-institutionalisation, showing that the ideology that people are always better at home is perhaps inadequate (Prior, 1993).

The second constraint is defined by the underpinning knowledges that exist in mental health; it is about how the professionals understood this woman's situation. Unfortunately, they had no alternatives to offer her: they had no alternative services to refer her to but also, they didn't seem to know *how* to work with her distress. They ignored her most shocking behaviour and understood it as provocative and ultimately as a negative personal trait. This is not a point that should reflect badly on the professionals. The mobile team workers had been visiting her for two years. These were individuals who were invested in the work, who despite these constraints were going back to visit this woman and that is admirable to say the least (not everyone would). Yet they seemed unable to change much and it could be argued that from the fear of their own and their team's inadequacy they ultimately made sense of her distress by protecting themselves. The problem *is not* their initial intentions, but it is how those were proven not to be enough. This second story is not an attempt to undermine the first story.

For both these stories I have the same questions: How are these women's lives better than before the involvement of the mobile teams? What has changed? What is the plan for these women's lives to change? How can their distress be alleviated? These stories are not described simply to provoke or invoke emotion, they are about the people the mobile teams meet and about the limited possibilities they have to offer them. These are examples of people who do not fit in services, for whose difficulties there is no long-term solution at the moment. Those two stories and so many more, in the context of this research, in what was said in the interviews, in what I witnessed during the observations, they all point to the immense paradoxes of mobile work, of this reform and of psychiatry and mental health in general and how those may have still not been addressed.

Forming relationships

Relationships were reflected in the hierarchies that were put in place within the teams as well as the alliances and partnerships outside of them, with other services. Specifically, relationships can be understood on a micro level (on a team level) but also on a macro level (between and within wider structures), including the imposed structures of “promoting” hospitals and government. Furthermore, the micro-hierarchies that existed between users and professionals and within teams could also serve as a blueprint to understand higher hierarchies within the reform, where teams answered to “promoting” hospitals and federal government guidelines and demands (p34-35). Deontological notions such as medical responsibility (appendix A.1), confidentiality or professional secrecy (appendix A.2), person-centred approaches including choice and consent, explored as focal values, were also very much at play here and will be further explored in this section (Morgan, et al., 2016).

Level I: Team work

On relationships at a team level there were again two parts. One concerned the relationships between the professionals and the services users (Shea, et al., 1992; Anthony, 1996; Thomas, 2014). The other regards the relationships within the teams (Prior, 1993; Hall, 2005). Both those relationships were subject to the hierarchies represented by the parties involved (Yank, et al., 1992).

The relationship between the professional and the user were presented at the forefront, especially if they were said to be grounded in person-centred ideologies (Rogers, 1951; Anthony, 1996). It is in these relationships that the true reform could take place, with participants explaining that they were given the possibility to let go of the ‘expert’ role. However, these shared decision-making, person-centred approaches would presuppose that there was no inequality in professional-user relationships (Morgan et al., 2016), which was perhaps not entirely the case in reality, as will be discussed later in this chapter.

In general, it was hoped that the relationship between service-users and professionals would be based on an alliance, on mutual understanding, respect and trust, where the workers would lend a listening ear to the users’ needs.

> *We try to listen very closely to the patient’s needs: what does the client want? Making these wishes possible and providing support in doing so allows you to create a bond of trust which highly facilitates collaboration* (2B team member).

However, there was a lot of talk about people being “malignant”, “provocateurs” or “difficult” without always taking the time to consider the meaning behind these interpretations. These labels were assigned to people the professionals worked with and although many participants did not identify with the concept of “illness”, they did express “affinity with this public” during their interviews. In other words, workers used particular symptomatology quite readily, they stated clear preferences with working with certain “diagnoses” but did not always identify with people’s experiences (Burstow, 2013). This point will be explored further under the theme of ‘language’.

As mentioned earlier in this work (p118, p165), the question of peer support work came into focus during the second visit to the teams. Many workers expressed difficulty in identifying with people's experiences, especially when preoccupied by symptomatology (Walker and Bryant, 2013; Penney and Prescott, 2016). One team had originally included two members of staff who represented users and carers. However, the user representative was no longer with the team on my return visit. A worker explained that the team could not carry the person's "vulnerability" and their "risk of relapse" (such perceptions of service-users often led to distant relationships; Felton, Repper and Avis, 2017). Another had three members of staff but by the second observation period only one remained. Other teams had the opportunity to experience peer support work firsthand, with peer students having come for a few weeks on placements. In general, the experiences professionals fed back were negative. More specifically, the teams had faced harsh criticism on several fronts, from the language they used during their meetings, as mentioned in the examples above such as "malignant", "provocateurs", but also their stigmatising humour to their use of what the student called "emotional blackmail" (coercion through guilt and fear; Morgan, et al., 2016). Existing competitions were relayed and sparked further oppositions between teams within the project, with the student stating clear preferences for one of the mobile team over the other.

Conversely, one team had a peer support worker representing carers. He was very active within the team work and proved to be effective. He explained his work as "building bridges" to help families understand a service-user's view. He shared personal stories only when they were deemed relevant and he aimed to keep his involvement at a low level in order to remain easily accessible. This was a clear example of a peer support worker who had found his place in a function where people often express a feeling of being lost. Conversely, he was not a service-user but a representative of the carer role, yet paradoxically perhaps his main goal was to relay service-users' experiences to families.

The intra-team relationships were a big theme throughout this research, with different roles implemented (Prior, 1993; Hall, 2005). As a direct result of the cuts in federal funding for the teams, considerable strain was added on those inter-personal relationships between team members due to the pressure of their uncertain future. As mentioned, the different disciplines which existed in the mobile teams were based on a blueprint of hospital teams (p168). As a result, workers from certain disciplines wished to be more explicitly valued, in contrast with the residential sector. This was especially true for psychologists in many teams, while some OTs (especially in more hospital-like teams) found it difficult to establish a function and role for themselves. Social workers were also not always engaged as such but perhaps that had more to do with their work not being as relevant in certain areas where social services operated more smoothly than others (Prior, 1993). Other members didn't see the need for those to be explicit but preferred their presence to be implicit, interpreting this scenario as more democratic. The relationships which arose within a team proved important in understanding the models and values employed.

> *We all have precise functions. […] We are all therapists and yet we do not do therapy. […] There is something very precise from everybody and at the same time we share. I cannot do my work if I don't trust [my colleagues] completely and know that the patient can come when he is unwell. And I trust absolutely that he will be welcomed in the same way as if I was doing [welcoming him]* (2B team member).

> *In effect, we do not pay attention to functions so it's not that if somebody has a social problem that we will involve the social worker. We are not attentive to this. We will even be vigilant to avoid this, maybe so that the [professional] network can take its place. But clearly, we go with what we are and so I think […] that there still is an experience of I don't know how many years in a [long-term service] here in hospital and so clearly there are reflexes. […] But I find that there has been an evolution there too. […] We tried to distance ourselves [from hospital work] with the experience in the mobile team. […] There was a detachment from our primary function, but we still carry it of course. […] With the team being multidisciplinary they come from different horizons, they come from different trainings etc. It will bring little touches, different connotations* (2B team leader).

In general hierarchies were represented negatively, either because they were implicit and therefore presented as non-existent or because they were so explicit that they became oppressive. In other words, some teams presented themselves as "horizontal", but psychiatrists still held "medical responsibility" which meant that a hierarchy did exist (Yank, et al., 1992). Other teams were clearly headed by the psychiatrist and team leader, to the extent that no decision could be taken without their agreement. Many workers appreciated the possibility to have guidance with some even asking for more. In one team that didn't have a coordinator the lack of such a position was understood specifically as a lack of guidance. This clear hierarchy ultimately reflected the work itself including the teams' model and their function, which could not always be implemented in practice due to a lack of guidance. Still, autonomy was valued with the teams enjoying less of it feeling more frustrated (Hall, 2005).

> *We are a very autonomous team. At the same time, we often go towards the team leader and towards [the psychiatrist] when we are in need of advice* (2B team member).

> *I find that horizontality allows for better repartition with respect to a certain problem and it really allows for each person to give his human input, both clinical and professional, each with*

> *their training. But what I find very specific is that each person is a psychosocial worker and they are considered competent* (2A team psychiatrist).

> *This job is so different from what every one of us was doing before and I realise that the team really wants a guide, or certainly expects an injunction. So, we have [questions such as]: "and this? How do we do this?" [There is a need for] somebody to decide and so we're not exactly in a horizontal model, that's clear. Having said that, each person's opinion is heard. But as soon as there is a need to decide, then it will be vertical. It will be either on a medical level/plan, or an organisational level/plan […]. But it's true that we are not in a completely horizontal model, no* (2A team leader).

All teams (that had a psychiatrist) were very clearly headed by the psychiatrist who took up the decision-making role, as presented in the interviews (Prior, 1993; Hall, 2005).

> *There are different things in the [psychiatrist's] function in the teams: a little bit of team coordination/management, some team training, and there is still the clinical aspect* (P2, 2A/2B team psychiatrist).

There was a great deal of variety in how explicit or implicit this hierarchy was with some teams actively directing all discussions towards the psychiatrist and other being more "fluid".

> *When we are between ourselves, we are a team member like all the others. We have our specificity. We are a psychiatrist and we give out prescriptions. We have our theories, our studies on psychopathology. We can explain things and be conscious of certain things given our training/studies. But in the team, even if I sometimes have the last word, sometimes, sharing is the same. We are one of the partners around the patient* (2B team psychiatrist).

Most accounts about why the psychiatrist had a stronger voice were around notions of medical responsibility as well as experience and knowledge specific to the psychiatric function taking also into account the community and home setting (Prior, 1993).

> *So, from the moment a doctor has taken the Hippocratic Oath he really is linked to this thing and it's impossible to undo. There is a responsibility that is linked to this with which you need to fight a bit, make peace a bit, but at the same time we cannot pretend it doesn't exist. That is something that is sometimes difficult. That's just the medical-legal side but there is also the support you give to people. I don't know how to explain this. I think that I have baggage from support offered in hospital, in mental health centres, in hospital consultations, in general hospital. […] I have a certain notion of how things can often evolve and so sometimes when you have this baggage you come with some prejudices. I have the impression that the other*

> *[workers] have fewer of these prejudices and that they work more easily with the person. I think that my psychiatrist's baggage and the difficult things that I saw in hospital ensure that I am a more anxious actor than others and sometimes […] I think that this is also associated to my function. And that also participates in the fact that we feel more bare when we are in people's homes and that we have to work with this. It's to say "ok, I am here, the situation is serious and at the same time I am not in a position of strength and I need to work with other weapons than those with which I have the habit of working with"* (2A team psychiatrist).

For example, there were several teams for which the decision to include somebody in the service was taken solely by the psychiatrist. In one team, they even went as far as to say that this was in order to implement their exclusion criteria more strongly, specifically for people diagnosed with personality disorders and especially "borderliners". Furthermore, many psychiatrists chose to oversee any contact made between the service and doctors from other services.

> *So, there is the medical responsibility. That means that in any case, there are obviously no new inclusions without first passing by the psychiatrist, nor indeed - and I have to often insist on this - discharges without first passing from the psychiatrist. There is a whole function of clinical diagnosis, in any case of a clinical view on the person. There is all the contact […] with GPs, treating psychiatrists etc. The contact between doctors is something that [the psychiatrist] preserve[s]* (2A/2B team psychiatrist).

In general, "greater importance" was given to the psychiatrist's voice. In one instance, a team had been quite angry with the decision to separate the psychiatrist and the rest of the team when doing the interviews (p77-80). It was deemed too "institutional" (resembling the hospital sector). Yet the same team was very hierarchical, with the psychiatrist directing care interventions. It begged the question whether 'keeping up appearances' of a desired horizontality were more important than the reality of practice. The psychiatrist as main or sometimes sole decision maker was ensured even in their absence. The active involvement or lack thereof did not change their hierarchical power (Prior, 1993; Hall, 2005; Felton and Stacey, 2018). This was true also for psychiatrists who did not do any home visits and in effect, saw no service-users in their mobile team function.

> *We need to always have [the psychiatrist's] endorsement too, who needs to be informed even if she is not always here. In any case, we need to find the moment when she will be here to participate in decisions too* (2A team member).

Teams were therefore often presented as very hierarchical and as a result, team members actively sought more autonomy (Hall, 2005). This was shown through the interviews as well as in practice, where autonomy was somewhat practiced, nonetheless. In other words, the work demanded workers to be autonomous. For example, it was not always possible to wait for the psychiatrist's decision on matters that were happening during a home visit or whilst on the road. The team knew the limits of this autonomy, yet they still deemed that having more of it with a clearer frame and formally recognised would be beneficial for their everyday work (Yank, et al., 1992).

In some teams, more involvement was sought from the psychiatrist, including the possibility to do home visits. They also hoped for more supervision, guidance and direction in their work. Some however, didn't particularly like this idea, fearing that it could prove prescriptive and restrictive, as shown in the categorical levels (p117). One team chose to avoid having an active psychiatrist working in the team. However, one had to be attached for reasons of medical responsibility as well as for political validity (regarding the federal government guidelines and demands). The psychiatrist therefore ended up not seeing people but still operating within a "consultant" role, whenever he was present.

Many members felt they carried too much responsibility, especially when the psychiatrist was not present for home visits, but still hoped for more guidance and autonomy.

> *P1: He has a very clear vision which he can phrase beautifully […] so he should be more present so you can hear it repeatedly until you fully grasp those ideas. […]*
> *P2: The experience also, I think. [The psychiatrist] is someone with tons of experience and because he has little feeling with the case or barely knows the referral, we often get a lot of [questions]. You get the feeling that you work superficially, while if we work [together] on a case for a long time, more information emerges where I think "wow, what a strange line of thought, how does that work? How did he think about that?" […] The experience that he has; it's very interesting what he has to say, but it could be broader, I think* (2A team members).

In any case, the psychiatrist was the definite decision maker while setting the frame in most teams, with members implementing those decisions and frames (Prior, 1993; Felton and Stacey, 2018). This was true to the extent that some team meetings resembled ward rounds, rather than multi-disciplinary discussions.

Level II: Working with other services

Based on the interviews, there was a sense in which the competition between 2A and 2B teams could be felt in those projects where it was central. However, although the competition was palpable there were also examples of the close and efficient collaboration and relationship between the two teams. Observation at a home visit with representatives from both teams during a mixed assessment proved an example of a space in which all were accounted for, including professionals from both teams, as well as the service-user and his personal network. It could only be seen as an example of practices that are clearly beneficial for all.

In terms of the collaboration between mental health structures and other general health structures, it became apparent that the psychiatrists and doctors were often called to be at the forefront of those collaborations, as mentioned earlier in this theme, with many psychiatrists being the sole communicators with other doctors (Yank, et al., 1992; Hall, 2005). A good example of this was an anecdote told during one of the interviews, where a psycho-social worker explained he would sometimes use words such as “patient” in order to make himself sound like a doctor. In this way, he had more success of collaborating effectively with other services.

> *[When we use the term “patient”] they often think we are doctors, so it happens/we get through more easily* (2B team member).

In terms of the collaborations between services, one could very often and quickly see that decision-making roles were not clear cut as medical responsibility should ensure (Yank et al., 1992; Hall, 2005). With fragmented services and many doctors existing around a situation, it could often be felt that there was a culture of “passing the ball” (or “hot potato”). For example, teams who believed one of their service-users needed an admission would opt for somebody else to take the decision in order to retain a positive relationship with the person and in doing so keep some control in that person coming back following their discharge for any “care needs”. Other times, workers pushed for an admission by motivating people to go into hospital voluntarily (Morgan, et al., 2016). It raised the question as to how this work was linked to the function of preventing admissions.

In the notions used to describe populations, there was also that of “chronicity”, especially for 2B populations provided with long-term care (Service Soins de Santé Psychosociaux, 2010; Natalis and Pieters, 2016). It became apparent service-users were thought to be responsible of their chronic presentations, even when considering their relationships and personal context. Furthermore, this could also be said of the professionals who they themselves could become “chronic” with people (Coles, et al., 2013). This is certainly the case in residential spaces, where people have repeatedly been shown to become “institutionalised”, meaning that people lose important social and life skills as a result of living in an institution for a long period (Goffman, 1961). Perhaps, however, this was also true for mobile teams, who became “stuck” in certain situations with people. In one instance, this chronicity was further pushed on the service-user when it was suggested to impose a residential “treatment” on them. This was interlinked with a wish to close the file, but it was more shocking that this person had not been in hospital before and there was no apparent reason as to why he may need it. On the other hand, this is also a good example of the lack of possibilities for teams to refer elsewhere other than the residential sector as a last resort (Friedli, 2009). In other instances, teams consciously took the decision for somebody to experience “total relapse” deeming it better for that person to be admitted. This could mainly be seen in situations where service-users had used up a lot of the team’s time and energy and where professionals became ‘stagnant’. As a result, an intervention could seem somewhat fragmented with referrals towards “the network” of other services, while the state of “chronicity” was perhaps not always specific to users but could be identified in professionals themselves.

> *Sometimes it’s our own frustration. Those are patients that are there and we try to find them an activity but well, they do not want to* (2B team member).

In other instances, the doctors around a service-user would actively avoid communicating or collaborating, due to having different styles and backgrounds. This was also linked to their promoting hospitals. Although this may sound somewhat negative at first, there is something to be said about the possibility for people to move from one professional to the other and claiming those spaces as their own, each with their own specific relationships and goals (see appendix A.1, A.2).

> *I think that for the public we meet, it is important also to appropriately have more than one person towards whom they can turn to, but also that they can have different spaces where they can rest, in a different way, without saying the same thing, without having the same relationship with everybody. That they can travel a little from one person to another* (2B team member).

However, it can also be said that this is a strain on the system, especially one with scarce resources.

It was considered very important to have ‘gaps’ within people’s care, with different services operating separately without constant communication and feedback between them. For example, a person could be both a user of a mobile team service as well as one of an ambulatory team while at some point she/he could also be admitted in hospital (appendix A1; Natalis and Pieters, 2016). All these structures operated with their own professional and confidentiality clauses (appendix A.2). This was a way in which professionals didn’t operate on notions of social control but instead were said to celebrate choice (Moriarty, et al., 2007). Nevertheless, many teams as seen in the interviews, especially within the Flemish region, expressed the wish to close those gaps with one sole representative and treating professional body for each service-user and other actors attached to it.

One of the values mentioned during the interviews was the idea of in- and outreaching practices (Natalis and Pieters, 2016). There was an opportunity to experience work around in-reaching firsthand by being present during a hospital team meeting for a mobile team service-user. This was also an opportunity to see hospital work up close, as well as the collaboration with mobile teams. As explained in the interviews, it was clear that the teams were very psychiatric, with all discussions directed at the doctor. Furthermore, the lack of communication and collaboration between the services was very clear, although it has to be noted that this deficit was true from both sides.

> *I think that they have their little functioning, their habits and just like ours, like we are outside their framework, I don't think they are very implicated in understanding how we work* (2A team member).
>
> *The world ends at the service's door* (2A team member).
>
> *It's not like it's their fault. […] Surely, it's also something we should work on* (2B team member).

During the hospital visit, it became increasingly apparent that the hospital team had not been informed of the person's situation nor did they actively seek it out although the service-user themselves had been in hospital for several months. This showed the standard practices of long hospitalisations and perhaps the reasons behind them not being necessarily "therapeutic" but due to lack of efficiency, especially in gathering essential information on a person's care history. It seemed that the hospital appeared to remain indispensable when it perhaps was not necessarily so.

Collaborations between mental health and other health sectors were not always positive. For example, at the time, a plan was being put in place for pharmacies to keep records of prescriptions, since no record-keeping was in place. In terms of the relationships based on collaborations with first line care, many services experienced it as difficult, as mentioned in the previous chapter. This was certainly true in terms of the fact that the doctor who had medical responsibility was not always clear (Appendix A.1). Moreover, depending on the situation doctors would actively seek or avoid this responsibility. In one example during the second observation, a GP had failed to treat a person suffering with cataracts for 12 years, yet he could not be held accountable. Given that the person was from a low socioeconomic background and the fact that he was ageing made things even more complicated. GPs in Brussels published a book on their negative experiences with the mental health sector, further putting pressure on the 107 reform officials and practitioners (FAMGB, 2018). The political and economic reforms at the time of the second observation were not only happening at the team level but also concerned psychiatric hospitals as well as general health.

Level III: Working within a wider context

The idea of a collaboration through a network was the main idea of the 107 reform, however this was not very relevant for all (p124-125). For the projects where it was relevant, due to the difficulties imposed by the political and financial powers, the referrers from other services who formed the network stayed close to the projects. In some instances, they actively tried to make this period a little easier on the mobile teams, for example, by decreasing the number of referrals so as not to overburden teams who were losing employees. There was also a sense in which teams felt that the network partners were falling onto themselves even more. “Everybody is thinking of themselves” mentioned a worker. With this generalised political and financial crisis looming over the teams, it was increasingly felt that a top-down structural hierarchy was imposing change on the teams, without them necessarily having a say in the process.

> *There is a power that is imposed on us, to which we will have to get used to. Changes are planned at the geographic area level etc. They will oblige us to rethink our functioning, maybe our team, all of this* (2A team member).

Although this political and financial restructuring was true on a national level, the Flemish region projects felt it perhaps to a lesser extent than the Brussels and Wallonia ones, which have less finances due to the low number of beds and a higher number of service-users within their areas (p25-26; Service Soins de Santé Psychosociaux, 2010). This reflected the relationship with other structures within the Flemish region, which happened more smoothly but which were also perhaps more fragmented. As mentioned, the region’s social services and first-line care were not overwhelmed and that left the mental healthcare services running more or less on their specific functions. Conversely, the political and financial reforms had a much more negative effect on the rest of the projects. In general, due to the disarray produced as a result of the political and financial restructuring the teams directly affected were to some extent experiencing an existential crisis. As one team member remarked it made them feel unrecognised on an “institutional level”.

> *It’s difficult to explain sometimes, the fact of putting a network in place, detect the little grains of sand that block the network, or the support that we will bring to a person within the network and not the user, to be sure that they’ll be able to stay the course, because they are overloaded with this user who is giving them a hard time. [It’s difficult] to explain this work, which is not quantifiable* (2A team leader).

Borrowing Words and Diffusing Language

With new temporalities and spaces explored by the mobile teams while carrying memory and developing a different value system, participants in the (mostly) newly developed mobile teams were given the challenge of forming relationships within teams and outside of them. Through that process, they developed different ways of thinking and seeing service-users in their situations and in turn re-evaluated mental healthcare settings. With a mobile function based on existing residential structures and the concepts surrounding them, the teams presented this ‘new’ vision. Participants’ language became a mirror of their work and vice versa. It became quickly apparent that this ‘new’ language was riddled with paradoxes, with contested categories and values, many of them similar to the ones that have always existed within the mental health field (Read, et al., 2004; Burstow*,* 2013).

Level I: Team work

A way of understanding professional representations of the relationship between workers and service-users was by their preferences in the way they designated people. During the interviews, participants were asked directly whether they employed the word “user”, “client” or “patient” or any other and also whether they employed diagnostic criteria in their descriptions of people’s situations (Russo and Shulkes, 2015; Burstow, 2013; Morgan et al., 2016). Preferences ranged and generally most team members employed the same language/wording amongst them for the most part but, in many instances, members did not agree on specific words. This was definitely true according to the disciplinary background of certain members, with psychiatrists using clinical and medical terms more readily. How language was used, within the team or outside of it, towards service-users, family members, other professionals or in formal documents also differed considerably (Amsalem, Hasson-Ohayon, Gothelf and Roe, 2018).

For example, medical and para-medical professions, most notably nurses, would more easily use the word “patient” to describe their population while social workers and psychologists used “user” or “client”. The terms “user” or “client” were most widely used in 2A teams while 2B teams employed the word “patient” more. This may reflect the difference assigned by some teams between ‘mental health’ and ‘psychiatry’ (p132; Barker and Buchanan-Barker, 2011). This was sometimes paradoxical given the 107 ‘mental health’ reform.

> *The reform speaks of mental health. It’s true that we have a position that is a little… […] Everything that is of the mental health agenda is not that of psychiatry. So maybe we are still very attached to the psychiatric model. At the level of the 2B team, we can work with patients that are ‘heavy’, for whom there are no real solutions etc. And we don’t want to make all mental health problems psychiatric. That is something that we hold onto. But maybe that puts us in a bit of trouble with respect to the reform* (2B team leader).

These differences were sometimes linked to team models with 2B teams using “patient” more, rather than “user” or “client”, especially when bringing in the difference between mental health and psychiatry (Barker and Buchanan-Barker, 2011). In contrast, 2A target populations may be “new” to the mental healthcare sector and presenting with more “social” problems, while 2B team service-users are known by the residential psychiatric sector (‘revolving door’). 2A teams were therefore more at ease with using the word “user”, which was somewhat also linked to the notion of consent.

> *In our presentation, when we talk of psychic difficulty, it’s large and vague on purpose and it is not centred on psychiatry. Precisely because I think that when we say “user”, it’s about ordinary people. We are not in ‘psychiatric relapse’. Sometimes yes, it can happen but not systematically. And so, when I say ordinary people, yes, it's ordinary people who encounter a life event that entraps them and is complicated. […] We are not addressing a “patient”. “Patient” is pretty restrictive; it’s to only see the clinical and health side. While here, I think, we really consider the individual in her/his entirety, in her/his global system, which is her/his family system, her/his care system too, even her/his educational system […] where s/he lives, what s/he lives from […]. And so, it’s more than the health focus. […] And there is also the notion […] that we always work with the person’s consent. So, if they are using our services, […] it’s because they want to* (2A team leader).

Linguistic differences also played a role in the use of different denominations. The word “user” is not readily used in the Flemish language, with professionals using “client” more. By contrast, in formal 107 reform texts it originally was the word “user” rather than “patient” which was employed, making it the somewhat official term for teams. Some workers however consciously chose to avoid it, preferring the term “patient” instead. Later official texts referred to a study on therapeutic relationships and preference in address, showing that most people preferred to be called patients by doctors, GPs and psychiatrists specifically (McGuire-Snieckus, McCabe and Priebe, 2003). This reference reflects the considerable wider need to embrace experiential knowledge including service-user and survivor voices in all their heterogeneity within the 107 reform both organisationally and in practice (see later chapter 9). It also points to the immense power of medical professions and psychiatry specifically while the voices critiquing them remain widely marginal and unheard (Read, et al., 2004).

Ultimately, any choices in how and what to call people using a service, were defined by the type of relationship the workers had with service-users. For psychiatrists, for example, operating within their medical responsibility, the word “patient” was more often used, while for “psycho-social” disciplines, the word “client” or “user” was preferred given the difference in the relationship and setting. However, workers who had been working in a hospital setting (using a medical framework for over 20 years) often used the word “patient” due to a habit which was difficult to break away from. Different notions were given as to the denominative preferences and those were, as mentioned, linked to the type of roles, relationships and rapports but also to the frame of understanding and the values the workers held when interpreting a person's experience (Morgan, et al., 2016), their "suffering", their "vulnerability", their "environment", the level of "control" they had over their situation and their ability to give their "consent" as well as their "resources" and their "strengths" (Anthony, 1996).

The disciplinary background also played an important role in the language used (Prior, 1993). Specifically, psychiatrists were relaxed in using the word "patient" (although not just them).

> *For me the word "patient" does not refer to the fact of having an illness, it refers to a rapport. A rapport between a care worker and a patient. When I go see my GP, even if I go for my annual check-up, to do a blood test […] I am his patient, but I am not ill as such. But I think that in fact there is a distrust of the word "patient" because of the stigmatisation of mental illness. It's the whole difficulty. The big question is indeed whether a mental illness is an illness. […] So mental illness has this status which is always a bit particular. Is it an illness or not? Patients are the first to ask that question, to know if it is an illness; in any case they don't want to be confined to a diagnosis. There is this enormous mistrust around the possible 'psychiatrisation', of the whole confining dimension […]. But, we must 'call a spade a spade'. I find that work should rather be done in de-stigmatising mental illness and de-stigmatising going to a psychologist or a psychiatrist rather than change words. Because it is not the fact of being a user that will change the institutional functioning* (2A/2B team psychiatrist).

> *Indeed, we talk of a 'patient' because these are people that have a psychiatric problem that by definition is an illness. They come here to be treated/cared. In that context: "patient"* (2B team member).

Aside from the forms of address, participants also made comments on diagnostic and (by effect) pathologising language (Read, et al., 2004; Burstow, 2013). Most participants stated that diagnostic categories and criteria did not interest them in their work and were unimportant for them. However, many explained that those offered an easy description of a person's situation (Callard, 2014).

> *It does offer some kind of framework in terms of frequency for instance, or to know what you should be doing, what you can't do. But the most important thing remains to get a general picture of your client* (2B team member).

> *Actually, a diagnosis doesn't matter. […] Maybe it offers a certain approach, but in the end, I think it is mainly our intention to really listen actively to the client in front of you. […] In some respects, it is important. For example, if you're dealing with people with a personality disorder,*

> *if you have that background, it can be important to say: "ok maybe we should expect this and not that" or "maybe we should take that into account.." "Maybe it's not the correct way of approaching". I think the support/intervention towards the client is the most important thing* (2A team member).

In everyday practice however, diagnoses and diagnostic criteria were used quite a lot in briefing meetings between professionals but seldom with users, which made for an interesting contrast. It was explained by participants that it was quite often a way to direct the approach taken with a service-user and the level of "tolerance" in interventions and in network building practices. Conversely, participants agreed that pathologies and symptoms were far from static but were fluid instead, which in turn allowed workers to be flexible in their interventions. A good example of this point happened during one of the observation days. We visited people with the same diagnosis, yet the way in which they presented themselves was very different (Blashfield, Keeley, Flanagan and Miles, 2014). This perhaps came into contrast with values of person-centred approaches.

As seen with the terms "user", "client" and "patient" the use of diagnoses were definitely different depending on people's disciplinary background as well as function within the teams but also setting. Psychiatrists were more prone to using diagnoses although they were very conscious about the setting in which those were to be used (Gantt and Green, 1986; Milton and Mullan, 2014).

> *In the unit where I work, the patient is on the team, so you have to speak the same language. You cannot speak about diagnostic criteria, you cannot speak in the same terms that you would speak [with the rest of the team]. So you change your language because the patient is there. I also worked in units where patients were really described in psychiatric terms. […] I don't know if the outreach makes the conversation different, or the psychiatrist or psychologist* (2A/2B team psychiatrist).

> *You need [diagnoses] for insurance purposes and you need it for referrals. It depends on the hospital and it depends on the unit. If you want to refer someone to a psychosis unit if the patient looks it up, […] you have to speak about the word psychosis. Because otherwise, everyone will be in shock. And if you prescribe antipsychotics you have to give an explanation about the word and why you think the medication is necessary* (2A/2B team psychiatrist).

However, even they were careful to make the nuance between the use of diagnoses as hypotheses or descriptions rather than ultimate facts. Most team members were more interested in using client-centred language and avoiding stigmatisation, leaning on language based on people's difficulties but also strengths and goals (Anthony, 1996).

> *P1: Actually, I find it important that we have an overview of- well, in itself it might be interesting to have an insight into the diagnosis, it might help direct the type of treatment or support, that's something I personally believe. But in my opinion, it's not necessarily useful for the client. I don't believe we need to include it in a team meeting report, because in a team meeting report we try to be transparent towards the client. […] Because that's part a psychiatrist's job, to sort things out in a diagnostic way, and if necessary, to adjust medication with that in mind. It's a doctor: he sees the client through different glasses. Maybe he's also more cause-consequence minded. He also focuses more on: what are the symptoms of the disease? Because it's also about psychiatric vulnerability. So, he has different role, in my opinion. A psychologist will also work diagnostically, but will be diagnosing other things, I think. […] We will focus on: how does this person experience life? What's going well, what's not?* (2B team member)

As mentioned in the theme of relationships, person-centred approaches were not always visible or audible, with many workers talking about people in pejorative terms. Diagnostic language and categorisation were also readily used, with examples of "typical cases" explored during team meeting. During a meeting, for example, members discussed the difference between "psychosis" and "psychotic behaviour". In general, however, despite this highly medicalised and diagnostic framework, the teams still aimed for "globality", as mentioned in the interviews (their task was to understand service-users' in a global way which included their wants and needs; Anthony, 1996). This meant for example, that a project's plans to develop more specialised teams was abandoned, preferring instead to focus on the work with the neighbouring network.

For teams that proposed a difference between psychiatry and mental health, diagnoses were linked to "psychiatric pathology", while mental health to "psychological suffering". Diagnoses were therefore left to professionals of the psychiatric field. For others, psychiatry and mental health were part of a continuum and descriptions were associated with phenomena (DeRosse and Karlsgodt, 2015). Very often workers would explain that diagnoses were only used when communicating with outside professionals, especially those within the mental healthcare sector or for insurance reasons although it varied widely depending on the structures (Corens, 2007). For professionals outside the mental health sector, due to matters of confidentiality and the "professional secret" (appendix A.2), diagnoses were often actively avoided. The use of diagnostic criteria, and language in general for that matter, was described as very different when a service-user was present and when not (Milton and Mullan, 2014). Finally, some workers who were themselves carers were perhaps more inclined to use certain diagnoses, which was somewhat seen as controversial.

> *P1: I am hearing a hospital nurse. Sorry, I have to say it.*
> *P2: I don't think you are hearing a hospital nurse, I think you are hearing a mum who has been confronted with someone with ASD every single day, and I have known him 17 years, and who is still surprised every day in how he thinks, still being surprised and thinking […] "he sees that differently"* (2A team members).

The very clear hierarchy between professional and service-user was made even clearer when, during a consultation, a professional responded to a service-user by saying "I am superman, here". In another instance, a professional desperately tried to avoid giving any validation to a service-user, even though he agreed with their premise, for fear of the risks of allying himself with them. Another professional actively chose not to agree nor deny with a series of diagnoses given to a service-user who was experiencing difficulty after having received her notes and learning about them. It was unclear whether that was actually helpful for that service-user or whether the professional was keeping her/himself safe. All these could be examples suggesting that professionals were actively "othering" service-users, by building walls between the two experiences and in turn, putting considerable brakes in processes of co-existence and in the co-production of meaning.

Diagnostic language was something that was deconstructed in some teams who chose to take on a role of raising awareness in terms of its validity, especially towards family members of carers (Natalis and Pieters, 2016).

> *It really is important for us to do this, if the family asks for a diagnosis to tell them: "look, for us even if there is a diagnosis, it doesn't mean that [the person] is it by definition, s/he is not his diagnosis, it's just a guideline to know what could eventually happen, what you could eventually do"* (2A team member).

However, it was also a conversation that was centred on users themselves.

> *I'm not saying that it is very common, but it happens often that people ask. Often, they have received a diagnosis and they will use it. They will say it and it's as if they have nothing else to define themselves, to present themselves with. […] It's logical, because first of all you are not alone anymore. That is very important. Because you put a name on something. You will be able to treat yourself, get better, because you know exactly what it is you need to do. But it's mainly the fact that you're not alone. […] Of course, there are many people that are disappointed, but it depends on how it is brought up, how it is said. That is also important, the right moment. […] But it is essential to show that a user is first and foremost a person before a diagnosis. That is so evident. But it's true that having it in mind is even better* (2A team member).

As mentioned in the interviews, the problem may not be the use of diagnoses or particular denominations but rather the meaning behind those, which pointed towards an unequal and perhaps dangerous hierarchy between care worker and service-user (Morgan, et al., 2016).

> *In my experience, the trap is in the words, in the attitudes of infantilisation. This is enormous, I find and there are many, many complaints/accusations at this level* (2A team member).

This was also shown in workers' interpretations or relationships as being interlinked with the question of dependency (Morgan, et al., 2016). Some welcomed this "mothering" function while others deemed it dangerous territory they would rather avoid.

> *For me, the mobile teams removed my fear of dependency. I find that when I worked in hospital services or in other services […] I would tell myself "patients shouldn't become too dependent on me, I shouldn't invest too much…" and now, here, it's the opposite. We will invest ourselves, but we know we are doing this. We are conscious of what we are putting in place and so the distance will come later, but perhaps there will be a passage by a stronger relation before. I allow myself this, sometimes. After all, never mind! We'll see! But it's about really being next [to the person] so that they can then re-appropriate something for themselves. […] After all, we are all dependent on somebody* (2B team member).

During the observation with the teams it was possible to meet a lot of different workers. What became clear was that imposed hierarchies meant that there was not always enough space for "dissensus" (Pilgrim, 2008; Morgan, et al., 2016). As seen in the theme of relationships, due to power hierarchies, psychiatrist often "had the last word" and as a result there was not always space for different views or discourses to be shared. Difference between workers' disciplines and their personalities were not always celebrated, with some teams actively trying to make themselves more homogenous. In another instance, some workers were deemed "too critical" or "too emotive". One example in which multi-disciplinarity could be immediately recorded was in the notetaking, with different members inputting very different notes for their visits. Some inputted direct quotes from visits while other relied on 'clinical' interpretations (Morgan, et al, 2016). The former was mostly employed by workers who had been working in the sector for over 20 years. Although this could be seen as a wealth in the voices, interpretations and meanings available, many team members opted to make the notes more fragmented and manualised.

With 107 reform guidelines remaining abstract, teams made different interpretations of central notions of their work (chapter 4; Service Soins de Santé Psychosociaux, 2010; Natalis and Pieters, 2016). An example of this was in the differing interpretations that were made on the notion of multi-disciplinarity. 107 guidelines clearly called for multi-disciplinary teams, but without necessarily imposing specific disciplines. For projects, this meant that clear representations of several disciplines had to be put in place, while some promoters argued that having a minimum of two or three disciplines was enough. Perhaps not surprisingly, in most cases hospitals chose the disciplines that already existed within their own structures that left social workers, OTs and psychologists behind. Those disciplines are also the ones that had historically more of an outreaching role when working from within hospitals while they have also always existed in community structures (Prior, 1993). As a result, the first disciplines to be made redundant when funding was retracted were the people who had that experience in the community and who in general had less representation in hospital structures. This was of course directly linked to the recruitment protocols, with many mobile team workers transferring from hospital to mobile teams through a ‘sliding’ process. In other words, most employers remained the same for many professionals transferring from hospital wards into mobile teams (Prior, 1993). It was, as mentioned, a hospital team that was the blueprint for mobile teams, without necessarily first thinking about the difference in the setting and function of those teams. Multi-disciplinary work was therefore clearly represented differently between structures.

Nevertheless, teams did fulfil a preventative role in most projects (Snyder and Lopez, 2002). By providing a safety net, service-users were able to avoid hospitalisation. For many 2B teams, for example, their interpretation of “crisis” was to handle their own, which meant that 2B teams continued their support and avoided to the best of their abilities to refer people towards other structures. This by default meant that in many cases there was no need for a close collaboration with 2A teams. In certain ways this lack has proved to be positive as it promoted strengthening relationships that had been founded with service-users. In other ways however, it also proved detrimental to some of those relationships. In some cases, 2B “crises” were often found in hospitals anyway. Whether those admissions were shortened however remains a valid question.

Level II: Working with other services

As explored previously (p118-130), the teams’ collaborations with other services were reflected in their communication and in how language differences or differences in visions became apparent through that communication. These language differences quickly became central to the study of mobile teams. Participants explained that viewing a person in their home environment gave way to a different understanding of this person, making different things important for their care (Anthony, 1996). When communicating with hospitals, such a view was novel and unknown to their interlocutors, which reflected these differing visions on service-users and the work being done around them.

> *It's a different reality between that of hospital and ours. It's about trying to understand each other, just like in all couples* (2B team psychiatrist).

> *The frames of reference are really different. Sometimes, I have the impression that we don't talk the same language. Well, I'm thinking of hospital services where there is an obligation for care/care constraint. But it's true that we will work more on the non-obligation for care, on the negotiation. Perhaps it is there that it's complicated because we come with things that are too flexible in comparison perhaps with the patient's state at the moment they see him. And one language is not better than another. I just think that our frames of reference at that moment are different* (2B team leader).

107 guidelines, as mentioned, remained very abstract on the notion of "crisis". This was originally done on purpose, suggesting a bottom-up approach whereby each project could develop their own frameworks to serve their region's particularities (Van der Jeugt, 2015; Natalis and Pieters, 2016). Obviously, for 2A teams the notion of "crisis" was central to their work, from the presentation of their population to the intensity and frequency of their visits. The teams were constantly invited to re-assess the term, in conjunction with the possibilities available. For example, due to lack of resources, as well as the competition with other structures, many teams chose to make the difference between "crisis" and "urgency". First, they didn't have the resources to answer to urgent situations but also "emergencies" had to remain a function for the hospital (given the latter's specific regulations).

> *Those are people that do not want to be hospitalised. Concerning crisis, when it really is an acute crisis with violent accents, we cannot do much because we don't have the means to frame that. In any case the mobile team cannot always supply a hospital frame, so if it is a really acute crisis then we propose to reorient towards a hospitalisation* (2A team member).

Most teams agreed that in order to communicate effectively, professionals would adapt their own language to that of the hospital professionals in order to be understood and achieve their given goal. With time they were then able to switch to their own new language habits and in turn influence hospital professionals in how they viewed a person. For example, a participant explained that they would use diagnostic criteria for referral purposes, yet once a user was accepted, they would then switch the way they relayed information about this person based on the (home) situation rather than the symptoms.

> *I think that we will try to adapt, at that moment. I'm not saying that it will always be like this, but I think that for the moment we try to adapt to be comprehensible on a hospital level* (2A team leader).

> *P1: Indeed, I think that we force ourselves to talk the interlocutor's language, to convince him for the necessity of a follow-up, if we are asking for a follow-up. […]*
> *P2: And after you can say "yes, but I do not agree completely". But you won't say this the first time [but] after you have ensured your follow-up* (2A team members).

Many teams hoped to have more of a "gatekeeping" function to hospital admissions, while still keeping a low threshold (broadly based on the CHRT model; National Audit Office, 2007). Instead, they mainly saw populations that would perhaps be more eligible to be seen by existing ambulatory services, while only a small percentage were people with a real risk of being admitted. Others enjoyed having that population, maybe because they weren't in direct competition with their hospital promoters.

There were a lot of interpretations between what was considered "therapeutic" and what was deemed support in the "here and now". For some teams, the distinction was clear, with many choosing to go with support in the "here and now" (p123). For others it wasn't, with some teams describing their work as both. This could somewhat be linked to the existing ambulatory sector which was in some respects in direct competition with the mobile teams' work and function. By distinguishing and comparing therapeutic practices and supportive ones, it seemed that certain teams made it clear that they were not interested in 'stepping on toes'. Others who may have also been closer to the residential sector and not in so much direct contact with ambulatory teams did not perhaps need to make that distinction so explicit. In any case, what was considered therapeutic was a constant discussion.

Teams did collaborate with other services successfully, especially for referrals from short towards long-term care. However, and as first seen in the interviews (p118-130), participants often felt that a difference in vision between structures meant that collaborations proved sometimes difficult.

> *When I visited patients in hospital and spoke with the team, their speech/discourse was much more clinical. Now it is logical […]. They do not have access to that side [of a person's life] that we have access to, which means that their discourse evolves in a certain way* (2B team member).

The difference in visions resulted in teams becoming involved in a situation where the description given by the referrer differed significantly to what the team understood or saw. “It is very difficult to coordinate [service-users’] relationships” mentioned a worker during the observation. However, there was something in the language that was shared between hospital and mobile teams.

> *I think we will try to adapt [our language to hospital], in this moment. I don’t think that it will always be like this, but I think that at the moment we try to adapt in order to be comprehensible at the hospital level. Although, I don’t have the feeling that we use a very different language, since pathologies are pathologies, denominations are denominations, treatments are treatments. It’s more to do with the actions we put in place or our modus operandi, finally* (2A team leader).

As with the language differences between the mobile teams and the hospital sector, the collaborations with the ambulatory and community mental health sector ran along the same lines. Again, the teams explained that they adapted their language in order to have a more effective communication. This was mainly due to the difference in visions. There was a sense in which workers felt the system to be fragmented with services representing “small islands” each with its own vision (their own models and ways of working). Furthermore, although workers agreed that they may share similar language, due to their different visions they could often feel as if they were “talking past each other”.

> *Right now, it’s like everyone’s sitting on their own island, I guess, and we do try to build bridges between these islands* (2B team member).

There were even bigger differences between the mobile team’s language and that of social structures (p123-124). With many participants seeing themselves as “translators” between social services and users, they also saw themselves as holding an expertise in mental health compared to those structures. For others, this was not the case.

> *I think that before everything there is a gap in the language between social structures, even mental health structures too, and the person who is suffering. And that gap disables people; they don’t know where to start. […] I am trained, I am interested in the question, I ‘swim’ in this and I am lost in the social fabric. So, for the person suffering who has ruminations, suicidal ideas, a low mood, no energy, how do you want him to get out of that kind of system? It’s not possible. […] I think there is clearly a lag between the jargon and people. Again, we have the impression that people are completely lost in that system and can’t find a place anywhere* (2A team psychiatrist).

All in all, the participants leaned towards a somewhat good but difficult communication with non-mental health structures. It was said that it was a challenge to find a common language due to the lack of knowledge and the mobile team's "specialisation" in mental health matters. Workers explained that they adapted their language and aimed at educating their interlocutors (Gask and Khanna, 2011). They regarded themselves as "translators" or "interpreters" decoding service-user's needs for non-mental health professionals to understand. This was especially true for workers within social services.

> *I think that we are translators. We do a lot of translations at a social service level, because [a user] comes with so many requests that need to be 're-centred'/centralised first* (2B team member).
>
> *It really is a translation of the difficulties the other is living, in such a way that the user's word can be heard. It's helping the user have the power to be understood elsewhere. […] It's really about helping the person structure their speech a little. This, he can't make happen very well, because he is very much taken up by all his thoughts. But it's helping him translate it through to the facilitator who in turn will be able to answer his request* (2B team leader).
>
> *It's good and it's sad, sometimes. I mean when we are translating, s/he is heard much more* (2B team leader).

Finally, participants explained that written language was different from spoken language when communicating with other professionals. Written language was more formal, and more attention was paid to it since it could be a potential trace for the service (Mead, Hohenshil and Kusum, 1997; Amsalem, et al., 2018).

> *If there is something official that gets out of here, we talk about "people with psychiatric disorders". We do not talk about "patients". That is [used] between us. But towards the exterior, personally, I avoid using "patient" and in […] progress reports, we talk of "people with important, difficult psychiatric disorders* (2B team member).

Level III: Working within a wider context

With 107 guidelines remaining abstract, each project was able to interpret them as they saw fit. This was true for the teams themselves but also for their financial promoters (each of course with their own interests in mind). However, due to the power of the promoters there was, especially during the time of the second observations, a huge clash between the two levels, the team and hospital level. This was especially true for matters of multi-disciplinarity as seen above in this chapter (p175-179, p190-191).

Another example of the theme of language can be explored through the differences in the regional context also reflected in the respective languages used by the teams. The Dutch and French linguistic properties differ widely, not only by account of their roots, but also in how they each employ models from different countries (p137-140). As a result, French teams were more prone to take inspiration from French or even Italian speaking countries, while the Flemish employed models from the Netherlands or the UK (p26-28; appendix A.6). This may have been linked to a linguistic identity and culture but also practically in how accessible each language was (also reflected in the difficulty in the interviewing process for this study). In other words, French speakers may have had difficulty with Dutch or even English texts, while Flemish speakers were more familiar with them, unlike with French ones.

Differences in language could also be seen in how they had an impact on relationships. One such example is the fact that in French there is a formal and informal way to address people (p138). Participants used both but preferences often depended on their backgrounds. For example, some participants who had been working in long-term residential wards were more used to using informal address, while others were more likely to use formal ones. Furthermore, formal or informal address was not static with some people employing both for the same person over the course of an intervention. This was also a way in which participants explained that they managed to put barriers between themselves and the service-users which was sometimes linked to the assigned diagnosis (especially ‘personality disorders’, p164; p176).

> *It’s according to each person’s affinity, the patient’s history in the service also, and of the pathology sometimes, because with certain patients it’s not a good idea to be in a position that is too distant or in a position that is too close. It’s a set of things that make it a case by case thing. (2B team member)*

For bilingual professionals, given that the Flemish speakers do not have such a distinction in their language, it was easier for them to jump from formal to informal unconsciously.

The glossary of terms for French-speaking teams versus Flemish-speaking teams offers a glimpse into the different understandings between the projects (p137-140). Ultimately, however, workers from both languages encountered the same paradoxes as their colleagues within the mental health field. The difference was in the way they could deal with those paradoxes that depended on the organisational constraints or possibilities their contexts would allow. The Walloon project especially stood out repeatedly in how limited the options offered were to people, beyond the teams’ support (Friedli, 2009; Service Soins de Santé Psychosociaux, 2010).

The difference of the language employed during home interventions between service-users and professionals, and that used in the interviews was also interesting. Furthermore, the language used at the team level (both during the interviews and observations) and the higher political structures made for a huge contrast also. There is a difference between the informal language used during home visits, the language used by teams when they present themselves and that used in government guidelines. Professionals often presented themselves as “translators” for their service-users and this could also be felt during their interviews, as if they were building the bridge between practice and the reform’s abstract language.

A good example of this difference in language between the teams’ ordinary work and the government language, could be seen through the main focus of communication between them, specifically involving outcome measures. Every year, the “promoting” structures and the government expected an “activity report” which included some specific statistics. It became clear that “numbers lie” as one participant put it, with team leaders especially, arguing that those didn’t reflect the actual work and were therefore far from meaningful measures. Moreover, it was argued that they could be manipulated to form any picture their analyst would want to them to. As mentioned earlier, many teams felt that a lot of their work was not quantifiable and, in many ways, difficult to put into words, especially ones to be understood by people not working in a mobile mental health team setting (p182).

The contextual environment of each project played a major role in the possibilities to work with non-mental healthcare services. The Brussels region, for example, stood out as it offers a wide scope of services where mental health service-users can find a place, such as cultural cafes or “social restaurants” (p156). However, for the rural projects there was a lack of such detached spaces and activities which often proved problematic for mobile team workers who aimed and wished to refer and redirect service-users towards such spaces and in doing so avoid psychiatric or mental healthcare spaces. Due to the lack of alternatives, workers were pushed to refer people to activities within residential structures, such as day hospitals for example. It was difficult to have a conversation around this in the interviews since there was not a lot of material to explore. As was said during the interviews: “*it is the opportunity that makes care*” (P2BTL:20).

Conclusion

The language and vision differences, the interpretations and meanings rendered to service-user experiences were constantly brought into focus throughout this study. It could be argued that in general, participants’ ideals (or at least the way they presented their work) were perhaps closer to notions of person-centred care, as opposed to how things were. There were some very thoughtful attempts by some workers to set up their team in new and reflective ways, even if they were limited by organisational constraints in practice. However, this was not always the case with many employing a language that was directly linked to their hospital experience (e.g. "patient") or mentioning a need for psychiatric "guidance" in their work. Furthermore, the contrast between mental health structures and service-users' experiences became increasingly obvious, especially in practice.

Thought and care was evident in how the teams presented themselves and their work. Person-centred care was always at the forefront with ideas celebrating choice, empowerment and even citizenship. For example, there was a lot of deconstructing ideas on the use or need for diagnoses, yet this scepticism was often limited. Team members seemed to recognise the controversial nature of labels and were often interested in the role of social circumstances in a person's life. Despite this, personal disorder was also very much considered or at least implied. For example, many services used 'personality disorder' diagnoses as an exclusion criterion for their service or organised their interventions differently for people with this label.

The home context definitely altered the perception institutionalised workers had of service-users. Moreover, these professionals were now forming relationships with workers from other sectors within the community, such as social services. The difference in the language used by each was interesting, with social workers interested in circumstance and context, without the need to discuss 'psychiatric symptomatology'. Especially revealing was the mental health professionals' approach who aimed to 'educate' their colleagues in social services about service-user experiences.

Many participants alluded to the fact that they became 'translators' between different services and structures. Although this appeared at first to promote person-centred ideals following on from the previous point, it could also be understood differently, suggesting that in fact workers failed to perhaps grasp the incommensurate nature of different perspectives, while also never questioning their own. As participants explained, the way they communicated and worked with other services often felt fragmented as if they each existed on separate 'islands' (often in competition with each other even within the same projects), rather than part of an integrated and heterogeneous whole. In this way, a perspective or story could not be 'translated' into another.

The teams seemed to present opposing values and beliefs, either within and between teams or between sectors and areas. It became increasingly clear that the 107 reform did not provide a valid alternative to resolve the contested nature of the prevailing bio-psycho-social model. The reform created the illusion of a deinstitutionalisation process based on evidence-based models. Actually, the same contested and unresolved issues remained. This evident lack of direction, originally based on ideas of a bottom-up approach and seen as a strength, could have pushed the teams to develop in ways that allowed for dissensus both within teams but also through the different hierarchical levels and structures. Failing to address those many ideological and linguistic differences became a gateway for the omnipresent promoting hospitals to permeate mobile community work, further entrenching established perspectives. Simply put by a service-user during a visit, they said: "*this is my story, but the science hasn't caught up with me*".

[This page intentionally left blank]

Part III: Navigating Paradox

[This page intentionally left blank]

Chapter 8:
Discussion - Emerging Paradoxes

Introduction to Chapter 8

This work started out as a piece of critical research which was to concentrate on how different models of community work were adapted and adopted by mobile teams (p35-43). However, broader social and political questions concerning the space and time in which the study was carried out broadened the focus. How the teams chose to (re)define the social construction of mental illness in their given structures and changing contexts became of interest. What that (re)definition involved, how it occurred and how it was represented through the work of psychiatric professionals in mobile teams became the main focus of this work.

Objects of psychiatric practice are represented in numerous tools, tests, therapies and everyday conversation, buildings, as well as in the division of labour, in disciplines and hierarchies that surround the service-user. Diverse theories intermingle and overlap with one another, each one highlighting a different part of a specific and powerful theoretical matrix (Joseph, 2015). Ultimately, however, professionals' ideologies and systems of reference are displayed in their effects on the lives and activities of hundreds of thousands of human beings who are said to be suffering from one or other form of 'mental illness'. Professional representations of such 'illness' often become evident only in so far as psychiatric workers describe, discuss and organise real live 'patients' or 'clients' or 'users' in real circumstances (Prior, 1993). Consequently, as well as examining various forms of written texts and spoken interviews from professionals as well as direct observations of their everyday work, this study also makes reference to the everyday experiences of people regarded as 'mentally ill' and users of those services, who have produced a wide area of 'experiential' works (for example, LeFrançois, 2013; Russo and Sweeney, 2016). These works deal exactly with how psychiatric ideology has impinged their lives.

To be explicit the analysis and ensuing discussion is only one part of the reform process. As such, it is partial as well as subjective and by no means all-encompassing (Charmaz, 2006). I have chosen to opt out of presenting a conclusion to this work. Instead, the paradoxes that emerged throughout the study are put forward with the opportunity to allow for possibilities rather than a given finality (Frank, 2012). As has been the case throughout, this discussion is grounded in the methodology and specifically in the ideas of confluence. Trusting this process may ultimately allow for possibilities and dialogues to develop through the emerging paradoxes.

In the following paragraphs, I will look at the paradoxes and contested meanings of that language and the hierarchies within those relationships as well as how those were and are embodied in practice based on the analysis presented. I will revisit the methodology developed for this study throughout, as well as the limits that I encountered while conducting it.

The 107 paradox(es)

A paradox is defined as a statement that, despite apparently valid reasoning from 'true' premises, leads to a seeming self-contradictory or logically unacceptable conclusion (Oxford Dictionary, 2019). It goes beyond the idea of a 'mistake', misunderstanding or irony. Rather a paradox involves contradictory yet interrelated elements that exist simultaneously and persist over time (Smith and Lewis, 2011). Moving beyond Aristotelian 'endoxa' (accepted wisdoms), in this case the established constructs within western society and specifically surrounding mental health and illness, this study became one of the ensuing 'paradoxa'. Throughout the analysis and observations, paradoxes emerged specifically concerning the reform as well as the wider contested field of psychiatry (Durkheim, 1982; Cormack, 1996).

Based on the analyses presented, it could be concluded that mobile teams are creating new 'spaces' within 'new' temporalities with 'new' values based on an adapted collective memory, founded on 'new' relationships, thus creating a 'new' language (chapter 5). However, it seems that looking more closely, especially when considering practice, a more complicated picture emerges (chapter 7). Mobile teams could be said instead to be colonising existing spaces (in this case people's daily life within their homes) and temporalities, through a system based on older yet adapted values. This seemingly 'new' way of working thus becomes a reflection of an older order, with the hierarchical relationships and the language created/used reflecting established yet contested and paradoxical meanings and views.

Social fact

This "107 paradox" could be explained in terms of a "social fact". A social fact, according to Durkheim, represents a broad tapestry of norms, assumptions as well as social and economic institutions that transcend any one individual or organisation and becomes as he describes "states of collective mind" (Durkheim, 1982). It constrains how we think and/or act and becomes simply the way things are done. Social facts "consist of manners of acting, thinking and feeling external to the individual which are invested with a coercive power by virtue of which they exercise control over him" (Durkheim, 1982:52). This does not mean that there is never innovation or attempts to fix the system. People are always developing creative ideas and approaches. However, most innovation takes place within the assumptions, beliefs and values of the social fact. At its core the social fact in psychiatry and mental health situates the “mad” as the ‘other’, as objects of care rather than as the subjects, who could also be protagonists in their own life story (if given the means). People may have the capacity to rise up from their situation but they do so only when they have certain key things many take for granted, such as legal protection against violence, justice in the courts, the ability to get financial help or freedom to work and links to wider circles of social life (Durkheim, 1982). The difficulty is that this ladder to an active social life is missing in many cases within the mental health system, both as a result of organisational constraints and pathologisation (Spandler, Anderson and Sapey, 2015), which in effect provides incentives for mental health services not to build such ladders.

Innovation and new approaches are developed and implemented within the current, given and accepted framework, which is actually a harmful one (chapter 7). If the new approach proves to be successful it is, in fact, making a harmful system more effectively harmful (Klein, 2010). The system of addressing the needs of users is, effectively, a system that is creating users (Metzl, 2010). The way that the mental health system is set up is based on the belief that there are issues or symptoms to be addressed rather than people (Pilgrim, 2009). Issues are addressed institutionally, programmatically. As first coined by Pierre Bourdieu a ‘symbolic violence’ ensues by “the imposition of systems of meaning that legitimise and thus solidify structures of inequality” (Wacquant, 1998:217). Using a medical model, people are understood mainly through their presenting symptoms (p188-194), considerably limiting possibilities for them to be addressed through other means. Although this may prove liberating for some who may self-identify (Callard, 2014), for others such an approach is understood as reductionist and harmful (Read, et al., 2004). “Mad” people are made to be the users and clients of an institution and other facets, such as their story, become unimportant. However, if they climb out of the current system, this institution becomes obsolete. That would presuppose that there is no physical, psychological or social coercion and control for users (Morgan, et al*.,* 2016). Climbing out of the current system becomes near impossible.

This is not to say that professionals’ intentions are not centred on creating support but the argument is that those are just not enough (see Two Stories section; p174-177). With health and mental health becoming a commodity it takes on all the aspects of an industry that creates wealth based on a need (Metzl and Kirkland, 2010; Cederström and Spicer, 2015). As a result, we need to ask ourselves: who benefits the most from the way things are currently set up? The people who we are trying to help or the people who work and are part of that institution? To notice and expose currents of power is not to expose people as malevolent. It is to claim that they, like everyone else, find it very difficult to understand a society as large and as complex as ours. Navigating the interface between individual meanings and actions and the collective narratives and powers is by no means easy, especially since a lot of it is hidden.

The main 107 reform paradox lies in the limited possibilities the teams were given to really provide alternatives to hospital admissions. Many teams were not happy with what their target populations had been reduced to and wished to be able to provide more of a “gatekeeping” function in order to prevent admissions (p116; p167-168; p197; CRHT model; National Audit Office, 2007). There was, however, no possibility to reassess their inclusion criteria by their promoting hospital. It became apparent that if the teams started supporting people with more severe presentations, this would mean that they would come into direct competition with hospital in-patients but also, they would not have the means or the tools to support them effectively (p.167-168; p196-197). With a lot of beds available and needing to be filled, the teams had to limit themselves to people who were either eligible for first line care or ambulatory sector care, for whom they were able to provide help, with what seemed a small percentage really representing people with a risk of admission. As a result, the teams occupied a very paradoxical position, they were said to operate within the community but were employed by hospital. Moreover, they were said to avoid or shorten admissions, but they were discouraged from coming into direct competition with their promoting hospital.

Social control practices

> It is clear that what people think and believe about mental disorder is invariably reflected in some manner in the conceptual, material and bureaucratic tools which they use to organise such conditions. Consequently, by examining those tools one inevitably comes to understand the nature of the raw materials which they shape (Prior, 1997:12).

The current mental health system is very much interlinked with the way the Belgian health, social, housing and legal system are organised. As mentioned throughout this work, the country presents wide differences in its economic systems across its regions and this very much affects those systems (Friedli, 2009). As a result, each region has its own particularities (p25-26). There were several aspects of the mobile team work that interlinked with the rest of the system, often in paradoxical ways. Bureaucratic procedures aimed at helping people were in fact experienced as volatile and uncertain, when seen from the perspective of its receptors. For people caught in those situations, professionals and service-users alike, such bureaucracies paradoxically produced precisely the insecurity that they sought to eliminate (p116; p165). Workers often claimed their care was person-centred and aimed at beneficence, yet they too often fell into coercive practices, as offered by the health, social, housing and legal system with such procedures ultimately beyond their grasp and logic (chapter 7). The following paragraphs are a few examples of these paradoxical procedures.

In a health system using a language promoting choice, it was revealing to see coercive-like practices in daily mobile work, from forced admissions (appendix A.4), administrative/money trustees (appendix A.3) or retention measures/CTOs (appendix A.5). Often, this made service-users angry but generally compliant. Unsurprisingly, people under a 'retention' showed compliance for the two years necessary and often disengaged when the time was up (sometimes to the professionals' surprise and confusion). As for the administrative/money trustee procedure it too created a set of different problems, including an increased risk of coercion when setting it up, as it was often used as a threat (e.g. to ensure compliance with medication). Moreover, it was also detrimental in the way people were constrained in their everyday life. Having limited access to their *own* money for various needs was inevitable and could become an increasingly complicated process. Any purchase that was 'out of the ordinary', any activity that was considered special had to be requested by the trustee who had to first be contacted and reached in order to finally decide whether an allowance was worthy to be increased.

These types of practices limited people's opportunity for "self-determination", which involves "the ability to act with free will and can be an important aspect in a person's recovery" (Morgan, et al., 2016:105). Furthermore, they raise concerns regarding increased coercion and the role of mental health professionals as enforcers of social control. Coercion has been identified as the use of physical force (such as restraint) or, more broadly, as incorporating a range of interpersonal interactions resulting in influencing service-users decision-making and actions. It can include manipulation of service-users' wishes and restricting access to information (O'Brien and Golding, 2003). Different techniques have been identified and were observed during this study such as persuasion or interpersonal leverage (e.g. disapproving professional), inducements by rewards and enticements or conditions set for a specific action to be taken, threats and compulsion or compulsory treatments which are supported by legislation such as 'retention' measures or CTOs (Szmukler and Appelbaum, 2008). Practices such as forced treatment, including pharmaceutical interventions, have been identified by service-users as a barrier to accessing care (Snow and Austin, 2009). This may be exacerbated for minority groups who are more likely to be the subject of these compulsory powers, including voluntary admissions through coercion (Laurence, 2003; Bindman, et al., 2005). Service developments such as locked wards, have also been identified as inherently coercive (Bentall, 2013).

Paradoxically, many participants in this study argued for a mental health system that would promote certain "gaps" for people to have the possibility to fall through them (p178). Many participants were shocked with the extent of social control imposed in the UK, for example, especially in the transparency between teams and services. They actively sought to avoid it in their practices. However, in pressured situations, such practices were employed albeit implicitly (as mentioned above), with some workers being repeatedly accused of "blackmail". The question also arises explicitly regarding people who do not consent to care: what options are there to choose? Moreover, how does one disengage from coercion practices (Morgan, et al., 2016)? Although the law in Belgium clearly proposes that if a person is not in danger and does not want care, he is free to do so, implementing this in practice was not always straightforward nor respected.

The notion of social control can also be examined through the nuance between the practice of ‘professional secrecy’ and confidentiality. In Belgium, certain professions operate under the law ‘professional secret’, by which workers cannot divulge any information that was transmitted to them in the process of their function. The ‘professional secret’ is permanent, even when an intervention has ended and involves information that is personal and could be used to identify a person. In this way, somebody that sees different professionals from different services can choose which information s/he shares, while each professional should not act in complete transparency between themselves, since they may not all have the same information. In general, the ‘professional secret’ is and should be seen as a tool and not a constraint, both for the service-user and the professional. In other words, “silence has meaning” (De Greef, 2018:37) and it is a right for the service-user that the professional is obligated to uphold. On a micro level guaranteeing confidentiality not only allows professionals to maintain people’s fundamental rights (even the right to lie, if one so wishes or needs) but also may act as a gateway to establish a relationship of trust. On a macro level, aside from protecting individual confidentiality, the concept of ‘professional secrecy’ also represents a societal value: the citizen’s right to a private life participating in a society that is cohesive and just (Bosquet, 2018).

Unfortunately, the founding ideology behind this law was not always upheld in practice. On a macro level, the ‘professional secret’ law has evolved, shaped by the Belgian social and political context. Social control politics in the form of security policies introduced in the 1990s allowed for the confusion between notions of prevention and the maintenance of public order. Meritocratic ideas, the individualisation of social responsibility and the criminalisation of poverty meant that work became a moral obligation. In this sense, a person out of a job and dependent on welfare was seen either as a fraudster and a criminal or a ‘good poor’ when an active job seeker. The beginning of the 20th century introduced evaluation and management techniques aiming to standardise care practices (or perhaps render them uniform) in order to make those ‘effective’ and profitable. At the same time, ‘transparency’ was introduced through the use of computer filing systems, despite reluctance as to whether they are actually facilitating practice (Bosquet, 2018). All those developments further shaped both societal understandings of confidentiality as well as the law and practice.

In Belgium, several events within the social and political context further promoted a 'leaking' culture between care professionals. Heavily mediatised cases including the 'Dutroux affair'[3] and the revelation of paedophilia practices in the Catholic Church in the 00s, a social fraud conflict (and the ensuing austerity politics) born in 2014 and the terrorist acts of 2016 (Bosquet, 2018) shaped public opinion leading to national organisational changes. Exceptions to the confidentiality law were broadened as a result of these events, namely when associated with risk but also for court case testimonies. However, in practice there was a clear "banalisation of the exception" (Bosquet, 2018:12), including due to ignorance as to the specific details of the law amongst professionals. There was a culture of oversharing, where when uncertain professionals spoke out rather than promote silence, arguing that as such they were acting with 'beneficence' and 'to be sure'. Moreover, service-users who were found out to have shared different versions of similar stories were seen as "manipulative". As a result, they were assigned specific diagnoses notably personality disorders (p164; 176; p196).

Deinstitutionalisation

There have been many explanations for mental healthcare and deinstitutionalisation reforms such as 107. Many have been concerned with technological explanations such as the emergence of new drugs but those have fallen short in giving a global picture (Prior, 1993). Scull (1977) argued that such processes were linked to a shift in the needs of late capitalism such that unproductive labour no longer needed incarcerating but could be monitored with newer community-based techniques. Based in Marxist terms, this explanation has some connection with Foucault's methodology of thought, which would argue that this was a shift from sovereign to disciplinary power, from "exile and enclosure" to "monitoring and surveillance" (Foucault, 1977). For example, as can been seen in practice and as mentioned in the interviews, the differentiation between psychiatry and mental health was relevant for the teams. This great separation between the healthy and the ill is effectively replaced by arguments of a 'continuum', where everyone is "precariously healthy and everyone [is] precariously ill" (Armstrong, 1998:455). This new form of 'surveillant' psychiatry utilises practices of social control (as seen above) to implement a reform in the community, based on established yet adapted powerful notions of mental illness.

> Just as the demise of the asylum can be linked to the disappearance of madness and the emergence of psychiatric disorder in the community (Armstrong 1979, Prior 1991, 1993), so the decline of the traditional hospital in the immediate post-war years can be seen as simply

---

[3] Marc Dutroux is a convicted child molester and murderer. His widely publicised trial in 2004 caused discontent amongst the Belgian public with the country's criminal justice system and was an important catalyst for the reorganisation of law enforcement agencies.

> the architectural and institutional manifestation of this new perception, of this new social representation, of the nature of illness: if there was not a separate population of the ill and a separate population of the healthy, what role for a bounded hospital (Armstrong, 1998:455)?

This shift in political ideology from sovereign to disciplinary power situates "the problem of health and disease at the level of the individual" (Crawford, 1980:365). Health and mental health become ideological positions based on value judgements, hierarchies and assumptions inevitably constructed by power (and privilege) as much as 'well-being'. In this respect, the individual produces a specific type of subjectivity constructed by the presently dominating neoliberal governmentality, (p51-52; Geekie and Read, 2009). Moving beyond the valid argument that health is a fixed entity which should merely be reallocated and redistributed evenly, health (including mental health) not only presents itself as a commodity but as a moral value of everyday life, with certain characteristics constructed as desirable and healthy, while demoting others as offensive and/or irresponsible (Metzl, 2010).

The resulting iatrogenesis means that health 'benefits' are promoted without necessarily supporting the person affected (Illich, 1976). Moreover, health-ism and sane-ism allow to discriminate against specific health or mental traits considered 'unhealthy'. Masked as objective certitudes promoting health and well-being, these ideologies effectively determine all matters of corporeality, ability and ultimately normalcy through a Foucauldian 'discourse of power' (Metzl, 2010). With the biomedicalisation of mental healthcare and a move to a new form of 'surveillant' psychiatry (within the community), mental health becomes the total absence or abnormality which is now considered a personal/individual responsibility and choice, promoted by societal value judgements reflected in professional practice.

'New' practices, same paradoxes

As mentioned, 'mental illness' could be shaped by the practices that surround it and as such the way the different disciplines are organised reflects what 'illness' is at any one time. The ways in which different professions fragment, divide, classify, analyse and organise a person's life contributes in the way in which they are perceived within the social order (Prior, 1993). As a result, the person is 'decomposed' into self-contained fragments, where parts of existence are dealt with based on differing professional interests and strategic positions. Examining this 'biopsychosocial' model more closely (Engel, 1977) both in theory and in practice shows that all professions, although aiming at autonomy, finally situate themselves in relation to the medical profession. This has been historically so, since the psychiatrist has always represented the "dominant profession" (Freidson, 1970) with other professions "subordinate to it" (Prior, 1993). This is visible in how all other disciplines represented in the mobile teams have to be at the very least approved by psychiatrists and hospital structures, as seen in both the interviews and ensuing observations.

As mentioned (p113-115, p179-183), in most teams professional disciplines were not always made explicit. Many workers alluded to having a general ‘psycho-social’ function and some mentioned that this was actually a ‘new’ discipline generated by mobile work. Their understanding of this new practice was based on their background and previous experience. Although they were now working outside the residential institutional setting they were not freed from the professional dominance of psychiatrists (Prior, 1993; Read, et al., 2004). There was, however, a shift in ‘responsibility’ with mobile team workers carrying more of it in the mobile setting and psychiatrist effectively less. Psychiatrists met with service-users much less than other mobile team professionals, if at all, yet they still carried the ‘medical responsibility’ for the team (appendix A.1).

Examining the disciplines and practices within the mobile teams the tendency remained to assist psychiatrists. Nurses, for example, were no longer confined to the technical acts and duties of psychiatrists within hospital and at first glance appeared to be active participants in the design and execution of intervention processes. However, their goals were more often than not directed by the psychiatrists. Social workers, who had been peripheral to the hospital setting and always looked to the outside and to the return in the home environment, were able to perhaps feel more at home within a mobile team. However, their work often remained dominated by the same concepts of ‘aftercare’ as it had been in hospital. Psychologists often felt undervalued and aimed to have a more specifically ‘therapeutic role’ (many expressed this in their ideal vision) but given the ‘medical responsibility’ held by psychiatrists, such a role would in any case be under psychiatric direction (appendix A.1). As for special educators (equivalent of occupational therapists), where relevant and present disciplines in teams, they didn’t seem to hold a clear identity to their role. This was perhaps the main reason why they could not break away from leaning onto psychiatric input.

The ‘colonisation’ of psychiatry into mental healthcare and specifically within the mobile work function became obvious, not only in the relationships between team members and disciplines but also within the intervention setting as well as the structural levels (p179-183). It could be argued that the theoretical distinction between ‘mental health’ and ‘psychiatry’ was an extension of this occurrence (p132; p183). More specifically, the focus of psychiatry widened in making this distinction by shifting the attention from relatively rare occurrences to ‘milder’ situations and minor ‘deviations’ from so called normality or average presentations (Armstrong, 1998). In doing so, it seems easier to ‘colonise’ the home setting in a ‘panoptical’ way, since the person’s everyday social life, including the family and community become objects to be examined more closely for finer details (p151-153;

Bloomfield and McLean, 2003; Read, et al., 2004; Moriarty, et al., 2007). Professionals 'dropped in' to service-users' homes and lives for short, predetermined time periods, while attempting to continue to manage and monitor for the remaining time, from a distance (chapter 6). Home, which is often (but not always) felt to be a 'safe haven' (Pinfold, 2000) came to be in most cases synonymous to mobile community care. Paradoxically, a few team members who made the distinction between psychiatry and mental health yet were more concerned with matters of the latter were often more prepared to return to their residential sector job. Similarly, others also wished for their team to be more detached from hospital. By widening the distinction both in theory and in setting, the clinical "gaze" through 'discourses of power' into people's life broadened (Metzl, 2010).

The role of peer support may be the most obvious example in showing how the mobile teams were perhaps not so novel in their way of working and approaching mental healthcare as originally thought. Peer support work became increasingly relevant in Belgium during the time of this research, with university courses developing and some teams employing workers in that function. As mentioned in the analysis however (p118, p165, p179), it was difficult for teams to understand and invite this function within their work. It brought into focus the need for the "pathology" to first be acknowledged and in turn accepted by the person for them to be considered a peer. Paradoxically, this was based on a medical model of 'mental illness', while the peers were employed to function because of their experiential knowledge. It therefore became increasingly apparent that, by 'professionalising' peers and positioning them within biopsychosocial models of work, specific stories of 'recovery' which were aligned with those models were more accepted than others. Specific 'types' of recovery stories determined who became a peer support worker, with many other stories left behind. Moreover, the notion that there is a singular and authentic 'voice' or 'story' of 'the recovered patient' is far from true, since people in any social group have varied interests and perspectives (Said, 1978; Pembroke, 2009; Cresswell and Spandler, 2016). Furthermore, this shows that if looked at closely the reform highlights the paradoxes of the false binary between the notions of responsibility and choice versus the medical model. However, not only do they co-exist, but one appropriates the other, depending on who is promoting them, in effect proving that they may be confluent and sides of the same coin.

Finally, it was revealing to reflect on what the teams did not talk about. Participants had difficulty thinking of ideals because they didn't know what possibilities could exist and were rather constrained by the way things were done. It became obvious that what people understood their work to be also constrained them in thinking outside their current practice and beyond the 'social fact' (Durkheim, 1982). Whilst it would be wrong to assume that the changes in the mental health system were wholly imposed by policy makers and were a result of organisational consequences or a general reconceptualization of mental illness, it is perhaps fair to assume that the ideologies and effects on the social life of service-users were not entirely foreseen or fully understood by professionals themselves. However, it is professional practice which ultimately comes to define mental illness and therefore inevitably holds a large part of the responsibility in how care is delivered and received (Prior, 1993).

(Re)established hierarchies

Team members often aimed at deconstructing their previous visions of mental healthcare. As shown in the analysis, the new spaces and temporalities in which they found themselves was also an exercise in unravelling certain so called ‘facts’ they had learned during their educational years as well as through their residential experiences (p156-160). Many participants showed active self-criticism. However, this research strongly suggests that for many the old patterns of understanding were still present despite ‘new’ found practices within novel contexts. I was invited into many ‘critical’ conversations during this research but most involved established narratives either of so-called anti-psychiatry or social psychiatry movements, with only limited knowledge of experiential movements.

Throughout the observations, it became obvious that instead of celebrating certain nuances or even differences and pluralities in meaning, many conversations turned to established meanings of “person-centred care”, “recovery”, “resilience”, “independency” amongst others. Some team workers who attempted to detach themselves from those established meanings, were quickly deemed “too critical” with established understandings, especially surrounding the ‘biopsychosocial’ model, that remained constantly at the forefront (Read, et al., 2004). Although teams presented as being ‘multidisciplinary’, most of them did not work in a horizontal way which would have allowed different views to coexist (e.g. p178-183, p193). Rather, the psychiatrists had a very clear directive role and the ‘final voice’ in how the teams operated and intervened. The same hierarchies that could be recorded in hospital teams were to be found in mobile teams (Prior, 1993), since both the finances and the blueprints of those teams were originally based on their promoting hospitals.

This “107 paradox” proved to be a type of ‘tug of war’ between the reform ideals and the status quo of powerful hospital structures. The teams came to be stuck between the people they were developed to provide care and those whom they were able to do so, with many dealing with presentations that were perhaps less ‘severe’ than the reform had originally called for. The teams were therefore adding to existing structures without necessarily changing the system, especially since the immense number of hospital beds had first to be filled. In cases where teams were said to indeed decrease admission periods, workers understood that this was only in fact to empty hospital beds quicker with new admissions (and money) welcomed as a result. To some extent the function of mobile teams became marginal, their interventions subsidiary, became perhaps unnecessary (to the point of disserving), impractical, 'un-therapeutic' or 'unsupportive' and in the end offered 'unhelpful help' for both the people themselves but certainly for the mental health system as a whole. Paradoxically, an originally hospital-centric system had perhaps become even more so thanks to the mobile teams, since the hospitals were the ultimate decision makers as financial promoters of 107 projects.

As demonstrated in Byrd's (1981) study on the organisational constraints of psychiatric treatment, it seems that key determinants of people's care often rest on organisational needs rather than service-user needs. Byrd contrasted the 'professional perspective', where care depends on objective expertise, and the 'bureaucratic perspective', where care depends on organisational patterns and constraints. The conclusion was that although people's needs were emphasised by the different professional groups, it was the organisational demands that structured care in practice. This was also reflected in the reclassification of people's presentation at various stages so as to better serve organisational demands. The same was observed within this reform. For example, people were only able to access care if there was availability. Whether someone was to be cared for in hospital or the community was ultimately determined by the available openings in each setting at that point in time, Hospital was favoured and when beds were no longer available people were referred to the mobile teams. Care was therefore not provided depending on a person's situation but by the extent of the available resources, so much so that the nature of their 'illness' was redefined so as to better fit those resources (Byrd, 1981). Consequently, this goes against concepts of person-centred care, which puts the person in need of support at the centre of decision-making, planning and delivery, rather than the concerns of the service itself (Morgan, et al., 2016).

As mentioned, it was evident that "it is the opportunity that makes care" (p201). In this way, a reform and a true alternative to existing structures of care could not be easily provided if new spaces were not created outside the current system. With hospital structures dominating the mental health sector it was often the first and last port of call for many teams. Although people could avoid or shorten their admission period, the possibilities for them in their everyday social life very much depended on the socio-political context in which they were themselves found (Friedli, 2009). All too often, people were still directed towards hospital day centres, psychiatric or mental health services, subject to the same contested values, constructs and understandings (p174-177).

At the political and financial levels, the reform became the subject of a discussion around bureaucratic notions such as implementations of reform "functions". This "functionalization" of mental healthcare was a direct result of the shift from bottom-up approaches, where teams could organise and develop based on the local possibilities available, to ones that were top-down, with the federal government becoming increasingly strict financially while also taking on a directive and executive role. Conversations became centred on funding of full-time equivalent workers rather than on creating meaningful work practices. This was also reflected in the requested outcome measures concerning “beds” and diagnoses as well as “catchment areas”. In this new language of policy, the term ‘community’ came to emphasise geographical and locational aspects (Prior, 1993), rather than values more directly associated with care.

During the time of this study the discourse surrounding the reform changed somewhat (or perhaps was always implicitly so). There appeared two separate narratives about it. One was a story of deinstitutionalisation where reform spokespeople made it clear that the purpose was to decrease beds in hospital in order to keep on developing the mobile functions. For others, however, the idea of the reform was to provide more care possibilities and alternatives to allow for more choice, promoted through a ‘balanced care model’ of healthcare (Thornicroft and Tansella, 2013). This is important both in understanding the positions people were able to take but also the way in which processes of change were recounted and historicised in a way that kept the original order somewhat intact, yet with an adapted hindsight.

(Re)creating the “other”

The move towards the development of mobile work did not seem to be a simple change of care setting but was presented as an active attempt towards autonomy and self-determination for individuals experiencing mental distress. Participants explained their work to be about giving *back* choice and responsibility to the individual, about reconstructing the previously disempowered inpatient into an independent citizen (p134-135; p154). As seen in the analysis, the language of person-centred mobile care therefore increasingly became about ‘choice’ (p130; p151-153), ‘personal responsibility’ (p. 156; p166-167) and ‘independence’ (p111), by individualising the person while promoting ‘social inclusion’ within the community. However, these apparently progressive, inclusive and person-centred approaches were more complex with often specific and prescriptive tactics in practice (p177-179; Spandler, 2007; Sayce, 2016).

Examining the prevailing mobile teams’ discourse and ensuing practice more closely it is evident that the defining characteristics of institutional care were fully present in the mobile and home setting (chapter 7). Aspects of daily activity were organised and directed by mental healthcare professionals who took on an authoritative stance. The concept of an intervention was therefore broadened to cover aspects of a person’s life, which were perhaps peripheral or in any case easily controlled within the hospital setting. Professional assessments of life became wider, from a person’s ‘needs’ to their ‘resources’ or capacities. This wider focus of the clinical “gaze” was evident inasmuch as it was directed towards a person's behaviours, social relations and everyday activities, therefore no longer confined to symptoms and biological characteristics of an illness (even if thought to be directly caused by it). For example, bathing or exercising, work or dining in 'social restaurants' were 'prescribed'. Those activities were seen as therapeutic and beneficial, part of a process of 'normalisation', of recovery and 'citizenship' (Sayce, 2016). Indeed, it was a "professionalisation of the mundane" (Prior, 1993). However, the aspect of 'mental illness' remained present and was often cited as the ultimate source and origin of a person's problems. Professionals continued to observe, describe and analyse service-users in terms of the same discourse that they were used to employ in residential settings, as they assured me that "we speak the same language" (p187). Furthermore, the dominant and prevalent constructs of mental illness were further underpinned by the wider organisational level as seen above. Based on this, it was perhaps less clear whether the person was actually given more choice or responsibility in the context of mobile work.

The concept of 'independence' therefore became part of a wider and broader discourse related to fundamental processes at work in the social, economic and political fabric at large. It pointed towards the reconstruction of the person from 'ill' and dependent to an individual within the social fabric. This new social position was built around the notion of "needs" so although the person was pushed to be independent, s/he remained different and socially distinct. As such, most people who were seen by mental health services and especially those with a journey of psychiatric admissions simply did not have sufficient material resources to position themselves as active agents within the wider society. Rather than entering the social world as economically active citizens, service-users in the community tended to live differently than the mainstream. In other words, these attempts at independence could be said to have been fleeting or superficial, given that the reality was that service-users were (made to be) different than their social community and as a result the social demands expected could not be fulfilled. They did not enter their social worlds automatically, nor were they accepted more openly and readily by the community at large (Spandler, 2007). Although psychiatric language was presented as having undergone change, this did not necessarily mean that the everyday experiences of service-users radically changed (p174-177; Sayce, 2016). After all, people attended the same day centres amongst the same individuals, many lived very solitary lives and the world of the hospital was not left behind for good, but was always present and looming if only as a possible eventuality.

Confluence

Based on the ideas of confluence, presented in this study's methodology, the resulting categories for this work show how this mental health reform has implicated all the actors present by making them complicit within established power hierarchies. As a result, there is no stable analytical position and difference. Identity or systems of domination are complicit between and within their formation as well as their (re)production (Joseph, 2015). In effect, the emerging paradoxes which were introduced and are explored below show how ideological and organisational constraints in the mobile teams' work are sides of the same coin. Moreover, relative positions within the hierarchy reflect the wider inequality and power imbalances. Service-users are limited by the same constraints and are part of the same paradoxes as professionals, despite their different positions.

Using this type of analysis allowed for the focus to become wider in time and space across procedures and processes. It unravelled how practices become institutionalised through policy (and law) as well as across disciplines, identities and/or categories, resulting in a system of domination (Prior, 1993). Rather than focusing on the distinct parts of an oppressive practice or the identity and categories of difference (between professionals and service-users or different modalities of care), the focus was on the *total* of these practices and social relations. By focusing on difference, understanding tends to become fragmented and based on competition; analyses suggest separate, discontinuous categories where someone else can possess expertise. In contrast, an analysis of confluence made it a process of examining continuities rather than differences, relationships rather than distinct categories. In turn, this process of continuity revealed the outlines of a set of power relations, systems and practices that (re)create hierarchical structures and interdependent 'knowledges' reflected on all the different levels of those structures (Joseph, 2015).

These profoundly biased while established forms of professional practice, disciplines, policies and law had important implications in the way the reform developed and operated. These deeply historical interdependent processes of mental health systems challenge conceptions of progress or advancement since they (re)produced the same outcomes: a denial of (helpful) care, a reliance on the old 'medical personage' and his (re)positioning as an expert through means of explicit 'othering' and difference as well as 'hidden' violence through practices of social control. Such a critique does not necessarily go against the reform. A position that is "anti" becomes problematic because it relies on difference, since it can only exist as an antithesis (instead of on its own). Instead, a position of confluence means that the reform is seen as part of a fluid and complex process, where *all* positions are complicit. Despite this, positions are also infinite and each has unique possibilities to transgress through this "encapsulation in a totalised system of discourse, power and knowledge" (Joseph, 2015:34).

Social Navigation

It was evident throughout this study that the professionals, the teams and the service-users were put in a position where they were made to 'navigate' structures that were constantly and tumultuously in motion. Teams were starting to establish themselves, professionals were learning a new way of working while political or hierarchical and financial changes also affected their work. Service-users were also constantly made to navigate health and social structures, either directly through the mobile teams' intervention or as a result of their distressing experiences. In this way, each actor's social action was seen to be constantly generated in the knowledge that the field of her/his representations was neither solid nor stable but shifting and fluid. More specifically, positions were in a movement between the 'here and now' as well as in relation to social goals and prospective positions (with the interviews questioning this process). The concept of 'navigation' points out this practice of moving across a moving environment, as it emphasises a tentative yet constant dialogue between possibilities and practice. It is a multiple process where planning and movement are constantly shaped and attuned to each other (Vigh, 2009). In this way, any position on this mapping process is only relative to the next and although this presented many constraints, it still allows for possibilities.

While navigating those structures, people were to direct their attention not only towards the immediate social flows and shifts but also to how these would influence their positions and possibilities towards their ideals. For example, during the second observation with the teams, there were many speculations about the looming changes due to impeding financial constraints. Team members discussed different scenarios and possible avenues to deal with them. Rather than being predefined, environments and futures became dependent on the knowledge of the past (memory), experiences of the 'here and now' and emergent or potential possibilities. How people chose to 'navigate' their social structures depended not only on the movement but on the possibilities for movement. For example, for service-users living in precarious situations and specific geopolitical contexts, possibilities were fewer and very much limited compared to others.

> Anxiety and audacity, fear and courage, despair and hope are born together. But the proportion in which they are mixed depends on the resources in one's possession. Owners of foolproof vessels and skilled navigators view the sea as the site of exciting adventures; those condemned to unsound and hazardous dinghies would rather hide behind wind-breakers and think of sailing with trepidation. Fears and joys that emanate from the instability of things are distributed highly unequally (Bauman, 2001:122).

In this 'seascape' (as opposed to a static landscape), there is no transparent structure that allows somebody to navigate but rather a changeable and constantly emergent process, with multiple forces. This 'social navigation', as a modality of movement, is related to one's social position and experience. This equally means that the background variables that influence one's navigation are not singular and objective. Rather, one's ability to control the flow of events is dependent upon one's position within this social order. In effect, we all navigate, but the necessity of having to move in relation to the movement of social forces depends on the speed and unpredictability of change as well as the level of exposure or shelter that our given social positions and 'capital' grants us. Participation in the 'flow of life' is therefore not only a question of will but just as much one of power (Vigh, 2009). It is exactly here that ideas of social justice became paramount to this work.

As discussed, psychiatry and mental health, including deinstitutionalisation reforms, are products of wider societal forces which are produced and shape this 'seascape' in which both professionals and service-users find themselves in. In today's context, positions within this 'seascape' are direct products of a neoliberal governmentality based on value judgements, hierarchies and assumptions inevitably constructed by power (Foucault, 1994; Oksala, 2013). Specifically, concepts and viewpoints within psychiatry and mental health (re)produce and occupy ideological constructs reflecting wider society. Navigating these structures (for both professionals and service-users) allow such positions to simultaneously be one's own possession, actively sought and occupied, making people dynamic and decisive participants in life and yet also the product of social and political forces advanced by effects of power outside of one's own influence (Vigh, 2009; Frank, 2012).

Discussed throughout this work, these wider hierarchies of power were seen to be (re)produced both on a macro and micro level within teams and in regard to professional relationships with service-users. In this respect, established value systems regarding health and illness were perpetuated despite the seemingly progressive reform process (Metzl and Kirkland, 2010). Neoliberal governmentality directed practice through the use of problematic medical value systems and contested reductionist approaches (Read, et al., 2004). Adopting seemingly progressive approaches, the reform presented as having undergone a shift from the psychiatric language of hospital, did not necessarily mean that the everyday experiences of service-users radically changed (Spandler, 2007; Sayce, 2016). The 'updated' mental health system reflected once more the dominant politics of individual responsibility and selfhood.

Politics and possibilities

> Collective representations are the result of an immense cooperation which stretches out not only into space but into time as well (Durkheim, 1915:16).

It is human activity which creates the social world and holds the various aspects of social life together as a coherent whole. Therefore, it could be argued that the social world is constructed through human action and social representations arise through that action. 'Mental illness' can only be the product of those who are concerned by it, who describe and explain it as well as those who manage and care for it. Inevitably, psychiatric professionals have produced the processes and ideas which define and shape the ‘object’ they attend to (Prior, 1993). However, those representations are only a part of a person’s existence, including their distress. It is therefore imperative to recognise that there are numerous other sources and other types or representations, most notably by survivors themselves, as will be explored in the following chapter.

Western biomedical and biopsychosocial models of mental illness deny people the opportunity to be seen as a whole person, capable of being well when given the chance to be supported and to belong. When systems of knowledge and law have historically fabricated and reinforced this idea of ‘illness’ through targeted practices, the possibility of not being seen as such becomes difficult for those targeted. Furthermore, the outcomes used in these practices are continuously being reinforced by disciplines claiming objectivity. ‘Illness’ becomes static and unchanging with clear distinctions being made across time and space, through relationships and language. The ‘ill’, the ‘mad’, the ‘other’ is eliminated by experts without the need for heterogeneity within the group or by sub-defining it (Said, 1978).

These ideological and structural or organisational constraints show us that we should reflect on the politics of mental healthcare, on who holds the knowledge and which kind of knowledge that is; on who holds the structural power and why. It is important to reflect on these questions to change them so that we are able to offer real possibilities for people experiencing distress. Building spaces for equitable dialogue to share in the complexity of human distress may allow us to make sense of it together, whatever our differences. Those spaces may in turn offer us new and different ways of understanding experience. However, if we retreat and maintain solely our ‘benevolent’ professional intentions, the risk runs high that mental healthcare will inevitably fall back on the same unhelpful, institutionalising and “othering” patterns.

> Oppressive language does more than represent violence; it is violence; does more than represent the limits of knowledge; it limits knowledge. Whether it is obscuring state language or the faux language of mindless media; whether it is the proud but calcified language of the academy or the commodity-driven language of science; whether it is the malign language of law without ethics, or language designed for the estrangement of minorities hiding its racist plunder in its literary cheek - it must be rejected, altered and exposed (Morrison, 1993).

Chapter 9:
Paradoxical Possibilities

> A doctor once pointed out to me - in the face of what he considered my obvious denial - all the behavioural indicators associated with my particular brand of madness. To him, my self-injury was a ‘symptom’; my panic was a ‘symptom’; my hearing voices and seeing people who were not there were all ‘symptoms’. When he proclaimed, not without disgust, ‘You have a mental illness’, I’d responded, ‘I thought I had stories to tell.’ [...]
> My ensuing battle with that doctor - and, quite frankly, many others along the way - had nothing to do with my ‘symptom profile’ or which ‘diagnostic category’ I belonged to. It did have to do with the complete abrogation of my right to be a person in the world with a history; a person trying to make sense out of her life. I was essentially disconnected from any context that could have explained the chaos in and around me. This is what happens when the individual is viewed as the problem, rather than the world the individual lives in. When the actions we take to cope, or adapt, or survive are deprived of meaning, we look - well, *crazy* (Filson, 2016:20-21).

Introduction to Chapter 9

The reform and this study of it has shed light on existing paradoxes within mental health, from dominant yet contested discourses to hierarchical relationships of power. It is, however, in and through those everyday paradoxes that the context for possibilities could be sought or created. All positions within a system (or ‘seascape’) are understood as complicit, always relative to the system itself and the differing positions within it (p56-57, p220-222; Joseph, 2015). Understanding this dynamic is key in creating such possibilities, even though they will also, in turn, prove to be complicit and relative to the system. Following this process, alternatives based on ideas of social justice could be formed by examining the current paradoxes and contrasting those with the existing context. These following pages will explore such possibilities for service-user and survivor-led approaches and practices in mental healthcare by also acknowledging their own limits and paradoxes.

This chapter’s general idea focuses on breaking the established and dominant hierarchies and discourses within mental healthcare relationships in order to allow for those alternatives. These could have included practical organisational tools which may shape an organisation that allows for care to be centred around the person rather than vice versa, by developing meaningful outcome measures for the service-users. Or perhaps, possibilities could have been about providing certain resources for the teams (such as a secretary function, supervision or further training in 'alternative' or experiential models) that would allow for more time and space to do real person-centred work.

Conversely, the discussion provided here is centred upon the conceptual underpinnings of processes that may help in creating the 'space' and allowing the 'time' for a justly new 'value' system to emerge. Based on the methodology for this work (supported by social justice ideas) and following on from the analysis, this chapter explores the possibilities for an alternative 'discourse/language' based on 'relationships' built on a more equal standing. As such, this chapter (re)presents a methodology, a process of creating possibilities and alternatives to current practices by considering the 'political'. Rather than 'fixing' a bad idea, the focus is on understanding how current practices are co-opted or 'mass-produced' and 'institutionalised', even though they may have started as 'alternatives' (see Russo and Sweeney, 2016); how they have in fact been colonised by the established 'social fact' and how they in turn colonise new spaces. In that sense, 'alternatives' will never be complete, all-encompassing or perpetual (long-lasting) but they will be about creating choices and avoiding 'narrow', coercive and forced practices.

This chapter is mainly directed towards the participants of this study and the professionals involved in mobile team work but may equally interest policy makers or researchers. Furthermore, an important aspect in presenting these alternatives would be to invite service-users and survivors from Belgium and outside to respond to both the study and the ideas presented below. Following on from the discussion, the concepts presented are discussed rather than recommended. Whether there exists the possibility for mental health services to inherently change in order to promote social justice, is an important question which I leave to the reader to decide.

Many of these concepts will probably be familiar to most readers and/or professionals. However, they are (re)presented using a different lens and position based on the methodology, analysis and discussion of this work, heavily influenced by service-user, survivor and allied scholars looking out toward social justice (p53-62). In this way, those familiar notions take on a different meaning in comparison to how they may have been understood before. These could be interpreted as existing within the 'social fact' of mental healthcare (p208-209), as they have indeed been used until now. However, they may also be key in creating a different understanding of them and may act as important possibilities in how we can step outside this 'social fact'.

This deconstructing methodology to understanding these concepts differently is perhaps what is key to creating real possibilities. In this sense, the following are not a set of strict recommendations. Rather, they are about how mental health concepts, some of which were even said to be adopted by the teams, may need to be deconstructed and thought through to progress them further into more socially just alternatives. It is therefore with a Leonard Cohen quote that I introduce the discussion of the following concepts, which a service-user offered me as guidance during this study: “There is a crack in everything. That's how the light gets in” (Cohen, 1992).

Dissensus

The need for partnership in healthcare may seem obvious, especially in multidisciplinary teams that present themselves as working using a person-centred approach (p111). However, as shown repeatedly in this work relationships are often unequal (p177-187). Service-users are frequently set into passive roles to be directed by professionals (p218-210). Furthermore, within the teams there is all too often a dominant discipline in psychiatry, while the teams as a whole are subject to the decisions of financial promoters and policy makers (p216-218). To seek equality in practice means therefore to seek equality of partnership in decision-making, to allow for ‘dissensus’ within relationships.

As previously mentioned in the analysis (p160), ‘dissensus’ refers to acknowledging diversity in values, without suppressing different perspectives through established hierarchies of power. Moving beyond notions of collaborative practices aimed to reach ‘consensus’ where ultimately one overriding value will dominate all others (Grebowicz, 2005), the focus is to allow “different values remaining fully in play to be balanced sometimes one way and sometimes another according to the particular circumstances of a given situation” (Morgan, et al., 2016:59). Success is therefore no longer described in terms of “collaboration” (p115, p118-119) and invariably in the rhetoric of rigor and reliability but instead relies on a radical shift towards sharp critical thinking and the precise use of language, with each position constructively included (Gregowicz, 2005). Rather than organisational procedures orienting and limiting what type of care a person has access to (p218; Byrd, 1981), the work becomes centred around the person and their specific situation to reach decisions. The reality is all too often that of leadership and dominance of an individual or a professional voice within practices of coercive treatment and inequality, as explored repeatedly throughout this study (p214-220). Conversely, dissensus (based in part on feminist innovation) relies on difference: between different individuals and groups coming from different social and cultural assumptions and with different stakes (Ziarek, 2001). It is therefore even more important to open spaces for a diversity of people and values including those that validate the minority voices, without putting the system as a priority.

In order to achieve real ‘person-centred’ care based on the original Rogerian understanding using a non-directive approach (p144; Rogers, 1951), as well as in order to include notions of dissensus it is important to understand that clinical practice is based on a series of technical acts from the first assessment to protocols and diagnostic categories (Read, et al., 2004). This fixed framework, which was often employed by the teams, means that there is little room to include a plethora of different views, let alone give them each a balanced space. Moreover, in this regard, service-users' experiences, stories and views are always mediated and interpreted through this technical framework. Personal meaning and the context of that meaning is often disregarded for the prevailing and contested 'biopsychosocial' models of understanding (Engel, 1977; Read, et al., 2004). People, including their stories, are ultimately represented as 'cases' to be interpreted by professionals, further hidden behind notions of professional secrecy (p212-213; appendix A.2). These interpretations, as seen during the observations, inevitably reflect the power imbalances, where the dominant psychiatric discourse becomes the prism through which a person's experience is viewed (Beresford, 2013).

Narratives

In order to achieve a space of 'dissensus', it is imperative to allow for personal narratives to have their place in mental health. However, personal narratives frequently undergo a "pathologisation" (Pembroke, 1994) or a "de-narrativisation" process resulting in service-users' stories to be narrated mainly through and for the mental health system (Morgan, et al., 2016). As explored in the analysis, the way in which professionals spoke of service-users, from the terminology to denominate them or the use of symptomatology to describe them, from note taking to directive interventions, pointed to this "pathologisation" (e.g. p188-190; p190-194). In other words, people are seen through the lens of professionals (or academics), which in effect could be understood as a "subtle form of silencing" since this process prevents service-users from producing knowledge about their experience on equal terms (Russo, 2012). A further issue is that certain narratives are prioritised and valued over others, which proves especially true for certain recovery stories, from "celebrity disclosures" to generally "positive" stories.

The problem with the dominance of psychiatric discourse is not linked to the existence of experiential knowledge through personal narratives and their validity in contributing to developing and changing the understanding around mental distress and mental health practices. Rather, the risk lies in how personal narratives are engaged with, in ways that often reduces them into another set of 'data', clinical discussions and notes or symptoms (e.g. 178-179) to be analysed and interpreted within the existing 'social fact' (p208), using established hierarchies, or as commodities for marketing institutional or organisational agendas. During this study, I was present in policy meetings solely interested in full-time equivalent workers, funding and catchment areas, ultimately pointing towards a strict 'functionalisation' of care (p218-219). I observed professionals invited into people's homes, yet directing conversations, prescribing behaviours and looking to psychiatry for definitive answers (both practically and intellectually). To avoid this co-optation, it is important to consider "context" using a wider frame, including the various subjective positions, which are heavily influenced by hierarchies of power. Moreover, it is important to keep the contexts within which meaning making can be diverse (Kalathil, et al., 2011). While many personal narratives focus on the loss of power inherent in the experience of mental distress within care settings, they can also point to a different kind of power that allows for self-determination through narrating one's own story. It is, therefore, imperative to be vigilant about existing inequalities and hierarchies that may affect meaning and knowledge.

Furthermore, in engaging fully with personal narratives one must confront the question of authenticity and truth. All too often, personal narratives are challenged by dominant discourses on whether they are authentic and 'true' (e.g. p173). As Arthur Frank suggests, authenticity is always in a type of negotiation, "always in dialogue, and sometimes a contest, between storyteller and listener" (2012:2). In that sense, it is important to avoid viewing stories as fixed but as dialogical processes and interactions. Moreover, pre-fixed frames of analysis without acknowledging the context and personal meaning processes increase the risk of losing unique insights to a collective understanding. In this way, the service-user's story can no longer be understood as "data" to be interpreted and analysed but as an "expert by experience" (Morgan, et al., 2016). Personal narratives offer their own theories, concepts and notions of distress and in doing so they offer the possibility to deconstruct the dominant psychiatric discourse by accepting it as just one of many. Rather than merely being "tolerant to symptoms", the focus shifts towards meeting the person 'as and where they are'.

Arthur Frank explains that narratives have a value beyond the information they provide; that the "witness offers testimony to a truth that is generally unrecognised or suppressed" and that an engagement with this testimony is a "moral responsibility" (1997:137). The moral responsibility of the reader/listener/viewer of narratives is to enter into a "dialogical relationship" (a relationship that opens a dialogue, forms a relationship and is reflexive of the predispositions and contexts). Frank suggests that "there is not, nor should there be, any method of narrative analysis, if *method* is understood as a prescribed set of steps that the analyst should follow" (2012:72). Instead, he proposes the idea of a "dialogical relationship" between the narrative and its recipient. Dialogue allows us to avoid "finalisation" of meaning. Analyses and interpretations based on a dialogical relationship have "little interest in excluding – it welcomes a proliferation of possibilities" (Frank, 2012:110). In essence, they "let stories breathe" (Frank, 2012).

Recovery

Throughout this study, the idea of promoting recovery was at the forefront of person-centred care for many teams (p34; p103-104; p112-113). The interpretation given in the context of mental health is paradoxical since it entails for people to return to their normal state of health or to regain a position (Oxford Dictionary, 2019). In this way, it could be said to share many elements with the concept of ‘cure’; it implies that the person has a ‘problem’. There are expectations that symptoms will decrease or disappear completely, that the ‘illness’ will no longer interfere in daily life and relationships and activities will be held as before. In this way, teams were often working with the idea that their intervention had an end (even more so for French-speakers and their use of the word ‘care’; see p137). In some cases, people were referred to hospital when several professional interventions in the community hadn’t produced results (p184). This interpretation of recovery is closely linked with the biomedical approach which also implies professionals as key figures in promoting recovery, including for example, in the use of ‘recovery plans’ as a fundamental intervention guide as seen in the context of the study (p103). In practice, however, psychiatry has struggled to find a ‘cure’ for mental health ‘problems’, with all too often a pessimistic outlook through the perception of ‘chronic’ conditions (Morgan, et al., 2016).

Although, the use of the recovery model was central for mobile teams, people with lived experience have repeatedly highlighted the devastating impact that such perceptions can have (Deegan, 2009). With small percentages of people diagnosed with ‘serious mental health problems’ experiencing recovery (to the extent that their problems do not interfere with their daily lives), using this framework leaves many people who have been diagnosed with limited hope for a rewarding and valid life (Harding, Brooks, Ashikaga, Strauss and Breier, 1987; Nicholas and Reifels, 2014; Slade and Longden, 2015). Inevitably, the value of this biomedical interpretation of recovery within mental health should be examined and re-evaluated. Challenges have mainly come from service-user/survivor movements, which have themselves represented a wide range of perspectives. They have challenged power relationships and questioned the view of the established recovery model as defined by others (Campbell, 2009; Pilgrim, 2009).

Based on the above, a different but valid and meaningful interpretation of recovery is an approach that is owned by (and owed to) service-users. As Gosling puts it “we decide what we mean by being well, we do not need someone else to tell us” (2010:13). In this way, recovery becomes a personal journey where a one-size-fits all definition is impossible (unlike the use of a ‘recovery plan’ for all; p164-165). The focus is on accepting the possibility of multiple interpretations, considering a person’s worldview rather than one based on an imposed framework. Even then, it risks reliance on Western notions of individualism and downplaying structural inequalities and more collective identities and cultures, which all need to be considered (Kalathil, et al., 2011).

There are common themes that outline the work of service-users across the relevant literature. For example, hope is a common thread and is seen as important for people to believe in the possibility of regaining a sense of self, beyond their disability. It also is an important resource for challenging times which resist pessimism, going beyond stigma (Deegan, 1996; Thornicroft, et al., 2007). Recovery can allow for a new sense of self to emerge, with opportunities to build new relationships and identities and where mental health problems are only a part of who they are. This process has been described as "recovery in" (Davidson and Roe, 2007). Another relevant theme is that of taking back control by recognising the person's own expertise in understanding themselves and their distress as well as their coping skills. All too often, people lose control over their daily life by handing it over to professionals. This of course is not only challenging for the person themselves but also for professionals and their responsibilities, especially when people are particularly distressed. However, workers could transition from their role of prescriptive professionals (p152) to people with knowledge and skill that are to be made available to service-users (Repper and Perkins, 2009). Service-users can retain control *through* professionals (Davidson, 2005).

As seen in the previous chapter, making choices and having control over one's life in a world of social control and forced treatment in the context of mental health is, at the very least, complicated (p210-212; appendix A.3; appendix A4; appendix A.5). The recovery approach focuses on much more than a mental health 'crisis', symptoms or getting 'back to normal'. It encompasses a person's journey, their context and identity while it touches on broader notions of rights, roles, values, relationships and opportunities within a socio-political setting. In this way, recovery has multiple interpretations and often divergent views. Pilgrim (2008) highlights that this has very clear implications for practice. For example, for one position a lack of insight is the barrier for recovery, whereas for the other it is the denial of opportunity to exercise rights and choices which may have been removed by mental health services. This 'false consensus' view of recovery was present throughout this study, leading to the risk that recovery came to mean whatever the different stakeholders wanted it to mean to service their interests, whether appearing in policy, professional practice or service-user narratives. However, when considering the power differences this process of appropriation proves problematic (Pilgrim, 2008).

Recovery, therefore, presents a challenge in terms of its underlying politics, which were to some extent often disregarded by professionals during this study. A focus on individual factors fails to recognise the context in which people develop distress. Damaging and oppressive social environments are not accounted for, with people in minority groups having only a limited voice within the recovery movement (Kalathil, et al., 2011). Moreover, the widespread acceptance of recovery in policy may reflect the fact that an emphasis on choice and autonomy suits current political ideologies. For example, employment has increasingly been presented by some as an important part, yet it may not be a goal for everyone. ‘Choice’ may be presented as important, but it may also mask the increased levels of privatisation and funding cuts across health and social care, with individuals having to manage their own support leaving people isolated, stigmatised and alone in tackling a socially unequal welfare system (Ferguson, 2007). Recovery can therefore often be perceived as ‘professionalised’ with notions of ‘choice’ and ‘personal recovery’ leaning heavily on models of rehabilitation rather than ‘empowerment’.

If recovery emphasises people’s rights to self-determination, increasing opportunity and taking back control, the reality is that often people are not facilitated in this. Suggesting self-management and certain coping strategies may in itself be biased with a view that people are more prone to lose control. For example, mobile teams often monitored triggers and early warning signs, a system which was ultimately concerned with control or self-surveillance. Furthermore, handing over control to others during a crisis, especially when people were admitted to hospital through the mobile teams, only confirmed that the power was given back to institutions rather than to the person themselves. An individual’s constant self-surveillance of their health and wellbeing forms part of a recovery that is very much within a neoliberal governmentality approach by emphasising individual autonomy, good citizenship and self-governance (p51-52). The ‘self’ controls itself, not the state. As a result, genuine ‘choice’ is never entirely possible since non-conforming behaviours are rejected (Scott and Wilson, 2011). This is further underpinned by the individualistic focus of recovery which fails to consider social environments that may cause and perpetuate distress. Recovery by way of this self-governing idea where autonomy and choice are celebrated only comes to reinforce neoliberal models by masking and ignoring social inequality.

Based on these points, promoting “recovering” should become a complex process which is personal, social, political and continuous. As Deegan (1995) suggests, people’s right to determine their own choices should be an outcome for recovery-oriented mental health services. Conversely, she also proposes that compliance is not a desired outcome since it maintains an “external locus of control” reinforcing a cycle of learned helplessness for people using services. Therefore, as suggested by the “anti-recovery” movement and survivor group, Recovery In The Bin (RITB): autonomy and self-determination can only be achieved through collective action against “the effects of social and economic circumstances such as poor housing, poverty, stigma, racism, sexism, unreasonable work expectations, and countless other barriers” (RITB, 2019).

Person-Centred Care

The prevailing idea in person-centred care has historically been to put the person affected at the heart of mental healthcare (Rogers, 1951), especially when promoting a recovery-oriented approach. Aside from working models with a focus on strengths and abilities, on individual self-determination or therapeutic risk taking to make choices, it has been proposed that shared decision-making may be an important start in departing from dominant and traditional mental healthcare models (Morgan, et al., 2016). Furthermore, although a person could benefit from an excellent relationship with a professional, the established power structures within mental health and psychiatry cannot be limited to the personal but may have to include the social and political. Person-centred care was mentioned throughout the interviews and observations as the pillar of mobile community work (p111; p116-117; p123). However, such a notion was repeatedly proven to be more complicated in the contested context of mental healthcare. From power imbalances within therapeutic relationships (p160-165; p178; p191; p219-220), but also within teams and throughout the wider system (p165-167; p217-219), person-centred approaches were continuously challenged. In this respect, person-centred models should perhaps start by including shared decision-making and non-directive approaches primarily focused on preventing abuse, putting forward people's rights by being extremely aware of the contested and complicated field in which the 'care' relationship exists.

Observed repeatedly throughout this study, the professional usually informed the person of the options and continued by persuading them to accept the option that was perceived to be the best (e.g. p178). Notions of shared decision-making have been used to counter this pattern, which involve sharing information, identifying the person's preferences and jointly agreeing an option (Coulter and Collins, 2011). In order to make negotiated decisions with service-users, it is deemed important to understand one's views, values and beliefs, without falling into assumptions that the person deemed mentally ill is irrational and incompetent to make decisions. Even if choices are perceived as risky or 'bad' it is important to follow the person's preferences, when and where possible. Furthermore, shared decision-making is dependent on enabling people to be involved. A trusting therapeutic relationship is key and it was repeatedly mentioned during the interviews as the main ingredient in mobile work which was to provide the necessary conditions for a person to share their preferences and be offered opportunities (e.g. p111; p134). Moreover, it is also important in that context to recognise the influence of culture on the experience of distress (Kalathil, et al., 2011). Therefore, a "culturally competent" approach to care which is aware of factors such as language, values, community and family relationships can prove important when developing therapeutic relationships (Dy and Purnell, 2012). Previous experiences of stigma, prejudice and discrimination may have caused people to be guarded about developing such relationships so the need for understanding and empathy may be key (Morgan, et al*.,* 2016).

In practice, however, including during the observations of this study, it was often the case that service-users' abilities came into question by professionals when faced with decisions (e.g. p164, p178). Discourses that emphasise a lack of rationality and competence are still prevalent and undermine a shared decision-making approach. 'Cognitive ability', 'paranoia' and 'insight' or diagnoses of 'personality disorder' are contested terms, yet frequently used in practice (e.g. p182) and seen as barriers, even if studies have shown that people with 'serious' mental health problems want to and feel able to be involved in decision-making (Matthias, et al., 2012). The power of mental health professionals and generally services endorsed by policy and legislation, limits the possibilities for shared decision-making. 'Capacity' was regularly used as an argument against autonomy and a person's liberty was often at risk when encountering services, from coercive practices to voluntary or even forced admissions (p210-213; appendix A.4; appendix A.5). This shows that professionals have the power to override people's personal preferences and many using services are fully aware of this. It would therefore be naïve to think that this disparity in power does not influence what is said, done and decided within the therapeutic relationships as well as the constraints on shared decision-making (Morgan, et al., 2016).

Lately, the Open Dialogue approach practices have become increasingly adopted in many mental health services across Europe and is increasing in popularity in Belgium over the last few years. It is thought to offer a few practical answers to the limits posed by person-centred care. Originally from Finland, Open Dialogue was implemented to change the hospital admission procedures (Seikkula and Olson, 2003). As a result, acute crises were handled by having a 'network meeting' between the person, their family and/or other key persons including professionals. This model supports transparency between the planning and decision-making processes with everyone present. It draws upon Mikhail Bakhtin's theories of polyphonic dialogic communication, with understandings reached not necessarily belonging to any one individual but rather collectively constructed. This approach is often seen as the model to use for person-centred work based on the wide area of interpretations, meanings and narratives that are invited into a 'network meeting'. With theoretical underpinnings in systemic family therapy, dialogical theory and social constructionism, it aims to work with families and social networks, within the home environment in order for a 'shared meaning' to emerge and 'healing' to become possible (Olson, 2015).

Open dialogue is seen as a possible way to avoid a 'professionalisation' of people's situation (Penney and Prescott, 2016). However, the way in which the approach is increasingly taught and disseminated points to its limitations in practice, especially since the model exists within established structural hierarchies (Seikkula and Olson, 2003). The same paradoxical professions remain while the practice is carried within existing psychiatric services and professionals still carry a role within those 'network meetings' as the main actors offering their reflections of a situation. In other words, Open Dialogue operates within the 'social fact' (p208-209). This is especially true in the key outcome measures used to show its effectiveness, with the use of diagnostic criteria, medication use and rates of return to work (Seikkula, et al., 2004). This critique serves as yet another example that it should be imperative to exercise caution along with a critical evaluation of the very possible and alarming pitfalls when using terms such as person-centred care, shared decision-making or even open dialogue. An awareness of the complexities of these processes is central in enabling more equal power relationships, moving from the personal to the political.

Peer Support

Peer support is an approach that has been used and valued, from self-help groups, to peer-led services, activism and collective mutual support (Faulkner and Kalathil, 2012). More recently, a growing attention has been given by statutory services across Europe and North America. During this study, the role of peer became increasingly important for mobile teams, with some including the role within their work. As such, the role and the ensuing particularities was explored during the interviews and observations (p118; p165; p179). Peer support is characterised by a helping relationship between a person who has experienced mental distress and someone who has progressed less in their 'recovery journey' (Davidson, et al., 2012). Peer support offers a unique opportunity for people who share an identity to also share their experiences of mental distress through acceptance, understanding and empathy as well as practical and emotional support. While definitions often differ, most highlight the positive impact a peer can have on a person's 'recovery journey' as it helps with feeling more in control, having a sense of empowerment and hope while also improving confidence and self-esteem (Repper and Carter, 2011). Peer support workers themselves have highlighted that their own recovery has benefited from this role, especially in terms of their identity and confidence (Mental Health Foundation, 2012).

The risk with peer support, as with many if not all service-user and survivor led initiatives is that of co-optation. Movements for the promotion of social justice by marginalised and oppressed groups are regularly challenged with co-optation, especially within mental health. More specifically, "co-optation is a process by which a dominant group attempts to absorb or neutralise a weaker opposition that it believes poses a threat to its continued power" (Penney and Prescott, 2016:35). It can take many forms, either by the way dominant groups assimilate the language of marginalised groups thus altering definitions over time or by appropriating personal narratives from oppressed groups to interpret them in ways that diminish their power (Coy and Hedden, 2005). This certainly has become true in the way service-users and survivors use different words to denominate their social group. Inevitably, the use of a name reflects experience and a particular worldview. For a group of people that is far from homogenised, the way in which mental health professionals make use of certain words in order to avoid terms such as 'patient' in conjunction with this growing concern with naming, quickly turns paradoxical. The term 'consumer' in the US is an interesting example reflecting a harming capitalist society for the very people it aims to 'de-stigmatise' (Penney and Prescott, 2016).

Challenges of peer support are evident with some already explored during this study (p216). Power differences have already been intensified through training, role structures and paid employment in statutory organisations, therefore making it difficult to protect the uniqueness of the role. 'Professionalisation' of peer support is also a risk to the range and diversity of approaches since experiences and values are varied (as seen with recovery; Penney and Prescott, 2016). Especially when it comes to funding cuts in services, peer workers run the risk of becoming cheap alternatives to professionals. Consequently, unique aspects of being a peer become overshadowed with potential expectations that workers start adopting the "controlling" aspects of healthcare. There is a risk that peer support workers become 'tokens' in further promoting established notions of care. There is an essential need to protect what makes peer support, especially now that it is being expanded through mainstream services, including mobile work (Faulkner and Kalathil, 2012). Discrimination against the role can be strenuous, as also seen in this work (p173-174) but it is also proof of the challenge it poses towards staff attitudes (Repper and Carter, 2011). Finally, boundaries between the helper and the helped may blur, questioning the wider boundaries between mental health professionals and service-users.

Peer support is an instructive example of survivor knowledge co-optation. What started as grassroots peer support practices developing out of necessity by service-users and survivors, became funded staff positions without any single accepted job description (p165). Although for some the opportunity for a paid position is a sign of progress for others this 'development' is a prime example of co-optation of survivors' experiential knowledge to benefit the mental health system, leaving its coercive practices unchanged (see also p210-213). With the increased 'manualisation' of peer support in an attempt to define a homogenised vision, the informal and relatively unstructured bases on which it was built is at risk of being replaced with a hegemonic definition (Penney and Prescott, 2016). As is already evident, peer support positions do not always offer peer support but become paraprofessionals in traditional mental health structures, often performing the same tasks as non-peer staff (Davidson, et al. 2012), while they are expected to disclose their personal histories and serve as role models. Many supporters who identify as service-users are those who have come to accept the biomedical model of 'mental illness'. However, research points that they too often feel ostracised and poorly treated by their non-peer colleagues (Walker and Bryant, 2013). Whether peer support can find an appropriate place in mental health care is highly dependent on how it is understood and on how it can be implemented and practiced.

'Madness' in the community

> Rather than go out into the world telling people at every turn when they are sanist in a sanist world, I would rather offer time to allow people to discover for themselves what it is to be seen as mad, mislabelled, have treatment forced on you, and be mentally incapacitated. Time and open questions might change a culture of coercion to a culture of relating, even between ignorances. And so the idea of socialising out of psychiatric control-care includes the idea of not marketing it, not sanesplaning it, not boxing it for the factory floor. This brings with it the attendant problem that it might not even be recognisable to people as anything like an alternative (Fabris, 2016:104).

"We are all a little mad" explained a participant during this study (p99). For her, the ultimate goal would be for madness to be understood as a variation of human experience, for it to be part society. Participants mentioned the need for collective spaces for service users (p129-130). However, practical implementation of this idea is definitely not straightforward. Opportunities for non-coercive spaces that exist within people's own frameworks, worldviews and understandings of their experiences are few. Nevertheless, there have been certain group-based projects that have developed that hold important clues as to what such an idea may/could look like.

In fact, throughout Belgium, survivor and service-user led initiatives have become established spaces yet separate from mainstream services and can serve as important examples. Many are constantly at risk of falling apart mainly as a result of financial cuts or by being overtaken or colonised by traditional mental health services. Such important initiatives are the "groupes de paroles" (talking groups) organised especially in French-speaking areas of the country. Those may resemble "hearing voices groups" (Dillon and Hornstein, 2013; Longden, Corstens and Dillon, 2013) but the subjects covered are wider than one experience. They are directed towards service-users and carers. Other initiatives are more culturally driven with many social cafes and restaurants across Wallonia, Flanders and Brussels. Activities are organised around everyday gatherings as well as larger social, cultural or intellectual events for any person interested. There has also been a growing interest for the development of survivor-led residential structures such as respite houses. Although, several similar projects do exist, they are part of mainstream services or at least professionally led. Homes that may develop as part of 'therapeutic communities', without the involvement and authority of professionals, are perhaps an interesting concept to implement. Moreover, for it to be regarded as service-user and survivor led they should be implemented as distinct from professional spaces.

Although professionals are present in such existing spaces and may be important partners and allies in the development of new initiatives, it is imperative that those remain service-user led. In this way, professionals are visitors and service-users their hosts. The idea behind creating and maintaining such initiatives goes beyond the use of a shared space or creating 'citizenship' and 'socialisation' between service-users, as mentioned in the interviews (p129-130). Although they do promote such processes, they are also about creating a different way of being a citizen, a different way of socialising as part of a particular and parallel culture. In other words, it is not about developing an alternative to mainstream care, but it is instead about creating something altogether different.

Values in practice

As seen throughout this work, including in this chapter, the power imbalances which exist within mental health care are major barriers in providing helpful support and although omnipresent they are often overlooked (p214-221). Established mental healthcare practices have been criticised and are still disputed by service-users and their allies, with many seeing psychiatric treatment as a form of "iatrogenesis" (Illich, 1976; Breggin, 1991) with abusive and pathologising practices often further silencing service-users not least because of their given diagnoses, as also observed in this study (e.g. 164; p179). The system has also proven to be damaging to the workers too, with stresses, anxieties and threats (McKeown and Spandler, 2017).

There is juxtaposition between different and opposing sets of values within mental healthcare. Throughout the interviews and observations, participants were at once care providers and employees of an organised institution of care, which often was a paradoxical position to occupy (p208-210; p217-219). Caring attitudes were recurrently put on hold for prioritised tasks and this at the expense of providing support and developing meaningful therapeutic relationships which could be assumed to be the essential components of care (p174-177; p178-179; Morgan, et al., 2016). This fact and its acknowledgement may be an opportunity to open up possibilities towards a common cause with the categories of "service-user" and "professional" overlapping (Morgan, et al., 2016).

It has been suggested that although students emerge from their education with strong professional values, several organisational factors often come to impede in their implementation. Factors identified have ranged from a lack of support to poor role models, time pressures, role constraints, staff shortages and work overload (Maben, et al., 2006). Frequently, professionals are pushed to believe that they are not living up to their convictions and may also internalise aspects of an organisational failure. Furthermore, it has been suggested that poor role models push new workers to shift their identity so as to justify the loss of their ideals and become proficient in their new role. Resisting is replaced with the desire to appear to conform, especially since it is challenging to be discouraged and not supported (Curtis, et al., 2012). Routine and task-based work may become even more embedded in work approaches where they are valued. As Brookfield suggests, it is "cultural suicide" since those who choose to take "a critical stance towards conventional assumptions and accepted procedures face the prospect of finding themselves excluded from the culture that has defined and sustained them up to that point" (1993:200). With those challenges and difficulties, from target pressures and other systemic constraints, to cultural conformity and loss of self-identity (Curtis, et al., 2012), the risk for professionals to lose their values runs high (p160-170). Resources such as the law and ethics should prove to be increasingly powerful in countering bad practice, especially in areas of human rights and anti-discrimination. However, those resources prove to be inadequate on a daily basis (p174-177; p217-221).

This learned conformity may appear to be passive but subcultures within medicine, amongst other settings, have challenged assumptions that stability and uniformity exist within a profession. This apparent conformity has been explained in two ways: "learning to play the game" and "presentation of the self" (as seen in this work; e.g. p192; Clouder, 2003). 'Playing the game' involves becoming aware of the rules and learning to comply with the systems in place, which requires understanding the power differentials. 'Presentation of the self' is the need to present oneself or act in accordance to expectations. These two processes suggest that individuals interact with others in order to establish what is 'professional', within an established structure. With many professionals coming into conflict with their beliefs when coming into the field of mental health, it is no surprise than many chose to leave and pursue alternative careers, thus rejecting the system (Robinson, et al., 2005). Indeed, the more empathic professionals often prove to be the most vulnerable (p194; Figley, 1995). This was true in the context of this study, with some participants choosing to leave mobile work or even mental health care entirely to pursue careers elsewhere.

Discourses between 'professionals' and 'service-users' that are built on difference maintain a lot of the issues faced in practice. Moreover, workers become inescapably complicit in interventions that service-users find harmful. Bearing this responsibility has serious consequences, as mentioned, from the loss of self-identity to many choosing to leave their profession, since they do not have the authority to alter systemic practices and established power hierarchies (McKeown and Foley, 2015). In this way, relations are more complex than merely oppositional, with cycles of "reciprocal traumatisation" emerging (McKeown and Spandler, 2017:86). Such relational processes and complexities between service-users and professionals should be considered carefully in order to first understand the reasons for mistrust, violence and coercion from all sides (Sweeney, et al., 2016). "Expertise", "intuition", "good intentions" and "beneficence" amongst others were all arguments used by professionals (e.g. p128, p135, p160) to carry on with established yet contested practices within mobile work. Shifting from those notions into ones that don't just provide help, by way of professional interpretation, but actual 'helpful' help based on service-users' meanings becomes a relevant process. This is not to say that professionals should do away with their experience but perhaps it is the service-users' needs and their expressions of what help they need that should frame what is offered rather than the other way around. On the other hand, it is not about alienating workers, who might feel criticised and become defensive (McKeown and Spandler, 2017).

Although acknowledging professionals' experiences should be addressed, it is important to consider the extent to which workers are themselves complicit. Power imbalances should perhaps be understood in more nuanced ways, as seen throughout this work, especially those between service-users and staff (McKeown and Spandler, 2017). As mentioned, dialogical processes hold an important key to setting up partnerships and alliances in order to create change. Bottom-up initiatives are perhaps the most important ones to create and make space for (Inwood and Alderman, 2016; see also Russo and Sweeney, 2016). Those radical social movements, as well as mental health services, need to be more critical to allow for dialogue, possibilities and strategies to be developed in order to avoid the reproduction of established and re-established power hierarchies existing within the 'social fact'. Structural change starts by changing established discourses. Finally, whilst the processes of dialogue might be healing, it is important that they are not imposed or co-opted by others (McKeown and Spandler, 2017).

To assess and create alternatives it may be first about recognising that those challenges exist and that they cannot be answered through established codes of ethics and practice or through laws that often fail to be upheld (p209-212, appendix A.2). Following this, it is imperative to raise awareness of the values that are at play, often conflictual and paradoxical. Theory, ideals and practice inevitably become interlinked (as seen extensively throughout the interviews of this study), so that frequently for example, person-centred practice comes to reflect professional values rather than those of service-users. Team work can be an important start in bringing diverse knowledges and skills into the complexities of practice through a range of values. With a process of 'dissensus' different values can be explored and allowed, without one becoming dominant.

Rights-based approach

With social control practices (p210-213) and other forms of subtle compliance recorded during this study though unequal relationships (p178-179), service users' rights inevitably have to become part of the conversation around social justice and mental health care. An important practical example in how thinking about mental health should be more rights-based and (by default) political, is in the use of the word “stigma”, which was mentioned repeatedly by many participants as an important intervention part of their work (p134-136). Many preventative approaches to mental health often employ this term from everyday practice to policy making and charity campaigns that aim to “fight it” (Stuart, 2013). However, stigma should perhaps be called discrimination instead, since it is the very idea of stigma that produced attitudes and practices that stigmatise. In other words, stigma refers to a legal, medical, social system and otherwise that actively works against the individual it is supposed to help. By discussing discrimination instead, one immediately enters the political realm by which such structural difficulties become apparent (Webb, 2016).

Although the link between disability and mental health has been and is still the subject of debate, it is nevertheless a relevant and valid one that seems to make sense for many users and survivors of psychiatry. Situating themselves as people with disabilities and advocating for human rights within that identity group, including through similar concepts such as “actual and perceived disability”, users and survivors have found answers to certain problems and practical avenues and approaches for change (see Spandler, Anderson and Sapey, 2015). Moreover, mental health service survivors were instrumental in the development of the United Nations Convention on the Rights of Persons with Disabilities (CRPD; United Nations, 2006).

The CRPD is a uniquely rights-based legislation which is international but also domestic. Through it, users and survivors have specified that their identity is self-defined and by doing so they have actively and formally rejected any medical characterisation. Furthermore, the convention clearly calls for the eradication of violent and abusive practices, such as mental health detention and compulsory treatment. It was founded on premises of equality without exception by acknowledging the right to liberty and the right to free and informed consent (United Nations, 2006). It is therefore an important piece of legislation towards the (equal) rights of people who have a variety of experiences, which have been mainly medically explained until now and have generally been seen as negative. The social model of disability was therefore instrumental in starting to shift the attention from a medical understanding of a condition to society’s response to it, in order to expose exclusion and oppression (Finkelstein, 1975).

Nevertheless, there are limitations of the social model to disability for mental health service-users and survivors, since the experience of physical disability considerably differs. For example, the disability movement rarely addresses important causal factors of impairment but rather focuses on society’s response to them. Although talking about discrimination may open up the conversation to structural and systemic problems linked to mental health, it fails to address the way in which this environment causes problems to begin with (as explored above). Furthermore, challenging psychiatric diagnoses is an important part of the survivor movement, which further raises awareness of society's perception and the psychosocial issues that arise as a result. In other words, the mental health survivor and service-user movement takes on a wider scope in naming violence and abuse as well as their fundamental causes. Although, the CRPD was an important step in the inclusion of survivors and mental health service-users, it is important to keep up this dialogue with the disability movement so that no experience is overlooked (Plumb, 2015).

The question of power therefore becomes central in any notion put forward by this piece of work, especially when it comes to partnerships and alliances. Power imbalances should be given particular attention, such as who upholds service-user and survivor values and how? Who qualifies as a service-user and survivor? How can service-users define discourse rather than be invited into an established one? How can co-optation of personal narratives be avoided? Who are the experts and who says so? Within a movement that is far from homogenised and where power imbalances exist as much within as outside it (Cresswell and Spandler, 2016), it is important to create opportunities for different approaches and especially those that have historically been suppressed, silenced and oppressed to be included. Only by working together can change happen.

It could be argued that such dialogical notions may be flawed since they may contribute in disguising the inequalities that are present. Work based on co-production/co-construction can never erase the differences that will inevitably exist between services users, survivors, professionals or allies (Cresswell and Spandler, 2016). It is therefore important to start by acknowledging those inequalities and allowing for dissensus across hierarchies, expertise, experience, degrees of influence or access to resources, cultures and languages. Expertise and influence vary, depending on context while survivors and service-users are not a homogenous group and recognising this is central. This is a difficult process, not just in challenging inequalities but also in recognising that failing such a process will probably burden those with less power to begin with, most notably due to whatever is left unspoken. Using differences constructively (dissensus), while constantly challenging and transforming them, may prove useful towards (re)creating strong relationships and partnerships.

Undoubtedly, a rights based approach to mental health has to be grounded in recognising the repeated abuses experienced by service-users and survivors of the mental health system and psychiatry, from historical examples such as "lobotomies, incarceration, seclusion and restraint, harmful drugging and electroshock and stigmatising diagnoses meted out to people of particular 'race', gender and sexuality" (Wallcraft and Shulkes, 2012:12 as cited in McKeown and Spandler, 2017). Such social control practices still occur today with physical 'containment' (restraint), seclusion and forced medication but also subtle coercions to comply (p210-213). The colonisation and expansion of the psychiatric discipline further constitutes such practices and continues the propagation of neglect against survivor perspectives. As a result, a form of epistemic injustice continues to occur by which experiential knowledge is systematically refused, as also seen in the development and implementation of this reform (Fricker, 2007).

Revising the past to change the present and promote social justice in a field that has often tragically failed to do so through established power imbalances, may be an important step in creating a more sustainable future. Following on from the theme of 'memory' in the analysis (p156-169), a valid idea in tackling these past and present injustices is that of organising a reparative "truth and reconciliation" process in mental health services (Rose, 2015; McKeown and Spandler, 2017). With many different service-user and survivor movements it is perhaps important to recognise that not all reject every aspect of an oppressive psychiatric system, which for some cannot be simply reduced to human rights violations (Plumb, 2015). It has further been argued that perhaps the challenge should be against psychiatric neglect rather than abuse (Spandler, 2016). However, whether it is by addressing more covert, yet damaging systemic relations (Rose, 2015), psychiatric epistemic injustice (Fricker, 2007; McKeown and Spandler 2017) or violence and human rights abuses (Russo and Shulkes, 2015), accepting and condemning psychiatric harm is long overdue. In other words, "perhaps healing or restitution cannot take place until the full extent of survivor grievances have been acknowledged" (McKeown and Spandler, 2017:89). With the guidelines to this Belgian reform failing to recognise survivor movements but also historicising its foundations in a veil of neutrality, it is perhaps time to acknowledge psychiatry's painful past but also the current work being done in best answering questions concerned with 'memory'. Bull, Gadsby and William's (2018) apology for the distress and disempowerment caused as a result of nursing violence is an important start in this recognition. This is not a process aimed at offering symbolic acts of reparations, but it is about acknowledging past harm and practically implementing new spaces where those can be addressed and transformed (McKeown and Spandler, 2017).

Resistance

Resistance and activism are important parts of both upholding valid and socially just principles but also convincing others to do so. Moving away from simplistic benevolent practices in mental health which may often fail to penetrate the question of injustices, activist practices may not promise a revolution but may open possibilities towards effective and desperately needed change in a system, which as we have seen, continuously propagates itself, apprehending professionals and service-users alike in its path. Given the inherent struggle within mental health professions, a constructive engagement with power may provide (some) answers to the power imbalances explored throughout this study.

The idea of resistance is concerned with challenging, reforming and transforming mental healthcare. It is after all through resistance to established and powerful models of psychiatry that initiatives and alliances between workers and service-users can fully take effect. This “conjoint activism” has proven repeatedly valuable (Cresswell and Spandler, 2013). Of course, there have been tendencies towards polarisation especially by oversimplifying an increasingly complex subject. This has further prevented a deeper exploration and mutual understanding of different perspectives. Some may see such proposals and possibilities as unnecessary, others as merely reforming a harmful system that should be abolished. As mentioned, the risks are that such approaches only reflect a temporary instrumentality that in effect only re-establishes an inadequate system (cf. ‘social fact’, p208-209). However, the propositions offered above are ultimately an invitation for each party involved to listen to others’ experiences and perspectives. It is imperative for the above paradoxes and approaches to be considered, allowing for dissensus and dialogue as well as social relations on which alternatives can be built. Dolly Sen and Anna Sexton explain: “a voice and a story without equality is an act of ventriloquism that can never be as beautiful as one with” (2016:168).

Individual testimonies and narratives may be key in starting to address psychiatric harm, but they may fall short in changing social inequalities and structural violence. The underlying socio-political conditions should be addressed for genuine justice to be delivered (Nagy, 2012). The risk runs high that if wider factors and strategies are not considered, psychiatry as it is practiced today may remain intact, if not further reinforced. However, such a critique is perhaps based on a false dichotomy between peace and justice or transitional and transformative justice (Rose, 2015). With reconciliation being an ongoing process of which personal narratives are an important part, this should not be seen as a replacement for wider social change but rather as an aspect of it. Those are not two opposing or mutually exclusive strategies but rather they are confluent, by which wider social change can be achieved through an attention to more nuanced discussions as well as activist strategies (McKeown and Spandler, 2017).

An important part of recollecting, understanding and ultimately reclaiming the experience of madness is in finding the right words. Inevitably, the psychiatric language has become a point of reference, as seen in this work (p187-201). Mary O’Hagan points out “there isn’t even a word for patients that doesn’t put us in relationship to the system that dominates us” (2014:16). Explored throughout this thesis, although perspectives vary widely on the biopsychosocial model and many adaptations have and could be made to it, there is no evidence to support this model to begin with (Read, et al., 2004). As such, perhaps this is the opportunity to turn away from trying to find proof of biomarkers or discover ‘mental illness’ but rather join forces towards creating a different discourse, based on difference that reflect the heterogeneity of existence and move beyond solely identity driven realities. Pembroke notes, “rather than trying to agree on terms we can all use, let’s celebrate, respect, understand and agree to differ from other people’s definition” (2009:6). Or as Faulkner puts it “language can broaden and describe so much better than it can abbreviate and classify. It seems to me that we need more words rather than less to describe experiences” (2002:7-8). Finally, “we have a choice: we can let our differences forever divide us and inhibit the work we do together, or we can find a way to embrace them and let them deepen, broaden and enrich the uniqueness of our contribution” (Russo, 2016:67). Of course, as with any new paradigm, this approach will in turn have its own paradoxes, its own power-driven discourse but at least at first its difference(s) may prove to be its validity.

Psychiatric discourse has become “a regime of ruling” (Smith, 2005). As such it imposes a language and an understanding of the world that is further established by the system of law. It is the only profession that can detain people who have committed no crime. Psychiatry becomes believable because “mental illness” is a hegemonic concept. Law, research, public services are all devoted to psychiatric discourse. With an established power/knowledge structure that not only continuously establishes itself in all areas of (mad) life but further dominates and colonises other discourses, it becomes an unquestionable fact that one has to problematise this discourse and the concepts which underpin it. Aside from critiques to psychiatry however, what perhaps matters more is the exercise of “semantic resistance” (Burstow, 2013) or “semantic disobedience” (Starquit, 2018).

> The average person in the street speaks of “schizophrenia”, of “mental illness” or “symptoms” of this or that “mental disorder”. When we talk this way, irrespective of our intentions, we are performing our designated role in the work of psychiatry. Just like the nurse who picks up a chart, we are activating it; we are helping it exist. On the other hand, when our talk is psychiatry-resistant or even psychiatry-free, we do something very different, potentially even revolutionary. Simply by how we speak, in other words, we are either tacitly upholding or undermining psychiatric rule. (Burstow, 2013:82)

Despite the ongoing conceptual, semantic and even tactical disagreements within the survivor and service-user movements, it is time for the language, the constructs and concepts we use to become actively oppositional. As Bonnie Burstow explains “we live in and through words, […] words matter.” (2013:79). She offers a list of refusal terms as a start to resist against this “ruling regime” promoting a language of acceptance and difference. Perhaps now more than ever before with psychiatry pathologising normal, everyday life, such a resistance is needed, both for current, future and/or potential service-users and survivors.

An active engagement presupposes that there is never an endgame; not only being "open" or "just" or having better care options available. As Fabris writes, "re-invention is a better way to consider multiple ways of theorising, politicising and resisting" (2016:102). The focus is on always being there, being questioned and reconsidered in order to re-invent the world we live in.

> Insofar as our "ontological vocation" (Freire, 1970) is to name the world in order to change the world, it is critical to keep reflecting on our discourse. We need discourse that serves us and we need to remember that, as Audre Lorde (1984) puts it, "the master's tools will never dismantle the master's house". By talking in the established language we are propagating it, we are helping it exist. On the other hand, refusing to use established psychiatric and mental health terms we are tacitly undermining established power hierarchies. Simply by how we speak, we are resisting (Burstow, 2013:79-80).

Epilogue

> One must say *Yes* to life, and embrace it wherever it is found - and it is found in terrible places; nevertheless there it is […]
>
> For nothing is fixed, forever and forever, it is not fixed; the earth is always shifting, the light is always changing, the sea does not cease to grind down rock. Generations do not cease to be born, and we are responsible to them because we are the only witnesses they have.
>
> The sea rises, the light fails, lovers cling to each other and children cling to us. The moment we cease to hold each other, the moment we break faith with one another, the sea engulfs us and the light goes out (Baldwin, 1964:60).

Recording and transcribing a small piece of the reform puzzle has been a privilege. It has also been a burden because I have to do justice to the people I met throughout it, both professionals and service-users, as well as myself and my journey. It is always sad to finish something on which one has worked for so long, as well as appeasing. This work is the result of countless little decisions that should add up to one big statement. To finish it means to destroy all those possible other outcomes of that very project. However, I do not present a conclusion to this work. Perhaps because there are so many and at the same time none at all. My attempt was to allow such outcomes to still have their space by putting forward the paradoxes that made this study an opportunity for possibilities rather than a given finality. As has been the case throughout, it is now about “trusting the process” and allowing for possibilities to emerge through those existing paradoxes.

This analysis was only one part of the reform process. It was partial as well as subjective and by no means all-encompassing. It is, however, my own and as such it is important for me to keep a certain intellectual integrity or honesty in how it is presented. Unfortunately, as is the case for so many of the viewpoints in mental health discussed here as elsewhere, this study runs the risk of being co-opted and assimilated by different powerful bodies to serve different purposes compared to its intentions. I am very much concerned by this and it is with a certain apprehension that I deliver this thesis to its public. It will be up to the reader to receive it as it was intended, to question their actions and beliefs and how these can be changed or valued.

This research, what I witnessed throughout it inevitably became about the immense and still unaddressed paradoxes of mobile work, of the reform and of psychiatry and mental health in general. It was not what I had expected. I thought I could ignore the contradictions; I thought they were not part of the story. I was wrong, they became the story. Public officials and mental health professionals may go to great lengths to "implement" reforms, to "functionalise" and "reorganise" care and its structures, to talk of "person-centred care" and "recovery", of "choice" and "self-determination" but in the end people are ultimately suffering the same fate as they were before. The organisational constraints and the ideological constraints which are facets of the same coin ultimately lead systems and professionals within them to continue "othering" service-users.

I have repeatedly heard the argument that things are better than they were before, even if they are not great. Perhaps, however, better is not good enough and it's a shame that anyone would be willing to settle for so little. Some people receiving appropriate care, does not mean that the oppressive psychiatric system is behind us. It proves that once more some of us are luckier than others. Of course, we must celebrate successes and acknowledge our privileges when we have them. But we should also refuse to settle. We should refuse to forget how much work there is still to be done. We should refuse to relish the comforts we have at the expense of others who are still seeking comfort.

Suppressing the knowledge produced by an oppressed group makes it easier for dominant groups to rule because the seeming absence of dissent suggests that subordinate groups willingly collaborate in their own victimisation. Maintaining the invisibility of critical ideas on madness and distress has been critical in maintaining social inequalities. Despite this, many service-users, survivors and their allies use their voices to raise important issues that affect people daily. In response to the prevalence of the limited ways care is structured, to the prevailing limited ways in which we talk, write and think about madness, no matter how good our intentions, no matter how finely crafted our approach, I cannot help but think that by settling we all lose. I'm not sure how we can get better at having conversations, but I do know we need to overcome our deeply entrenched positions and resistance to difference, to nuance and paradox to allow for dialogue and to explore possibilities. We have to be more involved in making things better rather than just being right or interesting.

I finish this work with a strong need to escape it, however complicit and ultimately impossible, and the challenge to persevere despite facing a sobering reality. These perhaps mutually exclusive feelings, I now experience as singular, part of a confluent whole. Reflecting on the act of witnessing, I look to the future with a reminder once again to 'trust the process'. A concept that was revisited throughout the different steps and phases of the research, it involved a leap of faith into the deconstruction of accepted and established constructs, leaving behind the safety of an illusory certainty. A moving subject within a moving environment, I constantly questioned and re-evaluated positions and views, including my own. This 'mobilis in mobili' ('motion within motion', changing in the changes, moving amidst mobility; Verne, 1870/2001) became pivotal in trusting the process. Despite the uncertainties and lack of control, the possibilities arose in all their sublime paradox.

The responsibility is to keep on setting the record straight, not as a spokesperson but as a witness. I invite and urge the reader into this creative dialogical process. I hope that this work will celebrate paradox and bring nuances to our discourses.

[This page intentionally left blank]

References

Adame, A. L. (2014). “There needs to be a Place in Society for Madness”: The Psychiatric Survivor Movement and New Directions in Mental Healthcare. *Journal of Humanistic Psychology, 54(4):*456-475.

Adams, J. & Drake, R. (2006). Shared decision-making and evidence-based practice. *Community Mental Health Journal, 42*, 87-105.

Adler, P.A. & Adler, P. (1987). *Membership Roles in Field Research*. Newbury Park, CA: Sage.

Adorno, T. W. (2000). *Problems of Moral Philosophy.* (Livingstone, R., Trans). Cambridge: Polity Press

Aguinaldo, J. P. (2007). The social construction of gay oppression as a determinant of gay men’s health: ‘homophobia is killing us’. *Critical Public Health, 18:*87-96.

APA - American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington DC: APA.

APA - American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed). Washington DC: APA

Amsalem, D., Hasson-Ohayon, I. Gothelf, D. & Roe, D. (2018). How Do Patients with Schizophrenia and Their Families Learn About the Diagnosis? *Psychiatry, 81*(3):283-287.

Anthony, W.A. (1996). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Innovation and Research, 2(3)*:17-23.

Armstrong, D. (1998). Decline of the hospital: reconstructing institutional dangers. *Sociology of Health & Illness, 20*(4):445-457.

Austin, J.L. (1962). *How to do things with words*. Oxford: Clarendon Press

Baldwin, J. (1961/1993) Faulkner and Desegregation In Baldwin, J. Nobody Knows My Name: More Notes of a Native Son (pp117-126) New York: Dial Press (Original work 1961)

Baldwin, J. (1964) Nothing Personal. In Avedon, R. & Baldwin, J. *Avedon Baldwin: Nothing Personal*. (pp. 49-60) Switzerland: C. H. Bucher

Baldwin, J. (2017). *I Am Not Your Negro.* St Ives: Penguin Random House

Barker, P. & Buchanan-Barker, P. (2011). Myth of mental health nursing and the challenge of recovery. *International Journal of Mental Health Nursing, 20*:337-344.

Bauman, Z. (2001). Identity in the Globalising World. *Social Anthropology, 9(2)*:121-129.

Bentall, R. P. (2013). *Reconstructing Schizophrenia* (Kindle ed.) London: Routledge

Beresford, P. (2013) Foreword In LeFrançois, B. A., Menzies, R. & Reaume, G. (eds). *Mad Matters: A Critical Reader in Canadian Mad Studies.* (pp. ix-xii). Toronto: Canadian Scholars’ Press Inc.

Bergson, H. (1999). *Introduction to Metaphysics.* Indianapolis: Hackett Publishing Company (Original work published 1903)

Bhugra, D. & Arya, P. (2005). Ethnic density, cultural congruity and mental illness in migrants. *International Review of Psychiatry, 17*(2):133-137.

Bindman, J., Reid, Y., Szmukler, G., Tiller, J., Thornicroft, G. & Leese, M. (2005). Perceived coercion at admission to psychiatric hospital and engagement with follow-up: a cohort study. *Social Psychiatry and Psychiatric Epidemiology, 40(2)*:160-166

Birks, M. & Mills, J. (2011). *Grounded Theory: A Practical Guide.* Thousand Oaks: Sage

Blashfield, R. K., Keeley, J. W., Flanagan, E. H., & Miles, S. R. (2014). The cycle of classification: DSM-I through DSM-5. *Annual Review of Clinical Psychology, 10:*25–51.

Bloomfield, B. P. & McLean, C. (2003). Beyond the walls of the asylum: information and organisation in the provision of community mental health services. *Information and Organisation 13*:53-84.

Bonney, S. & Stickley, T. (2008). Recovery and mental health: a review of the British literature. *Journal of Psychiatric and Mental Health Nursing, 15(2)*, 140-153.

Bonsack, C., Ferrari, P., Gibelinni, S., Gebel, S., Jaunin, P., Besse, C. & Morandi, S. (2013). Le Case Management de Transition: Assurer la continuité du rétablissement après une hospitalisation psychiatrique. *Association «Réseau de la Communauté Sanitaire de la Région Lausannoise», 8:*1-62.

Bosquet, C. (2018). Le secret professionnel empêché : Évolution, contours et enjeux actuels pour le travail social. In Service Droit des jeunes de Bruxelles (2018). *Le silence a du sens : Secret professionnel en danger.* (pp. 8-14) Available at: http://www.sdj.be/IMG/pdf/dossier458ter_final-2.pdf [Accessed March 2019]

Breggin, P. (1991). Toxic Psychiatry: *Why Therapy, Empathy and Love Must Replace the Drugs, Electroshock, and Biochemical Theories of the "New Psychiatry".* New York: St. Martin's Press.

Brookfield, S. (1993). On impostership, cultural suicide, and other damages: How nurses learn critical thinking. *Journal of Continuing Education in Nursing, 24*(5):197-205

Bull, P., Gadsby, J. & Williams, S. (2018). *Critical Mental Health Nursing: Observations from the Inside*. Monmouth: PCCS Books

Burgess, P., Pirkis, J., Jolley, D., Whiteford, H. & Saxena, S. (2004). Do nations' mental health policies, programs and legislation influence their suicide rates? An ecological study of 100 countries. *Australia and New Zealand Journal of Psychiatry, 38*:933-939.

Burstow, B. (2013). A Rose by Any Other Name: Naming and the Battle against Psychiatry. In LeFrançois, B., Menzies, R. & Reaume, G. (eds.) *Mad Matters: A Critical Reader in Canadian Mad Studies* (pp. 79-104). Ontario: Canadian Scholars' Press Inc.

Byrd, D. E. (1981). *Organizational Constraints on Psychiatric Treatment: The Outpatient Clinic.* Greenwich: JAI Press

Caestecker, F. (2000*). Alien Policy in Belgium 1840-1940: The Creation of Guest Workers, Refugees and Illegal Aliens.* Oxford: Berghahn Books

Callard, F. (2014). Psychiatric diagnosis: the indispensability of ambivalence*. Journal of Medical Ethics, 40*:526-530

Campbell, P. (2009). The service-user/survivor movement. In Reynolds, J., Muston, R., Heller, T., Leach, J., McCormick, M., Wallcraft, J. & Walsh, M. (eds) *Mental Health Still Matters.* Basingstroke: Palgrave Macmillan

Cederström, C. & Spicer, A. (2015). *The Wellness Syndrome*. Cambridge: Polity Press

Chan, P. (2002). In Whose Best Interests? An Examination of the Ethics of the UK Government's White Paper 'Reforming the Mental Health Act', *Journal of Psychiatric and Mental Health Nursing, 9:*399-404.

Charmaz, K. (2005). Grounded Theory in the 21st Century: Applications for Advancing Social Justice Studies In Denzin, N. K. & Lincoln, Y. S. (3rd ed). *Strategies of Qualitative Inquiry* (pp. 204-242). Thousand Oaks: Sage

Charmaz, K. (2006). *Constructing Grounded Theory: Practical Guide through Qualitative Analysis*. London: Sage

Chen, J-S. (2011). Beyond human rights and public health: Citizenship issues in harm reduction. *International Journal of Drug Policy, 22*(3), 184–188.

Clarke, A. E. (2005). *Situational Analysis: Grounded Theory after the Postmodern Turn*. Thousand Oaks: Sage.

Clayton, A., O'Connell, M. J., Bellamy, C., Benedict, P., & Rowe, M. (2013). The citizenship project part II: Impact of a citizenship intervention on clinical and community outcomes for persons with mental illness and criminal justice involvement. *American Journal of Community Psychology, 51*, 114–122

Clouder, L. (2003). Becoming professional: Exploring the complexities of professional socialisation in health and social care. *Learning in Health and Social Care, 2*(4):213-222

Cohen, L., (1992). Anthem. On *the Future* [MP3 file]. Montreal: Columbia

Coles, S., Keenan, S. & Diamond, B. (2013). *Madness Contested: Power and Practice.* Herefordshire: PCCS Books

Collins Dictionary (2019). In *Collins: Free Online Dictionary*. Retrieved from https://www.collinsdictionary.com/

Collins, H. (2010). *Tacit and Explicit Knowledge*. USA: University of Chicago Press.

Collins, P. H. (1991). *Black Feminist Thought: Knowledge, Consciousness and the politics of empowerment.* New York, NY: Routledge.

Cook, B. A. (2002). *Belgium: A History. Studies in Modern European History.* New York: Peter Lang Pub, New York.

Corbascio Fox, C. G. (2006). Mental Health Assistance in Italy: The Torino Rehabilitation Program. In Sapouna, L. & Hermann, P. *Knowledge in Mental Health: Reclaiming the Social* (pp. 69-83). New York: Nova Science Publishers, Inc.

Corbin, J. & Strauss, A. (2008). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (2nd ed). Thousand Oaks: Sage.

Corens, D. (2007) Belgium: Health system review. *Health Systems in Transition, 9*(2):1-172

Corker, E., Hamilton, S., Henderson, C., Weeks, C., Pinfold, V., Rose, D., Williams, P., Flach, C., Gill, V., Lewis-Holmes, E., Thornicroft, G. (2013). Experiences of discrimination among people using mental health service in England 2008-2011. *British Journal of Psychiatry, 202*:58-63.

Cormack, P. (1996). The paradox of Durkheim's manifesto: Reconsidering t*he Rules of Sociological Method. Theory and Society 25*(1):85-104

Corrigan, P. W., Watson, A. C., Byrne, P., & Davis, K. E. (2005). Mental illness stigma: Problem of public health or social justice? *Social Work, 50:*363–368.

Coulter, A. & Collins, A. (2011). *Making Shared Decision-making a Reality: No decision about me, without me.* London: King's Fund

Coy P.G. & Hedden, T. (2005). Stage Model of social movement co-optation: community mediation in the United States. *The Sociological Quarterly 46*(3):405-435

CP Saint-Bernard (2019). *Centre Psychiatrique Saint-Bernard MANAGE: Historique*. Available at: https://www.cp-st-bernard.be/qui-sommes-nous/historique/#1511353466300-48161d5d-6cb5 [Accessed March 2019]

Crawford, R. (1980). Healthism and the Medicalization of Everyday Life. *International Journal of Health Services, 10*(3):365-388.

Cresswell, J. W. (2013). *Qualitative Inquiry and Research Design: Choosing among Five Approaches* (3rd ed). Thousand Oaks: Sage.

Cresswell, M. & Spandler, H. (2013). The Engaged Academic: Academic Intellectuals and the Psychiatric Survivor Movement. *Social Movement Studies, 12*(2):138-154

Cresswell, M. & Spandler, H. (2016). Solidarities and Tensions in Mental Health Politics: Mad Studies and Psychopolitics. *Critical and Radical Social Work, 4(3):*357-373.

Crotty, M. (1998). *The Foundations of Social Research: Meaning and Perspective in the Research Process.* London: Sage

Curtis, K., Horton, K. & Smith, P. (2012). Student nurse socialisation in compassionate practice: A grounded theory study. *Nurse Education Today, 32*(7):790-5

Darkenwald, G.G. (1980) Field Research in Grounded Theory. In Long, H., Heimstra, R. and Associates. *Changing approaches to adult education.* London: Jossey-Bass.

Darton, K. (2016) *Making Sense of anti-psychotics.* Mind. Available at: https://www.mind.org.uk/media/4703393/antipsychotics-2016-pdf.pdf [Accessed March 2019]

Davar, B. (2016). Alternatives or a way of life? In Russo, J. & Sweeney, A. (Eds.), Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies (pp. 14-19). Monmouth: PCCS Books.,

Davidson, D. (1974). On the very idea of a conceptual scheme. *Proceedings and Address of the American Philosophical Association. 47*:5-20.

Davidson, L. (2005). Recovery, self-management and the expert patient-changing the culture of mental health from a UK perspective. *Journal of Mental Health, 14*(1):25-35

Davidson, L. & Roe, D. (2007). Recovery from versus recovery in serious mental illness: Once strategy for lessening confusion plaguing recovery. *Journal of Mental Health, 16*(4):459-470

Davidson, L., Bellamy, C., Guy, K. & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11(2):*123-128.

Davies, J. (2013). *Cracked: Why Psychiatry is doing More Harm than Good.* London: Icon Books.

Deegan, P. E. (1995). Principles of a recovery model including medication. Available at: https://power2u.org/wp-content/uploads/2016/06/MedicationMeetingPacket.pdf [Accessed February 2019]

Deegan, P. E. (1996). *Recovery and the Conspiracy of Hope. The Sixth Annual Mental Health Services Conference of Australia and New Zealand.* Brisbane: Australia

Deegan, P. E. (2009). Recovery: The lived experience of rehabilitation In Reynolds, J., Muston, R., Heller, T., Leach, J., McCormick, M., Wallcraft, J. & Walsh, M. (eds) *Mental Health Still Matters.* Basingstroke: Palgrave Macmillan

De Greef, V. (2018). Conclusion de la journée de réflexion In Service Droit des jeunes de Bruxelles. In *Le silence a du sens : Secret professionnel en danger*. (pp. 36-37) Available at: http://www.sdj.be/IMG/pdf/dossier458ter_final-2.pdf [Accessed March 2019]

Demarest, S., Gisle, L., Hesse, E. Miermans, P.-J., Tafforeau, J. & Van der Heyden, J. (2004) Enquête de Santé par Interview Belgique 2004. Bruxelles: Institut Scientifique de la Santé Publique. Available at: https://his.wiv-isp.be/fr/Documents%20partages/synthese_2004.pdf [Accessed March 2019]

Dell'Acqua, G. (1995). Trieste twenty years after: From the criticism of psychiatrist institutions to institutions of mental health. Trieste: www.triestesalutementale.it

Department of Health (2001). The Mental Health Policy Implementation Guide. London: TSO

Department of Health (2008). *Mental Health Act 1983 Code of Practice – 2008 Revision*. London: TSO

Denzin, N. K. & Lincoln, Y. S. (2017). *The SAGE Handbook of Qualitative Research* (5th ed). Thousand Oaks: Sage

DeRosse, P. & Karlsgodt, K. H. (2015). Examining the Psychosis Continuum. *Current Behavioural Neuroscience Reports, 2*(2):80-89

Deswaef, A. (2016*). Santé Mentale : Secret professionnel et pratiques de réseau*. Bruxelles: Ligue des droits de l'Homme. Available at: http://www.comitedevigilance.be/IMG/pdf/LDH_BrochureSP_santementale.pdf [Accessed March 2019]

de Witte, B. (1992). Surviving in Babel? Language rights and European integration. *The Protection of Minorities and Human Rights, 2*(1): 277-300.

De Witte, L. (2002). *The Assassination of Lumumba*. London: Verso

Dillon, J. & Hornstein, G. A. (2013). Hearing voices peer support groups: a powerful alternative for people in distress. *Psychological, Social and Integrative Approaches, 5*(3):286-295

Duquet, N. (2015) Paris attacks: Is Belgium Europe's favourite gun shop? *BBC News*. Available at: https://www.bbc.com/news/world-europe-34871872 [Accessed March 2019]

Durkheim, E. (1915). *The Elementary Forms of the Religious Life.* New York: Dover Publications, INC.

Durkheim, E. (1982). *The Rules of Sociological Method.* (Lukes, S, ed., W. D. Halls, trans.). New York: Free Press. (Original work published 1985)

Dy, S. & Purnell, T. (2012) Key concepts relevant to quality of complex and shared decision-making in healthcare: A literature Review. *Social Science and Medicine, 74*:582-587

Elstad, T. A & Hellzen, O. (2010). Community mental health centres: A qualitative study of professionals' experiences. *International Journal of Mental Health Nursing, 19*:110-115.

Engel, G. L. (1977). The Need for a New Medical Model: A Challenge for Biomedicine. *Science, 196(4286):*129-136

England, E. & Lester, H. (2005). Integrated mental health services in England: a policy paradox? *International Journal of Integrated Care, 5*, e24

Englert, M., Luyten, S., Mazina, D. & Missinne, S. (2017). Baromètre social: Rapport Bruxellois sur l'état de la pauvreté 2017. Bruxelles: Commission Communautaire Commune. Available at: http://www.ccc-ggc.irisnet.be/sites/default/files/documents/graphics/rapport-pauvrete/barometre-welzijnsbarometer/barometre_social_2017_fr.pdf [Accessed March 2019]

EPSM Lille-Metropole (2019). EPSM Lille-Metropole. [ONLINE] Available at: http://www.epsm-lille-metropole.fr/soins/59g21. [Accessed 14 January 2019]

Estroff, S. (1981). *Making it crazy: An ethnography of psychiatric clients in an American Community.* California: California University Press

Eurostat (2018) Population on 1 January – persons. Availlable at: https://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=tps00001&plugin=1 [Accessed March 2019]

Fabris, E. (2016). Community Treatment Orders: once a rosy deinstitutional notion. In Russo, J. & Sweeney, A. (Eds.), *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies* (pp. 97-105). Monmouth: PCCS Books.,

FAMGB – Fédération des Associations de Médecins Généralistes de Bruxelles (2018). *Livre Noir de la Santé Mentale à Bruxelles : Le vécu de médecins généralistes.* Bruxelles : Commission Santé Mentale de la FAMGB

Farnworth, L., Nikitin, L. & Fossey, E. (2004). Being in a Secure Forensic Unit: Every Day is the Same, Killing Time or Making the Most of It. *British Journal of Occupational Therapy, 67(10)*:430-438

Faulkner, A. & Kalathil, J. (2012). *The Freedom to be, the Chance to Dream: Preserving User-Led Peer Support in Mental Health*, commissioned by Together at: http://www.together-uk.org/wp-content/uploads/2012/09/The-Freedom-to-be-The-Chance-to-dream-Full-Report1.pdf [Accessed February 2019]

Felton, A., Repper, J. & Avis, M. (2017). Therapeutic relationships, risk, and mental health practice. *International Journal of Mental Health Nursing, 27*(3): 1137:1148

Felton, A. & Stacey, G. (2018). Power at play: The Doctor-Nurse Game in acute mental healthcare. In Bull, P., Gadsby, J. & Williams, S. (eds) *Critical Mental Health Nursing: Observations from the Inside*. (pp. 89-105). Monmouth: PCCS Books

Ferguson, I. (2007). Increasing User Choice or Privatizing Risk? The Antinomies of Personalization. *British Journal of Social Work, 37*:387-403

Fetterman, D. M. (2010). *Ethnography: Step by Step,* (3rd ed). Thousand Oaks: Sage.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), Brunner/Mazel psychological stress series, *No. 23. Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). Philadelphia: Brunner/Mazel

Filson, B. (2016) The haunting can end: trauma-informed approaches in healing from abuse and adversity. In Russo, J. & Sweeney, A. (Ed.), *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies* (pp. 35-45). Monmouth: PCCS Books.

Finkelstein, V. (1975). Phase 2: Discovering the person in 'disability' and 'rehabilitation'. *The Magic Carpet 27*(1):31-8

Foucault, M. (1972). *Histoire de la folie à l'âge classique*. Paris: Gallimard

Foucault, M. (1972). *The Archaeology of Knowledge* (A. Sheridan, Trans.). New York: Vintage (Original work published 1969)

Foucault, M. (1982). Truth, Power, Self: An Interview with Michel Foucault conducted by Martin, R. In Martin, R. H., Gutman, H. & Hutton, P. H. (1988). *Technologies of the self: A seminar with Michel Foucault* (pp. 9-15) London: Tavistock Publications

Foucault, M. (1983). Afterword: The Subject and Power In Dreyfus, H. L. & Rabinow, P. *Michel Foucault: Beyond Structuralism and Hermeneutics* (2nd ed). Chicago: University of Chicago Press

Foucault, M. (1976/1990). *The History of Sexuality: An Introduction, volume 1* (R. Hurley, Trans.). New York: Vintage, 1990. (Original work published 1976)

Foucault, M. (1978/1994). Dits et écrits : Tome IV. Paris: Gallimard (Original work 1978)

Foucault, M. (1977/1995). Discipline and Punish (A. Sheridan, Trans.). New York: Vintage (Original work published 1977)

Foucault, M. (1979/2004). *Naissance de la biopolitique: Cours au Collège de France 1978-1979* edited by Ewald, F., Fontana, A. & Senellart, M. Paris: Gallimard (Original work 1979)

Foucault M. (2006) *History of Madness* (Murphy J. & Khalfa J., Trans). New York: Routledge (Original work published 1961)

Foucault, M. (1978/2007). Security, Territory, Population. Lectures at the Collège de France 1977 – 1978 (G. Burchell, Trans). New York: Palgrave Macmillan (Original work published in 1978)

Foucault, M. (2008). *The Birth of Biopolitics*. Lectures at the Collège de France 1978 – 1979 (G. Burchell, Trans). New York: Palgrave Macmillan

Frances, A. (2013). *Saving Normal*. New York: William Morrow.

Frank, A. W. (1997). *The Wounded Storyteller: Body, Illness and Ethics.* Chicago: University of Chicago Press

Frank, A.W., (2012). *Letting stories breathe: a socio-narratology*. London: University of Chicago Press.

Freidson, E. (1970). *Professional Dominance: The Social Structure of Medical Care*. New Jersey: Transaction Publishers.

Freire, P. (1970). *Pedagogy of the oppressed*. New York: Seabury Press

Fricker, M. (2007). *Epistemic Injustice: Power and the Ethics of Knowing.* Oxford: Oxford University Press.

Friedli, L. (2009). *Mental Health, Resilience and Inequalities*. Copenhagen: WHO.

Friedli, L. & Stearn, R. (2015). Positive affect as coercive strategy: conditionality activation and the role of psychology in UK government workfare programmes. *Medical Humanities, 41:*40-47

Gantt, A. B. & Green, R. S. (1986). Telling the Diagnosis. *Social Work in Healthcare, 11*(2):101-110

Gask, L. & Khanna, T. (2011). Ways of working at the interface between primary and specialist mental healthcare. *The British Journal of Psychiatry, 198*(1):3-5

Geekie, J. & Read, J. (2009). *Making Sense of Madness: Contesting the Meaning of Schizophrenia.* Abington-on-Thames: Routledge

Gilburt, H., Rose, D. & Slade, M. (2008). The importance of relationships in mental healthcare: A qualitative study of service-users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research, 8*:92-104.

Giot, M. & Mann, N. (2016) Quel est le rôle des «maisons pirates» qui accueillent des personnes en difficultés, sans cadre légal. *RTBF.be* Available at: https://www.rtbf.be/info/regions/liege/detail_quel-est-le-role-des-maisons-pirates-qui-accueillent-des-personnes-en-difficultes-sans-cadre-legal?id=9428982 [Accessed March 2019]

Glaser, B. G. (1992). *Basics of Grounded Theory Analysis.* Mill Valley: Sociology Press.

Glaser, B. G. (1994). *More Grounded Theory Methodology: A Reader.* Mill Valley: Sociology Press.

Glaser, B. G. & Strauss A. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patient and other inmates*. New York: Anchor Books

Goldstein, J. L. & Godemont, M. M. L. (2003). The Legend and Lessons of Geel, Belgium: A 1500-Year-Old Legend, a 21st-Century Model. *Community Mental Health Journal, 39*(5):441-458

Gosling, J. (2010). The Ethos of Involvement as the route to recovery. In Weinsten, J. (ed.). *Mental Health Service-user Involvement and Recovery*. London: Jessica Kingsley.

Grebowicz, M. (2005). Consensus, Dissensus, and Democracy: What is at Stake in Feminist Science Studies. *Philosophy of Science, 72*(5):989-1000

Greenberg, G. (2013). *The Book of Woe. The DSM and the Unmaking of Psychiatry.* London and Melbourne: Scribe Press.

Gronholm, P.C., Henderson, C., Deb, T. & Thornicroft, G. (2017). Interventions to reduce discrimination and stigma: the state of the art. *Social Psychiatry and Psychiatric Epidemiology, 52*(2):249-258.

Gutting, G. (2005). *Foucault: A Very Short Introduction*. Oxford: Oxford University Press

Hacking, I. (1999). *The Social Construction of What?* London: Harvard University Press.

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care,* 1:188-196.

Harding, C.M., Brooks, G. W., Ashikaga, T., Strauss, J.S & Breier A. (1987). The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia*. American Journal of Psychiatry, 144*(6):727-735.

Harris, M. (1968). *The Rise of Anthropological Theory: A History of Theories and Culture*. New York: T. Y. Crowell.

Helman, C. G. (1981). Disease versus illness in general practice. *Journal of the Royal College of General Practitioners, 31*:548-552

Herman, E.S. & Chomsky, N. (1988). *Manufacturing Consent: The Political Economy of the Mass Media.* London: Vintage

Hoffman, M. (2011). Protester debate what demands, if any, to make. *The New York Times.* Available at: https://www.nytimes.com/2011/10/17/nyregion/occupy-wall-street-trying-to-settle-on-demands.html [Accessed February 2019]

Holley, L. C., Stromwall, L. K. & Bashor, K. H. (2012). Reconceptualizing Stigma: Toward a Critical Anti-Oppression Paradigm. *Stigma Research and Action, 2(2):*51-61.

Holloway, I. (2008). A-Z of Qualitative Research in Healthcare. (2nd ed). Chichester: Blackwell.

Holloway, I. & Wheeler, S. (2009). *Qualitative Research in Nursing.* Chichester: Blackwell.

Hughes, E. C. (1971). *The Sociological Eye.* Chicago: Aldine

Illich, I. (1975). *Medical Nemesis: The Expropriation of Health*. New York: Pantheon Books

Inwood, J. & Alderman, D. (2016) How grassroots truth and reconciliation commissions can help activists to reclaim their communities and advance social justice. Available at: http://blogs.lse.ac.uk/usappblog/2016/06/17/how-grassroots-truth-andreconciliation-commissions-can-help-activists-to-reclaim-their-communities-andadvance-social-justice [Accessed February 2019]

Iqbal, N., Rees, M. & Backer, C. (2013). Decision-making, responsibility and accountability in community mental health teams. *Mental Health Practice, 17*(7):26-28.

Johnson, S. & Thornicroft, G. (2008). The development of crisis resolution and home treatment teams. In Johnson, S., Needle, J., Bindman, J. & Thornicroft, G. (Ed.) *Crisis Resolution and Home Treatment in Mental Health.* Cambridge: Cambridge University Press.

Joseph, A. J. (2015). Beyond Intersectionalities of Identity or Interlocking Analyses of Difference: Confluence and the Problematic of “Anti”- oppression*. Intersectionalities, 4*(1):15-39.

Joyce, P.R, Khan, A. & Jones, A.V. (1981). The revolving door patient. *Comprehensive Psychiatry, 22*(4):397-403

Junker, B. H. (1960). *Field Work: An Introduction to the Social Sciences*. Chicago: University of Chicago Press.

Kalathil, J. & Perry, E. (2014). Speaking about Ourselves. *Mental health Today.* May-June: 21.

Kalathil, J., Collier, B., Bhakta, R., Daniel, O., Joseph, D. & Trivedi, P. (2011). *Recovery and Resilience: African, African-Caribbean and South Asian Women's Narratives of Recovering from Mental Distress.* London: Mental Health Foundation

Klein, R. (2010) What is Health and How Do You Get It? In Metzl, J. M. & Kirkland, A. (2010). *Against Health: How Health Became the New Morality.* (pp. 15-25) New York: New York University Press.

Kuhn, T. S. (1962). *The Structure of Scientific Revolutions*. Chicago: University Chicago Press.

Kupfer, D., First, M. & Regier, D. (2002). *A Research Agenda for DSM-V*. Washington, DC: APA.

Kvale, S. (1996). *InterViews: An Introduction to Qualitative Research Interviewing.* Thousand Oaks: Sage.

Laurence, J. (2003). *Pure Madness: How Fear Drives the Mental Health System.* London: Routledge

Larousse (2012). *Anglais: Dictionnaire de poche*. France: Larousse.

L'Autre «lieu» (2019*) L'administration provisoire de biens : KESSEKSSA ?* Bruxelles: L'Autre «lieu» Available at: http://www.autrelieu.be/documents/biblio/ecrits/admin_contenu_site.pdf [Accessed March 2019]

Lefebre, H. (1991). *The Production of Space*. Oxford: Blackwell.

LeFrançois, B. A., Menzies, R. & Reaume, G. (2013). *Mad Matters: A Critical Reader in Canadian Mad Studies.* Toronto: Canadian Scholars' Press Inc.

Lister, R. (2004). *Poverty*. Cambridge: Polity Press

Longden, E., Corstens, D. & Dillon, J. (2013). Recovery, Discovery and Revolution: The work of Intervoice and the Hearing Voices Movement In Coles, S., Keenan, S. & Diamond, B. *Madness Contested: Power and Practice.* Ross-on-Wye: PCCS Books

Lorde, A. (1984). *Sister outsider: Essays and speeches by Audre Lorde*. Berkeley: Crossing

Lupton, D. (1997). Foucault and the Medicalisation Critique In Petersen, A. & Burton, R. (eds) *Foucault, Health and Medicine.* London and New York: Routledge

Macdonald, D. (2016). Crisis Theory and Types of Crisis. Available at: http://dustinkmacdonald.com/crisis-theory-types-crisis/ [Accessed March 2019]

Maben, J., Latter, S. & Macleod Clark, J. (2006). The theory-practice gap: Impact of professional-bureaucratic work conflict on newly-qualified nurses*. Journal of Advanced Nursing, 55*(4):465-477

Mallet, S. (2004). Understanding home: A critical review of the literature. *The Sociological Review, 52(1)*:61-89

Marchal, C. (2019) *La mise en obs' sous expertise : Une campagne d'information et de sensibilisation de l'Autre «lieu».* Bruxelles: L'Autre «lieu». Available at: http://www.autrelieu.be/documents/biblio/ecrits/MEO_contenu.pdf [Accessed March 2019]

Matthias, M., Salyers, M., Rollins, A., & Frankel, R. (2012). Decision-making in recovery orientated mental healthcare. *Psychiatric Rehabilitation Journal, 35*(4):305-314

McCall, L. (2005). The Complexity of Intersectionality. *Signs: Journal of Women in Culture and Society, 30(2):*1771-1800.

McEvoy & McConnachie (2013) Victims and Transitional Justice: Voice, Agency and Blame. *Social and Legal Studies, 22*(4):489-513

McKeown, M. & Foley, P. (2015) Reducing physical restraint: an employment relations perspective. *Journal of Mental Health Nursing, 35*(1):12-15.

McKeown, M., Scholes, A., Jones, F. & Aindow, W. (2017) Coercive practices in mental health services: stories of recalcitrance, resistance and legitimation. In Daley, L. Costa & P. Beresford (Eds) *Madness, Violence and Power*. (pp. 201-220) University of Toronto Press, Toronto

McKeown, M. & Spandler, H. (2017). Exploring the Case for Truth and Reconciliation in Mental Health Services. *Mental Health Review, 22*(2):83-94

McGuire-Snieckus, R., McCabe, R. & Priebe, S. (2003). Patient, client or service-user? A survey of patient preferences of dress and address of six mental health professions. *F*(8):305-308

McInerney, S. J. (2018). Introducing the Biopsychosocial Approach as the Model for Good Medicine and Good Doctors. *British Medical Journal, 24 (7353):*1533.

Mead, G. H. (1932). *Philosophy of the Present.* LaSalle, IL: Open Court Press

Mead, M. A., Hohenshil, T. H. & Kusum, S. (1997). How the DSM System Is Used by Clinical Counselors: A National Study. *Journal of Mental Health Counselling, 19*(4):338-401

Meadows, G. N., Harvey, C. A., Joubert, L., Barton, D. & Bedi, G. (2007). Best practices: the consultation-liaison in primary-care psychiatry program: a structured approach to long-term collaboration. *Psychiatric Services, 58*(8):1036:1038

Meers, J. (2018) Belgium: Tax haven and hell. *The Brussels Times* Available at: http://www.brusselstimes.com/magazine2/11080/belgium-tax-haven-and-hell [Accessed March 2019]

Mental Health Foundation (2012). *Peer Support*. Available at: https://www.mentalhealth.org.uk/a-to-z/p/peer-support [Accessed February 2019]

Merton, R. K. (1967). *On Theoretical Sociology: Five Essays, Old and New.* New York: Free Press

Metzl, J. M. (2010) Introduction: Why “Against Health”? In Metzl, J. M. & Kirkland, A. (2010). *Against Health: How Health Became the New Morality.* (pp. 1- 11) New York: New York University Press.

Metzl, J. M. & Kirkland, A. (2010). *Against Health: How Health Became the New Morality.* New York: New York University Press.

Mezzina, R. (2014). Community Mental Healthcare in Trieste and Beyond. An “Open Door-No Restraint” System of Care for Recovery and Citizenship. *The Journal of Nervous and Mental Disease, 202*(6): 451-459.

Milton, A. C. & Mullan, B. A. (2014). Communication of a mental health diagnosis: a systematic synthesis and narrative review. *Journal of Mental Health, 23*(5):261-270

Minkowitz, T. (2015) Advancing the Rights of Users and Survivors of Psychiatry using the UN Convention on the Rights of People with Disabilities in Spandler, H. Anderson, J. and Sapey, B. (Eds) *Madness, Distress and The Politics of Disablement* (pp. 171-182). Bristol: Policy Press

Moncrieff, J. (2008). *The Myth of the Chemical Cure: A Critique of Psychiatric Drug treatment*. Basingstoke: Palgrave Macmillan

Morfee, A. (2002) *Antonin Marie Joseph Artaud*. Gale Literature Resource Center Available at: http://go.galegroup.com/ps/i.do?id=GALE%7CH1200010684&v=2.1&u=csunorthridge&it=r&p=LitRC&sw=w&asid=ca041aa318b4b8e9fe8d56620a267715 [Accessed March 2019]

Moriarty, J. et al. (2007). *Practice guide: the participation of adult service-users, including older people, in developing social care.* London: Social Care Institute for Excellence

Morgan, A., Felton, A., Fulford, B., Kalathil, J. & Stacey, G. (2016). *Values and Ethics in Mental Health: An Exploration for Practice.* London: Palgrave

Morgan, D. L. (1996). Focus Groups. *Annual Review of Sociology 22,* 129

Morrison, T. (1993). *Toni Morrison: Nobel Lecture*. The Nobel Prize. Available at: https://www.nobelprize.org/prizes/literature/1993/morrison/lecture/ [Accessed March 2019]

Morse, J., Stern, P. N., Corbin, J., Bowers, C., Charmaz, C. & Clarke, A. (2009). *Developing Grounded Theory: The Second Generation.* Walnut Creek, CA: Left Coast Press.

Myers, M. D. (2013). *Qualitative Research in Business and Management.* Thousand Oaks: Sage.

Myria (2015). Myriatics #2 – décembre 2015 : Immigré, étranger, Belge d'origine étrangère : de qui parle-t-on ? Brussels: Myria – Federal Migration Service. Available at: https://www.myria.be/files/Myriatics2__layout.pdf [Accessed March 2019]

Nagy, R. L. (2012). The Scope and Bounds of Transitional Justice and the Canadian Truth and Reconciliation Commission. *International Journal of Transitional Justice, 7*(1):52-73

Natalis, S. & Pieters, G. (2016) Manuel des pratiques innovantes. Available at: http://www.innopsy107.be/images/Pdf/Guide_FR.pdf [Accessed March 2019]

National Audit Office (2007). *Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services.* London: The Stationary Office.

National Collaborating Centre for Mental Health (2011). *Common Mental Health Disorders: Identification and Pathways to Care.* Leicester: The British Psychological Society: Leicester and London: The Royal College of Psychiatrists. Available at: https://www.nice.org.uk/guidance/cg123/evidence/cg123-common-mental-health-disorders-full-guideline3 [Accessed March 2019]

NICE – National Institute for Health and Care Excellence (2013). Patient and Public Involvement Policy. Available at: https://www.nice.org.uk/about/nice-communities/nice-and-the-public/public-involvement/public-involvement-programme/patient-public-involvement-policy [Accessed March 2019]

Nicholas, A., Reifels, L. King, K. & Pollock, S. (2014). *Mental Health and the NDIS: A Literature Review.* Melbourne: Centre for Mental Health, University of Melbourne

O'Connell, B. (2005). *Solution-focused Therapy.* London: Sage.

O'Hagan, M. (2014). *Madness Made Me*. Wellington: Open Box

Oishi, E. (2006). Austin's Speech Act Theory and the Speech Situation. *Esercizi Filosofici, 1*:1-14.

Oksala, J. (2013). From Biopower to Governmentality. In Falzon, C., O'Leary, T. & Sawicki, J. (eds). *A Companion to Foucault.* (pp. 320-336) West Sussex: Willey-Blackwell

Olson, M. (2015). An Auto-Ethnographic Study of "Open Dialogue": The Illumination of Snow. *Family Process, 54*(4):716-129

Onyett, S., Pillinger, T. & Muijen, M. (1995). *Making Community Mental Health Teams Work: CMHTs and the People Who Work in Them.* The Sainsbury Centre for Mental Health: London.

Otkay, J. S. (2012) *Grounded Theory Pocket Guide*. Oxford: Oxford University Press.

Paradox (2019). In *Oxford English dictionary*. Available at https://en.oxforddictionaries.com/definition/paradox [Accessed March 2019]

Pembroke, L. (ed.) (1994). *Self-harm: Perspectives from Personal Experience*. London: Survivors Speak Out.

Pembroke, L. (2009). Mind Your Language. *Open Mind, 156*:6-9

Penney, D. & Prescott, L. (2016). The co-optation of survivor knowledge: the danger of substituted values and voice. In Russo, J. & Sweeney, A. (Ed.), *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies* (pp. 35-45). Monmouth: PCCS Books.

Pierre, M. P. (2008). Deconstructing Schizophrenia for DSM-V: Challenges for clinical and research agendas. *Clinical Schizophrenia and Related Psychoses, 2*(2):166-74.

Pilgrim, D. (2008). 'Recovery' and mental health policy. *Chronic Illness, 4*(4):295-304.

Pilgrim, D. (2009). *Key Concepts in Mental Health* (2nd Ed) London: Sage

Pinfold, V. (2000). 'Building up safe havens… all around the world': users' experiences of living in the community with mental health problems. *Health & Place, 6*(3):201-212.

Plumb, A. (2015). UN Convention on the Rights of Persons with Disabilities: out of the frying pan into the fire? Mental health service-users and survivors aligning with the disability movement. In Spandler, H., Anderson, J. & Sapey, B.(Eds) *Madness, distress and the politics of disablement.* (pp. 183- 198). Bristol: Policy Press

Polanyi, M. (1967). *The Tacit Dimension*. London: Routledge & Kegan Paul.

Prior, L. (1993). *The Social Organization of Mental Illness.* London: SAGE.

Prus, R. C. (1996). *Symbolic Interaction and Ethnographic Research: Intersubjectivity and the Study of Human Lived Experience.* New York: State University of New York Press.

Psytoyens (2017). *Loi : Administration des biens et de la personne.* Bruxelles: Psytoyens ASBL Available at: https://www.psytoyens.be/ressources/loi-administration-des-biens-et-de-la-personne/ [Accessed March 2019]

Psytoyens (2014). *L'usager comme partenaire de soins en santé mentale : Guide à destination de professionnels de la santé mentale.* Bruxelles: Psytoyens ASBL Available at:

https://www.psytoyens.be/ressources/guide-lusager-comme-partenaire-de-soins-en-sante-mentale/ [Accessed March 2019]

Rabinow, P. (1984). *The Foucault Reader*. New York: Pantheon Books

Raine, R., Carter, S., Sensky, T. & Black, N. (2006). 'Referral into a void': opinions of general practitioners and others on single point of access to mental healthcare. *Journal of the Royal Society of Medicine, 98*:153:157

Rajkumar, A. P., Brinda, E. M., Duba, A. S., Thangadurai, P. & Jacob, K. S. (2013). National suicide rates and mental health system indicators: an ecological study of 191 countries. *International Journal of Law and Psychiatry, 36(5-6):*339-342

Razack, S. (1998). *Looking white people in the eye: Gender, race, and culture in courtrooms and classrooms.* Toronto, ON: University Toronto Press.

Read, J., Mosher, L. & Bentall, R. (2004). *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia.* Hove: Brunner-Routledge

Read, J. & Dillon, J. (2013). Models of Madness: Psychological, Social and Biological Approaches to Psychosis (2nd ed). London and New York: Routledge.

Recovery (2019). In *Oxford Dictionary*. Available at: https://en.oxforddictionaries.com/definition/recovery [Accessed March 2019]

Recovery in the Bin (2009). RITB – Key Principles. Available at: https://recoveryinthebin.org/ritbkeyprinciples/ [Accessed February 2019]

Repper, J. & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 24*(4):392:411

Repper, J. & Perkins, J. (2009). Recovery and social inclusion: Changing the mental health agenda. In Brooker, C. & Repper, J. (eds). *Mental Health from Policy to Practice.* Edinburgh: Churchill Livingstone.

Rijckmans, M., Garretsen, H., van de Goor, I. & Bongers, I. (2007). Demand-oriented and demand-driven healthcare: the development of a typology. *Scandinavian Journal of Caring Sciences, 21*(3):406-416.

Robinson, S., Murrells, T., Hickey, G., Clinton, M. & Tingle, A. (2005). A Tale of Two Courses: Comparing Careers and Competencies of Nurses Prepared via Three-year Degree and Three-year Diploma Courses. Kings College London Nursing Research Unit, Careers and Working Lives Research. Available at: https://www.kcl.ac.uk/nursing/research/nnru/publications/Reports/A-tale-of-two-courses-2003.pdf [Accessed February 2019]

Roelandt, J-L., Daumerie, N., Defromont, L,. Caria, A., Bastow, P. & Kishore, J. (2014). Community mental health service: an experience from the East Lille, France. *Journal of Mental Health and Human Behaviour 19:*10-18.

Rogers, C. (1951). *Client-centred Therapy: Its Current Practice, Implications and Theory.* London: Constable.

Rogers, A. & Pilgrim, D. (2014). *A Sociology of Mental Health and Illness (5th ed).* Berkshire, UK: Open University Press

Rose, E. (2015) Twenty Years Since Democracy in South Africa: Reconsidering the Contributions of the Truth and Reconciliation Commission. *Melbourne Journal of Politics, 37*:61-77.

Rose, D. (2016) Book review: Bonnie Burstow (2015) Psychiatry and the business of madness: an ethical and epistemological accounting. *Critical and Radical Social Work, 4*:433-337

RTBF (2018). Élections communales 2018 : les gagnants et les perdants, ce qu'il faut retenir. *RTBF.be* Available at: https://www.rtbf.be/info/belgique/detail_elections-communales-2018-les-gagnants-et-les-perdants-ce-qu-il-faut-retenir?id=10046597 [Accessed March 2019]

Russo, J. (2012). *'Give me your story and I will take care of the rest?': The case of Agnes's Jacket: A psychologist's search for the meaning of madness*. *Asylum*, winter:28-30.

Russo, J. (2016). Towards our own framework, or reclaiming madness part two. In Russo, J. & Sweeney, A. (Ed.), *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies* (pp. 59-68). Monmouth: PCCS Books

Russo, J. & Shulkes, D. (2015). What we talk about when we talk about disability: Making sense of debates in the European user/survivor movement In Spandler, H., Anderson, J. & Sapey, B. (eds). *Madness, Distress and the Politics of Disablement.* (pp. 27-42) Bristol: Policy Press

Russo, J. & Sweeney, A. (2016). *Searching for a rose garden: Challenging psychiatry, fostering mad studies.* Monmouth, UK: PCCS Books

Said, E. W. (1978). *Orientalism* (5th Ed.). London: Penguin Classics

Sangalang, C. C. & Vant, C. (2017). Intergenerational Trauma in Refugee Families: A Systemic Review. *Journal of Immigrant and Minority Health, 19*(3):745-754

Sartorius, N. (2007). Stigma and mental health. *The Lancet, 370*(9590):810-811.

Sayce, L. (2016). *From psychiatric patient to citizen revisited*. Basingstoke: Palgrave

Scott, A. & Wilson, L. (2011). Valued identities and deficit identities: Wellness Recovery Action Planning and self-management in mental health. *Nursing Inquiry, 18*(1):40-49

Scull, A. (1977). *Decarceration.* Prentice-Hall: Eaglewood Cliffs.

Sedgwick, P. (1982/2015). *Psycho Politics: Laing, Foucault, Goffman, Szasz and the Future of Mass Psychiatry*. Unkant Puplishers: London. (Original work published 1982)

Seikkula, J., Aaltonen, J., Birgittu, A., Haarakangas, K., Keränen, J. & Lehtinen, K. (2006). Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research, 16*(2):214:228

Seikkula, J. & Olson, M. (2003). The open dialogue approach to acute psychosis: Its poetics and micropolitics. Family Process, 42:403-18

Sen, D. & Sexton, A. (2015). More voice, less ventriloquism: building a mental health recovery archive. In Russo, J. & Sweeney, A. (Ed.), *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies* (pp. 163-171). Monmouth: PCCS Books.

Service Public Fédéral Belge (2019a). La Belgique, un Etat fédéral. Service Public Fédéral Belge. Available at: https://www.belgium.be/fr/la_belgique/pouvoirs_publics/la_belgique_federale [Accessed March 2019]

Service Public Fédéral Belge (2019b). *CPAS.* Service Public Fédéral Belge. Available at: https://www.belgium.be/fr/famille/aide_sociale/cpas [Accessed March 2019]

Service Soins de Santé Psychosociaux (2010). Guide vers de meilleurs soins de santé mentale. SPF Santé Publique

Shah, A., Bhandarkar, R. & Bhatia G. (2010). The relationship between general population suicide rates and mental health funding, service provision and national policy: a cross-national study. *International Journal of Social Psychiatry, 56(4):*448-453

Shimrat, I (2013). The Tragic Farce of "Community Mental Healthcare" LeFrançois, B. A., Menzies, R. & Reaume, G. (eds). *Mad Matters: A Critical Reader in Canadian Mad Studies.* (pp. 144-157). Toronto: Canadian Scholars' Press Inc.

Simmonds, S., Coid, J., Joseph, P., Marriott, S. & Tyrer, P. (2001). Community mental health team management in severe mental illness: a systematic review. *British Journal of Psychiatry, 178:*497-502

Slade, M. & Longden, E. (2015). Empirical evidence about recovery and mental health. *BMC Psychiatry, 15*:285-299

Smith, D. (2005)*. Institutional Ethnography: A sociology of the people*. Landham: Altamira Press

Smith, W. K. & Lewis, M. W. (2011). Towards a theory of paradox: A dynamic equilibrium model of organising. *Academy of Management Review, 36*(2):381-403.

Smyth M.G. & Hoult J. (2000) The home treatment enigma. *British Medical Journal 320*, pp.305-9

Snow, N. & Austin, W. J. (2009). Community Treatment Orders: The Ethical Balancing Act in Community Mental Health*. Journal of Psychiatric and Mental Health Nursing, 16*(2):177-186

Snyder, C. R. & Lopez, S. J. (2002). *Handbook of Positive Psychology*. New York: Oxford University Press

Sood, L., Owen, A., Onyon, R., Sharma, A., Nigriello, J., Markham, D. & Seabrook, H. (2017). Flexible assertive community treatment (FACT) model in specialist psychosis teams: an evaluation. *British Journal of Psychiatry Bulletin, 41*(4):192-196.

Spandler, H. (2007). From Social Exclusion to Inclusion? A Critique of the Inclusion Imperative in Mental Health. *Medical Sociology Online, 2*(2):3-16

Spandler, H. (2016a) From Psychiatric Abuse to Psychiatric Neglect? *Asylum magazine, 23*(2):7-8

Spandler, H., Anderson, J. & Sapey, B. (2015). *Madness, Distress and the Politics of Disablement.* Bristol: Policy Press

SPF Intérieur (2014). *Chambre : Répartition des sièges*. Available at: http://elections2014.belgium.be/fr/cha/seat/seat_CKR00000.html [Accessed March 2019]

Shaw, C. (2016). Deciding to be alive: self-injury and survival. In Russo, J. & Sweeney, A. (Ed.), *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies* (pp. 77-85). Monmouth: PCCS Books.

Shea, M., Elkin, I., Imber, S., Sotsky, S., Watkins, J. Colins, J. et al (1992). Course of depressive symptoms over follow-up: Findings from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Archives of General Psychiatry, 49*:782-787.

Starquit, O. (2018) Les mots importent. *Agir par la culture : Magazine politique culturel*. Available at: https://www.agirparlaculture.be/index.php/reflexions/446-les-mots-importent [Accessed March 2019]

Statbel (2018). Emploi et chômage : *Taux d'emploi, taux de chômage, taux d'activité par sexe pour la Belgique et les régions, derniers 4 trimestres*. Belgium : Statbel, La Belgique en chiffres Available at: https://statbel.fgov.be/fr/themes/emploi-formation/marche-du-travail/emploi-et-chomage#figures [Accessed March 2019]

Stein, D., Seedat, S., Kaminer, D., Moomal, H., Herman, A., Sonnega, J. & Williams, D. (2008). The impact of the truth and reconciliation commission on psychological distress and forgiveness in South Africa. *Social Psychiatry and Psychiatric Epidemiology, 43:*462-468.

Stern, P. N. & Porr, C. J. (2011). *Essentials of Accessible Grounded Theory*. Walnutt Creek: Left Coast Press.

Strauss, A. (1987). *Qualitative Analysis for Social Scientists*. London: Sage.

Strauss, A. & Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, (2nd ed). London: Sage.

Stuart, H. (2008). Reducing the stigma of mental illness. *Global Mental Health, 3(17):*1-14.

Stuart, H. (2013). Fighting the stigma caused by mental disorders: past perspectives, present activities and future direction. *World Psychiatry, 7*(3):185:188

Sweeney, A., Clement, S., Filson, B. & Kennedy, A. (2016) Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal, 21*(3):174-192.

Szasz, T. (1973). *Ideology and Insanity: Essays on the Psychiatric Dehumanisation of Man.* London: Calder and Boyers.

Szmukler, G. & Appelbaum, P. S. (2008). Treatment pressures, leverage, coercion, and compulsion in mental health. *Journal of Mental Health, 17(3)*:233-244

Thomas, P. (2014). *Psychiatry in Context: Experience, Meaning & Communitites*. Monmouth: PCCS Books

Thomas, P. (2016). Psycho Politics, neoliberal governmentality and austerity. *Self & Society, 44(4):*382-393.

Thornicroft, G., Rose, D., Kassam, A. & Sartorius, N. (2007). Stigma: ignorance, prejudice or discrimination? *British Journal of Psychiatry, 190*:192-193

Thornicroft, G. & Tansella, M. (2004). Components of a modern mental health service: a pragmatic balance of community and hospital care: Overview of systemic evidence. *The British Journal of Psychiatry, 185*(4):283-290

Thornicroft, G. & Tansella, M. (2013). The balanced care model: the case for both hospital- and community-based mental healthcare. *British Journal of Psychiatry, 202*(4):246-8

United Nations (2006). *Convention on the Rights of Persons with Disabilities*. New York: UN

Urquhart, C. (2013). *Grounded Theory for Qualitative Research: A Practical Guide.* Thousand Oaks: Sage

Van der Jeugt, P. (2015). *Connecting mobile mental health teams expertise in Europe: April 2012-April 2015. Mobile Mental Health Teams in Belgium – Formation programme based on expertise in other countries.* Belgium: Belgian Federal Public Service-Health.

Veldhuizen, J. R. van & Bähler, M. (2013). *Manual Flexible Assertive Community Treatment: Vision, model, practice and organization.* Groningen: Manual Flexible ACT

Verne, J. (1870/2001). Vingt mille lieues sous les mers : Tour de monde sous-marin. Paris : Librairie Générale Française

Verniest, R. Laenen, A. Daems, A. Kohn, L., Vandermeersch, G. Fabri, V., Mertens, R. Van Audenhove, C. & Leys, M. (2008). *Les séjours psychiatriques de longue durée en lits T: KCE reports 84B.* Brussels: Centre fédéral d'éxpertise des soins de santé (KCE) Available at: https://kce.fgov.be/sites/default/files/atoms/files/d20081027347.pdf [Accessed March 2019]

Vervliet, M., Reynaert, D., Verelst, A., Vindevogel, S. & De Maeyer, J. (2017). "If You Can't Follow, You're Out." The Perspectives of People with Mental Health Problems on Citizenship. Applied Research Quality of Life, 1-18

Vigh, H. (2009). Motion Squared: A Second Look at the Concept of Social Navigation. *Anthropological Theory, 9(4):*419-438.

Wacquant, L. (1998). Pierre Bourdieu. In Stones, R. (1998). *Key Sociological Thinkers* (pp. 215-229). London: MacMillian Press Ltd.

Walker, G., & Bryant, W. (2013). Peer support in adult mental health services: a metasynthesis of qualitative findings. *Psychiatric Rehabilitation Journal, 36*(1):28-34

Wallcraft, J., Schrank, B. & Amering, M. (2009). *Handbook of Service-user Involvement in Mental Health Research.* London: Wiley

Wallcraft, J & Shulkes, D. (2012) Can Psychiatry Apologise for Crimes Against Humanity? *Open Mind Jan and Feb*: 12-13

Warner, R., de Girolamo, G., Belelli, G., Bologna, C., Fioretti, A. & Rosi, G. (1998). The quality of life of people with schizophrenia in Boulder, Colorado and Bologna, Italy. *Schizophrenia Bulletin, 24*(4):559-568.

Webb, D. (2016). Thinking (differently) about suicide. In Russo, J. & Sweeney, A. (Eds*.), Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies (pp. 86-96).* Monmouth: PCCS Books.

Wegner, D. M. (1987). Transactive Memory: A Contemporary Analysis of the Group Mind. In Mullen, B. 7 Goethals, G. R. (eds) *Theories of Group Behaviour* (pp. 185-208). New York: Springer-Verlag New York Inc

Whitaker, R (2010). Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs and the Astonishing Rise of Mental Illness in America. New York: Broadway Paperbacks.

Wolcott, H. (2008). *Ethnography: a way of seeing*. Thousand Oaks: Sage.

World Health Organisation (WHO) (1994). *International Classification of Diseases* (10th ed). Geneva: WHO

WHO (2001). *Mental Health: New Understanding, New Hope*. Geneva: WHO.

WHO (2002). *Mental Health: Responding to the Call for Action*. Geneva: WHO

WHO (2008). *Policies and Practices for Mental Health in Europe: Meeting the Challenges*. Geneva: WHO

WHO (2014). *Preventing suicide: A global imperative.* Geneva: WHO

Witte, E., Craeybeckx, J. & Meynen, A. (2010). Political History of Belgium: From 1830 Onwards. Brussels: Academic and Scientific Publishers

Witte, E. & Mares, A. (2001). *19 keer Brussel = 19 fois Bruxelles = 19 times Brussels*. Brussels: VUBPRESS

Yank, G. R., Barber, J. W., Hargrove, D. S. & Whitt, P. D. (1992). The Mental Health Treatment Team as a Work Group: Team Dynamics and the Role of the Leader. *Psychiatry, 55*:250:264

Yin, R. K. (2009). *Case study research: Design and methods* (4th Ed.). Thousand Oaks, CA: Sage

Ziarek, E. P. (2001). *An Ethics of Dissensus: Postmodernity, Feminism, and the Politics of Radical Democracy*. California: Stanford University Press

[This page intentionally left blank]

Appendices

[This page intentionally left blank]

Appendix A: Legal procedures used in mental health

Appendix A.1: Treating Medical Bodies

In Belgium, there is usually a nominated 'treating' doctor, who is an equivalent of a general practitioner in the UK system (Corens, 2007). The same concept is often used for psychiatrists, with one psychiatrist effectively acting as a 'treating' psychiatrist. This means that s/he is the main agent in setting up a person's psychiatric treatment (especially pharmacological). In this way, a person can still visit other psychiatrists if s/he wishes.

Whilst in hospital, a person is mainly treated by the ward doctor and no longer by their 'treating' psychiatrist in the community, who takes on a secondary role. When somebody is forcibly admitted, a 'retention' procedure is put in place (see Appendix A.4). As such, a different psychiatrist (to their 'treating' psychiatrist) is responsible for the person in terms of their hospital admission, stay and discharge. This procedure is set up to push for 'impartiality' both in terms of 'patient rights' for the forced admission itself (between psychiatrist and service-user) but also to avoid 'treating' psychiatrists admitting people in the hospital which also employs them. A different psychiatrist, who is seen as impartial, takes on that decision and the admission procedure. As a result, a person can have many doctors involved in their care, from their GP to other 'specialists', including a 'treating' psychiatrist as well as others (non-treating) psychiatrists, depended on the context of their care.

Appendix A.2: 'Professional Secret'

The 'professional secret' is included in a penal code (article 458) guaranteeing certain fundamental rights concerning confidentiality within a therapeutic relationships between service-user and professional. It is an essential element in mental healthcare, both in terms of its ethical bases but also in terms of the relationship and trust between service-user and professional. The 'professional secret' aims first and foremost to protect a person's right to private life. Many reasons may exist for people to share intimate parts of their life, to receive care or be defended in the courts; the 'professional secret' guarantees that any such disclosure is not shared. In effect, the 'professional secret' renders 'care' possible, by upholding a person's rights to be upheld by health, social and mental healthcare professionals (Deswaef, 2016).

Although at first the 'professional secret' was seen as an absolute concept, it is now used more relatively. It can be erased under strict circumstances. Those exceptions include legal or legislative inquiries or for the responsibility concerning minors. Moreover, it can be disregarded when a person gives their consent for their private information to be shared or when they are unable to express their wishes in an urgent situations, including for professionals to inform and be guided by their superiors. The concept of 'necessity' is also an important legal notion although it is not included in the law. A 'state of necessity' happens when a professional has to choose between two different values: to respect confidentiality or protect others from danger that is serious and imminent (e.g. suicidal risk, danger for loved ones). This is the result of interpretations based on a professional jurisprudence (Deswaef, 2016).

Service-users in the community have many professionals involved in their care, often from different services including mental health, social care and home care etc. Professional networks develop and collaborate with the service-user at their centre, while workers remain bound by the professional secret. If and when workers determine that specific information ought to be shared with colleagues (including within the same team or service), they are obligated to obtain consent from the person first and should only do so if the professional collaboration is aimed towards a common goal. In other words, there should be a shared and articulated mission in the service-user's best interest when sharing private information between professionals from different services. A service-user should always give their consent first and is always within their rights to object or change their minds (Deswaef, 2016).

Appendix A.3: Administrative Trustee

First of all, aside from the benefits system which is often very complicated to navigate and necessitating support especially for people using mental health services, Belgium has a particular administrative (including money) trustee procedure. There are two such 'protection' measures. The 'extra-judiciary' one is only linked to a person's property or assets. The judiciary protection is linked to both the person and their property or assets. It concerns adults, who due to their health, are deemed 'incapable' (fully or partially) to handle and manage their interests without assistance or protection. This latter type of protection is the most widely used in services (Psytoyens, 2017).

Anybody in a person's network can request for them to have a trustee, including family, employers or care workers. In such a case, a 'peace judge' decides whether to appoint an administrator or trustee. To some extent the person can state a preference of a trustee while the level of assistance can be partial or completely representative i.e. the trustee then handles all the actions in relation to interests, depending on the given 'incapability' as decided by the judge (Psytoyens, 2017)..

There are two measures in the assistance provided by an administrative trustee. The first, the 'assistance measure' allows the trustee to assist the person in accomplishing certain tasks or actions relating to their interests. The 'representation measure' allow for the trustee to complete the tasks under their own responsibility regarding the person concerned (Psytoyens, 2017).

Anybody can be a trustee but often the responsibility is given to a judicial professional, such as a lawyer or notary/solicitor, but it can also be a parent, a loved one, a partner or legal cohabitant. Their tasks usually revolve around income, bills and social and fiscal formalities. Furthermore, they also act as a safeguard, including a person's living environment and allowance while also ensuring regular contact. The trustee must also fill in a report to the 'peace judge' about the person's interests and income, including a balance sheet. This report must also be transmitted to the person concerned (l'Autre «lieu», 2019).

Appendix A.4: 'Placement under Observation' (Forced Admission Procedure)

The law for the protection of mentally ill persons (i.e. in regards to their person) was announced in 1990 and included a 'placement under observation' procedure ('mise en observation' in French; Collins, 2019). This forced admission procedure concerns the protection of persons suffering from mental health difficulties and introduces the rules for involuntary admission. The law stipulates that a protection measure (a temporary restriction of an individual's freedom with a view to their hospitalisation) may be taken, provided that three conditions are fulfilled: a) the person must be recognised as "mentally ill", b) they must endanger their health and safety and/or constitute a serious threat for the life or the integrity of others and c) no other treatment can be considered. There are two procedures possible: one is the normal approach and the other is for urgent situations (Marchal, 2019).

Under the normal procedure, any person who is interested may make a written request to a competent 'peace judge'. The request has to describe the symptoms and the danger of the person themselves and others and concludes that no other treatment is possible. A detailed medical report must also be attached to this request (no more than 15 days old) describing the concerned person's "health" state. Note that the doctor who draws up this medical report cannot be the concerned person's parent or "relative by affinity" or be attached to the psychiatric ward the person may be staying at. Within 24 hours, the judge fixes the date and time of a hearing, including a visit to the person concerned. At the same time, a lawyer is appointed and their details sent to the person. The person has every right to choose their own lawyer other than the designated one, as well as a psychiatrist and a "person of trust". During the hearing or what is called "adversarial debate", the judge hears the "patient" as well as anybody who s/he may deem important, in the presence of their lawyer. A reasoned and detailed judgement is delivered by the judge within 10 days, following the request. If they allow an admission to take place they also designate the psychiatric service in which the person will be held for a maximum of 40 days (Marchal, 2019).

In case a situation is considered urgent, the procedure needs to be activated by the area's public prosecutor. Once confident of the situation's urgency, they may decide to involuntary admit the person concerned in a psychiatric service that they designate. The prosecutor's intervention will either include a doctor's written opinion, appointed by the prosecutor (in the context of a judicial inquiry for example) or a written request by a person who is interested in starting the procedure including a detailed medical report. Within 24 hours, the prosecutor submits his written request to the competent "judge of peace". They also inform the person concerned about the measure and any other people living with them as well as the person who sent the request in the first place. It is important to note that as part of this emergency procedure, the restriction of the liberty of the individual for whom protection is sought is immediate. The judge then takes the same measures as those described above regarding the "normal" procedure (having a lawyer appointed, determining the day and time of their visit to the "patient" and the hearing etc.; Marchal, 2019).

The police participates in such procedures since part of their mission involves the protection of people and goods, assistance to people in danger, surveillance of those who seriously endanger their health and safety or pose a serious threat to the life or to the integrity of others. The police services inform the public prosecutor in the event of a person's arrest whose condition suggests s/he be suffering from 'mental health problems' and may justify an emergency involuntary admission. In this case, the prosecutor invites the police to present the person to the doctor they appoint, in order to establish a detailed medical report. This report is most often drawn up by one of the doctors attached to the hospital psychiatric emergency services. These services operate 7 days a week and have a multidisciplinary team that can intervene at any time of the day or night (Marchal, 2019).

There are several ways to end or stop an involuntary admission. The doctor in charge of the establishment where a person is involuntary admitted can decide at any time to lift the measure by simply sending a report of their decision to the competent judge. Furthermore, the prosecutor can also decide to terminate an admission as long as the judge has not taken a decision yet. The judge who orders the involuntary admission can also remove the measure at the request of the person or any other person, after obtaining the opinion of the doctor in charge. Finally, in the context of the urgent procedure, the measure is automatically cancelled when the prosecutor does not forward his request to the judge within 24 hours or when the judge has not rendered judgement within ten days of filing the request (Marchal, 2019).

Appendix A.5: 'Retention Measure'

On the 25th day of the 40 day (maximum) involuntary admission, a 'retention' measure can be put in place. This measure is usually a specific 'best care modality' which the ward's doctor usually recommends to the judge who in turn decides whether to apply it. The service-user is obliged to follow this proposed intervention in order to avoid re-admission. Interventions can be a referral to another ward or obligatory community support, which often includes depot injections (form of anti-psychotic medication administered by injection, which releases it slowly so it lasts longer; Darton, 2016). The 'retention' period lasts for two years following the forced admission, although it can be extended if deemed necessary (Marchal, 2019).

This measure is very similar to Community Treatment Orders (CTOs) in the UK, which were first introduced in 2007 through the amendments made to the Mental Health Act. It is a form of legally mandated supervised community treatment, by which a person can be required to meet certain conditions ensuring that they undertake their treatment and prevent harm to themselves and to others. A person subject to a retention measure (or CTO) can be recalled to hospital if they do not comply with their treatment. As a result, they act as mechanisms to ensure that a person experiencing mental health problems undertakes their treatment. Internationally, a form of supervised community treatment has existed for a number of years (Morgan et al., 2016).

Appendix A.6: European Models

UK: The UK model is a clear reference for the Belgian 107 reform, especially the way in which community mental health teams are organised. The main models referenced are the Crisis Home Treatment Teams (CRHT) for the «2A teams», the Community Mental Health Teams (CMHTs) and the Assertive Outreach Teams for the «2B teams» (p34-35; Service Soins de Santé Psychosociaux, 2010; Natalis and Pieters, 2016). Note that the UK's National Health Service (NHS) has a secondary care that is boosted while its tertiary care (or equivalent of «Function 4» in the Belgian system) is smaller (National Collaborating Centre for Mental Health, 2011).

Crisis Resolution Home Treatment Teams (CRHT) were introduced by the NHS to provide intensive treatment at home for individuals experiencing an acute mental health crisis and who would otherwise be admitted to hospital care. The intended value was for CRHT teams to act as gatekeepers to relieve the pressure on in-patient services, not only by reducing admissions but also by supporting the early discharge of patients for acute wards to home treatment (Smyth and Holt, 2000; Johnson and Thornicroft, 2008).

Although flexibility exists, the guidelines from the Mental Health Policy Implementation Guide (Department of Health, 2001) recommended CRHT services for adults aged 18-65 with severe mental illness who would ordinarily require admission to hospital. Typically, CRHT is offered to individuals diagnosed with 'schizophrenia' and affective disorders and excludes those with primary diagnoses of alcohol or drug misuse, personality disorders or learning disabilities. Other key features of CRHT may include 24-hours availability during a crisis, intensive intervention in the early stages of the crisis and active involvement until the crisis resolves. A core principle of these services is the successful engagement with the service-user and the involvement with the individual's family and social network in the care management plans. Patients are also provided with practical help on social issues, such as financial, housing and childcare arrangements, which make the CRHT a holistic approach (Department of Health, 2001; Smyth and Holt, 2000; Johnson and Thornicroft, 2008).

Community mental health teams (CMHTs) support people living in the community who have complex or serious mental health problems and who may need more support than the one primary care has to offer. CMHTs are multidisciplinary teams with professionals from health and social care backgrounds. All service-users are assigned a "care coordinator" from within the team who ensures the right support and treatment through a "care plan" based on needs. Furthermore, care coordinators make sure that the different people involved in a person's care are informed of this care plan. Most teams use a "stepped care" approach which means that a service-user gets the lowest intensity intervention appropriate for their needs, moving up a step if the problem is not resolved. CMHTs are usually based within a clinic but also do mobile work by visiting people at home (Onyett, Pillinger and Muijen, 1995; Simmonds, Coid, Joseph, Marriott and Tyrer, 2001).

Assertive Outreach Teams (AOT) and/or Assertive Community Teams (ACT) are part of community mental health services but are separate from the traditional CMHTs. Those are specialist teams set up to work with adults with a 'mental illness' or 'personality disorder' who may find it difficult to work with services. Often, they have been admitted to hospital several times and may have shown violence, self-harm, substance abuse or may have been homeless. AOTs offer an intensive, long-term relationship to build up trust. They are multidisciplinary and include staff with a variety of skills to meet services users' needs. Also note that, due to the intensity in care, workers in these teams have smaller caseloads than care coordinators in other teams (Department of Health, 2001).

Netherlands: The Netherlands Flexible Assertive Community Treatment (FACT; Veldhuizen and Bähler, 2013) was mainly adopted and adapted in Flanders. It was developed in the Netherlands and aims to combine the ACT and CMHT models into one team. It targets 20% of the ACT population and another 80% who need less intensive treatment and support. To combine care for these two groups, the FACT team employs a flexible 'switching' system. The group requiring the most intensive care is discussed daily using a "FACT board" for which the team adopts a shared caseload approach. For the service-users requiring less intensive care, the same team provides individual case management with multidisciplinary treatment and support. When people's presentations become more stable, they do not have to be transferred to a different team but rather stay with the same FACT team. This flexibility to switch between the two modes of service delivery within the same team is said to enhance continuity of care and reduces drop-out rates. For service-users who are at risk of recurring episodes of psychosis and/or hospitalisation stays, the same team immediately switches to intensive ACT support. This combination of flexibility and continuity ties in well with the "natural" course of people who may present chronic difficulties, recurring episodes and relapses (Veldhuizen and Bähler, 2013; Sood, Owen, Onyon, Sharma, Nigriello, Markham and Seabrook, 2017).

Italy: Trieste in Italy has long been a source of inspiration for other European countries that seek ways to organise mental healthcare differently with mainly community and neighbourhood-oriented care along with a minimum number of beds. The city became famous for its model of "democratic psychiatry" in the 1970s. At the time, Franco Basaglia, a psychiatrist, considered the classical psychiatric hospital as pathogenic and wanted it replaced with a model aimed at restoring the civil rights of psychiatric inpatients. He first started by changing the role of patients within the psychiatric hospital by no longer giving them work on a therapeutic basis but by paying them, starting the first social cooperative. Physical coercion and electroshock treatments were abolished. Gradually, people were transferred to the community and the psychiatric hospital was closed. Based on this model by 1978 in Italy, the Law 180 went into effect by which no new patients could be admitted to any of Italy's psychiatric hospitals. The hospitals were closed and replaced by ambulatory care, focusing on people's 'socialisation'. With the hospital no longer active, attention was given to establish support and care in the neighbourhoods. A team of doctors, psychologists, social workers and volunteers were given the opportunity to set up mental health community centres which were low-threshold and included residential care if needed. The family was also closely involved in the changes and in supporting the service-users. Neighbourhood support was further boosted by integrating with and reinforcing other services in the city, while also establishing new services with a focus on coordination of rehabilitation and housing (Dell'Acqua, 1995; Mezzina, 2014).

Based on this history, the services in Trieste have developed a few guiding principles. The team focuses on the whole person taking on a holistic approach, they include the network and social group that the person is part of with the aim to include as many actors as possible. Finally, the teams have a rights-based approach with an emphasis on the civil rights of people. At present, services in Trieste are divided by districts each of which has their own Community Mental Health Centre (CMHC). These centres offer both a first point of contact resembling walk-in services but also support with treatment, care and continuity of care for people with mental health problems, regardless of severity. They also include prevention and outreach services as well as provisions for individual and group therapy. Family support, medication and day-care are also part of care provision. There are a number of other services built around the CMHC which also form part of it, including rehabilitation services and work activities as well as a crisis unit within the general hospital with an inflow from the emergency room, which includes a number of inpatient beds to be used if needed. The centres also work with services that are closely related to mental healthcare such as social cooperatives, self-help groups and family organisations. In addition, the CMHC maintain relationships with various external groups such as the police, social neighbourhood teams and welfare organisations (Dell'Acqua, 1995; Mezzina, 2014).

France: The model from the city of Lille, in the North of France, was also referenced in the 107 reform practices. This model is based on a system of integrated care with different services acting as partners from primary care to specialised services. This includes mental healthcare centres and Medico-Psychological Centres, home care services, Therapeutic Care Family Centres, Therapeutic Foster Family care, Mobile Community teams as well as hospitals including day hospital, crisis beds, Post-Cure Centres or long-term hospital wards. Furthermore, there are rehabilitation workshops, hospitalisation at home as well as Therapeutic Apartment units to help with social reintegration. All those services link and network with the primary care sector which includes GPs, A&E departments and mental health services for the homeless or people in precarious situations (Roelandt, Daumerie, Defromont, Caria, Bastow and Kishore, 2014).

In particular, the Community Mental Health Mobile teams in Lille offer home hospitalisation services in the form of intensive care with the help of other professionals either in health, mental health, the social or the justice sectors. The teams are mobile and do home visits while they also work closely with residential facilities such as sheltered housing. They also have daily contacts with the emergency services in general hospitals. Their main aim is to avoid situations escalating, based on a system of accessibility, coordination and networking (EPSM Lille-Metropole, 2019; Roelandt, et al, 2014).

Ambulatory community care has been boosted with a full-time support and social inclusion offered as community interventions. A continuous link with primary care through the GP is put in place while there is an emergency response at any time provided by the mobile team. As a result, hospital bed numbers have decreased and those that remain are on open wards (EPSM Lille-Metropole, 2019; Roelandt, et al., 2014).

Switzerland: The Lausanne model in Switzerland was also important for the Belgian reform. This model was based on a plan of action aiming to reinforce psychiatry in terms of liaison and coordination. A network association in the community was set up including 70 members from doctors to patient associations. The main goal was to improve continuity of care between the different institutions as well as to find better solutions for the population's expectations. As part of the solution to this, a mobile team was developed with the aim to ensure interventions within the community. This team is based on a Transition Case Management Model (Case management de transition or CMT; Bonsack, Ferrari, Gibellini, Gebel, Jaunin, Besse and Morandi, 2013) loosely based on an ACT model and aimed towards people suffering from long-term difficulties with limited access to care and with situations presenting high risks and major complications. The mobile team therefore reinforces coordination and liaison between services through the practice of case management. It offers support for people with difficulties in accessing care through a cooperation between the person's personal network and first line workers. Furthermore, the team supports the reintegration of people within their community and promotes their resources as well as those of their primary carers. This in turn, reduces the number and duration of hospitalisations. Differences with the ACT model include the fact that each service-user is appointed one case coordinator without a team approach. This support is not offered at any time but rather during the service's opening hours. Furthermore, the case manager offers support through the network of partners available, not on their own and finally, the intervention is limited in time (Bonsack et al., 2013).

Appendix A.7: The '107' Five Function Model

Function 1: prevention, promotion, early detection, screening, diagnosis. The first function is conceptualised as the main basis and first access towards mental healthcare within the community. It involves prevention, early detection and/or a first intervention, through an accessible point of entry and a local response based on the mental health difficulties, ensuring if necessary, a continuity of care for the long-term. In this setting, it is important to associate general practitioners' support as much for general as for mental healthcare. Ambulatory mental healthcare was generally included in this function, although historically they have often informally executed many of the following community functions (Service Soins de Santé Psychosociaux, 2010).

Function 2: intensive ambulatory/mobile teams for both acute and chronic mental health problems. This second function concerns teams that are mobile and visit people at home or elsewhere. One type of team can support people in acute or sub-acute situations and another can support people who present chronic difficulties. This new function is designed to explore a new form of care that is quicker and more accessible as well as adapted to the home or live-in situation. In offering an alternative to hospital, the offer of care is one that is mobile, with an immediate and intensive intervention for acute situations. Intensity and duration of care is also adapted for people in chronic situations since those may vary greatly. Care is organised based on resources and as a complement to the first function, but with a mobile approach and expertise. The partnership is structured around a holistic approach considering the person's environment and general health as well as ensuring continuity in care. Resources from other functions are used in an individual manner according to service-user need (Service Soins de Santé Psychosociaux, 2010).

Function 3: rehabilitation teams working towards social inclusion. The third function concerns the psychosocial rehabilitation sector. It comprises an offer of particular programmes for people at a specific time during their recovery. Psychosocial rehabilitation is a dynamic process that involves a social and professional reinsertion within society and requires a cross-sectional approach. It is a particular programme that needs to consider the development of a person's capabilities permitting him or her to be sufficiently autonomous in his/her daily life, socially capable of participating in community and cultural life, including in their ability to work within an adapted environment. These programmes can be complementary to the basic care offered by the first function or can act as a continuity in daily life interventions offered by the mobile teams (Service Soins de Santé Psychosociaux, 2010).

Function 4: intensive residential care units, both for acute and chronic problems, when a hospitalisation is deemed essential. The fourth function concerns the intensification of specialised residential care for people who are in a serious condition and where help in their home or daily environment is temporarily not indicated. Those units can deliver an observation or a residential treatment which is specific and intensive, focusing on acute care with a goal to set a diagnosis. Those small units are characterised by short-term stays within a specialised framework. During hospitalisation the coordination of care is also taken over. To keep admissions as short as possible, an admission screening process allows for a good coordination and ensures a follow-up to the acute phase (if possible by the professional closest to the service-user). Permanent communication with the other functions ensures that ties are maintained with the social network all the while setting optimum conditions for a service-user's return home. Crisis is also focused around fine-tuning a diagnosis with a general health, psychological and psychiatric approach that can be further ensured by any other given function of the network. A psychiatric emergency includes the modes of residential care which are necessary (Service Soins de Santé Psychosociaux, 2010).

Function 5: specific residential care when organisation of care at home or elsewhere is not possible. This fifth function concerns the development of specific housing for people who suffer from chronic problems, who are stable and present reduced possibilities in social integration. Those housing initiatives have as main goal to offer support in the organisation of daily living. This goal is pursued by facilitating social integration through individual programmes that take into account the service-user's expressed need for autonomy. Integrated within the social fabric, they are organised on the same bases as sheltered housing, supervised accommodation or other forms of adapted accommodation (Service Soins de Santé Psychosociaux, 2010).

Appendix B: Statistics

In 2015, the largest Flemish network of healthcare providers, Zorgnet, produced a series of data on the psychiatric services across the country. Note that these numbers are not exhaustive. At the time the Belgian population was a total of 11,209,044 people. The total number of psychiatric beds across the country were 18,547 in hospitals, 4,224 in sheltered housing and 2,964 in psychiatric care housing. This amounted to 9,300 whole time equivalent (WTE) workers in hospital and over 2,200 WTE workers in other mental healthcare structures. The total number of “frozen” beds at the time was 967 with a total WTE of around 539 people working across the 107 projects.

Brussels: HERMESplus

The participating Brussels Project, covered a total population of 202,866 people at the start of this study, which is served by a total of 1433 beds in hospital, 558 in sheltered housing and 257 in psychiatric care housing.

2A Team TANDEMplus: A 2015 report showed that the 2A team intervened mainly in municipalities of the north-west and the south, which are high in population density. Those are also the regions that are inhabited by people who live in highly precarious conditions whether in terms of earnings, education, employment and/or housing. Family members were the most frequent callers (34%). First line care such as social services (19%), services assisting people who are homeless (13%) and GPs (10%) were next, while psychiatric services at home or from hospital were limited amounting to less than 20% altogether. Half of the people referred had a previous hospitalisation (51%). The 2A team referred people towards psychiatric care (51%) either in function 2B teams (31%) or hospital (20%).

Wallonia: Region du Centre

The central region had 366 beds available in hospital, 74 beds in sheltered housing and 136 in psychiatric care housing. The budget for the mobile teams was raised by “freezing” a total number of 33 beds as well as the time-limited federal budget for the start of the project. The catchment area included 13 municipalities which are for the most part rural areas and included 303,022 people.

2A Team Emc²: Data collected during 2013 and 2014 showed that over 65% of referrals to the 2A teams were included. 40% of those came from mental health services (8% from residential care and 32% from ambulatory care), 25% from other services and 32% were self-referrals of from family members. Most people presented with “mood disorders”, “disorders linked to a dependency” and following close behind people with a diagnosis of “psychosis”. Fewer numbers presented “personality disorders”, “anxiety disorders” and others.

2B team: Data collected during 2013 and 2014 showed that at least 62% of people who were referred to the 2B team were accepted. Referrals were high from the ambulatory mental healthcare sectors (34%) and represented 54% of the caseload. 17% of the caseload were from the residential mental healthcare sector (23% of the caseload). About 13% were from other ambulatory care (18% of the caseload). Family referrals (14%) represented 7% of the caseload and 9% were self-referrals (8% of referrals). Most people referred had a diagnosis of “psychosis” and a few had “mood disorders”. Note that these data were collected between 2013 and 2014 during which the 2B team had only been in existence for five months.

PAKT

The population covered was for 789,316 people who was served by 1956 psychiatric beds, 480 beds in sheltered housing and a further 361 in psychiatric care housing. 96 beds were “frozen” which allowed 55.02 WTE to be employed for the 107 project.

2A Team Mobiele Crisis Team (MCT) and MCT South: Statistics from 2016 showed referrals to have nearly doubled in number since 2014. Most referrals were from GPs (27%), ambulatory mental healthcare centres (23%) and residential care (15%). Most referrals involved people with “mood disorders” (34%), “adjustment disorders” (18%) and “psychosis” (11%) amongst others. About 76% of referrals were accepted and all of them included some form of “suicidal ideation”. Once the team’s four to six week intervention period were over they were referred to a clinical psychologist (14%), a GP (9%) or the psychiatric ward of a general hospital (for a short-term admission, 9%) amongst others.

2B Team MOBiLteam North: Data collected in 2013 and 2014 showed that most referrals were done by health professionals (70%) with 37% from residential care and 27% from ambulant care. Most people presented diagnoses of “psychosis” (34%), “mood disorders” (22%) and “substance abuse” (12%). The team offered mostly ACT interventions (28%) and CMHT care (42%). 69% of people were based in the city of Ghent. The team discharged a total of 38 people in those two years, about 55% of those with a mutual agreement to end the intervention or because they referred them elsewhere (16%), amongst other reasons.

The assessment team for all four 2B teams for the PAKT project shared some data in 2016. It had received 452 calls during that year. Most referrals were from the psychiatric hospital (over 100) and fewer but a considerable number from people’s personal network and GPs. Most presented with diagnoses of “schizophrenia” and “mood disorders”. Most were offered a CMHT type model of care.

PRIT

The project served a total population of 240,688 who were served by a total of 260 psychiatric beds as well as 72 in sheltered living and 60 in psychiatric care housing. 24 beds were “frozen” to employ around 19 people working full-time for the 107 project.

Appendix C: First Observation Checklist

- Workers and disciplines (summary of job role)
- Caseload and individual caseloads
- Resources (cars, computers etc)
- Use of diagnoses, how
- Opening hours, shifts (when, by whom, why) and intervention times (when and for how long – difference between disciplines?)
- Length of engagement with users
- Closest (network) partners and their role
- Referrals from and to whom (numbers, how many on average per week or month in and out)
- Decisions about referrals (when and how)
- Assessment (including by whom, how – tools, when, risk etc.)
- Inclusion and exclusion criteria
- Waiting list?
- Meetings weekly and daily, when, what is the format
- Information sharing (meetings, computers, joint work)
- Information keeping (Files? What information and how?)
- Set dates for interviews and intervention
- Steering committee meeting dates (commutée de direction? commutée de fonction?)
- Collect project proposals
- Collect data collected (for spf and within service, outcome measures?)
- Intervention models (AOT, FACT?), including fidelity criteria if they have them and if any
- Which interventions are used most commonly, what is most common presenting problem (especially ‘social’, e.g. housing, finances etc.)
- Mobility (cars? limits?)
- Funding (
- Hospital beds available?
- Population served
- Recruitment criteria
- Team’s age and history

Appendix D: Interview Questions

Consent
Focus group ground rules

- Please respect other people whilst they're talking both so we hear everybody's opinion. Also, the conversation will be transcribed and this becomes difficult when people talk over each other so please take turns and repeat if talked over.
- You are the experts so I will be asking the questions but it is up to you to answer and discuss them.
- Please refrain from having separate conversations from the group. Every person's experience and opinions are important so speak up whether you agree or disagree.
- There are no right or wrong answers.
- It is important to hear a wide range of opinions and everybody's voice is equal. I may call on you if I haven't heard from you in a while as I would like everyone to participate.
- The conversation which is to follow will be recorded so that I don't miss anything important.
- You will remain anonymous and these interviews confidential. Of course, since this is a group setting other individuals participating will know you responses.
- I might move you along in the conversation since we have a limited amount of time. However, if you would like to add something important or you feel some parts may need more time to be discussed please point it out.

Overview

The interview questions are to be presented in 3 parts reflecting the three levels of service design:

- The first level will focus on the team and 'collaborative working'
- The second on intro-organisation or 'co-ordinated working': larger organisational structure that provides mental health services that would include other teams, departments, both hospital and community.
- The third will look at inter-agency or 'co-operated working': other statutory agencies separate from mental health organisations, primary care, general healthcare, social care/welfare, and agencies who provide supporting resources for mental health service-users in the community (e.g. housing, employment, cultural needs, leisure, education…).

All three levels will be looked at from: a realist perspective i.e. what is happening now, how things ***are*** and an idealistic perspective i.e. what *ought* to happen, how each of the respondents think things ***should be****.*

Introductions

At this point participants should each introduce themselves and their discipline (maybe also their WTE in the team).

I will be writing some key words down which I will be sharing with you.

Questions

A. Working as part of a team:

This first question concerns you, as members of a team. Why were you grouped together as a team, the principal elements that make up your service, the persons (users/patients) with who you work as well as how you work as individuals and as a team.
I would be very interested to hear what you have to say on this subject.

Prompts:
Define current / target population? Who decides?
Model origin? Who decided?
How do you organise your service? Principal/Distinct features?
(Modalities/setting and specificities/therapeutic interventions)
(How do you experience working in a mobile team?)
Clinical roles and shared and distinct functions.
Model implementation

How do you think things should be?
Shoulds

B. Working as part of an organisation:

The intra-agency level includes all mental health services that are part of the same organisation i.e. the team is one part of a larger organisational structure that provides mental health services that would include other teams, departments, both hospital and community. This forms the perspective of *co-ordination* at an intra-agency level.

The focus of the question is about how you work with your organisation, how your populations may compare and how the ways in which you describe the people you work with may change from team on an organisational level, if at all.

Prompts:
Comparable populations? Unexpected differences?
Interfaces?
Focus and purpose of contacts (user/patient, administrative tasks)?
Categories/Descriptions? Same or imposed? (Communication style)
Does the organisation define your service?
(Different “temporality”?)

And how do you think things should be?
Shoulds

(NOTE: If the participants do not comment directly on the use of a particular terminology question its specificity, if any. So think user vs. patient, categories vs. diagnoses)

C. Working as an agency:

The inter-agency level includes other statutory agencies: separate from mental health organisations, such as primary care, general healthcare, social care/welfare, and agencies who provide supporting resources for mental health service-users in the community (e.g. housing, employment, cultural needs, leisure, education…). This can also be described as the network level. This forms the perspective of *co-operation* at an inter-agency level.

This question is about how your work is different from your partners, how you work with them and how categories, descriptions, language may change from team level.

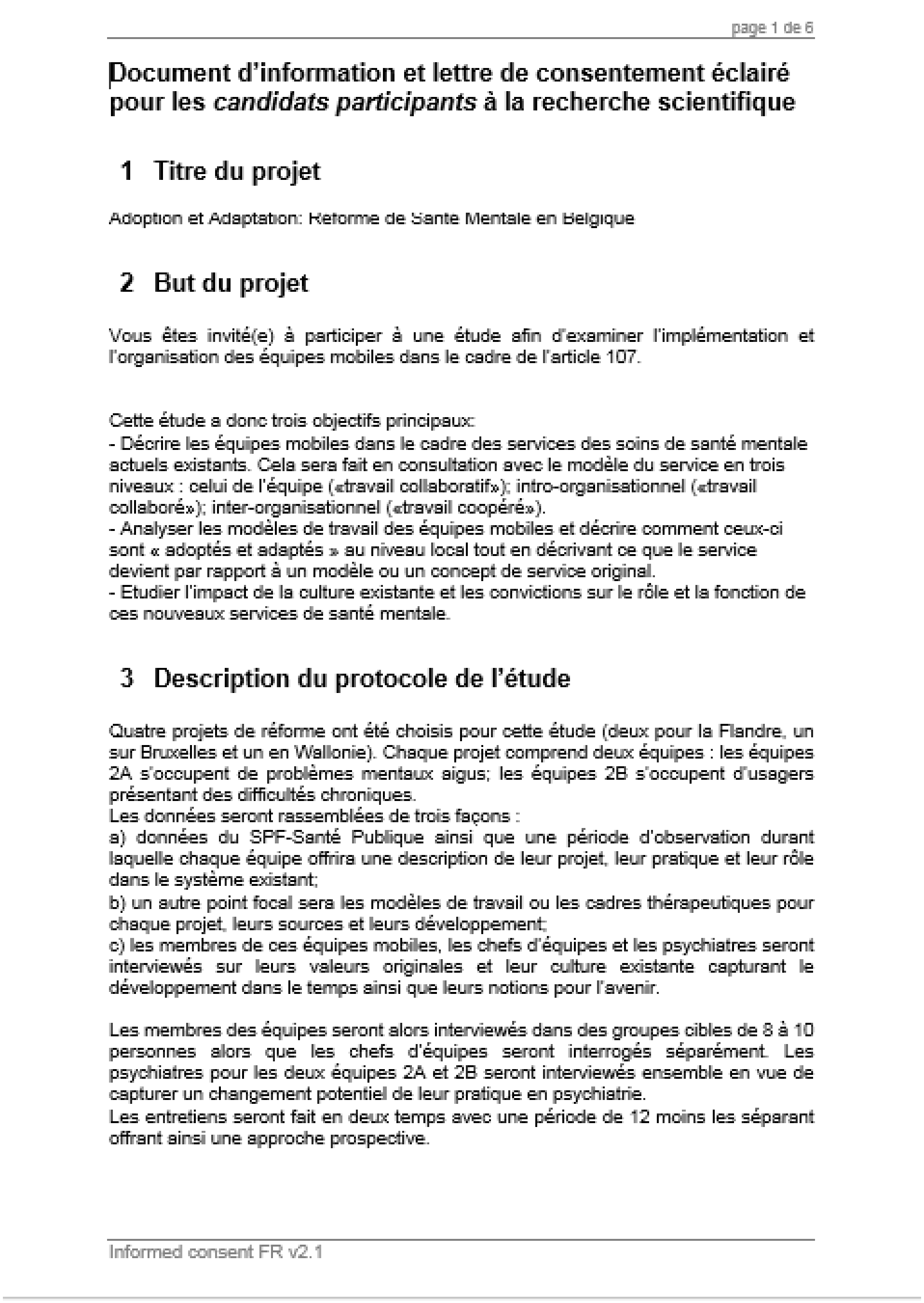
Prompts:
User needs described differently? How?
Categories change? An influence on who your service is for?

And how do you think things should be?
Shoulds

(107 – Ideology and practice: true/real alternative to hospital?
Broader reflections on society: change in culture, education)

Appendix E: Participant Information and Consent Forms

Appendix E.1: French Participant Information and Consent Form



Document d'information et lettre de consentement éclairé pour les *candidats participants* à la recherche scientifique

1 Titre du projet

Adoption et Adaptation: Reforme de Sante Mentale en Belgique

2 But du projet

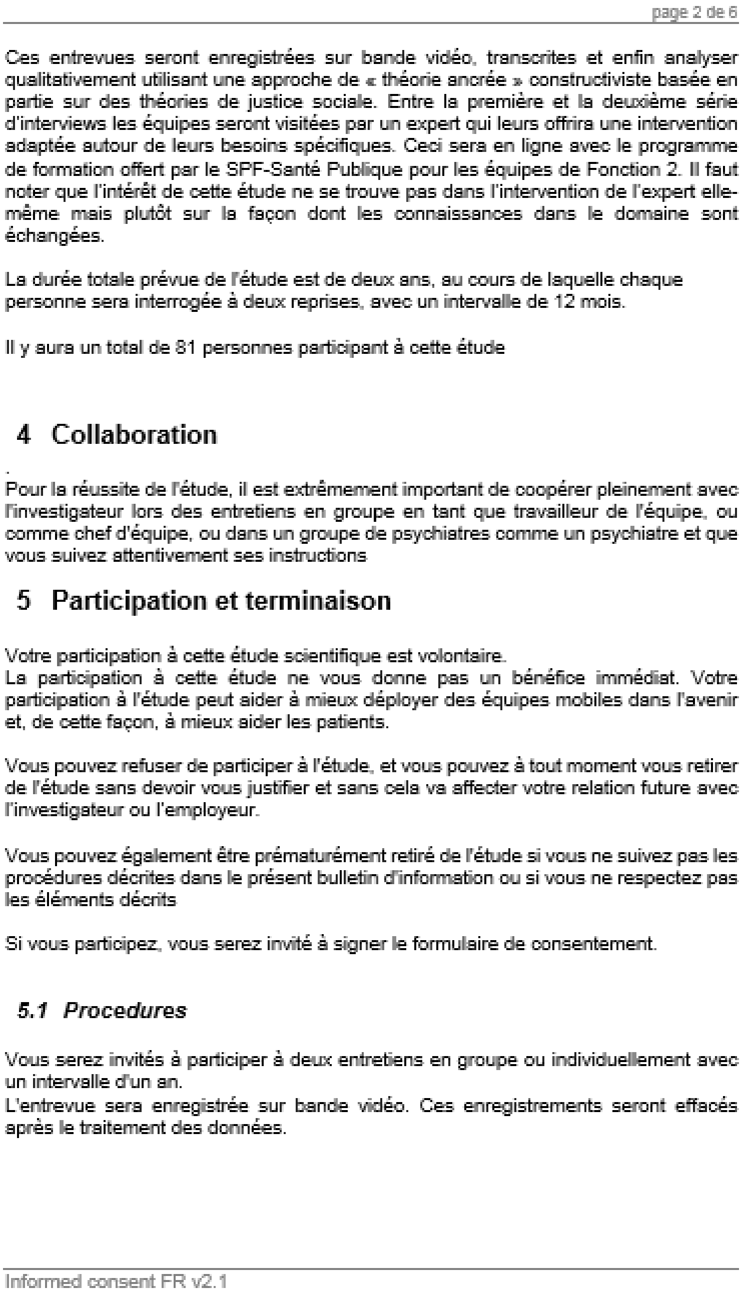
Vous êtes invité(e) à participer à une étude afin d'examiner l'implémentation et l'organisation des équipes mobiles dans le cadre de l'article 107.

Cette étude a donc trois objectifs principaux:
- Décrire les équipes mobiles dans le cadre des services des soins de santé mentale actuels existants. Cela sera fait en consultation avec le modèle du service en trois niveaux : celui de l'équipe («travail collaboratif»); intro-organisationnel («travail collaboré»); inter-organisationnel («travail coopéré»).
- Analyser les modèles de travail des équipes mobiles et décrire comment ceux-ci sont « adoptés et adaptés » au niveau local tout en décrivant ce que le service devient par rapport à un modèle ou un concept de service original.
- Etudier l'impact de la culture existante et les convictions sur le rôle et la fonction de ces nouveaux services de santé mentale.

3 Description du protocole de l'étude

Quatre projets de réforme ont été choisis pour cette étude (deux pour la Flandre, un sur Bruxelles et un en Wallonie). Chaque projet comprend deux équipes : les équipes 2A s'occupent de problèmes mentaux aigus; les équipes 2B s'occupent d'usagers présentant des difficultés chroniques.
Les données seront rassemblées de trois façons :
a) données du SPF-Santé Publique ainsi que une période d'observation durant laquelle chaque équipe offrira une description de leur projet, leur pratique et leur rôle dans le système existant;
b) un autre point focal sera les modèles de travail ou les cadres thérapeutiques pour chaque projet, leurs sources et leurs développement;
c) les membres de ces équipes mobiles, les chefs d'équipes et les psychiatres seront interviewés sur leurs valeurs originales et leur culture existante capturant le développement dans le temps ainsi que leurs notions pour l'avenir.

Les membres des équipes seront alors interviewés dans des groupes cibles de 8 à 10 personnes alors que les chefs d'équipes seront interrogés séparément. Les psychiatres pour les deux équipes 2A et 2B seront interviewés ensemble en vue de capturer un changement potentiel de leur pratique en psychiatrie.
Les entretiens seront fait en deux temps avec une période de 12 moins les séparant offrant ainsi une approche prospective.



Ces entrevues seront enregistrées sur bande vidéo, transcrites et enfin analyser qualitativement utilisant une approche de « théorie ancrée » constructiviste basée en partie sur des théories de justice sociale. Entre la première et la deuxième série d'interviews les équipes seront visitées par un expert qui leurs offrira une intervention adaptée autour de leurs besoins spécifiques. Ceci sera en ligne avec le programme de formation offert par le SPF-Santé Publique pour les équipes de Fonction 2. Il faut noter que l'intérêt de cette étude ne se trouve pas dans l'intervention de l'expert elle-même mais plutôt sur la façon dont les connaissances dans le domaine sont échangées.

La durée totale prévue de l'étude est de deux ans, au cours de laquelle chaque personne sera interrogée à deux reprises, avec un intervalle de 12 mois.

Il y aura un total de 81 personnes participant à cette étude

4 Collaboration

.

Pour la réussite de l'étude, il est extrêmement important de coopérer pleinement avec l'investigateur lors des entretiens en groupe en tant que travailleur de l'équipe, ou comme chef d'équipe, ou dans un groupe de psychiatres comme un psychiatre et que vous suivez attentivement ses instructions

5 Participation et terminaison

Votre participation à cette étude scientifique est volontaire.
La participation à cette étude ne vous donne pas un bénéfice immédiat. Votre participation à l'étude peut aider à mieux déployer des équipes mobiles dans l'avenir et, de cette façon, à mieux aider les patients.

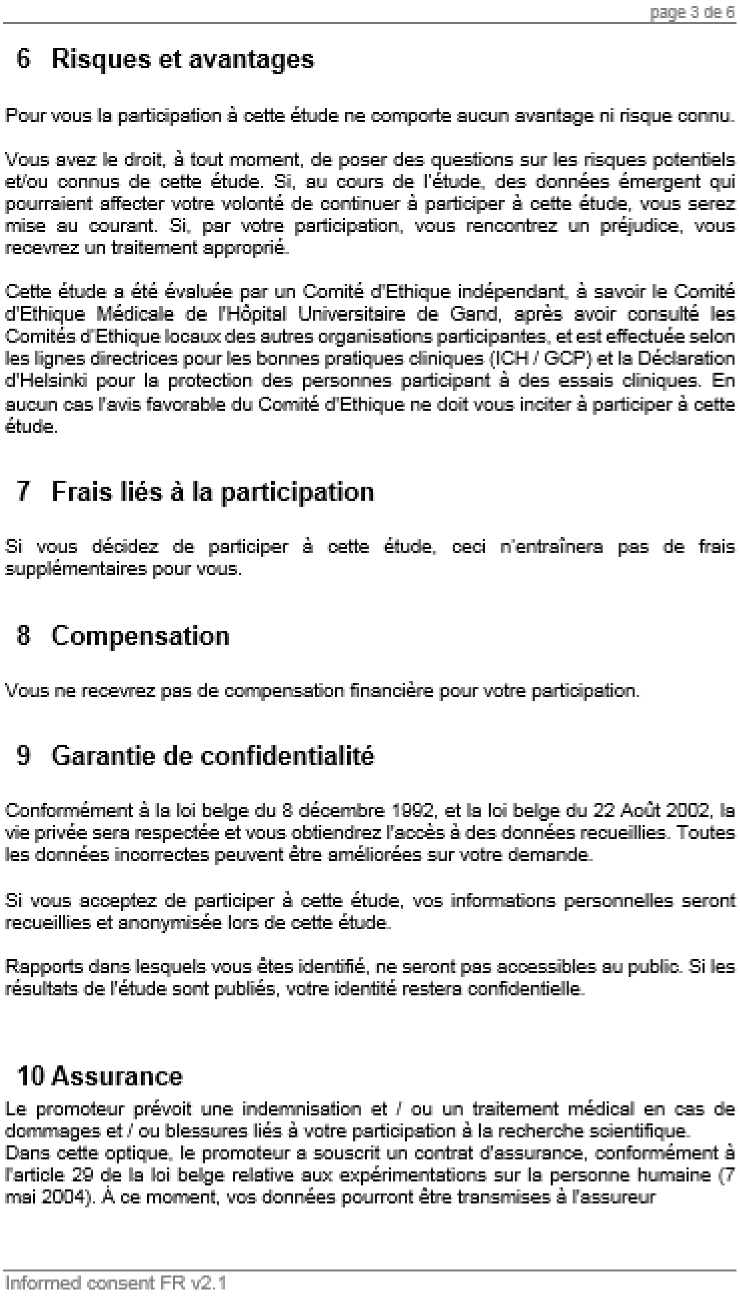
Vous pouvez refuser de participer à l'étude, et vous pouvez à tout moment vous retirer de l'étude sans devoir vous justifier et sans cela va affecter votre relation future avec l'investigateur ou l'employeur.

Vous pouvez également être prématurément retiré de l'étude si vous ne suivez pas les procédures décrites dans le présent bulletin d'information ou si vous ne respectez pas les éléments décrits

Si vous participez, vous serez invité à signer le formulaire de consentement.

5.1 Procedures

Vous serez invités à participer à deux entretiens en groupe ou individuellement avec un intervalle d'un an.
L'entrevue sera enregistrée sur bande vidéo. Ces enregistrements seront effacés après le traitement des données.



6 Risques et avantages

Pour vous la participation à cette étude ne comporte aucun avantage ni risque connu.

Vous avez le droit, à tout moment, de poser des questions sur les risques potentiels et/ou connus de cette étude. Si, au cours de l'étude, des données émergent qui pourraient affecter votre volonté de continuer à participer à cette étude, vous serez mise au courant. Si, par votre participation, vous rencontrez un préjudice, vous recevrez un traitement approprié.

Cette étude a été évaluée par un Comité d'Ethique indépendant, à savoir le Comité d'Ethique Médicale de l'Hôpital Universitaire de Gand, après avoir consulté les Comités d'Ethique locaux des autres organisations participantes, et est effectuée selon les lignes directrices pour les bonnes pratiques cliniques (ICH / GCP) et la Déclaration d'Helsinki pour la protection des personnes participant à des essais cliniques. En aucun cas l'avis favorable du Comité d'Ethique ne doit vous inciter à participer à cette étude.

7 Frais liés à la participation

Si vous décidez de participer à cette étude, ceci n'entraînera pas de frais supplémentaires pour vous.

8 Compensation

Vous ne recevrez pas de compensation financière pour votre participation.

9 Garantie de confidentialité

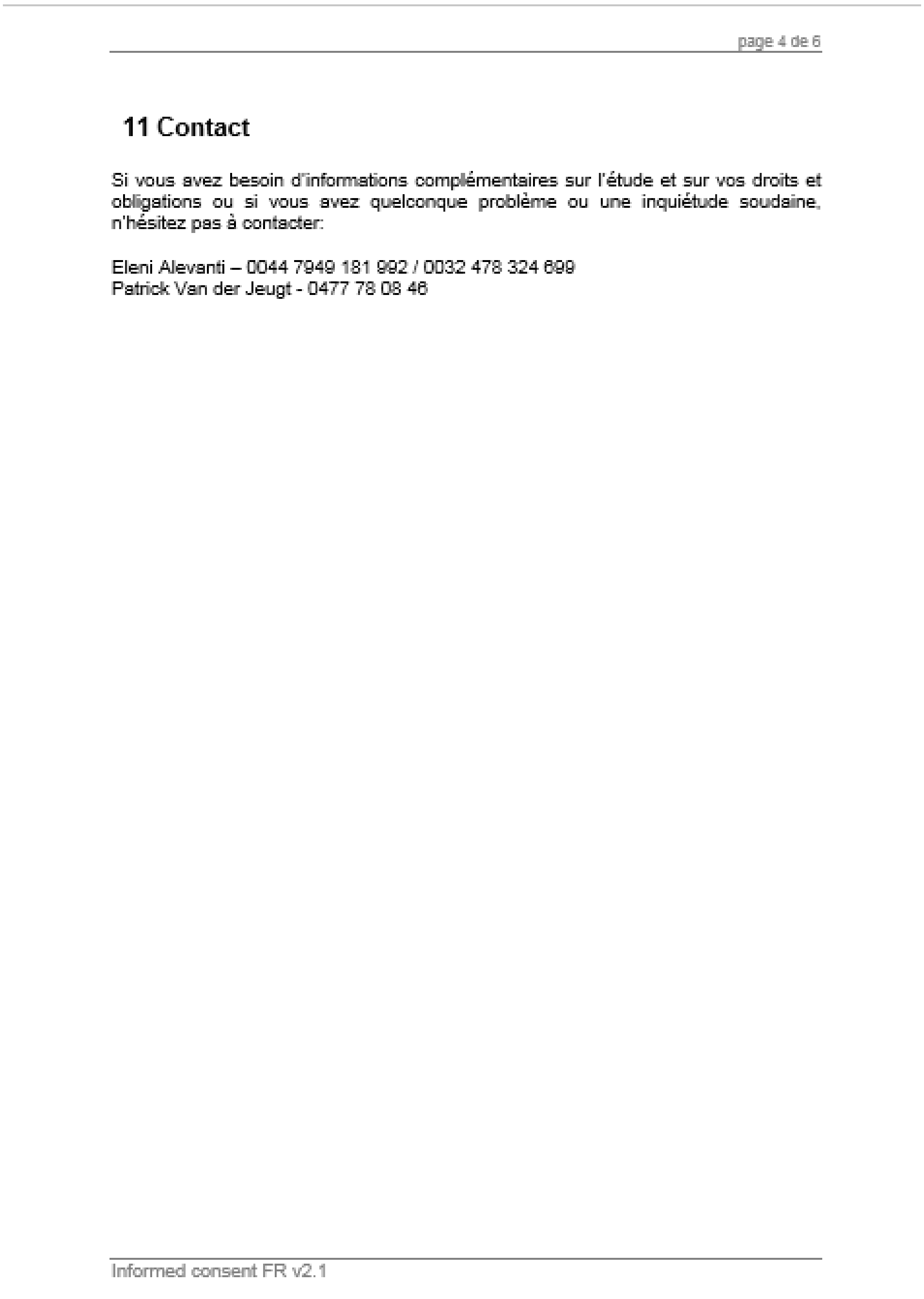
Conformément à la loi belge du 8 décembre 1992, et la loi belge du 22 Août 2002, la vie privée sera respectée et vous obtiendrez l'accès à des données recueillies. Toutes les données incorrectes peuvent être améliorées sur votre demande.

Si vous acceptez de participer à cette étude, vos informations personnelles seront recueillies et anonymisée lors de cette étude.

Rapports dans lesquels vous êtes identifié, ne seront pas accessibles au public. Si les résultats de l'étude sont publiés, votre identité restera confidentielle.

10 Assurance

Le promoteur prévoit une indemnisation et / ou un traitement médical en cas de dommages et / ou blessures liés à votre participation à la recherche scientifique.
Dans cette optique, le promoteur a souscrit un contrat d'assurance, conformément à l'article 29 de la loi belge relative aux expérimentations sur la personne humaine (7 mai 2004). À ce moment, vos données pourront être transmises à l'assureur



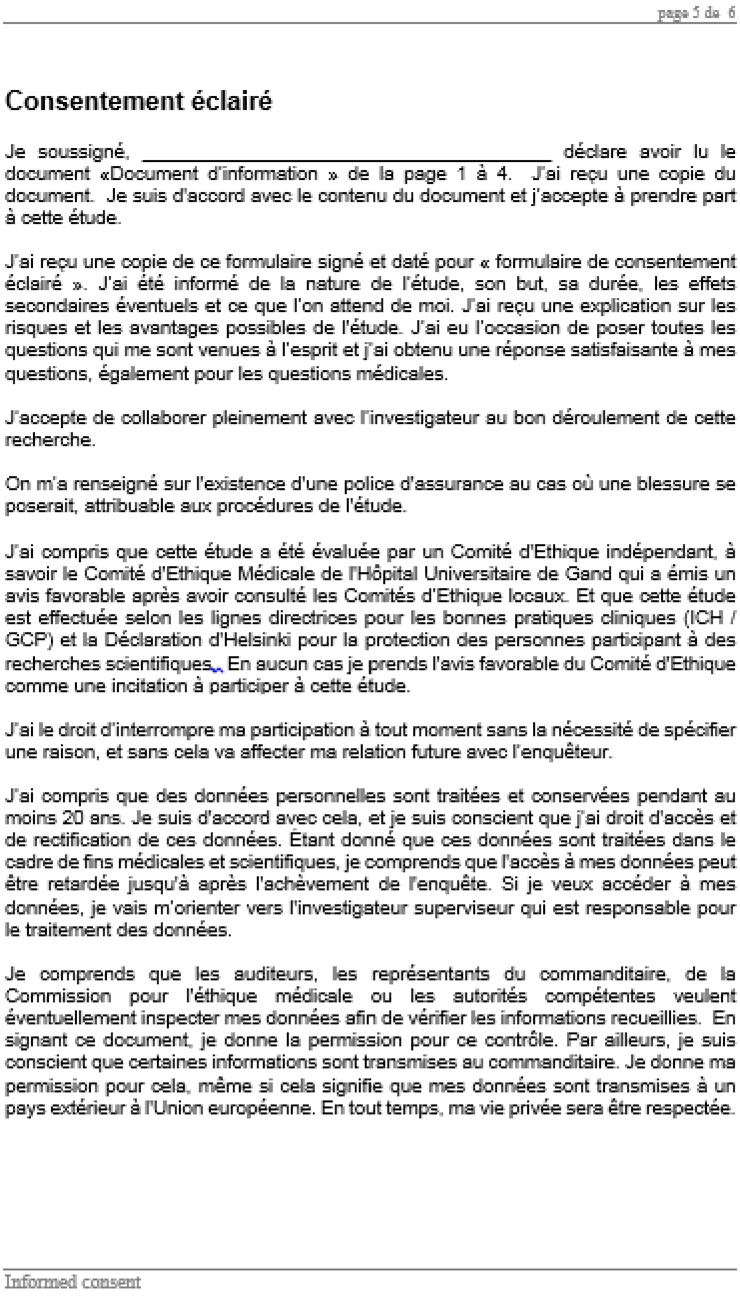
page 4 de 6

11 Contact

Si vous avez besoin d'informations complémentaires sur l'étude et sur vos droits et obligations ou si vous avez quelconque problème ou une inquiétude soudaine, n'hésitez pas à contacter:

Eleni Alevanti – 0044 7949 181 992 / 0032 478 324 699
Patrick Van der Jeugt - 0477 78 08 46

Informed consent FR v2.1



Consentement éclairé

Je soussigné, ______________________________________ déclare avoir lu le document «Document d'information » de la page 1 à 4. J'ai reçu une copie du document. Je suis d'accord avec le contenu du document et j'accepte à prendre part à cette étude.

J'ai reçu une copie de ce formulaire signé et daté pour « formulaire de consentement éclairé ». J'ai été informé de la nature de l'étude, son but, sa durée, les effets secondaires éventuels et ce que l'on attend de moi. J'ai reçu une explication sur les risques et les avantages possibles de l'étude. J'ai eu l'occasion de poser toutes les questions qui me sont venues à l'esprit et j'ai obtenu une réponse satisfaisante à mes questions, également pour les questions médicales.

J'accepte de collaborer pleinement avec l'investigateur au bon déroulement de cette recherche.

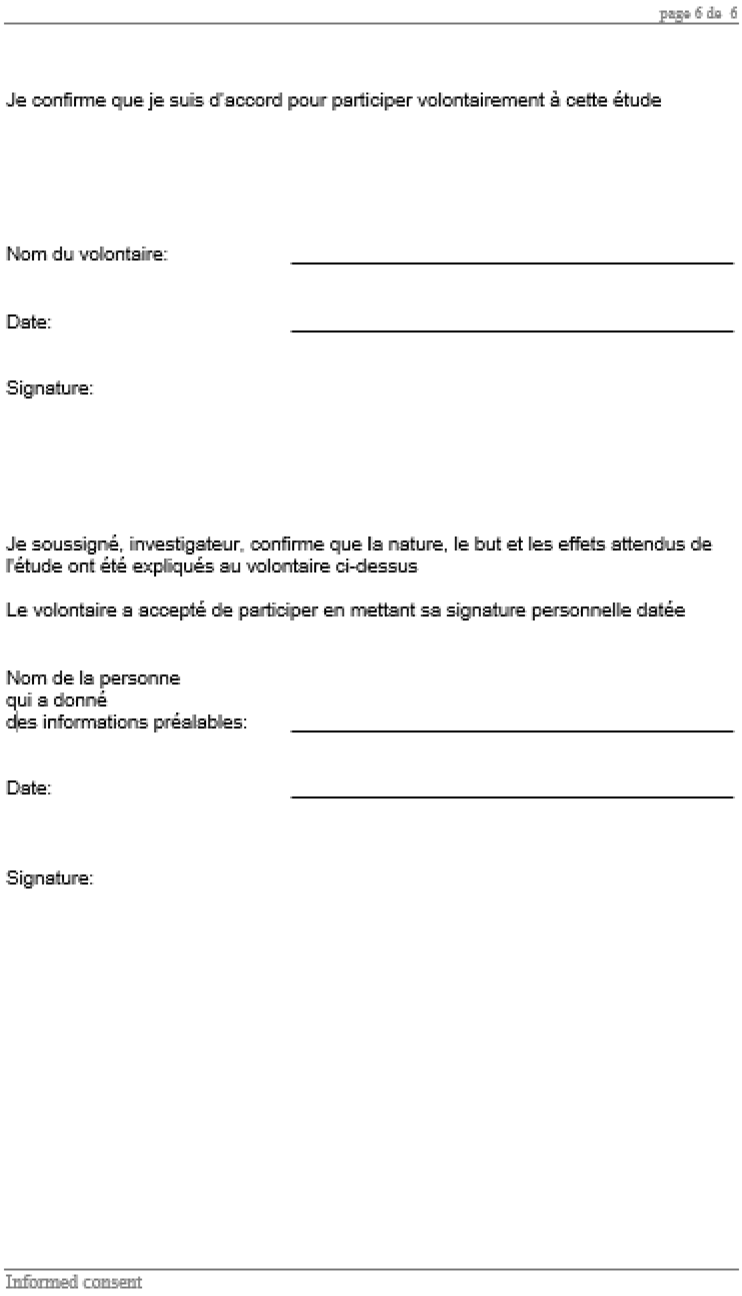
On m'a renseigné sur l'existence d'une police d'assurance au cas où une blessure se poserait, attribuable aux procédures de l'étude.

J'ai compris que cette étude a été évaluée par un Comité d'Ethique indépendant, à savoir le Comité d'Ethique Médicale de l'Hôpital Universitaire de Gand qui a émis un avis favorable après avoir consulté les Comités d'Ethique locaux. Et que cette étude est effectuée selon les lignes directrices pour les bonnes pratiques cliniques (ICH / GCP) et la Déclaration d'Helsinki pour la protection des personnes participant à des recherches scientifiques. En aucun cas je prends l'avis favorable du Comité d'Ethique comme une incitation à participer à cette étude.

J'ai le droit d'interrompre ma participation à tout moment sans la nécessité de spécifier une raison, et sans cela va affecter ma relation future avec l'enquêteur.

J'ai compris que des données personnelles sont traitées et conservées pendant au moins 20 ans. Je suis d'accord avec cela, et je suis conscient que j'ai droit d'accès et de rectification de ces données. Étant donné que ces données sont traitées dans le cadre de fins médicales et scientifiques, je comprends que l'accès à mes données peut être retardée jusqu'à après l'achèvement de l'enquête. Si je veux accéder à mes données, je vais m'orienter vers l'investigateur superviseur qui est responsable pour le traitement des données.

Je comprends que les auditeurs, les représentants du commanditaire, de la Commission pour l'éthique médicale ou les autorités compétentes veulent éventuellement inspecter mes données afin de vérifier les informations recueillies. En signant ce document, je donne la permission pour ce contrôle. Par ailleurs, je suis conscient que certaines informations sont transmises au commanditaire. Je donne ma permission pour cela, même si cela signifie que mes données sont transmises à un pays extérieur à l'Union européenne. En tout temps, ma vie privée sera être respectée.



page 6 de 6

Je confirme que je suis d'accord pour participer volontairement à cette étude

Nom du volontaire: ______________________________

Date: ______________________________

Signature:

Je soussigné, investigateur, confirme que la nature, le but et les effets attendus de l'étude ont été expliqués au volontaire ci-dessus

Le volontaire a accepté de participer en mettant sa signature personnelle datée

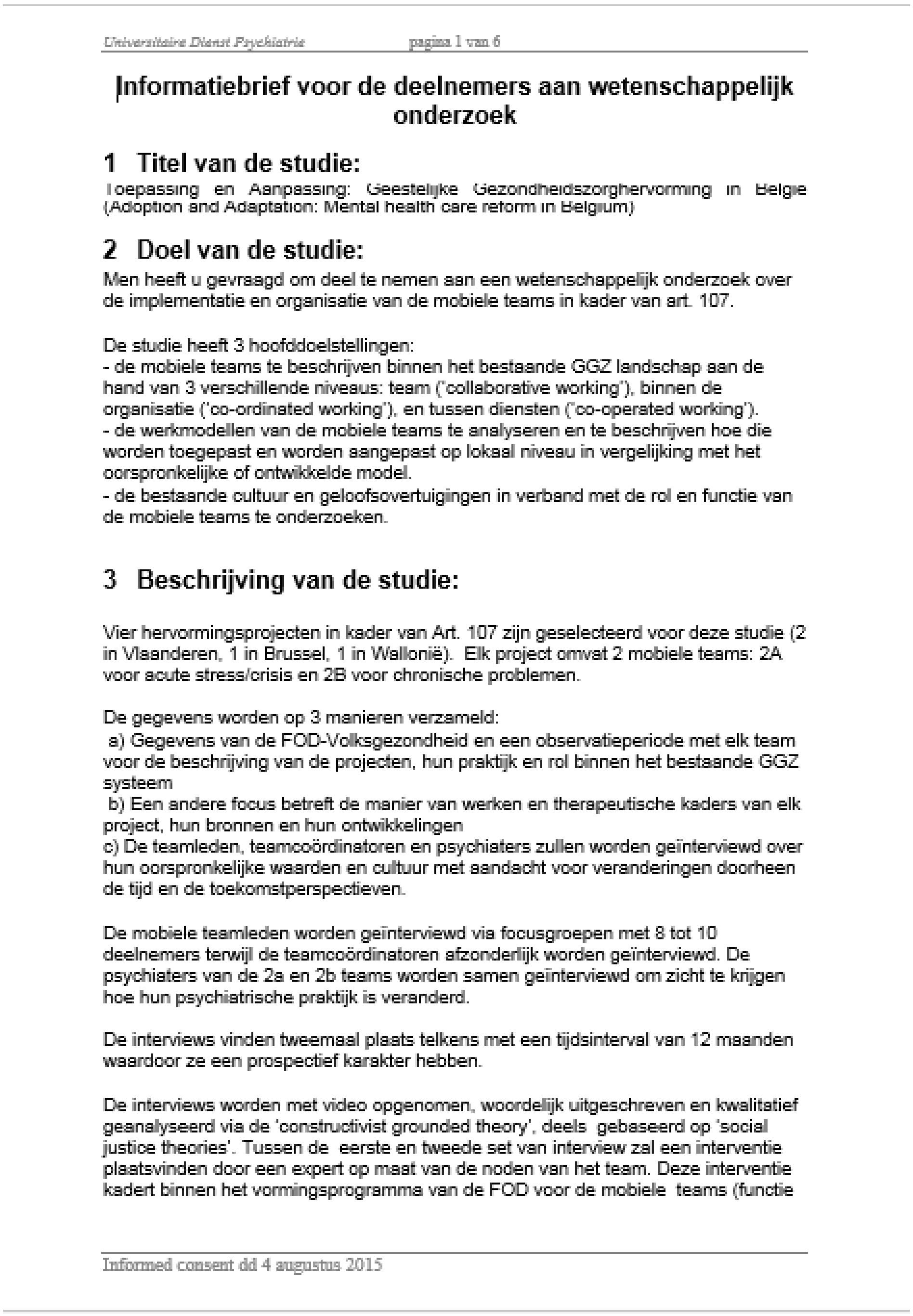
Nom de la personne
qui a donné
des informations préalables: ______________________________

Date: ______________________________

Signature:

Informed consent

Appendix E.2: Dutch/Flemish Participant Information and Consent Form



Universitaire Dienst Psychiatrie pagina 1 van 6

Informatiebrief voor de deelnemers aan wetenschappelijk onderzoek

1 Titel van de studie:

Toepassing en Aanpassing: Geestelijke Gezondheidszorghervorming in Belgie (Adoption and Adaptation: Mental health care reform in Belgium)

2 Doel van de studie:

Men heeft u gevraagd om deel te nemen aan een wetenschappelijk onderzoek over de implementatie en organisatie van de mobiele teams in kader van art. 107.

De studie heeft 3 hoofddoelstellingen:
- de mobiele teams te beschrijven binnen het bestaande GGZ landschap aan de hand van 3 verschillende niveaus: team ('collaborative working'), binnen de organisatie ('co-ordinated working'), en tussen diensten ('co-operated working').
- de werkmodellen van de mobiele teams te analyseren en te beschrijven hoe die worden toegepast en worden aangepast op lokaal niveau in vergelijking met het oorspronkelijke of ontwikkelde model.
- de bestaande cultuur en geloofsovertuigingen in verband met de rol en functie van de mobiele teams te onderzoeken.

3 Beschrijving van de studie:

Vier hervormingsprojecten in kader van Art. 107 zijn geselecteerd voor deze studie (2 in Vlaanderen, 1 in Brussel, 1 in Wallonië). Elk project omvat 2 mobiele teams: 2A voor acute stress/crisis en 2B voor chronische problemen.

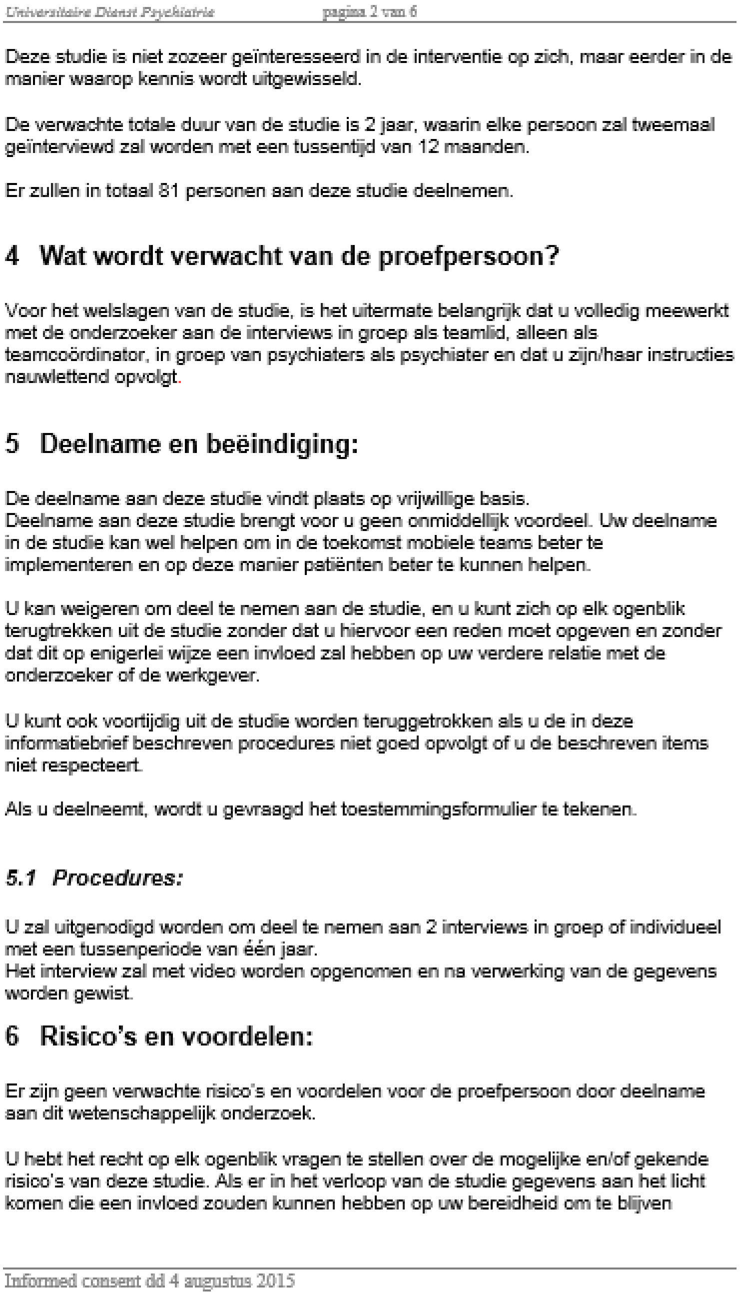
De gegevens worden op 3 manieren verzameld:
a) Gegevens van de FOD-Volksgezondheid en een observatieperiode met elk team voor de beschrijving van de projecten, hun praktijk en rol binnen het bestaande GGZ systeem
b) Een andere focus betreft de manier van werken en therapeutische kaders van elk project, hun bronnen en hun ontwikkelingen
c) De teamleden, teamcoördinatoren en psychiaters zullen worden geïnterviewd over hun oorspronkelijke waarden en cultuur met aandacht voor veranderingen doorheen de tijd en de toekomstperspectieven.

De mobiele teamleden worden geïnterviewd via focusgroepen met 8 tot 10 deelnemers terwijl de teamcoördinatoren afzonderlijk worden geïnterviewd. De psychiaters van de 2a en 2b teams worden samen geïnterviewd om zicht te krijgen hoe hun psychiatrische praktijk is veranderd.

De interviews vinden tweemaal plaats telkens met een tijdsinterval van 12 maanden waardoor ze een prospectief karakter hebben.

De interviews worden met video opgenomen, woordelijk uitgeschreven en kwalitatief geanalyseerd via de 'constructivist grounded theory', deels gebaseerd op 'social justice theories'. Tussen de eerste en tweede set van interview zal een interventie plaatsvinden door een expert op maat van de noden van het team. Deze interventie kadert binnen het vormingsprogramma van de FOD voor de mobiele teams (functie

Informed consent dd 4 augustus 2015



Universitaire Dienst Psychiatrie pagina 2 van 6

Deze studie is niet zozeer geïnteresseerd in de interventie op zich, maar eerder in de manier waarop kennis wordt uitgewisseld.

De verwachte totale duur van de studie is 2 jaar, waarin elke persoon zal tweemaal geïnterviewd zal worden met een tussentijd van 12 maanden.

Er zullen in totaal 81 personen aan deze studie deelnemen.

4 Wat wordt verwacht van de proefpersoon?

Voor het welslagen van de studie, is het uitermate belangrijk dat u volledig meewerkt met de onderzoeker aan de interviews in groep als teamlid, alleen als teamcoördinator, in groep van psychiaters als psychiater en dat u zijn/haar instructies nauwlettend opvolgt.

5 Deelname en beëindiging:

De deelname aan deze studie vindt plaats op vrijwillige basis.
Deelname aan deze studie brengt voor u geen onmiddellijk voordeel. Uw deelname in de studie kan wel helpen om in de toekomst mobiele teams beter te implementeren en op deze manier patiënten beter te kunnen helpen.

U kan weigeren om deel te nemen aan de studie, en u kunt zich op elk ogenblik terugtrekken uit de studie zonder dat u hiervoor een reden moet opgeven en zonder dat dit op enigerlei wijze een invloed zal hebben op uw verdere relatie met de onderzoeker of de werkgever.

U kunt ook voortijdig uit de studie worden teruggetrokken als u de in deze informatiebrief beschreven procedures niet goed opvolgt of u de beschreven items niet respecteert.

Als u deelneemt, wordt u gevraagd het toestemmingsformulier te tekenen.

5.1 Procedures:

U zal uitgenodigd worden om deel te nemen aan 2 interviews in groep of individueel met een tussenperiode van één jaar.
Het interview zal met video worden opgenomen en na verwerking van de gegevens worden gewist.

6 Risico's en voordelen:

Er zijn geen verwachte risico's en voordelen voor de proefpersoon door deelname aan dit wetenschappelijk onderzoek.

U hebt het recht op elk ogenblik vragen te stellen over de mogelijke en/of gekende risico's van deze studie. Als er in het verloop van de studie gegevens aan het licht komen die een invloed zouden kunnen hebben op uw bereidheid om te blijven

Informed consent dd 4 augustus 2015

deelnemen aan deze studie, zult u daarvan op de hoogte worden gebracht. Mocht u door uw deelname toch enig nadeel ondervinden, zal u een gepaste behandeling krijgen.

Deze studie werd goedgekeurd door een onafhankelijke Commissie voor Medische Ethiek verbonden aan het UZ Gent, na raadpleging van de lokale Commissies voor Medische ethiek van de andere deelnemende centra, en wordt uitgevoerd volgens de richtlijnen voor de goede klinische praktijk (ICH/GCP) en de verklaring van Helsinki opgesteld ter bescherming van mensen deelnemend aan klinische studies. In geen geval dient u de goedkeuring door de Commissie voor Medische Ethiek te beschouwen als een aanzet tot deelname aan deze studie.

7 Kosten:

Uw deelname aan deze studie brengt geen extra kosten mee voor U.

8 Vergoeding:

Er is geen vergoeding voorzien voor deelname aan de studie

9 Vertrouwelijkheid:

In overeenstemming met de Belgische wet van 8 december 1992 en de Belgische wet van 22 augustus 2002, zal u persoonlijke levenssfeer worden gerespecteerd en zal u toegang krijgen tot de verzamelde gegevens. Elk onjuist gegeven kan op uw verzoek verbeterd worden.

Als u akkoord gaat om aan deze studie deel te nemen, zullen uw persoonlijke gegevens tijdens deze studie worden verzameld en geanonimiseerd.

Verslagen waarin u wordt geïdentificeerd, zullen niet openlijk beschikbaar zijn. Als de resultaten van de studie worden gepubliceerd, zal uw identiteit vertrouwelijke informatie blijven.

10 Letsels ten gevolge van deelname aan de studie:

De onderzoeker voorziet in een vergoeding en/of medische behandeling in het geval van schade en/of letsel ten gevolge van deelname aan het wetenschappelijk onderzoek. Voor dit doeleinde is een verzekering afgesloten met foutloze aansprakelijkheid conform de wet inzake experimenten op de menselijke persoon van 7 mei 2004. Op dat ogenblik kunnen uw gegevens doorgegeven worden aan de verzekeraar.

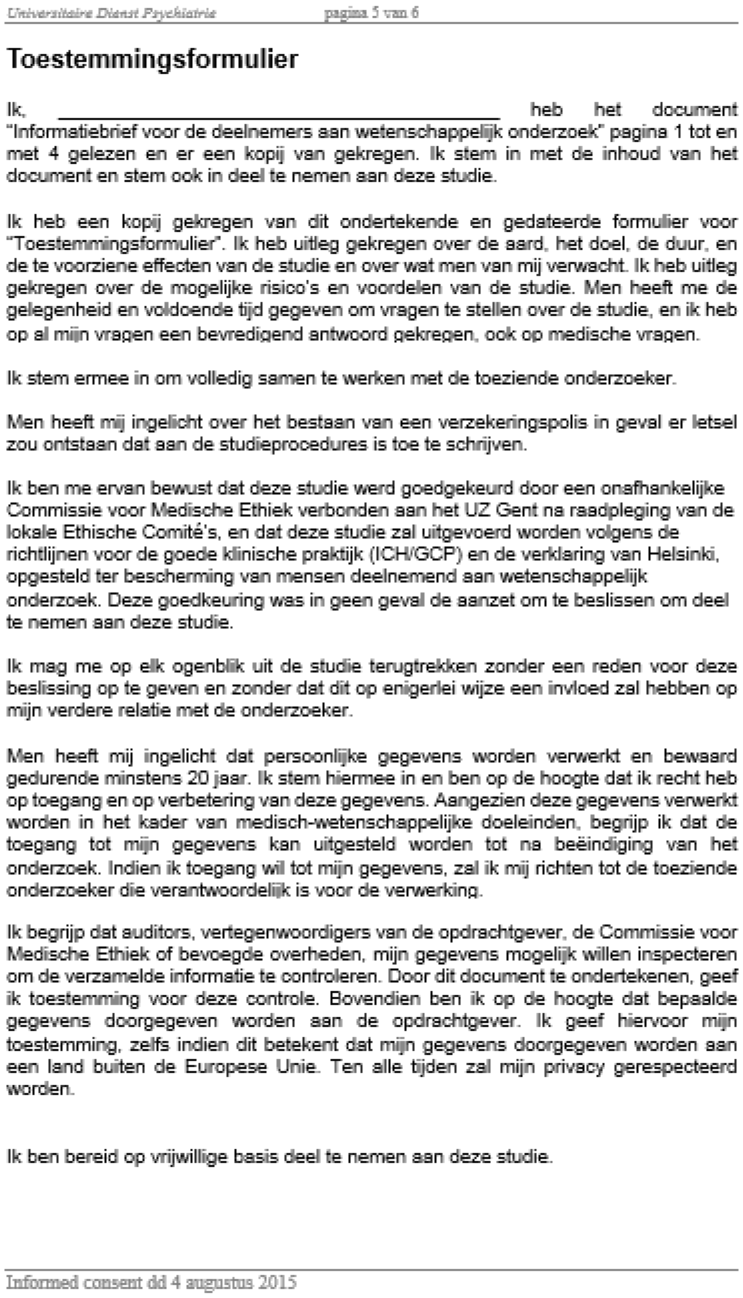
Universitaire Dienst Psychiatrie pagina 4 van 6

11 Contactpersoon:

Als er letsel optreedt ten gevolge van de studie, of als u aanvullende informatie wenst over de studie of over uw rechten en plichten, kunt u in de loop van de studie op elk ogenblik contact opnemen met:

Eleni Alevanti – 0044 7949 181 992 / 0032 478 324 699
Patrick Van der Jeugt - 0477 78 08 46

Informed consent dd 4 augustus 2015



Toestemmingsformulier

Ik, ____________________________________ heb het document "Informatiebrief voor de deelnemers aan wetenschappelijk onderzoek" pagina 1 tot en met 4 gelezen en er een kopij van gekregen. Ik stem in met de inhoud van het document en stem ook in deel te nemen aan deze studie.

Ik heb een kopij gekregen van dit ondertekende en gedateerde formulier voor "Toestemmingsformulier". Ik heb uitleg gekregen over de aard, het doel, de duur, en de te voorziene effecten van de studie en over wat men van mij verwacht. Ik heb uitleg gekregen over de mogelijke risico's en voordelen van de studie. Men heeft me de gelegenheid en voldoende tijd gegeven om vragen te stellen over de studie, en ik heb op al mijn vragen een bevredigend antwoord gekregen, ook op medische vragen.

Ik stem ermee in om volledig samen te werken met de toeziende onderzoeker.

Men heeft mij ingelicht over het bestaan van een verzekeringspolis in geval er letsel zou ontstaan dat aan de studieprocedures is toe te schrijven.

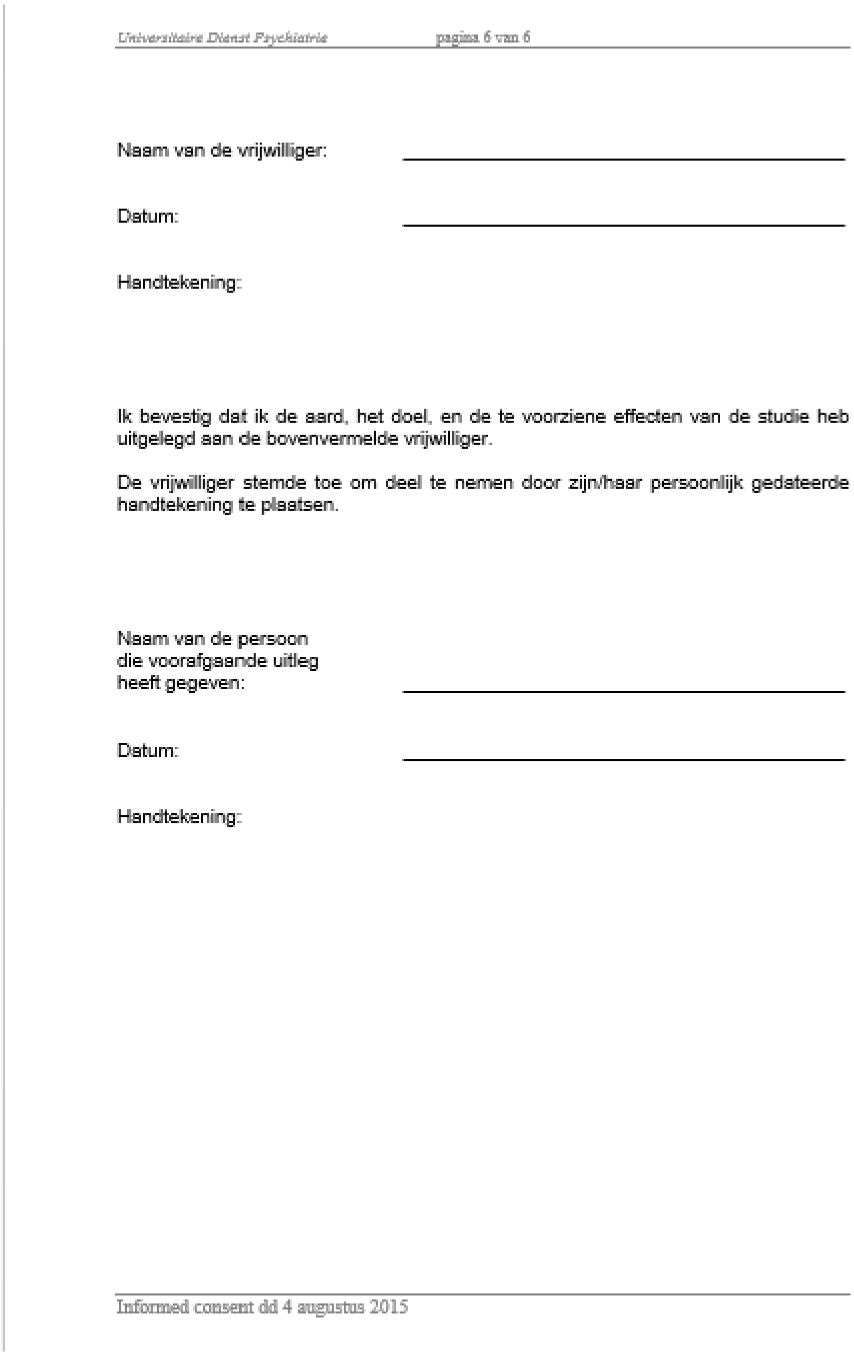
Ik ben me ervan bewust dat deze studie werd goedgekeurd door een onafhankelijke Commissie voor Medische Ethiek verbonden aan het UZ Gent na raadpleging van de lokale Ethische Comité's, en dat deze studie zal uitgevoerd worden volgens de richtlijnen voor de goede klinische praktijk (ICH/GCP) en de verklaring van Helsinki, opgesteld ter bescherming van mensen deelnemend aan wetenschappelijk onderzoek. Deze goedkeuring was in geen geval de aanzet om te beslissen om deel te nemen aan deze studie.

Ik mag me op elk ogenblik uit de studie terugtrekken zonder een reden voor deze beslissing op te geven en zonder dat dit op enigerlei wijze een invloed zal hebben op mijn verdere relatie met de onderzoeker.

Men heeft mij ingelicht dat persoonlijke gegevens worden verwerkt en bewaard gedurende minstens 20 jaar. Ik stem hiermee in en ben op de hoogte dat ik recht heb op toegang en op verbetering van deze gegevens. Aangezien deze gegevens verwerkt worden in het kader van medisch-wetenschappelijke doeleinden, begrijp ik dat de toegang tot mijn gegevens kan uitgesteld worden tot na beëindiging van het onderzoek. Indien ik toegang wil tot mijn gegevens, zal ik mij richten tot de toeziende onderzoeker die verantwoordelijk is voor de verwerking.

Ik begrijp dat auditors, vertegenwoordigers van de opdrachtgever, de Commissie voor Medische Ethiek of bevoegde overheden, mijn gegevens mogelijk willen inspecteren om de verzamelde informatie te controleren. Door dit document te ondertekenen, geef ik toestemming voor deze controle. Bovendien ben ik op de hoogte dat bepaalde gegevens doorgegeven worden aan de opdrachtgever. Ik geef hiervoor mijn toestemming, zelfs indien dit betekent dat mijn gegevens doorgegeven worden aan een land buiten de Europese Unie. Ten alle tijden zal mijn privacy gerespecteerd worden.

Ik ben bereid op vrijwillige basis deel te nemen aan deze studie.



Universitaire Dienst Psychiatrie pagina 6 van 6

Naam van de vrijwilliger: ____________________

Datum: ____________________

Handtekening:

Ik bevestig dat ik de aard, het doel, en de te voorziene effecten van de studie heb uitgelegd aan de bovenvermelde vrijwilliger.

De vrijwilliger stemde toe om deel te nemen door zijn/haar persoonlijk gedateerde handtekening te plaatsen.

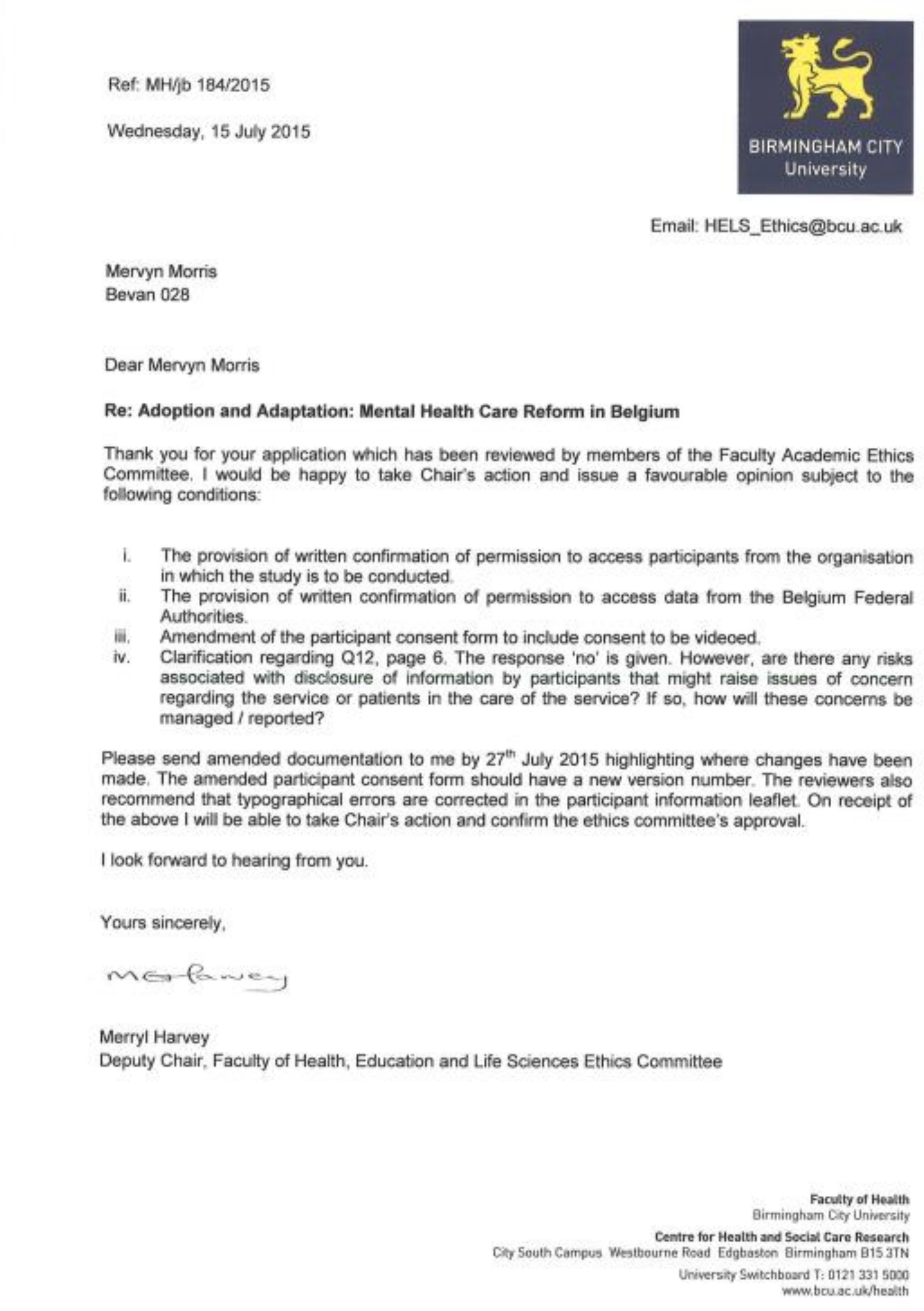
Naam van de persoon
die voorafgaande uitleg
heeft gegeven: ____________________

Datum: ____________________

Handtekening:

Informed consent dd 4 augustus 2015

Appendix F: BCU Ethical Approval



Ref: MH/jb 184/2015

Wednesday, 15 July 2015

BIRMINGHAM CITY
University

Email: HELS_Ethics@bcu.ac.uk

Mervyn Morris
Bevan 028

Dear Mervyn Morris

Re: Adoption and Adaptation: Mental Health Care Reform in Belgium

Thank you for your application which has been reviewed by members of the Faculty Academic Ethics Committee. I would be happy to take Chair's action and issue a favourable opinion subject to the following conditions:

i. The provision of written confirmation of permission to access participants from the organisation in which the study is to be conducted.
ii. The provision of written confirmation of permission to access data from the Belgium Federal Authorities.
iii. Amendment of the participant consent form to include consent to be videoed.
iv. Clarification regarding Q12, page 6. The response 'no' is given. However, are there any risks associated with disclosure of information by participants that might raise issues of concern regarding the service or patients in the care of the service? If so, how will these concerns be managed / reported?

Please send amended documentation to me by 27th July 2015 highlighting where changes have been made. The amended participant consent form should have a new version number. The reviewers also recommend that typographical errors are corrected in the participant information leaflet. On receipt of the above I will be able to take Chair's action and confirm the ethics committee's approval.

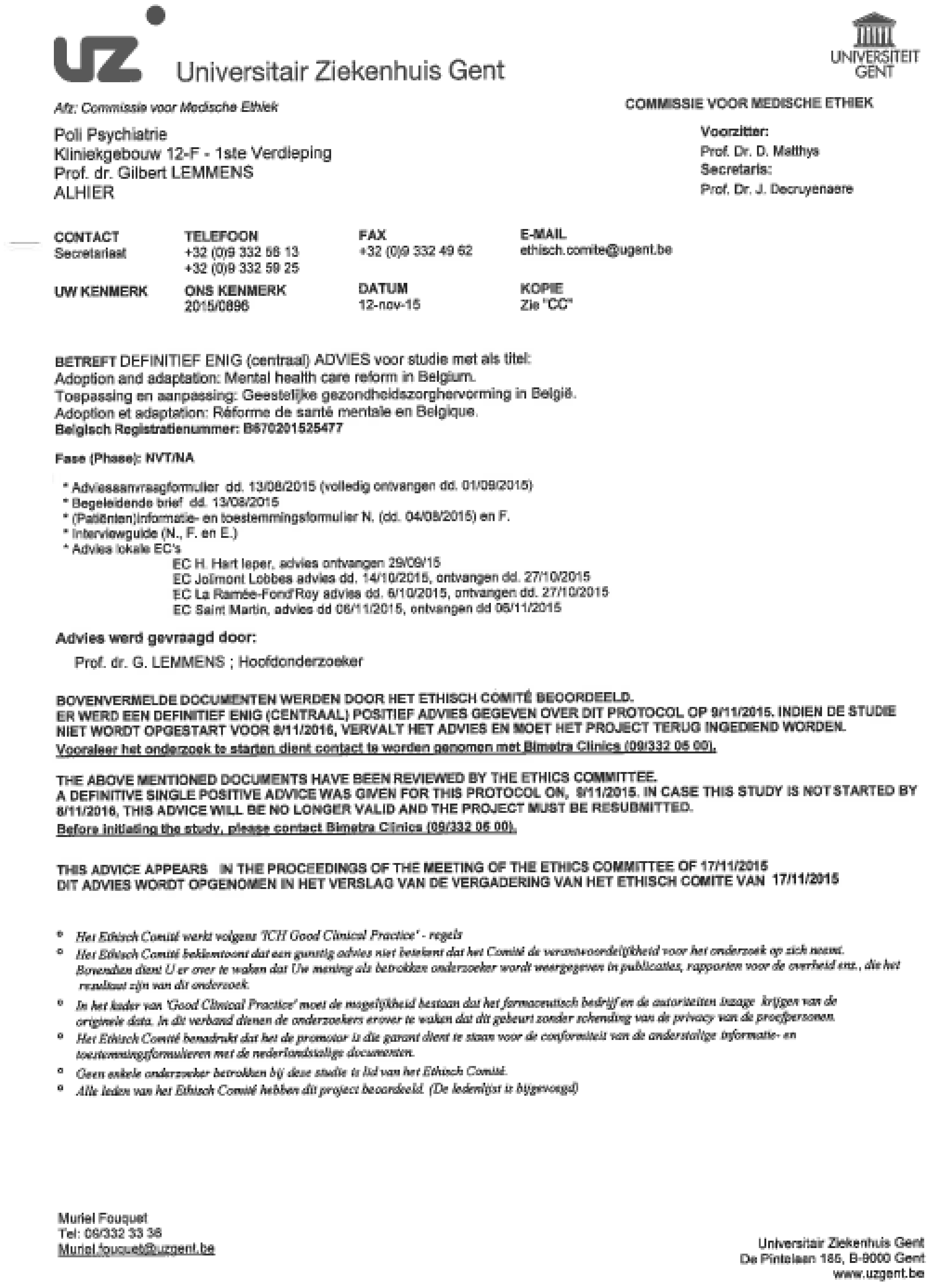
I look forward to hearing from you.

Yours sincerely,

Merryl Harvey
Deputy Chair, Faculty of Health, Education and Life Sciences Ethics Committee

Faculty of Health
Birmingham City University
Centre for Health and Social Care Research
City South Campus Westbourne Road Edgbaston Birmingham B15 3TN
University Switchboard T: 0121 331 5000
www.bcu.ac.uk/health

Appendix G: UGent Ethical Approval



Universitair Ziekenhuis Gent

UNIVERSITEIT GENT

Afz: Commissie voor Medische Ethiek

COMMISSIE VOOR MEDISCHE ETHIEK

Voorzitter:
Prof. Dr. D. Matthys
Secretaris:
Prof. Dr. J. Decruyenaere

Poli Psychiatrie
Kliniekgebouw 12-F - 1ste Verdieping
Prof. dr. Gilbert LEMMENS
ALHIER

CONTACT Secretariaat	**TELEFOON** +32 (0)9 332 56 13 +32 (0)9 332 59 25	**FAX** +32 (0)9 332 49 62	**E-MAIL** ethisch.comite@ugent.be
UW KENMERK	**ONS KENMERK** 2015/0896	**DATUM** 12-nov-15	**KOPIE** Zie "CC"

BETREFT DEFINITIEF ENIG (centraal) ADVIES voor studie met als titel:
Adoption and adaptation: Mental health care reform in Belgium.
Toepassing en aanpassing: Geestelijke gezondheidszorghervorming in België.
Adoption et adaptation: Réforme de santé mentale en Belgique.
Belgisch Registratienummer: B670201525477

Fase (Phase): NVT/NA

* Adviesaanvraagformulier dd. 13/08/2015 (volledig ontvangen dd. 01/09/2015)
* Begeleidende brief dd. 13/08/2015
* (Patiënten)informatie- en toestemmingsformulier N. (dd. 04/08/2015) en F.
* Interviewguide (N., F. en E.)
* Advies lokale EC's
EC H. Hart Ieper, advies ontvangen 29/09/15
EC Jolimont Lobbes advies dd. 14/10/2015, ontvangen dd. 27/10/2015
EC La Ramée-Fond'Roy advies dd. 6/10/2015, ontvangen dd. 27/10/2015
EC Saint Martin, advies dd 06/11/2015, ontvangen dd 06/11/2015

Advies werd gevraagd door:

Prof. dr. G. LEMMENS ; Hoofdonderzoeker

**BOVENVERMELDE DOCUMENTEN WERDEN DOOR HET ETHISCH COMITÉ BEOORDEELD.
ER WERD EEN DEFINITIEF ENIG (CENTRAAL) POSITIEF ADVIES GEGEVEN OVER DIT PROTOCOL OP 9/11/2015. INDIEN DE STUDIE NIET WORDT OPGESTART VOOR 8/11/2016, VERVALT HET ADVIES EN MOET HET PROJECT TERUG INGEDIEND WORDEN.
Vooraleer het onderzoek te starten dient contact te worden genomen met Bimetra Clinics (09/332 05 00).**

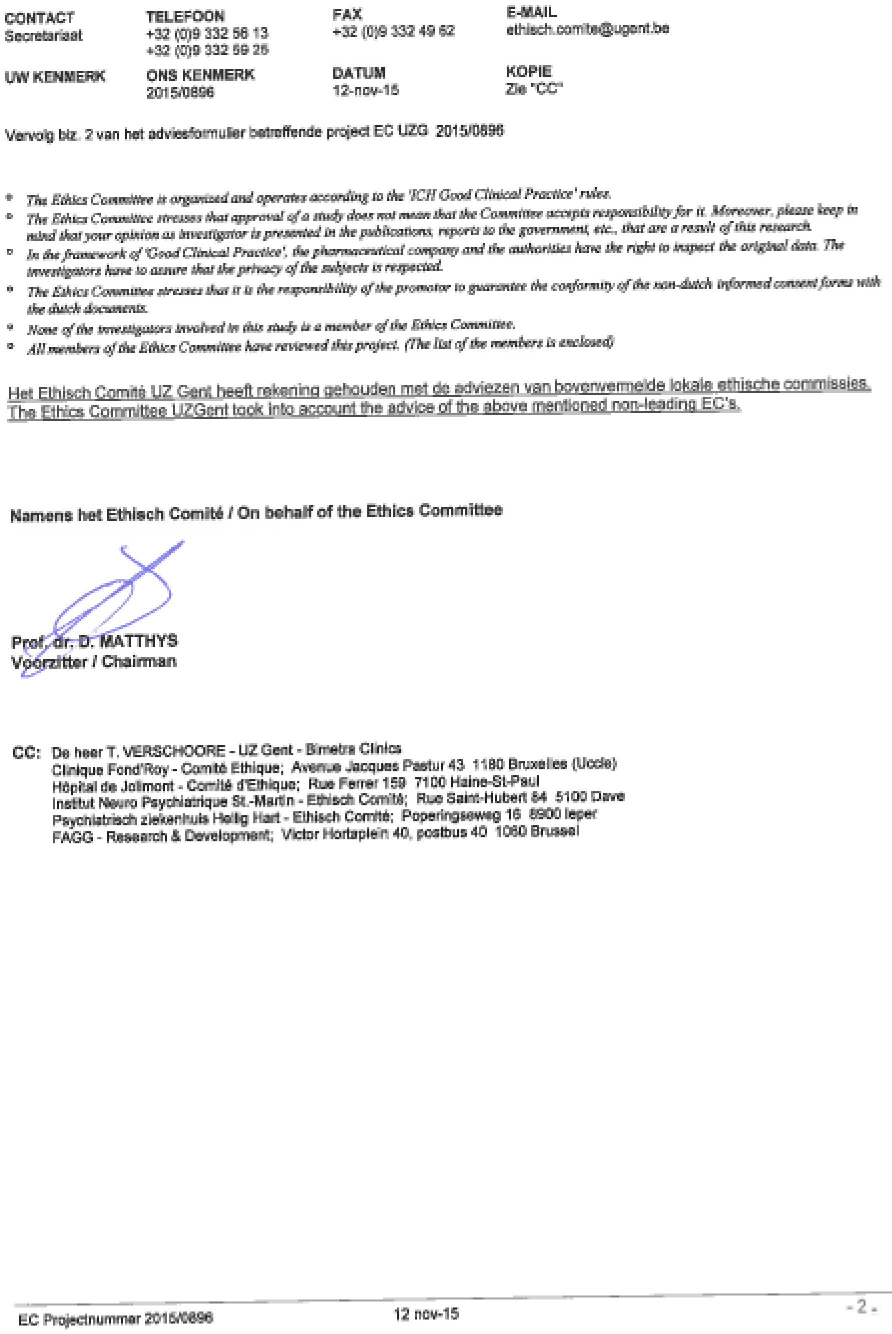
**THE ABOVE MENTIONED DOCUMENTS HAVE BEEN REVIEWED BY THE ETHICS COMMITTEE.
A DEFINITIVE SINGLE POSITIVE ADVICE WAS GIVEN FOR THIS PROTOCOL ON, 9/11/2015. IN CASE THIS STUDY IS NOT STARTED BY 8/11/2016, THIS ADVICE WILL BE NO LONGER VALID AND THE PROJECT MUST BE RESUBMITTED.
Before initiating the study, please contact Bimetra Clinics (09/332 05 00).**

**THIS ADVICE APPEARS IN THE PROCEEDINGS OF THE MEETING OF THE ETHICS COMMITTEE OF 17/11/2015
DIT ADVIES WORDT OPGENOMEN IN HET VERSLAG VAN DE VERGADERING VAN HET ETHISCH COMITE VAN 17/11/2015**

- *Het Ethisch Comité werkt volgens 'ICH Good Clinical Practice' - regels*
- *Het Ethisch Comité beklemtoont dat een gunstig advies niet betekent dat het Comité de verantwoordelijkheid voor het onderzoek op zich neemt. Bovendien dient U er over te waken dat Uw mening als betrokken onderzoeker wordt weergegeven in publicaties, rapporten voor de overheid enz., die het resultaat zijn van dit onderzoek.*
- *In het kader van 'Good Clinical Practice' moet de mogelijkheid bestaan dat het farmaceutisch bedrijf en de autoriteiten inzage krijgen van de originele data. In dit verband dienen de onderzoekers erover te waken dat dit gebeurt zonder schending van de privacy van de proefpersonen.*
- *Het Ethisch Comité benadrukt dat het de promotor is die garant dient te staan voor de conformiteit van de anderstalige informatie- en toestemmingsformulieren met de nederlandstalige documenten.*
- *Geen enkele onderzoeker betrokken bij deze studie is lid van het Ethisch Comité.*
- *Alle leden van het Ethisch Comité hebben dit project beoordeeld. (De ledenlijst is bijgevoegd)*

Muriel Fouquet
Tel: 09/332 33 36
Muriel.fouquet@uzgent.be

Universitair Ziekenhuis Gent
De Pintelaan 185, B-9000 Gent
www.uzgent.be



CONTACT	TELEFOON	FAX	E-MAIL
Secretariaat	+32 (0)9 332 56 13 +32 (0)9 332 59 26	+32 (0)9 332 49 62	ethisch.comite@ugent.be
UW KENMERK	ONS KENMERK	DATUM	KOPIE
	2015/0896	12-nov-15	Zie "CC"

Vervolg blz. 2 van het adviesformulier betreffende project EC UZG 2015/0896

- *The Ethics Committee is organized and operates according to the 'ICH Good Clinical Practice' rules.*
- *The Ethics Committee stresses that approval of a study does not mean that the Committee accepts responsibility for it. Moreover, please keep in mind that your opinion as investigator is presented in the publications, reports to the government, etc., that are a result of this research.*
- *In the framework of 'Good Clinical Practice', the pharmaceutical company and the authorities have the right to inspect the original data. The investigators have to assure that the privacy of the subjects is respected.*
- *The Ethics Committee stresses that it is the responsibility of the promotor to guarantee the conformity of the non-dutch informed consent forms with the dutch documents.*
- *None of the investigators involved in this study is a member of the Ethics Committee.*
- *All members of the Ethics Committee have reviewed this project. (The list of the members is enclosed)*

Het Ethisch Comité UZ Gent heeft rekening gehouden met de adviezen van bovenvermelde lokale ethische commissies.
The Ethics Committee UZGent took into account the advice of the above mentioned non-leading EC's.

Namens het Ethisch Comité / On behalf of the Ethics Committee

Prof. dr. D. MATTHYS
Voorzitter / Chairman

CC: De heer T. VERSCHOORE - UZ Gent - Bimetra Clinics
Clinique Fond'Roy - Comité Ethique; Avenue Jacques Pastur 43 1180 Bruxelles (Uccle)
Hôpital de Jolimont - Comité d'Ethique; Rue Ferrer 159 7100 Haine-St-Paul
Institut Neuro Psychiatrique St.-Martin - Ethisch Comité; Rue Saint-Hubert 84 5100 Dave
Psychiatrisch ziekenhuis Heilig Hart - Ethisch Comité; Poperingseweg 16 8900 Ieper
FAGG - Research & Development; Victor Hortaplein 40, postbus 40 1060 Brussel

EC Projectnummer 2015/0896 12 nov-15 - 2 -