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

Report June 2015

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CONTENT

1 INTRODUCTION

1.1 THE 2010 INTER-MINISTERIAL AGREEMENT AND GUIDE FOR A BELGIAN MENTAL HEALTHCARE REFORM

Spring 2010 resulted in an inter-ministerial agreement between federal and regional ministers with mental healthcare responsibilities and competences, and in a Belgian framework about the basic principles of the mental healthcare reform.

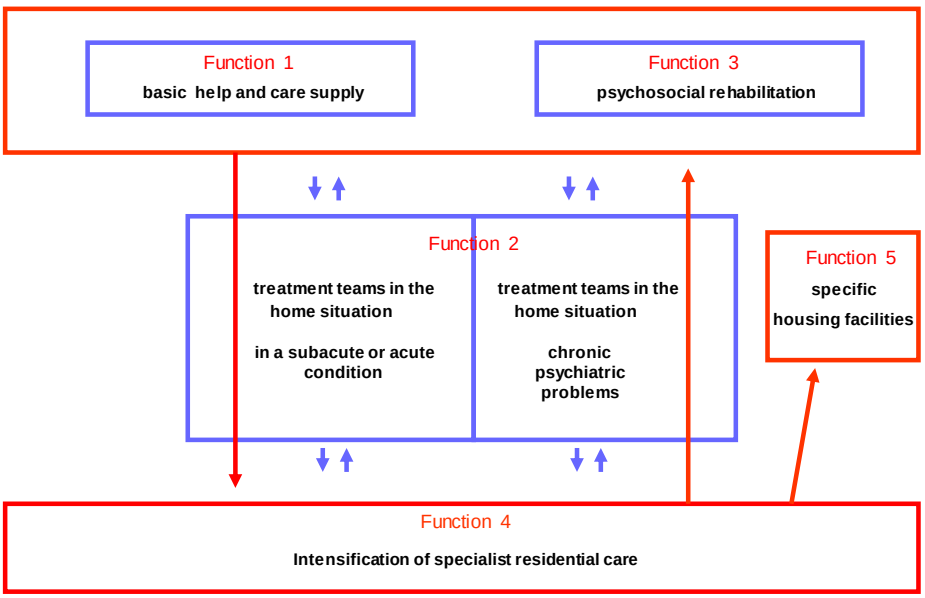
The inter-ministerial conference (IMC[1]) agreed to start the transformation from a largely residential oriented mental healthcare system towards a more community oriented system with 107-explorations for (young) adults (16 - 65 years) with mental health problems. "107" refers to article 107 in the Belgian hospital law. A first series of local transformation initiatives (so called 107-projects) was budgeted for 2011, in total 10 project, and some of them started end of 2011, others early 2012. The budget for a second series, the so called second wave of 107-projects, was approved in July 2012, allowing the launching of nine extra 107-projects in the beginning of 2013.

These 107-projects intend to realise local transformations of a certain percentage of the resources that have always been attached to hospital beds, into community oriented mental health care in working areas defined by the project applicants and approved by the authorities (100 000 up to a few 100 000s inhabitants). Although an important rule of the game specifies that it's not up to the individual hospital that makes a certain percentage of its budget available to be transformed, to decide on its own how this budget will be transformed or reoriented. All the current mental health services in the defined region will have to collaborate in sharing resources, in creating the capacity needed to start up the new forms of mental health care service delivery, realising the five functions described in the Belgian mental health reform guide, in re-allocating the budget from hospital beds or even hospital units, in linking up with primary care, general health services and supportive resources in the community (housing, employment, education, culture, sports, leisure, etc.). These five functions are globally described, as follows:

- Function 1: basic mental healthcare, prevention, promotion, early detection, screening and diagnostic activities, etc. (with emphasis on primary care mental health liaison);
- Function 2: home treatment for persons with a (sub)acute problem (function 2a) and home treatment for persons with a chronic problem (function 2b);
- Function 3: rehabilitation (focus on recovery, social inclusion);
- Function 4: residential intensive and small scale treatment units (short stay, for acute and long enduring problems, in situations in which an admission is needed and inevitable);

[1] To facilitate cooperation between the federal authorities and the federated entities, inter-ministerial conferences are regularly organized. A Mental Health Taskforce is operating within the Inter-ministerial Conference for Health Policy

- Function 5: specific housing facilities offering care (which, at that moment, can't be offered in the home or natural living environment).



It's obvious that transforming this functional map into practice needs a pre-conditional framework with key-principles regarding inter-organisational and inter-professional collaboration. Both, the functional map and the networking concept, were described in the *Guide towards a better mental health care by the realisation of care circuits and networks*, launched in May 2010 by the Federal and Federated Belgian Health authorities. The terminology of Mental Health Programme for age groups (children and adolescents, adults, the elderly), Care Circuits (realisation of a MH Programme) and Networks is defined in Belgian legislation. Networks of services should realise a comprehensive Mental Health Programme in a certain region.

With the functional map, the Guide provides inspiration for a comprehensive mental health programme for adults (16 – 65 years), realised in working areas as care circuits, and at the same time minimal directives are formulated regarding an organisational network model, facilitating the collaboration needed to realise a comprehensive and integrated mental healthcare to ensure that care circuits will be realised. Appointing network coordinators for each network is one of these minimal directives. But it's not only at service level, with focus on inter-organisational collaboration, that the network component is defined. Organisational key principals are also translated into inter-organisational co-ordination at individual client level in order to organise consultation and collaboration around the client.
Further on, the Guide offers a preview on the research and training plan, on necessary steps to take on legal and financial issues. This initiative is given an identity earmark (PSY107), a logo, promoting public recognition, and aims transparency in communication. The federated health authorities were willing to put some specific accents for the Belgian communities (Dutch, French

and German speaking) and/or regions (Flanders, Brussels and the Walloon region). This explain why several versions of the Guide were launched, all of them with the same 'Belgian' framework, but with some more specific details across communities and regions regarding the areas of competence of the latter (non-hospital mental health care).

The earmark PSY107 refers to article 107 of the Belgian Hospital Law: this article permits the redefining of a hospital bed related budget, as an temporary exploration, and as a step towards the realisation of an inter-organisational and functional mental health programme for adults, to be realised in a working area by an inter-organisational network sharing the necessary resources. The latter refers to article 11 of the Belgian Hospital Law: article 11 aims to replace the current regulations for the programming and financing, which is a rather administrative regulation mainly focussing on individual hospital services. It is the intention to evolve towards a system of financing care pathways instead of individual (hospital) services. Also for psychiatric hospitals and general hospitals with psychiatric units and services this means that the financing and programming (provision) will evolve from an individual and mainly hospital bed oriented financing and programming towards a financing of inpatient and other services as a component of a pathway (age group oriented, general , acute care pathway, continuing care pathway, pathways for specific target groups such as combination of mental health problems with judicial problems, with substance use and addiction, with intellectual disability). This is also the reason why in Belgium the expression "107-experiments" is used: as a step towards article 11, so both 107 and 11 being are interrelated articles in the Belgian Hospital Law. Important note is that article 107 is not about closing hospital beds but about re-orientating the destination of hospital resources in an experimental stage. Therefore it's not usual that Belgian working language is speaking about "frozen or neutralised beds" (kept in the portfolio of the hospitals). During this experimental stage, and this is very unusual and unfamiliar to most of the other European countries, there is no regulation, the context is rather voluntaristic than constitutional. This is a quite exceptional environment to start up new forms of mental health care services, such as mobile teams. And, we have to admit, quite difficult to explain to mental healthcare professionals and policy makers from other countries.

1.2 BUDGETARY ISSUES INFLUENCING THE LAUNCHING OF 107-PROJECTS

In several stages, with comments and suggestions of the Taskforce Mental Health (operating within the Belgian Inter-ministerial Conference on Public Health) in between them, the 107-project applicants had to argue and defend their proposals to a selection committee with representatives of the several mental health ministers and their administrations (federal, communities and/or regions). Eligible criteria were available.

In two stages budgetary arrangements were elaborated for 19 107-projects: June 2011 and July 2012. Since June 2011 all 19 of these projects received a budget for a network coordinator and the hospitals involved in these 19 projects could start with the transformation of a certain percentage of their hospital budget. But only ten 107-projects were licenced to start in 2011 and could appeal to an additional budget – additional to the redefined bed-related budget – that must be used, by priority, to start up the new mobile teams. In July 2012 the Inter-Ministerial Conference on Public Health agreed with the proposition of the Mental Health Taskforce to licence the nine other 107-projects to start in January 2013. Some of these nine so called second wave projects decided to start earlier than January 2013 anyway, others waited for the official permission or licence.

This doesn't mean that the whole territory of Belgium is covered by 107-projects. To cover more or less the whole territory, at least some adjustments of the working areas defined by the projects are needed. The other option, a few additional 107-projects, is becoming an issue at this moment (June 2015). Although, in some regions not covered by a 107-project agreement, proper initiatives of hospitals are started up with the intention to put some steps in the direction of applying the 107 reform framework.

The fact that the launching of 107-projects is spread over two waves, with perhaps a third one coming up, doesn't facilitate the development, the practical organisation and the choice of the best timing of starting up national information and formation programmes. Network coordinators were appointed in 2011, but the launching of mobile teams for instance was widespread over time.

1.3 FEDERAL FORMATION PLAN – PROCEDURES AND CONTENT

Alongside the Belgian reform framework, the federal ministry of health developed a formation plan – education, training, coaching, support – for a diversity of target groups: network co-ordinators, key persons in the network and network partners, leaders and members of new teams, others (local decision makers, representatives / members of user and family organisations, psychiatrists, GP's, hospital staff, etc.).

Although the formation plan considers planning formation activities during the complete experimental stage of 107-projects, the Federal Ministry will work with yearly budgets and yearly formation plans, while twice a year a proposal of formation activities (January – June / July – December) will be submitted for approval to Mental Health Taskforce operating within the Belgian Inter-ministerial Conference on Public Health.

End of 2010 and during 2011 some formation activities were already launched, especially for the new appointed network co-ordinators and key persons of the local strategic workgroups operating within the local project committees. Since 2012 the federal formation plan psy-107 includes three types of practice related support by experts from abroad, integrated and coordinated and with the aim to help the 107-projects in starting up and keeping the right direction in deploying mobile teams for persons with (sub)acute and continuing needs (function 2a and 2b of the Belgian functional map): group meetings for mobile team representatives of all Belgian projects, local developmental support for the mobile teams by experts from abroad, and opportunities for Belgian mobile team members or leaders to work with, to learn from and to share experiences with a team in another country.

In the meantime formation activities for the other target groups were started up and continued: collaboration in networks (for network coordinators, for network partners), and a rehabilitation and recovery component was introduced by the end of 2012 and was continued in 2013 - 2014 as part of the federal formation plan. The Rehabilitation formation programme is linked to function 3, while the recovery component is worked out as a recovery oriented approach in hospital setting (see function 4). For both, rehabilitation and recovery, a kick off meeting was organised late 2012. Moreover, on several occasions experts are invited to Brussels to discuss specific issues with representatives of the projects, the sector in general, authorities, etc.

The procedure of submitting, for every semester, a proposal of formation activities for approval to the Mental Health Taskforce, complicated the development of a formation programme for mobile teams based on expertise from abroad. Working in a time span of six months, while engaging several learning places and experts from different countries and holding on the intention of creating equal opportunities for mobile teams from the 19 projects, was not very constructive for the development of formation trajectory that would take three years, with respect for acceptable timings, reasonable preparation time, developmental stage of the Belgian teams, the agendas of Belgian teams, learning places and experts.

2 THE FORMATION PROGRAMME FOR MOBILE TEAMS (FUNCTION 2)

2.1 NEED FOR A SOLID CONSTRUCTION

As one of the components of the PSY107 formation programme, the formation programme for mobile teams is somewhat a-typical. A transparent and solid construction is desirable because, as indicated in previous points, the ideal timings of formation activities for the mobile teams of the different projects will vary considerably from project to project, and six monthly proposals of formation activities and (possible) approvals will interfere with decent preparatory work and planning, and with cost effectiveness in the organisation of the formation activities. Both the FPS-Health (Federal Public Service, to be understood as the Federal Ministry of Health) and the Belgian Federations of Mental Health suppliers representing the mental health services, engaged to build a specific and solid construction for the formation programme for mobile teams.

2.1.1 TRADITION OF DIALOGUE

On the one hand, this specific construction, a co-operative collaboration between representatives of the mental health sector and the federal authorities is a continuation of the tradition of dialogue, often mirrored in the advices by the National Council for Hospital facilities. Several mixed delegation visits with representatives of the authorities and federations of mental health care providers were organised, leading up to the 2010 Belgian reform framework. All these visits had the common purpose of exploring the characteristics and critical ingredients of the minimal necessary components of what should be the concept of a new comprehensive Belgian mental healthcare system, and to learn from already evidenced comprehensive mental health system transformations in other countries.

The Federations insisted for years to create more flexibility in using the mental health budget, which has always been, in Belgium, mainly a hospital budget. Mobile mental health teams – which became later function 2 as mentioned previously in pt. 1.1 (see the functional map of the *Guide*) – came into view as new types of functionalised services responding to the request of the Federations for more flexibility in utilising the hospital budget. So, in a functionalised way these mobile teams were seen as a very inspirational source for both the technical aspect of detaching mental health human resources in hospitals from hospital beds, and, as the potential engine of a transformation from a largely residential towards a more community oriented mental health system because having the potentiality of influencing and changing the complete concept of hospitalisation of persons with severe mental health problems.

2.1.2 EU-PROGRESS PROJECT PROPOSAL

On the other hand, the co-operative collaboration between FPS-Health and Federations regarding the formation programme for mobile teams was a direct sequel to a first initiative of reinforcing and structuring the exchange of expertise between several countries: in 2010 a partnership was set up to apply for some European funding, including the Belgian Federal Ministry and Mental health sector, represented by the Belgian Federations of mental health services, and

organisations from nine other European countries. The pre-phase of this European project proposal (EU-Progress VP/2012/007) was at the same time a first step to structure a mutual exchange of expertise between beacon sites in the U.K., Ireland, The Netherlands, France and Switzerland, and to share this exchange with partners from five other European countries (Norway, France, Slovenia, Romania, Greece and Malta). The importance of this partnership in 2010 is also explained on page 18, pt. 2.4.2.

2.1.3 SUSTAINABLE RELATION WITH PARTNERS FROM ABROAD

Another important aspect in building a solid construction for this formation programme is to guarantee a sustainable relationship with the partners from other countries, with learning places, with experts. This is about mutual trust, respect and loyalty.

This presupposes a transparent communication regarding the objectives, the possibilities and limitations of the collaboration, the expectations and the possible return on investment. And basically, this means explaining that the intended exchange of expertise should be an open dialogue, stimulating a mutual learning process between Belgian mobile teams (and make this learning process accessible for mobile teams from other countries), rather than a one way direction transfer of knowledge. The latter being less complex to organise. But this is not about short appearances in Brussels, it's about consecutive days abroad and in Belgium with an ongoing availability for a longer period. This requires a solid and long term framework, which doesn't fit with six-monthly proposals and approvals by the Mental Health Taskforce.

2.2 WHAT IS HELPFUL? NEED FOR A SPECIFIC APPROACH

Although it is still very tempting to focus on international guidelines, standards and evidence based literature regarding mobile teams, the majority of these guidelines and literature is not enough customised to the needs and the degree of diversity of the realities of the new Belgian mobile teams in their early start-up and deployment phase. The same for models implemented in other countries: this formation programme does not aim to copy them, but to learn from them. Moreover, comparing facts, figures and models between countries always struggles with the discrepancy between general descriptions and indicators used in literature, national policy level, WHO-data, etc., and the way services are implemented and operating in a local working area. Our formation programme for mobile teams intends to give Belgian team members and leaders the opportunity to see how mobile teams are operating in some places abroad, to hear from colleagues abroad how these mobile teams were started up, what the ambitions were, and how the teams, their missions, their target population, their daily practice evolved as a component of a regional mental health system.

2.2.1 CRITICAL KEY-INGREDIENTS IN TERMS OF THEIR POTENTIAL IMPACT ON CHANGE

From this point of view and concern, the types of activities in this formation programme should rather aim a can-do approach closely related to daily practice and clinical work of mobile team members and leaders, and an interaction with experts in utilising models, in supporting interpretation of the literature and responding to questions that seem not to be covered by that literature. The formation programme should allow to learn as you go (as a team, a team member, a team leader), to work alongside manualised guidance, to accept variation and to respect the needed developmental time regarding the implementation of these new mobile teams.

This formation programme is not taking available guidelines and literature regarding best practices or better evidenced interventions as the one and only starting point. Nevertheless, no one will discuss the usefulness nor the necessity of Belgian mobile teams to respond at least to some critical key-ingredients of the 'type 2a' and 'type 2b mobile treatment teams'. Attention will be paid to this by the scientific teams monitoring the Belgian mobile teams, and by the authorities (federal and regional) visiting and questioning the 107-projects on regular basis. Complementary to these types of evaluation, this formation programme intends to lead to a discussion about these critical ingredients in terms of their potential impact on the existing services, specifically the in many working areas strongly represented hospital services (function 4), changing the concept, modalities and even content of what is called 'hospitalisation', rather than a discussion about which type of model to implement, which type of system to prefer (specialist mobile mental health teams, responding to fidelity criteria, as part of a comprehensive system in a region, versus a comprehensive integrated community mental health service developing alongside hospital system as an alternative), which indicators to respond to, etc.

2.2.2 COMPONENTS OF DIFFERENT MODELS

The impact on change can't be understood without analysing the process of change: what these new types of services are changing from, in which existing structures and functions they have to fit in with, etc. The new Belgian mobile teams may include components of different models, to create the best fit.

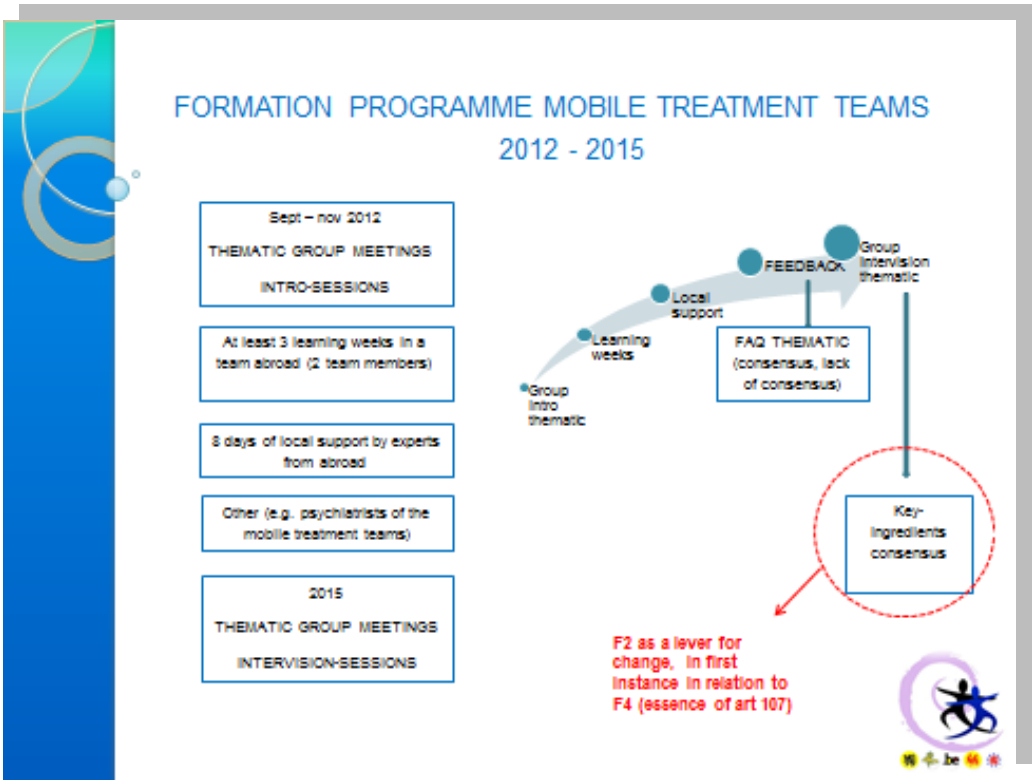
A few mobile team models from other countries are very interesting, as their related fidelity criteria are. But existing training programmes for mobile teams and their managers, focussing on these fidelity criteria, are not by definition useful for the Belgian mobile teams. For quite a few reasons it is not so obvious to respond to fidelity criteria of a specific model implemented in another country. Some particularities of the Belgian context, including the (lack of) implementation strategy for the new mobile teams at the time when the 107-projects were launched, need to be explained to potential partners from other countries:

- in contrast to most services in the surrounding countries, a majority of the Belgian residential and ambulatory mental health services are individual independent services (non-profit, Public Health funding), so the context of introducing a new type of service is very particular;

- while there are some expectations regarding these issues towards the new mobile teams, the funding of the existing mental health services doesn't target an accountability for a region, nor strictly defined inclusion and exclusion criteria, nor a mental health system approach;
- there is no specific model for mobile teams imposed by the authorities, no guidelines, no implementation strategy;
- not much attention is paid to fidelity in the eligible criteria for 107-projects. In submitting 107-project proposals the candidates could describe their intentions regarding the starting up of mobile teams in rather general descriptions. The budget issue, that is the accounting exercise transforming a certain percentage of the bed-related budget was far more put in front then responding to functional fidelity criteria;
- when attention was paid to fidelity criteria, different models showed up, and most of them are Anglo-Saxon inspired, which means not so familiar for the French speaking part of Belgium;
- looking at mobile teams abroad, as they are functioning currently, is often looking at a type of service that has already found its place in a mental health system (local, region, national level) that can't be compared with the Belgian system and its many regional and local varieties. Most of these teams abroad are not the teams one would have met a few years ago, and they won't be the exactly the same teams within a couple of years. So their current fidelity criteria or critical success factors might be strongly coloured by their current specific context (and the budgetary context being quite decisive) and current objectives;
- before they were started up, the Belgian mobile teams were subjected to local negotiations with often new partners, in new committees and working groups, about their mission, place and role, daily functioning. Local interpretations are occurring, often influenced by historical relationships and positions. This explains why some teams are at risk of working up- and downstream to the psychiatric hospital as "central office", of becoming small islands difficult to integrate into the local system, of filling the gaps in the current system building on small-scale pilot projects or targeting populations largely excluded by the current services;
- the mental healthcare reform in Belgium can't be viewed separately from the almost continuous debate on constitutional reform and the redistribution of competences between federal, community and / or regional level. Dispersion of budgets and competences at several levels is characteristic for mental health care in Belgium. There is always the risk that political reform prevails, and the mental health services and professionals involved in the mental health care reform are pushed to be more accountable for their financing authority. One example to illustrate that this is affecting the setting up of the mobile teams. Hospital budgetary issues remain at federal level while for instance care for the disabled is community and/or regional level. It is therefore inevitable that more attention is paid by our communities/regions to issues as long stay in hospitals and long enduring serious mental health problems, resulting in more attention to functions 3 and 5 and the overlap with function 2b (mental health mobile treatment teams for persons with complex and chronic problems);
- ./…

2.3 PROGRAMME CONTENT: TYPE OF FORMATION ACTIVITIES FOR BELGIAN MOBILE TEAMS BASED ON EXPERTISE IN OTHER COUNTRIES

Previous points clarify why the formation programme for mobile teams aims to offer a didactical different approach, stimulating a mutual learning process between Belgian mobile teams by sharing learning experiences based on expertise in other countries. The programme mainly includes three types of activities of practice related support by experts or teams from abroad, for team members and / or team leaders of Belgian mobile teams. The formation programme is presented as a formation trajectory, where the various activities are interrelated in a time span of about 3 years, respecting an acceptable timing for the teams of all the 107-projects.



2.3.1 THEMATIC GROUP MEETINGS

Successive group meetings will be organised for mobile team representatives of all the Belgian 107-projects. A first series of thematic group meetings is organised in the period September - November 2012. These are announced as thematic introduction sessions, led by at least two experts from abroad. What is meant by 'thematic' is explained on page 15, in pt. 2.4.1. The intention is to finalise the formation programme in 2015, if possible with thematic inter-vision sessions as the capstone, using the structured feedback from internships and local support. Chapter 4 presents a possible alternative.

2.3.2 LEARNING WEEKS ABROAD

The formation programme for mobile teams contains, for each 107-project, the opportunity of visiting three times a team in another country for a about a week. These visits are organised as learning weeks or internships, spread over a certain period responding to what is accepted as a suitable timing by the Belgian teams and the hosts abroad, and aiming a certain balance between 2a- and 2b-oriented learning weeks.

2.3.3 LOCAL INDIVIDUAL DEVELOPMENTAL SUPPORT (BY EXPERTS FROM ABROAD)

Third component of this practice related formation contains a number of days of advice, coaching and support for each mobile team (acute needs mobile team, continuing needs mobile team), locally organised and performed by experts from abroad. The number of these days of local support is limited, e.g. not more than 8 days per 107-project.

2.3.4 OTHER ACTIVITIES

Each year a limited number of other initiatives, directly related to daily practice in mobile teams, are possible. One example is the international meeting between psychiatrists working in acute mobile teams, organised in Birmingham in November 2012.

A detailed overview of the organised activities between April 2012 and April 2015 can be found on p. 25 (pt. 2.5)

2.4 ORGANISATION AND COORDINATION OF THE FORMATION PROGRAMME FOR BELGIAN MOBILE TEAMS

In order to organise and to coordinate the formation activities for Belgian mobile teams, some choices had to be made to guarantee that this formation programme serves the intended objectives. Some practical choices, some related to budgetary issues, some to didactic issues.

2.4.1 THEMATIC APPROACH

Nine themes are used to organise group meetings and to structure the learning experiences of Belgian mobile team members.

Working with themes, before launching the formation programme for mobile teams, is a well-considered choice. For the mobile teams, the start-up phase was strongly coloured by ambiguity: no stringent guidelines were formulated, at least three years of 'experimentation' were announced, the authorities didn't work out implementation strategies, etc., but on the other hand there were undeniable a lot of expectations – from network partners, from the authorities – to respond to, while some of the latter are inspired by rather fragmented interpretations of models from abroad. To help the teams to escape from this ambiguity, the thematic approach invites them to focus on daily practice related issues, on choices to make that are strongly related with and fit in their own reality, with aspects that seem to be useful, interesting and critical for them. The thematic approach also helps to look beyond a country specific model, avoiding that such a model is too much put in front, which is important to explain to learning places in and experts from abroad (it's not about selling or implementing a model). Finally, the format of themes and topics helps to avoid a rather general input (expertise from abroad) and output (learning experiences of Belgian teams). All these themes and attached topics must considered from the point of view of the new mobile teams, just started up, and in need for some practice related experiences and advice:

	1 Starting up and further development/deployment of mobile teams
	➢ multidisciplinary team composition
	➢ multidisciplinary team functioning
	➢ necessary competences of team members
	➢ starting up step by step (stages in the development)
	➢ recovery oriented approaches in mobile teams
	➢ outcome oriented approach and impact on further development/deployment (such as: description of targets, evaluation of results/data, impact of these evaluations…)
	➢ critical success factors for starting up and further development/deployment (such as: team related, working area related, target group related, accessibility, …)
	➢ limits of an assertive approach ('meddle care')
	➢ useful practice supporting instruments important for starting up and further development/deployment
	➢ practical organisation

	2 Hospitalisation
	➢ role, place and function of the hospital
	➢ interventions at or before the front door (of emergency units, psychiatric units, psychiatric emergency units), gatekeeping
	➢ decision process (leading to an admission, avoiding an admission to hospital)
	➢ role of the mobile team when the user is admitted to hospital: in-reach in residential units, early discharge
	➢ interferences with MH-act (coercive interventions)
	➢ mobile teams as a real alternative to hospitalisation (high quality alternative)
	➢ useful in facilitating coordination between mobile teams and hospital

	3 Crisis and risk
	➢ perspectives (point of view: patient, environment, professional)
	➢ Perspectives of the professional: vulnerability, aggression, personal safety
	➢ risk assessment
	➢ crisis assessment
	➢ crisis management
	➢ avoiding hospitalisation in a crisis / risk situation
	➢ avoiding, in situations of crisis and risk, freedom restrictive and/or judicial measures
	➢ visit procedures
	➢ crisis communication
	➢ assessment safety factors in the home environment
	➢ coordination 2a and 2b

	4 Role of the psychiatrists
	➢ clinical / medical responsibility
	➢ clinical leadership
	➢ guarantee of quality in mobile working
	➢ guarantee of quality in the context of negotiability
	➢ collaboration with GP's
	➢ collaboration with psychiatrists working external to the mobile team ("treating psychiatrist")
	➢ number of hours/week available for the team, number of WTE psychiatrist (full-time, part-time..)
	➢ duty system
	➢ combination of work in a mobile team and in other services, hospital unit…
	➢ home visits by psychiatrists (as a team member)
	➢ different accents for 2a and 2b teams?

	5 Valorisation of expertise by experience (user expertise)
	➢ expert by experience as a team member
	➢ preconditions for valorising expertise by experience
	➢ how to introduce this, how to put the first step?
	➢ integrating this expertise: examples of results, outcome
	➢ formation, training, specific role as a member of a mobile team
	➢ statute: volunteer, employee, …
	➢ having or taking responsibilities in daily work in mobile teams as expert by experience
	➢ family, carers: integrating their expertise in mobile teams
	➢ different accents for 2a and 2b teams?

	6 Specific problems in combination with mental health problems
	➢ mobile teams: possibilities, limits
	➢ what means "regular", what means "specialist"?
	➢ mental health problems in combination with substance use, addictions
	➢ mental health problems in combination with learning problems (intellectual disability)
	➢ mental health problems in combination with judicial problems
	➢ personality disorders
	➢ integration of specific competences, expertise in mobile teams
	➢ problem related exclusion criteria
	➢ different accents for 2a or 2b teams?

	7 The acute care pathway
	➢ acute care pathway: which activities, how (modalities), an acute care pathway programme
	➢ actors involved (services, professionals), "who"
	➢ other functions psy107, than function 2, involved in the acute care pathway
	➢ exchange of information in the acute care pathway
	➢ coordination of an acute care pathway

	8 The continuing care pathway
	➢ continuing care pathway: which activities, how (modalities), an continuing care pathway programme
	➢ actors involved (services, professionals), "who"
	➢ other functions psy107, than function 2, involved in the continuing care pathway
	➢ exchange of information in the continuing care pathway
	➢ coordination of an continuing care pathway

	9 Cultural diversity
	➢ alternatives for “western” psychiatry
	➢ cultural sensitivity
	➢ languages (spoken by team members, cultural diversity in team composition)
	➢ different accents for 2a or 2b teams?

2.4.2 COUNTRIES INVOLVED

The countries where our experts work and our learning places are located were already involved in a pre-phase of a European project proposal (EU-Progress VP/2012/007) in the period January – June 2011. In 2010 a partnership was set up, including the Belgian Federal Ministry (FPS-Health) and Mental health sector, represented by the Belgian Federations of mental health services, completed with five project partners from other European countries (Norway, Slovenia, Romania, Greece and Malta), bringing these partners and European experts from five other countries (England, Ireland, France, Switzerland and the Netherlands) together around the Belgian 107-experiments.

This partnership responded to the call for proposals for social experiments (EU-Progress). Because of the delay in the evaluation procedure, the FPS-Health was prepared to take an extra commitment in financing a so called pre-phase of the Progress project. Once the partnership was informed by the European Commission that the grant requested wasn't rewarded, the FPS-health and the Belgian federations of Mental health services agreed to continue their partnership and to adjust the framework and context. This led to the agreement between FPS and the federations to invest a part of the budget for the PSY107-formation specifically in formation activities for the new Belgian mobile teams.

End 2011 – early 2012 possibilities in the countries involved in the Progress pre-phase were explored, but this time with a specific focus on mobile team expertise (*potential learning places*) and practice related expertise about starting up and deploying these mobile teams (*experts for group meetings and for local support*). Starting the group meetings (thematic introduction sessions), introduction days for local support and the first learning weeks abroad in 2012, additional contacts were made later, also in other countries (Greece, Italy, Wales), to achieve a sufficient number of potential learning places.

Potential learning places were explored, taking the following criteria into account:

- the mobile team has to be a functionalised service, with a clear place and role in a mental health system;
- the mobile team must be experienced as a learning place for other teams in the own country (a beacon site in the own country) and / or mobile teams from other countries;
- the mobile team must have some experience with the target population profile of the Belgian 2a- and 2b-type of mobile teams (as – part of the - current target population, or as target population in the past);
- the mobile team must be prepared to document the Belgian mobile team in advance;
- the gain is not the money: except for some limited organisational costs, there's no budget available to finance the hosts;
- 'walk the walk', instead of 'talk the talk': prepared to invite Belgian visitors to let them see how they work, to let them walk with them, to illustrate strong and weak points, challenges in past and future. Accept that the Belgian visitors will learn more from what the host team does than from what the host team tells them what they are doing;
- respect the framework of themes/topics utilised to structure the learning experiences of Belgian visitors.

From the *experts*, invited for group meetings and local support in Belgium, is expected that they are prepared to spend the time needed to understand the complex Belgian context, the local 107-projects, the complexity of the starting situation of the Belgian mobile teams, to understand that these teams are not started up from scratch but next to current existing services and a variety of non-structural pilot project and own initiatives, to get a view on the current state of the art of the mobiles teams they will work with and to take the latter as a starting point for their input based on expertise rather than promoting or trying to introduce a concept or a model.

2.4.3 OVERVIEW OF POTENTIAL LEARNING PLACES

Not all of the potential hosts listed below can be defined as 'pure 2A or 2B type of mobile teams'. F-ACT teams in the Netherlands for instance cover function 2b, function 3 and – in part – also function 5. In South Wales, an AOT-function is integrated in the community mental health team. The 'Habicité'-team in Lille combines function 2b and function 5 and the community mental health teams in Trieste are integrated multifunctional services. Both brief and detailed descriptions of the potential learning places are made available by the project coordinator, in collaboration with the contact persons of the learning places.

For Belgian 2a mobile teams, ten organisations from six European countries agreed to collaborate, to except the criteria and conditions, and to host Belgian collaborators:

2A	**England**
	➢ Crisis Resolution Home Treatment Team, Solihull Hospital (Bruce Burns Unit) - Birmingham and Solihull Mental Health NHS Foundation Trust
	➢ Home Treatment Teams, Oleaster - Birmingham and Solihull Mental Health NHS Foundation Trust
	➢ The Stoke Acute Home Treatment Team - North Staffordshire Combined Healthcare NHS Trust
	Wales
	➢ Crisis Resolution and Home Treatment Team, Neath & Port Talbot - ABM ULHB Mental Health
	The Netherlands
	➢ IHT (Intensive Home Treatment) Noord Kennermerland, Alkmaar and surrounding - GGZ Noord Holland Noord
	France
	➢ Team E.R.I.C. (Equipe (équipe rapide d'interventions de crise) - Centre Hospitalier Jean-Martin Charcot, Yvelines Sud, South-East of Paris
	➢ Soins Intensifs intégrés dans la cité (SIIC) / Intensif Care integrated in the City - Etablissement Public de Santé Mentale (EPSM) Lille Métropole
	➢ ULICE, Unité Locale d'Intervention et d'Evaluation de Crise (Local Unit for Crisis Intervention and Evaluation) - Assistance Publique/Hôpitaux de Marseille (service de psychiatrie à l'hôpital Ste Marguerite)
	Norway
	➢ Ambulant Acute Team Ålesund - Sunnmøre Hospital Trust
	Italy
	➢ Centri di Salute Mentale Barcola and Via Gambini – Dipartimento di Salute Mentale Trieste

Belgian collaborators of 2b mobile teams were welcome in 16 organisations from seven European countries (in total more than 40 potential host teams).

2B	**England**
	➢ Assertive Outreach Team, Matthews Centre - Birmingham and Solihull Mental Health NHS Foundation Trust
	➢ Cheltenham Assertive Outreach Team - Trust 2togehter
	➢ Sandwell Assertive Outreach Team – Black Country Partnership HNS Foundation Trust
	Wales
	➢ Community Mental Health Team (in which AOT is integrated), Neath & Port Talbot - ABM ULHB Mental Health
	The Netherlands
	➢ F-ACT teams Hoorn Kersenboogerd, Hoorn Centrum, Enkhuizen, Heiloo, Noord-Kennermerland, Schagen, Heerhugowaard, Alkmaar Centrum, Alkmaar Noord, Alkmaar-Noordoost, Alkmaar Zuid, Alkmaar West, Den Helder Julianadorp, Den Helder Texel – GGZ Noord Holland Noord
	➢ ACT 3 ('forensic ACT team) Utrecht, F-ACT Utrecht North East – Altrecht GGZ
	➢ F-ACT teams Heerlen Centrum, Landgraaf, Kerkrade, Maastricht, Hoensbroek, Brunssum – GGZ Mondriaan
	➢ F-ACT teams Breda Noord, Etten-Leur, Tilburg-Oost, Tilburg-West – GGZ Breburg
	➢ F-ACT teams 2 (Geleen/Munstergeleen) and 3 (Beek, Schinnen, Stein) – GGZ Orbis
	France
	➢ Santé Mentale de proximité - Etablissement Public de Santé Mentale (EPSM) Lille Métropole
	➢ Habicité - Etablissement Public de Santé Mentale (EPSM) Lille Métropole (covers function 2b and function 5)
	➢ MARRS (équipe du Mouvement et Action pour le Rétablissement Sanitaire et Social) - Assistance Publique/Hôpitaux de Marseille (service de psychiatrie à l'hôpital Ste Marguerite)
	Switzerland
	➢ SIM (Suivi Intensif dans le Milieu) Lausanne, CMT (Case Management de Transition) Lausanne, SIM Yverdon, SIM Prangins - Le Département de psychiatrie du Centre Hospitalier Universitaire Vaudois (DP-CHUV)
	➢ SIM (Suivi Intensif dans le Milieu) Genève - Hôpitaux Universitaire de Genève (HUG) – Genève (Département General Psychiatry)
	Norway
	➢ ACT Moss – Østfold Hospital Trust
	➢ ACT Ålesund - Sunnmøre Hospital Trust
	Italy
	➢ Centri di Salute Mentale Barcola and Via Gambini – Dipartimento di Salute Mentale Trieste

2.4.4 PUTTING AND KEEPING THE PROGRAMME ON TRACK

To get the programme organised, much time is spent in clarifying conditions, in explaining the basic principles, the content, the expected results, etc. This requires a continued intensive communication with contact persons from the 107-projects, with the organisations and host teams and the experts, mainly about the budgetary issues, the preparatory work for each internship and local support and the feedback of the participants.

An activity-related budget

Once the content or the programme of this formation programme for mobile teams was approved by the FPS-Health and the Belgian Federations of mental health services, an activity-related budget was assigned: financing experts contributing to the group meetings, financing learning weeks for Belgians abroad, financing local support for Belgian teams by experts from abroad. Early 2012 these financial issues, the possibilities and limitations, were explained and negotiated with experts and already some potential learning places abroad. They were also explained to a first series of 107-projects and their mobiles teams, the so called first wave. This work was repeated in 2013 – 2014 for the second wave of 107-projects, additional potential learning places and new invited experts. Some potential learning places and experts couldn't agree with the budgetary restrictions and were, for this reason, excluded from the programme.

One example of a budgetary restriction is that learning places abroad are not reimbursed for organising a learning week for Belgian people. A maximum cost is defined, based on EU-projects guidelines, for transport and hotel stay abroad for Belgian team members. For the teams abroad not more than a symbolic financial reimbursement of 250 euro is possible for each learning week they organise for representatives of a Belgian 107-project. Another example is that inviting experts from abroad just for one day in one of the projects or one group meeting is avoided in case of considerable transport and hotel costs. This explains why in 2012 experts are invited for group meetings combined with at least a day of local support, or for at least two consecutive days of local support for at least two different 107-projects. Since the end of 2013 the format for local support is adjusted (see point 2.5.3 on page 29) and three to four consecutive days are organised, which also had a positive impact on transport costs.

Because it's a project-related formation budget and not a team-related one, the formation programme offers less possibilities, both for learning weeks as for local support, for projects with an extensive working area where several new mobile teams are started up. For these two types of activities, a maximum investment of +/- 15 000 Euro for each 107-project was possible, depending on the individual needs and interests of the teams, their preferences in terms of learning places and experts to work with, and their willingness to work within the confines of the framework of this formation programme and to collaborate with the FPS-coordinator in order to prepare each activity in the best possible way. The in theory available budget for learning weeks includes all hotel costs (including breakfast), travel costs and a symbolic contribution for some hosts, while for the local support the budget covers hotel, travel, subsistence costs and fees for the invited experts.

Planning, organising and coordinating, reporting

The activities listed below, illustrate the main activities of the coordinator of the formation programme for Belgian mobile teams:

- informing network co-ordinators and mobile teams about the design and the finality of this formation programme; the fact that 107-projects are started up in two waves, and some projects of the second wave already started up mobile teams earlier (before 2013), doesn't facilitate the planning;
- drafting of a formation plan (learning weeks, local support) for the mobile teams in consultation with team and project management or responsible persons; taking into account: preferences, feasibility, estimations of added value of each activity; timing is also directly related to the developmental stage of the teams;
- contacting, step by step, for each possible internship, for each local support, learning places and experts from abroad, in order to concretise an internship plan; agree on timings, start to consult agenda's;
- whenever practicable and not making plans to complicated, internships are organised for members of mobile teams of different projects, or parallel formation plans are developed for teams from neighbouring area's; this can encourage exchange of learning experiences
- arranging accommodation and transport in other countries (internships) and in Belgium (for the invited experts);
- making a documentation map of the learning place, based on a template used to document Belgian visitors about all potential learning places;
- a concise description of the Belgian mobile teams and their network context to inform learning places and / or experts they will meet abroad;
- developing a template for Belgian participants in order to describe their learning experiences (feedback);
- at the request of some learning places: drawing up an internship agreement between learning place, employer and trainee;
- finalising the preparation of each learning week/internship with a final communication addressed to contact persons of the host team and Belgian participants (including all practical and substantive information);
- finalising the preparation of local support with a final communication to the invited experts, team coordinators, network coordinators, summarising all practical information and the programme for the local support;
- stay in contact with the learning place during the learning week; try to be present at least at the launch and completion of local support;
- after the learning week or local support: invest time in helping the participants and team to structure their learning experiences utilising the themes an topics;
- when available, putting the learning experiences in an Excel application;
- make the learning experiences in the Excel file available in three languages, making them accessible for all Belgian mobile teams, learning places and experts involved in the formation programme;
- valorising the feedback: report regarding the learning experiences

Facilitators and barriers

It took quite some time and energy to introduce this formation programme for mobile teams to contact persons and experts from other countries. Interesting for other countries seemed to be the construction of a collaboration agreement between the FPS-health and the Belgian Associations of mental health providers regarding this formation programme, a curiosity, that needed some extra explanation about the Belgian tradition of negotiations between federal authorities and mental health sector. Not only the formation programme but also this unique part of it, opened doors in other countries. There was a certain appeal of this mix of voluntarism of mental health representatives and mobile teams including the commitment of the federal ministry of health.

Also facilitating for connecting with other countries was the result-oriented framework. Form the start is was very clear that this project should be well-documented and that a method for documentation exchange should be available. The choice to introduce the programme as a mutual learning process, and to get it documented by teams and team members themselves, to stimulate and facilitate the exchange of learning experiences, including problem-solving questions, descriptions of – for each team or team member - recognisable problems and their impact, gave the whole initiative a result-oriented character. Including an intrinsic evaluation that goes far beyond a global satisfaction survey (no learning experiences can mean that for instance an internship in a team abroad was not that successful).

Due to the Belgian context of negotiating and collaboration between federal authorities and mental health providers, transparency was guaranteed before this formation programme was started up: content, organisational issues and the budget estimate were elaborated before the programme was started up. It helped to communicate with contact persons abroad, having some eligible criteria at hand for learning places and for local support.

But there were also some barriers in exploring the needed and expected expertise from abroad. Ready-made country specific formation or training programmes didn't fit with the spirit of this programme, and it was not always easy to explain that we needed something else than already existing formation programmes. Nor was it always evident to reassure teams in other countries that any chance of overburdening them with Belgian visitors would be countered. Very clear agreements were made in advance about the maximum number of learning weeks that could be organised annually by one particular learning place. And this can vary very significantly between countries, for instance a learning place in the Netherlands may have a handful, sometimes two hands full of mobile teams, which makes it possible to spread in the same week a delegation of Belgian team members over several teams creating more flexible formulas, that is, organising a learning week for more than two Belgian team members if savings can be made on hotel and transport costs with respect to the defined maximum cost per learning week. Members of French speaking Belgian mobile teams couldn't benefit as much from this flexibility as their Dutch speaking colleagues could.

It was also important that Belgian teams understand that team members selected for a visit to a team abroad, should be persons able and authorised to disseminate learning experiences that are potentially relevant for their team. Of course, this is a decision on behalf of the teams or responsible persons of each 107-project.

One of the toughest obstacles, in Belgium, in informing each individual 107-projects and their teams, communicating with them and planning their formation programme for mobile teams, is

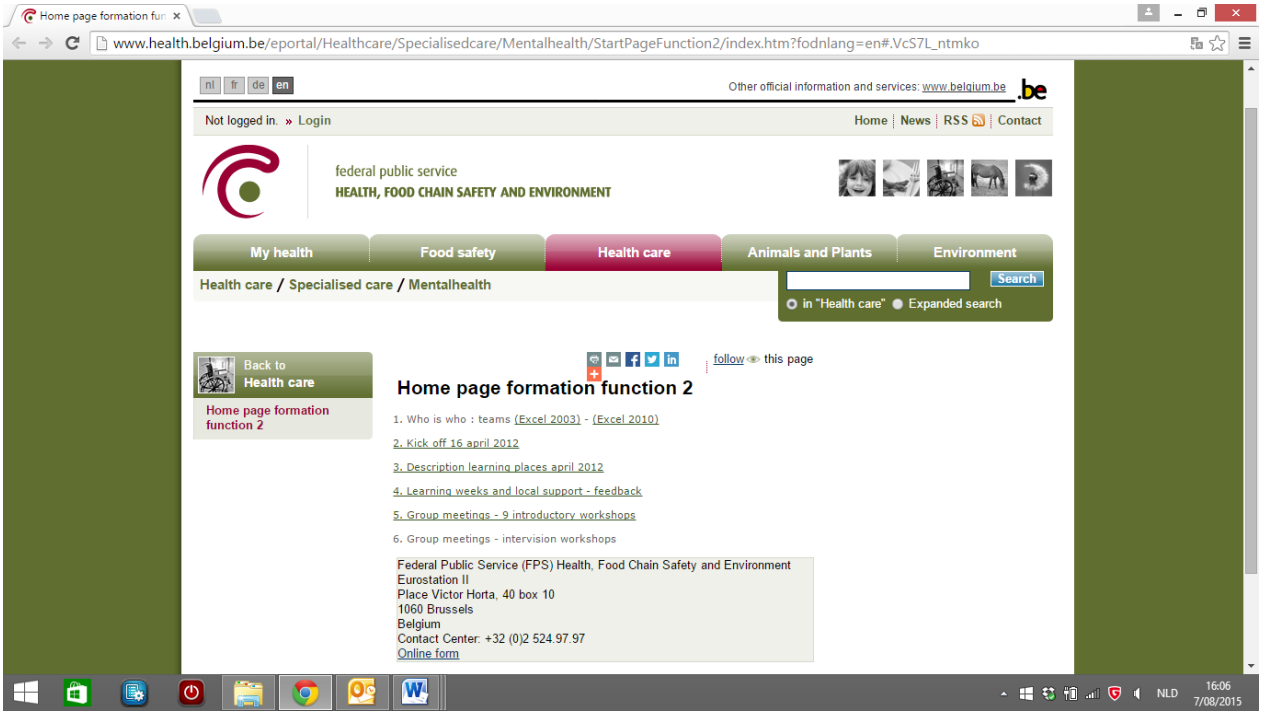
the fact that the 107-projects didn't have to appoint one or more responsible key-persons to start up and deploy the mobiles teams as functionalised services for their project, and to authorise them as contact persons for the development of a formation programme for their mobiles teams. This in contrast with the assignment of network coordinators and the creation a communication channel for network related issues and formation.

And, finally, in the course of this formation trajectory, it became clear that potential learning places abroad were put under pressure, mostly in the context of reorganisations or budget savings.

2.4.5 AVAILABLE DOCUMENTATION

During the formation programme, the following information is available on a FPS-Health webpage (Dutch, French and English version), containing:

- Documentation on the kick-off of the Function 2 formation programme, April 2012 (presentations, documents from invited experts from England, The Netherlands, France, Switzerland)
- Documentation on the formation programme (organisational and budgetary principles, objectives, feedback templates)
- A list of names, functions and email addresses of members of the mobile teams ('who is who?')
- Brief descriptions of learning places
- Presentations of the thematic group sessions (introduction meetings September, October and November 2012)
- An updated state of the art of internships abroad, local support and feedback



2.5 OVERVIEW OF FORMATION ACTIVITIES APRIL 2012 – APRIL 2015

2.5.1. THEMATIC GROUP MEETINGS: INTRODUCTION SESSIONS

Representatives of Belgian mobile teams were invited to participate at thematic introduction sessions, where the nine themes were introduced and illustrated by experts from England, France, The Netherlands and Switzerland. These sessions were spread over September, October and November 2012, each time one day with three parallel sessions. The participants – maximum 25 participants for each session – were invited to formulate some questions and thoughts in advance. Subsequent to the Kick-off sessions in April 2012, where more attention was paid to country specific contexts (U.K., The Netherlands, France and Switzerland) and a first acquaintance for mobile team members with mobile service designs, these thematic sessions aim to deliver more detailed information about the nine mobile team related themes used to structure the learning experience (see pt. 2.4.1. on page 15), potential learning places and of course, a first contact with experts that could be involved in local support. Each session was animated by two experts from different countries, allowing the audience to get insight in different models, point of views and meanings.

The first thematic group meetings were organised on Sept. 7th, 2012. Following themes were introduced:

- The starting up and further development of mobile teams, introduced by Kevin Heffernan and Pascale Ferrari;
- Hospitalisation and mobile teams, introduced by Prof Mervyn Morris and Rokus Loopik;
- Crisis and risk in mobile teams, introduced by Harry Gras, Nicolas Daumerie and Gery Kruhelski

A second series of thematic introductions sessions followed on October 15th, 2012

- The role of the psychiatrist in mobile teams, animated by Dr Eve Le Bihan and Dr Remmers Van Veldhuizen
- Valorisation of expertise by experience in mobile teams, animated by Atie Dekker, Michiel Bahler and Annette Furnemont
- Specific problems in combination with mental health problems, animated by Prof Mervyn Morris and Nicolas Daumerie

A third series of thematic introductions sessions took place on November 21st, 2012:

- The acute care pathway, by Prof Mervyn Morris and Dr Fédéric Mauriac
- The continuing care pathway, by Dr Laurent Defromont and Rokus Loopik
- Cultural diversity and mobile teams, by Harry Gras

2.5.2. INTERNSHIPS ABROAD

Overview

Between July 2012 and April 2015, 81 internships were organised for members or leaders/ coordinators of Belgian mobile teams.

Table 1 presents a chronological overview of the organised internships, from the point of view of the Belgian 107-projects, that is, the number of internships organised abroad for members of their mobile teams, whether or not the internship is integrated in a mixed internship with members of teams from another 107-project. Besides the date when and the place where the internship was organised, table 1 indicates for each internship the 107-project or region in which the Belgian mobile team operates, the type of mobile team in which the participants work and the number of participants, split up in participants from a 2a/2b-team when the learning place offers the possibility of organising both an internship in 2a-type and in a 2b-type of mobile team.

Table 1 Chronological overview internships abroad

2012	**Date**	**Place**	**107- Project**	**Team**	**N Participants**
1	2 - 8 July	Birmingham	De Kempen	2a/2b	1/1
2	2 - 6 July	NHN (Noord Holland Noord)	Leuven-Tervuren	2b	6
3	10 - 14 Sept	Équipe E.R.I.C. (Plaisir)	Fusion Liège	2a	2
4	8 - 12 Oct	Lausanne	Région Hainaut	2b	4
5	22 - 26 Oct	E.R.I.C.	Réseau Santé Namur	2a	2
6	22 - 26 Oct	NHN	Leuven-Tervuren	2b	6
7	22 - 26 Oct	NHN	Noord W-Vlaanderen	2b	2
8	5 - 10 Nov	Birmingham	Gent-Eeklo	2b	2
9	12 - 14 Nov	EPSM Lille	Bruxelles-Est	2a/2b	3
10	12 - 14 Nov	Lille	Ieper-Diksmuide	2a/2b	2
11	12 - 14 Nov	Lille	Zuid W-Vlaanderen	2a/2b	2
12	12 -16 Nov	Lausanne/Genève	Réseau Santé Namur	2b	2
13	19 - 23 Nov	E.R.I.C.	Bruxelles-Est	2a	2
14	10 - 14 Dec	Birmingham	Région Hainaut	2a/2b	1/1
15	17 - 19 Dec	Lille	Hainaut Occicental	2a/2b	3
16	17 - 19 Dec	Lille	Leuven – Tervuren	2a/2b	2
2013	**Date**	**Place**	**107- Project**	**Team**	**N Participants**
17	14 - 18 Jan	Lausanne	Fusion Liège	2b	4
18	22 - 26 Jan	Birmingham	Noord W-Vlaanderen	2a	3
19	28 Jan - 1 Feb	Lausanne/Genève	Hainaut Occidental	2b	2/2
20	25 Feb - 4 Mr	Birmingham	Hainaut Occidental	2a/2b	1/1
21	25 Feb - 1 Mr	E.R.I.C.	Fusion Liège	2a	2
22	11 - 13 Mr[2]	Lille	Région Hainaut	2a/2b	4
23	11 - 13 Mr[3]	Lille	PRIT	2a/2b	2
24	22 - 26 April	E.R.I.C.	Gent-Eeklo	2a	2
25	13 - 17 May	North Staffordshire	Leuven-Tervuren	2a	2
26	13 - 17 May	NHN	Reling	2b	4
27	13 - 17 May	NHN	Noolim	2b	4

[2]Interrupted due to weather conditions, resumed in May 2013

[3] Interurpted due to weather conditions, resumed in May 2013

	Date	Place	107- Project	Team	N Participants
28	13 - 15 May	Lille	Région Hainaut	2a/2b	4
29	13 - 15 May	Lille	PRIT	2a/2b	2
30	24 - 26 June	Lille	Hermesplus	2a/2b	2
31	24 - 26 June	Lille	Bruxelles-Est	2a/2b	2
32	24 - 26 June	Lille	Région du centre	2a/2b	2
33	9 - 13 Sept	E.R.I.C.	Région du centre	2a	2
34	16 - 18 Sept	Lille	Gent - Eeklo	2a/2b	3
35	16 - 18 Sept	Lille	Halle-Vilvoorde	2a/2b	3
36	23 - 28 Sept	Birmingham	Reling	2a	2
37	24 - 26 Sept	Utrecht	Fusion Liège	2b	2
38	21 - 25 Oct	E.R.I.C.	Hainaut Occidental	2a	2
39	11 - 15 Nov	NHN	Hermesplus	2b	2
40	11 - 15 Nov	NHN	Zuid W-Vlaanderen	2b	3
41	11 - 15 Nov	NHN	Halle-Vilvoorde	2b	3
42	18 - 20 Nov	Lille	Gent-Eeklo	2a/2b	2
43	18 - 20 Nov	Lille	Hermesplus	2a/2b	3
44	18- 20 Nov	Lille	Région du Centre	2a/2b	2
2014	**Date**	**Place**	**107- Project**	**Team**	**N Participants**
45	13 - 15 Jan	Lille SIIC	Hainaut Occidental	2a	2
46	20 - 24 Jan	Lausanne	RéSME	2b	4
47	27 - 31 Jan	Birmingham	SaRA	2a/2b	4
48	27 - 31 Jan	Lausanne	RéSME	2b	3
49	10 - 14 Feb	GGZ Mondriaan	Noord W-Vlaanderen	2b	3
50	10 - 14 Feb	GGZ Mondriaan	Ieper – Diksmuide	2b	2
51	10 - 14 Feb	GGZ Altrecht	SaRA	2b	3
52	10 - 12 Mr	Lille SIIC	Région du Centre	2a	2
53	7 - 11 April	E.R.I.C.	Ieper – Diksmuide	2a	2
54	12 - 14 May	Lille	RéSME	2a/2b	6
55	12 - 16 May	Birmingham	Reling	2a	2
56	26 - 30 May	Aalesund	GGZ De Kempen	2a	2
57	16 - 20 June	GGZ Breburg	GGZ De Kempen	2b	2
58	16 - 20 June	GGZ Breburg	Reling	2b	2
59	16 - 20 June	Trieste	Hermesplus	2a/2b	2
60	16 - 20 June	Birmingham	Halle-Vilvoorde	2a/2b	3
61	16 - 20 June	Birmingham	Hermesplus	2a/2b	2
62	23 - 25 June	Lille	RéSME	2a/2b	6
63	23 - 27 June	E.R.I.C.	Région Hainaut Leuze	2a	2
64	1 - 5 Sept	GGZ Altrecht	SaRA	2b	2
65	7 - 12 Sept	Lausanne	Région du Centre	2b	2
66	14 - 19 Sept	Neat Port Talbot (AMB)	Réseau Santé Namur	2a/2b	4
67	21 - 16 Sept	NHN	Halle-Vilvoorde	2a/2b	4
68	21 - 16 Sept	NHN	Noolim	2a/2b	4
69	21 - 25 Sept	Birmingham	PRIT	2a/2b	2
70	21 - 25 Sept	Birmingham	Zuid W-Vlaanderen	2a/2b	2
71	5 - 10 Oct	Birmingham	Noolim	2a/2b	4
72	3 - 7 Nov	GGZ Mondriaan/GGZ Orbis	Noolim	2b	4

	Date	Place	107- Project	Team	N Participants
73	10 - 14 Nov	Aalesund	Zuid W-Vlaanderen	2a	2
74	17 - 21 Nov	NHN	Prit	2a/2b	4
75	17 - 21 Nov	NHN	Zuid W-Vlaanderen	2a/2b	4
76	23 - 28 Nov	Birmingham	SaRA	2a	3
2015	**Date**	**Place**	**107- Project**	**Team**	**N Participants**
77	12 - 16 Jan	Aalesund	PRIT	2a/2b	2/1
78	9 - 12 Feb	NHN	PAKT (Gent-Eeklo)	2a/2b	6/1
79	9 - 12 Feb	NHN	GGZ De Kempen	2a	1
80	9 - 13 Feb	Birmingham	Région du Centre	2a/2b	2/2
81	27 - 29 April	E.R.I.C.	Région Hainaut Mons	2a	2

Table 2 on next page summarises more detailed information: for each visited learning place, the number of internships is indicated (from the point of view of each Belgian 107-project), the number of periods in which these internships are organised (form the point of view of the learning place), the total number of days of the internships and the number of 107-projects being represented by at least one their teams in one or more internships organised in the learning place.

In total, 881 days of internship were organised for 224 Belgian team collaborators: 349 days in French speaking teams (France and Switzerland), 293 days in Dutch speaking teams (The Netherlands), 239 days in English speaking teams (U.K.) or in teams where the communication with the Belgian guests was in English (Norway, Italy).

For all 107-projects it was possible to organise, at least, three internships abroad for each time at least two professionals (members or leader/coordinator) of their mobile teams.

More detailed information per 107-project can be found in pt. 5 on pages 54 – 60.

Table 2 Summarised information per country and learning place

	N Internships	N periods	N participants	N days	N 107-Projects
The Nederlands					
GGZ Noord Holland Noord	14	7	54	204	10
GGZ Altrecht (Utrecht)	3	3	7	26	2
GGZ Mondriaan (1 x comb. GGZ Orbis)	3	2	9	45	3
GGZ Breburg	2	1	4	18	2
England					
Birmingham (BSMHFT)	15	13	39	169	13
Stoke-on-Trent (North Staffordshire)	1	1	2	10	1
Wales					
Neath Port Talbot (ABM University NHS Trust)	1	1	4	16	1
France					
EPSM Lille Métropole	21*	10	53	156	12
E.R.I.C. (CH JM Charcot - Plaisir)	10	10	20	84	8
Switzerland					
CHUV-Lausanne (1 x comb. HUV Genève)	7	7	23	109	6
Norway					
Aalesund - Sunnmøre Hospital Trust	3	3	7	34	3
Italy					
Mental Health Department Trieste	1	1	2	10	1

*two internships were twice organised because weather conditions interrupted the first internship

2.5.3. LOCAL SUPPORT

In the original proposal, five days of local support for the mobile teams of each 107-project were planned and budgeted. To manage the costs of the support by experts invited from abroad, savings were made on travel and hotel costs. The point was to avoid just one day of work in Belgium, so to organise a few consecutive days of local support for mobile teams of several projects, or to combine the presence of an expert in one of the group meetings with a day of local support before or after the group meeting. This is how the local support was started up in 2012. However, this formula didn't seem to be the best option. For practical reasons, such as travelling distances during these couple of days of work in Belgium, and for didactic reasons, such as the finding that the impact of one day of local support was rather limited, that is, considered very

welcome and useful by the team, but not communicated and shared with the mobile team key-partners of the new build network.

Early 2013 a proposal to adapt the formula for local support was accepted by both the FPS-Health and the Federations of mental health care providers. At the same time, the maximum number of days of local support per project was increased from five to eight, because it was already clear at that time that savings were made on internships and group meetings. Instead of organising a few (isolated) days of local support for mobile teams across a certain period of time, the new formula suggests to organise a local support in three to four consecutive days, involving representatives of services and professionals working around the mobile teams of a 107-project. The concept is to invite two experts from abroad, by preference from two other countries, one person with specific experience with a 2a-type of mobile team and one with a 2b-type of experience, and to start the local support with a discussion about the state of the art of the mobile teams, inviting key persons from the mobile teams (not the whole team) and other key persons in the network. Next, two complete days of participative observation are organised, in which the experts walk with the mobile teams, accompany them in their daily practice without disturbing the daily activities. Finally, the fourth day is meant to deliver a translation of the most relevant observations of the two experts, discussed with the mobile team members in the presence of persons representing other functions in the network and/or of professionals working closely together with the mobile teams. This new approach for organising the local support requires a profound preparation: exchange of information about the teams and their current place and role, the best timing for the local support, the choice of experts, briefing and coaching of these experts. To facilitate this preparation, one or two introduction days by inviting an expert to a team and project, are possible to organise for each project.

Although this new formula is meant to offer a potentially richer experience for the mobile teams, it was also kept in mind that it might be difficult to realise, not only but certainly for the mobile teams of the so called second wave of 107-projects, due to a complexity of agenda's and timings, the required preparatory work and the readiness to go for it.

Table 3 Chronological overview of the organised local support

2012	Date	Expert	Country/place	107-project	Team
	April 17	Kevin Heffernan	UK/Birmingham	GGZ De Kempen	2a
	April 17	Philip Delespaul	Neth/Maastricht	Reling	2b
	April 17	Mervyn Morris	UK/Birmingham	GGZ Noord West-Vl	2a/2b
	April 17	Remmers Van Veldhuizen	Neth/Alkmaar	Leuven-Tervuren	2a/2b
	April 17	Philippe Huguelet	Switz/Geneva	Bruxelles-Est	2a/2b
	April 18	Laurent Defromont	France/Lille	Région Hainaut	2a/2b
	April 18	Jean-Luc Roelandt	France/Lille	Hainaut Occidental	2a/2b
	Sept 6	Pascale Ferrari	Switz/Lausanne	Réseau Santé Namur	2b
	Sept 6	Harry Gras	Neth/Utrecht	GGZ De Kempen	2b
	Sept 6	Kevin Heffernan	UK/Birmingham	Leuven-Tervuren	2a
	Oct 16	M Morris/Atie Dekker	UK/Birmingham	Reling	2a/2b
	Nov 19	Harry Gras	Neth/Utrecht	PAKT	2b
	Nov 20	Frédéric Mauriac	France/Plaisir	Fusion Liège	2a
	Nov 20	Harry Gras/Rokus Loopik	Neth/several	GGZ Noord West-Vl	2b

2013	Date	Expert	Country/place	107-project	Team
	Jan 30	Jean-Luc Roelandt	France/Lille	Région Hainaut	2a/2b
	April 24	Mervyn Morris	UK/Birmingham	Fusion Liège	2a/2b
	May 23	Jean-Luc Roelandt	France/Lille	Région Hainaut	2a/2b
	May 30	Mervyn Morris	UK/Birmingham	PRIT	2a/2b
	May 31	Mervyn Morris	UK/Birmingham	Hermes Plus	2a/2b
	Dec 9-12	Frédéric Mauriac, Mathias Lippuner, Mervyn Morris	France/Switz/UK	Fusion Liège	2a/2b
2014	**Date**	**Expert**	**Country/place**	**107-project**	**Team**
	Feb 3-6	Mervyn Morris	UK/Birmingham	Prit	2b
	Feb 7	Mervyn Morris	UK/Birmingham	Hermes Plus	2a/2b
	May 16	Mervyn Morris	UK/Birmingham	SaRA	2a/2b
	May 16	Mervyn Morris	UK/Birmingham	Halle-Vilvoorde	2a/2b
	May 18-20	Kevin Heffernan	UK/Birmingham	Prit	2a
	July 7-9	Harry Gras, Kevin Heffernan	Neth/Utrecht UK/Birmingham	Leuven-Tervuren	2a/2b
	July 7-10	Roberto Mezzina, Mervyn Morris	Italy/Trieste UK/Birmingham	Hermes Plus	2a/2b
	Aug 26-29	Laure Zeltner, Mervyn Morris	France/Plaisir UK/Birmingham	Région Hainaut	2a/2b
	Sept 23-26	Frederic Mauriac, Maud Lapaire	France/Plaisir Switz/Lausanne	Hainaut Occidental	2a/2b
	Oct 13-15	Harry Gras, Kevin Heffernan	Neth/Utrecht UK/Birmingham	GGZ De Kempen	2a/2b
	Nov 17-21	Mervyn Morris, Kevin Heffernan	UK/Birmingham	PAKT	2a/2b
	Dec 8-9	Jo Volle, Victor Grondstad, Mervyn Morris	Norway/Aalesund UK/Birmingham	Leuven-Tervuren	2a
2015	**Date**	**Expert**	**Country/place**	**107-project**	**Team**
	Mar 10-13	Frederic Mauriac, Cristina Garcia	France/Plaisir Switz/Lausanne	Région du Centre	2a/2b

In the period between April 2012 and March 2015, 82 days of local support were realised. For most of the 107-projets, at least an introduction day – a visit by one of the experts – was possible. The renewed formula of three to four consecutive days of local support was possible to realise in 9 out of the 19 107-projects: Fusion Liège, PRIT, Leuven-Tervuren, Hermes Plus, Région Hainaut, Hainaut Occidental, GGZ De Kempen, PAKT (Ghent-Eeklo) and Région du Centre. Six other 107-projects expressed their interest for this formula (Noolim, Reling, Zuid West-Vlaanderen, SaRA, Halle-Vilvoorde-Brussel, Réseau Santé Namur, Réseau Santé Mentale Est), but unfortunately it was impossible to organise this type of local support within the proposed time schedule.

2.5.4. OTHER ACTIVITIES

Besides the three core activities of group meetings, internships and local support, a limited number of other activities, directly related to daily practice in mobile teams, could be organised when certain 'low cost' opportunities arise. A few of these activities were organised in collaboration with the Centre for Community Mental Health from Birmingham City University and Dr Victor Grøndstad and Jo Volle from Ålesund (Sunnmøre Hospital Trust). Dr Grøndstad was

involved in a Norwegian governmental working group regarding guidelines for acute mobile teams, while the Ålesund team being on its way to become a 'prototype 2a-team' or beacon site in Norway.

On November 28th 2012, an international meeting was organised in Birmingham for psychiatrists working in mobile crisis teams. About 30 psychiatrists from Norway, Belgium, The Netherlands, France and Switzerland exchanged experiences regarding guidelines for mobile crisis resolution home treatment teams. The idea was to continue at least a yearly transnational meeting between mobile team psychiatrists. But because of possible interferences with other PSY107 formation activities organised for psychiatrists, further initiatives of international meetings for mobile team psychiatrists were put on hold.

The Ålesund experience – and how this team learned from the experience in the West Midlands – was a few times introduced in Belgium for a mixed audience of mobile crisis team representatives and Federations of mental health care providers.

2.6 FINANCIAL OVERVIEW

Prospective budget (December 2011)

Subsequent to the *Progress Pre-phase project*, a prospective budget was negotiated with the FPS-Health and the Federations of mental health care providers for the formation programme for Belgian mobile teams. Budget estimates were based on EU-project references for travel, hotel and subsistence costs, and included:

- A maximum of three complete weeks of internship abroad, for 3 x two team members or team coordinators per project. With an estimated cost for one learning week for two persons of 250 Euro x 2 persons (500 Euro for transport), 200 Euro x 7 nights x 2 persons (2 800 Euro for the hotel). Three times 3 300 Euro for each project means a theoretical maximum budget of 9 900 Euro per project. In this way, the budget estimate came up with a maximum total cost of 188 100 Euro for the 19 107-projects (which is an equivalent of a maximum of 399 internship days in total for all the 107-projects)

- Minimal 3 and maximum 5 days of local support for the mobile teams of each project, so minimal 57 days and maximum 95 days of local support in total. Based on estimates for transport (360 Euro as a mean transport cost), hotel (200 Euro per night), and some additional subsistence costs, and on a certain fee per day (expert costs), the budget estimate came up with a minimum total cost of 74 600 Euro and a maximum total cost of 121 400 Euro for the 19 107 projects

- The cost for each thematic group meeting (intro session) does not only include the animation of each day session by two invited experts, but also their preparatory work, as an organisation costs as well (meeting room, catering, interpreters…). The estimated cost is 10 625 Euro per session or 95 625 Euro for the nine thematic introduction sessions.

- Since the input of the invited experts will be less time consuming in the thematic intervision sessions (half a day), the cost of an individual sessions is estimated to be 7 532 Euro per session. A maximum of 18 intervision sessions, spread over 6 days, are budgeted (in total 135 570 Euro).

Real costs (2012 -2015)

The real cost for all the activities summed up in previous point 2.5, is less than 50 % of the budget estimate in December 2011. Thematic intervision sessions were not organised, so far. If we don't take the estimated costs for the intervision sessions into account, then the real cost is still less than two-thirds (63%) of the estimated cost, although much more internships (81 versus 57), much more days of internship (881 versus 339 days), for much more Belgians (224 versus 114 participants) were organised as planned, while the number of organised days of local support is not that far from the maximum as defined in December 2011 (82 versus 95 days).

The thematic group meetings (introduction sessions) were much less expensive than estimated, because the majority of the preparatory work was realised by the coordinator of the formation programme. Less expert hours needed to be paid, some costs could be distributed over two posts (group meeting, local support the day before or after the group meeting). The mean real cost of one introduction session was around 4 670 Euro, while the estimated cost was 10 625 Euro per session.

Table 4 A few financial results

INTERNSHIPS		
Total real cost		€ 121 948,27
No. of days internship	881	
Mean cost per day		€ 138,42
No. of participants	224	
Mean cost per participant		€ 544,41
LOCAL SUPPORT		
Total real cost		€ 86 460,36
No. of days of local support	82	
Mean cost per day		€ 1054,39

Not yet mentioned in this report, because not making part of the negotiated and approved proposal, is the Kick-Off for the formation programme for mobile teams, which took place on April 16th 2012. From four countries (the U.K., The Netherlands, Switzerland and France), 13 guests were invited to introduce the National context and some local contexts. In the afternoon workshops were organised in Dutch, in French and in English.

3 FEEDBACK (INTERNSHIPS, LOCAL SUPPORT)

Let's face some experiences of quite a few persons that started to work in the new Belgian mobile teams. Some might sound like a caricature, but for the new team collaborators they were not so unfamiliar at the time the mobile teams started up. Empty offices to start with, no equipment, no telephones. This was an exception, but, no cars, no mobile phones were not so exceptional at all.
Some of the appointed team leaders were not directly involved in recruitment of staff for the mobile teams. Criteria used for recruitment were often a mix of motivation, experience (but not with mobile work), involvement in the former psychiatric home care projects, in organising consultation around the client, psychiatric emergencies, etc.
The new teams had poor experiences in working with persons with severe mental health problems – whether acute or not – in their home situations. And they couldn't rely on a strong network of professional colleagues who developed some of this experience. Most of the new team collaborators and coordinators or leaders became part of a type of service who was supposed to respond to a mission that has, no doubt, hierarchically been thought through. Documented with literature about models, about fidelity criteria for 2a- and 2b-types of mobile teams, even getting the opportunity to meet experts from abroad, the mobile team collaborators had to face the most imaginable ambiguities about the place and role of their teams, about their daily work, about expectations in terms of number of interventions, about impact on hospitalisation, about expectations to work with the patient's 'own psychiatrist' (which limited, mainly the 2b-teams, as a service), being almost stigmatised because of doing a bad type of psychiatry until now and being challenged to change insights, habits and attitudes first.
The vocabulary of globalisation and political agendas took it over, an auction of knowledge appeared on integrating mental health into primary care services, improving access to specialist (secondary) mental health services, developing community based specialist mental health services, about citizenship (integrating mental health services with social services and wider social agenda), about human rights, user/ consumer movement, recovery, etc. While the same political agendas include issues like health economics (cost of untreated disease versus cost of treating disease) and the growth of the psychiatric and wellbeing industry. So, all this became at least very ambiguous, as if behaving political correctly was becoming more important than working with people. As if 'doing the right thing' as recommended in the globalisation and political agendas, was going to work without 'doing the thing right', that is, learn from the experienced, learn as you go as a mobile team and getting some developmental support taking the local realities into account. As if 'talk the talk' is paramount, and can make a difference without a real life and practice oriented can-do approach, how to work, to meet and learn from and work with people ('walk the walk').
Giving Belgian team members the opportunity to get in touch with experienced mobile teams, with people experienced in managing change in different contexts (distinguishing personalised and system / political level), and connect as mobile teams around these opportunities, might at least create a foundation for a culture of knowledge and experience exchange which can complement (or compensate) the findings in literature and scientific publications and the current implementation strategies used by authorities.

3.1 COLLECTING, STRUCTURING AND SHARHING RELEVANT LEARNING EXPERIENCES

The objective is to collect, to structure and to share relevant experiences, so called "lessons learned", as these are reported by members of mobile teams participating at an internship abroad or by teams for whom a local field support by an expert from abroad is organised.

To keep these learning experiences to the point, and even more, to make them hopefully very relevant and recognisable for each Belgian mobile team, a template for feedback suggested the participants to perceive the intended feedback as comparable with the notion of an 'aha-Erlebnis or experience': *'Aha ! Interesting what I see, hear or understand in this team or from this person, because it might be useful to help our team to cope with some problems and deficiencies in our current daily functioning'*. In this way, to report a learning experience means to start with a description of a team-related problem or a situation that can be improved, and with a brief description of the impact or consequences of this problem or situation, which might be broader than strictly team-related (e.g. the impact could be user-related, network-related, etc.). Next, this description is supposed to be transformed into a type of problem solving question form (e.g. "how to improve, how to guarantee, how to avoid…."), and completed with a "to do", related to the learning experience. These to do's don't need to be the big problem solvers but rather something that might be useful and necessary, as the team, to consider. The participants is asked, when available, to make references to documents, to additional information, internet links, etc. For example scans of documents made available by learning places or experts illustrating the learning experience, or more detailed descriptions of the learning experiences by teams or team members.

Next step is to make the feedback or learning experiences accessible for the other Belgian mobile teams. To facilitate the exchange of learning experiences, all feedback is delivered in word-version to the formation@psy107.be mailbox. The coordinator of the formation programme for mobile teams enters the feedback into an Excel file, adding some information about the learning experience (contact person, type of mobile team, 107-project, date, learning place, etc.) and connecting the learning experiences to themes and topics (see pt. 2.4.1). He also makes the learning experiences available in 3 languages. For the French and Dutch speaking Belgian teams a possible barrier for mutual exchange of learning experiences is removed, but also for the non-French and non-Dutch speaking learning places and experts all feedback becomes accessible. In this way practice examples, recommendations, were pooled and shared, not as a good practice guide, but as trigger for a mutual learning process between the new Belgian mobile teams.

The collected feedback can be found at www.mobileteamsconnecting.eu

3.2 LEARNING EXPERIENCES

3.2.1 THEMES AND TOPICS

In total, 249 records were retained and entered in the Excel file as learning experiences. Table 5 presents an overview of the themes and topics used to structure the feedback, and the number of learning experiences attached to them. More than half of the learning experiences can be linked to the theme 'Starting up and further development/deployment of mobile teams', with the following three topics touched most frequently: critical success factors for starting up and further development (62 learning experiences), useful practice supporting instruments important for starting up and further development/deployment (31 learning experiences) and recovery oriented approaches in mobile teams (17 learning experiences). Learning experiences can be linked more frequently to two other topics: number of psychiatrist hours available per week for the team (11 times) and multidisciplinary team functioning (9 times). Learning experiences related to three topics of the continuing care pathway theme – actors involved, information exchange and coordination – are often reported as well.

Some themes do only occasionally show up: valorisation of expertise by experience (user expertise), specific problems in combination with mental health problems, and cultural diversity.

Table 5 Themes/topics – N and % of the reported learning experiences

	N	%
Starting up and further development/deployment of mobile teams	**141**	**56,6**
multidisciplinary team composition	5	
multidisciplinary team functioning	9	
necessary competences of team members	5	
starting up step by step (stages in the development)	2	
recovery oriented approaches in mobile teams	17	
outcome oriented approach and impact on further development/deployment	2	
critical success factors for starting up and further development/deployment	62	
limits of an assertive approach ('meddle care')	5	
useful practice supporting instruments important for starting up and further development/deployment	31	
practical organisation	3	
	N	**%**
Hospitalisation	**19**	**7,6**
role, place and function of the hospital	3	
interventions at or before the front door (of emergency units, psychiatric units, psychiatric emergency units), gatekeeping	1	
decision process (leading to an admission, avoiding an admission to hospital)	4	
role of the mobile team when the user is admitted to hospital: in-reach in residential units, early discharge	6	
interferences with MH-act (coercive interventions)	-	
mobile teams as a real alternative to hospitalisation (high quality alternative)	-	
useful in facilitating coordination between mobile teams and hospital	4	

	N	%
Crisis and risk	**16**	**6,4**
perspectives (point of view: patient, environment, professional)	3	
Perspectives of the professional: vulnerability, aggression, personal safety	2	
risk assessment	3	
crisis assessment	2	
crisis management	1	
avoiding hospitalisation in a crisis / risk situation	-	
avoiding, in situations of crisis and risk, freedom restrictive and/or judicial measures	-	
visit procedures	-	
crisis communication	4	
assessment safety factors in the home environment	-	
coordination 2a and 2b	1	
	N	**%**
Role of the psychiatrists	**19**	**7,6**
clinical / medical responsibility	2	
clinical leadership	1	
guarantee of quality in mobile working	-	
guarantee of quality in the context of negotiability	-	
collaboration with GP's	2	
collaboration with psychiatrists working external to the mobile team ("treating psychiatrist")	1	
number of hours/week available for the team, number of WTE psychiatrist (full-time, part-time..)	11	
duty system	-	
combination of work in a mobile team and in other services, hospital unit…	-	
home visits by psychiatrists (as a team member)	2	
different accents for 2a and 2b teams?	-	
	N	**%**
Valorisation of expertise by experience (user expertise)	**5**	**2,0**
expert by experience as a team member	1	
preconditions for valorising expertise by experience	-	
how to introduce this, how to put the first step?	1	
integrating this expertise: examples of results, outcome	-	
formation, training, specific role as a member of a mobile team	2	
statute: volunteer, employee, …	-	
having or taking responsibilities in daily work in mobile teams as expert by experience	-	
family, carers: integrating their expertise in mobile teams	1	
different accents for 2a and 2b teams?	-	

	N	%
Specific problems in combination with mental health problems	**4**	**1,6**
mobile teams: possibilities, limits	-	
what means "regular", what means "specialist"?	-	
mental health problems in combination with substance use, addictions	1	
mental health problems in combination with learning problems (intellectual disability)	-	
mental health problems in combination with judicial problems	-	
personality disorders	1	
integration of specific competences, expertise in mobile teams	1	
problem related exclusion criteria	1	
different accents for 2a or 2b teams?	-	
	N	**%**
The acute care pathway	**19**	**7,6**
acute care pathway: which activities, how (modalities), an acute care pathway programme	4	
actors involved (services, professionals), "who"	2	
other functions psy107, than function 2, involved in the acute care pathway	4	
exchange of information in the acute care pathway	4	
coordination of an acute care pathway	4	
	N	**%**
The continuing care pathway	**25**	**10,0**
continuing care pathway: which activities, how (modalities), an continuing care pathway programme	4	
actors involved (services, professionals), "who"	7	
other functions psy107, than function 2, involved in the continuing care pathway	-	
exchange of information in the continuing care pathway	7	
coordination of an continuing care pathway	7	
	N	**%**
Cultural diversity	**1**	**0,4**
alternatives for “western” psychiatry	-	
cultural sensitivity	-	
languages (spoken by team members, cultural diversity in team composition)	1	
different accents for 2a or 2b teams?	-	

We refer to the Excel files at www.mobileteamsconnecting.eu to read through or to analyse the feedback. On the same webpage each learning experience is available in article form. The next three points provide a few more words about both topics that are most frequently linked with the learning experience, and an overview of the problem solving questions that were used to introduce the learning experiences.

3.2.2 CRITICAL SUCCESS FACTORS

Almost 25 % of all the learning experiences has to do with critical success factors for the starting up and further development of mobile teams. These critical success factors refer to:

- the missions of a mobile team. Team members wonder: is it realistic to continue to be a very low threshold service? Shouldn't we stop trying to copy therapeutic missions (how we use to work) into this new type of service? About the network expectations: hell, we run like chickens…! And what's the use of talking about missions for the mobile teams without talking about who's supporting and surrounding the mobile teams?

- the target group. Uncertainty: what's should be done, broaden or refine the target population, why do the messages about this continue to be unclear and non-consistent? Team members explain that a 2b-team is doing so much more than serving persons with serious mental illness, social problem situations are included as well. Some of the 2a-teams explain that they are working without an operational crisis definition. Very often mentioned issues are: indistinct inclusion criteria, a not well-defined target group and the lack of proactive search for the target population;

- the team perspective or approach, and the lack of the benefit of working as a team: can individual case management, with accent on individual competencies, be continued in rather small teams with a constantly increasing caseload?

- the working area: the lack of efficiency, some first experiences with organising home visits indicate that working areas are not 'functional' organised, other experiences show that there's a risk of centralisation of service delivery when a working area is defined from the point of view of the existing services rather than from opportunities of meeting users in the community;

- accessibility: 24/24h and 7/7, guarantee for a rapid response, for an accessibility at least by phone;

- gatekeeping function of 2a mobile teams: some experiences are referring to the necessity of trying to make a first step, trying to do at least something ('it doesn't make much sense to deny this important function');

- completion of an accompaniment by a mobile team: illustrations of how teams don't succeed in mobilising possible relays (no step down service), how they don't have clearly defined criteria at their disposal to decide to complete a treatment or accompaniment by a mobile team;

- critical mass: a minimum of means within and around the team is paramount;

- home visits: some team members insist on not underestimating their importance, and to resist the temptation to bring people to the services for consultations ('we are just starting to learn and work outside offices, we don't have to be easy-going by maintaining the tradition of staying in the office'). 'More on the spot' is really needed, although home visits should be timely phased out. If, for some reasons, a home visit doesn't seem to be the best thing to do, we should creatively search for easy accessible meeting places in the community;

- transition from hospital: isn't it critical to start the interventions already in hospital (in case the user is admitted), why isn't this understood as obvious?

- medical assistance in home situations: far too little for the moment;

- in general: what's the point of not responding to at least some critical ingredients for a 2a and 2b team, is it tolerable to continue to fill gaps in the region?

3.2.3 USEFUL PRACTICE SUPPORTING INSTRUMENTS

One out of eight learning experiences point at useful practice supporting instruments important for the starting up and the further development/deployment of mobile teams. It's quite an exploration for the new Belgian mobile teams to find tools or instruments that are helpful in facilitating communication (at team level, at network level), in decision making (assessing requests at first contact, reception of demands, uniform application documents in a region), in doing the thing right (network maps, crisis plans, relapse prevention plans meant to be a recovery tool for the user).

Quite a lot of the described to do's are referring to the incompatibility of the current tools with the mobile work out of office: there's a need for 'mobile tools', easy accessible information tools on the road, permitting a smooth information transmission. Current tools are rather disruptive, taking the pace out of the interventions. Some tools discovered abroad seemed to be very functional: e.g. the use of these tools can lead to a reorganisation of team consultations or discussions, restructuring them in such a way that team discussions are guided by tools that provide besides clarity also an overview and bottlenecks, questions and urgent actions of the accompaniment of the client.

While in most learning places comparable components are integrated in tools that support the decision making processes, the formulation, communication (and evaluation) of objectives, HoNOS for instance, the E.R.I.C. team developed a very pragmatic organisation of multidisciplinary consultation within the team but also with partners. 'Form follows Function': diaries, journals, briefings, files, even the way the team and the working place is equipped, are all adapted to the function of the team.

3.2.4 PROBLEM SOLVING QUESTIONS

The list of questions is a very interesting way to get a first impression of the collected feedback. Similar questions can be linked with different themes and topics, because these questions are related to a problem description, a description of the consequences of the problem, and a 'to do'

or ‘to consider’ that might be helpful to try to deal with the problem within the own mobile team. It’s often the problem description or the description of a ‘to do’, that links the learning experience to one of the themes and topics. These links are made in consultation with the persons delivering the feedback.

The following pages present an overview of these questions, and the themes and topics they are related with. In the first column the type of team is indicated (is it a 2a or 2b learning experience, or a mixed 2a/2b experience?).

Table 6 Problem solving questions, theme ‘starting up and further development/deployment of mobile teams’

	Multidisciplinary team composition
2B	Shouldn’t each mobile team have their own administrator (administrative function)? x 2
	How to reduce the burden of administrative tasks of each individual team member, so that the focus on client support could be increased?
	How to utilise in an optimal way the profession of occupational therapist in a mobile team?
	How can we offer low threshold activities that are more accessible for the client?
	Multidisciplinary team functioning
2A	How do we have to see the interaction between professional disciplines within the team?
	Is a briefing and team discussion regarding the entire caseload, with all present team members participating, needed on a daily basis?
	How can we optimise the multidisciplinary team work, taking into account the limited number of hours of availability of the psychiatrist?
	How to optimise briefings in a mobile crisis team?
	How can we, as team members, share more cases and compose treatment plans in an interdisciplinary way?
2B	How can we guarantee a limited time interval in between two visits?
	How to avoid to be there on your own for a patient?
	Shouldn’t we rely more often on the discipline-specific expertise available within the team, instead of rather use other services in case the situation requires a specific professional competence?
	How can we increase the shared caseload?
	Necessary competences of team members
2A	How can we ensure an efficient follow-up for a user who refuses to involve the family, and how to involve the system or environment optimally in such situations?
	Can there be a training programme organised, with specific focus on acute psychiatric home visits?
2B	To what extent is it desirable and feasible that the place and role of the mobile teams is stronger delineated and linked with an appropriate substantive formation?
	How can we improve the efficiency of, and also the involvement of the team members in, the team meetings?
	How can we explore more profoundly, develop and deploy the competences of our collaborators within our functioning?
	Starting up step by step (stages in the development)
2A	How to deal with improper referrals in the start-up phase of a mobile team?
2B	What must be the focus in the starting up of a mobile team?

	Recovery oriented approaches in mobile teams
2A+2B	How to help the decision making of mental health service users during their recovery process?
2A	How important is it to acquire a shared vision, a common philosophy regarding people with acute mental health problems?
	Is it always necessary to intervene in a crisis situation?
2B	How to use a recovery oriented language in a mobile team?
	How to involve families and important relatives (non-professionals) in the care around the patient?
	How can we increase the involvement of the clients during the care taking by the mobile team?
	Can, and must we give the client the control regarding his treatment?
	How accessible should a team member be when he's doing a home visit? Can he have a phone call with another client?
	How can we implement the communitisation of care in our vision and transform recovery into something real?
	How can we improve the contact between peers (users)?
	How can we evolve towards a more personalised treatment plan, related to the SRH-act (Systematic Rehabilitation oriented acting), in which the client is fully involved and gets a voice, and how can we ensure that other mental healthcare partners will continue to work with this treatment?
	How to give substance to the recovery vision in the daily contact with the clients?
	Does the treatment plan belongs to the client or to the mobile team, or to both?
	Is the non-professional network undervalued in the mobile teams?
	Can we, as a mobile team, develop further with what we have, without having the impression that there are lot of changes around us?
	Can we put a few concrete steps to direct the delicate privacy issue to a recovery oriented approach?
	How to increase the partner role for the client in the process of change?
	Outcome oriented approach and impact on further development/deployment
2A+2B	How to reflect on and to report in an objective way about the activity and daily work of mobile teams?
2B	Is it feasible to invest in the development of an unambiguous, client oriented and easily to handle measurement tool, with the intention of introducing a care monitoring into our functioning/region?
	Critical success factors for starting up and further development/deployment
2A+2B	Persons belonging to the caseload of type 2b-team who go through a crisis: is this a mission for the 2b-team or is the 2a-team taken this over?
	How to avoid saturation of the active caseload?
	If we find that a mobile team does not meet some critical ingredients of a prototype 2a or 2b team, and tends to look like an ambulatory mental health service "+" (upgrade), do we then whether or not have to adjust our concept?
	How to avoid that the mobile teams become the pillars for the patient on whom the network can lean on?
	Must mobile teams refine their target population or, on the contrary, keep the target group rather broad?

2A	How to apply the shared caseload methodology without compromising on some benefits of the individual approach?
	How can we avoid an uncontrolled inflow of demands?
	How can we ensure continuity of care in a crisis situation?
	How, in a crisis situation, improve the maintaining in the home situation by activating all possible resources?
	How can we define the nature of the interventions of a mobile crisis team (what type of intervention)?
	How to define the target population better and more precisely?
	Is exploring, managing and triage of requests for crisis treatment a priority task of a 2a-team?
	Is it possible for a 2a-team to work at the pace of the patient, to respect his rhythm?
	If the client is not asking for help, then isn't it better to look for an alternative to a home visit in certain situations?
	What are the advantages of home visits, compared to consultation at the office?
	What is the importance of the gatekeeping function?
	What is the importance of a permanent availability (24/24h and 7/7d occupancy)?
	Is our system of working with individual reference persons (appointed key-worker) leading to an added value in care delivery or is it rather an obstacle for the health and well-being of the team?
	How to respect our professional prerogatives in crisis situations where medical care is not available in the home situation?
	Is the priority given to the frequency of home visits not too strong ?
	How to reduce the emotional burden that home treatment can bring about to the team members?
	How to clarify the target group of a 2a-team in a better way? Does it makes sense to define the target group in terms of the presence of a psychiatric disorder .... ?
	Does crisis work allows therapeutic work ?
	To what extent can (and is it allowed that) a therapeutic vision affect the delimitation of the target group of a mobile crisis team?
	How can we, already now, take into account the impact of an increased awareness of the existence of the mobile crisis team on the type of demands and referrers?
	How can we respond to the network expectations regarding the responsiveness of our 2a-team EMSI?
	How to set up relays within the network to consolidate the gains of an intensive accompanying by a crisis team over the long term and to avoid relapses ?
	How can we coordinate the itineraries for several home visits more efficiently?
	Which criteria are important in determining the duration of the service delivered by the mobile crisis team?
	Which approach to use: shared caseload or individual case management?
	Are short home visit more efficient?
	How can we focus more on the target group and in this way work more efficiently and avoid an overloading of the team?
	In what way can we work time-saving, in order to avoid an admission stop and a burn-out of team members?
	Isn't the introduction of a gatekeeper function for a mobile crisis team not by far the best way to enhance communication and cooperation with emergency and duty services?

2B	Can a 2b-team continue to work with a not clearly defined target audience?
	How to make an explicit therapeutic approach possible within the 2b-functioning?
	What should we keep in mind to make the work of a mobile team accessible and efficient?
	How can we avoid a saturation of the caseload?
	When is a client ready for completion of the follow up?
	How to improve our accessibility for new patients?
	Is it recommended to distinguish a sub-target group of people "in transition" (people leaving the hospital) and to adopt a specific approach for this sub-target group?
	Is it recommended to appeal to members of function 2a (mobile crisis team) and function 4 (hospital units) in moment that the 2b-team is in lack of adequate resources to ensure a high standard (quality) care?
	How can we maintain consistent and high standard quality follow ups by members of the mobile team type 2b ?
	How can we define the target population of the 2b mobile team?
	What to do with patients that are not followed up in a safe and sustainable way, people without an official address and / or persons who refuse any kind of care?
	Are intensive assertive outreach and rather supportive interventions for relatively stable persons compatible in one and the same team?
	How to prevent or reduce stigmatisation?
	How can we optimally organize our accessibility and availability by phone?
	How to integrate and to ensure multidisciplinary work at patient level?
	How can we make the functioning of mobile teams better known in our region?
	Is co-working, or a shared caseload in complex multi problem situations, preferable to a one-to-one relationship case manager – client in the functioning of a mobile team type 2B?
	How can we develop clear and objective assessment criteria, within our own functioning, in order to finish a support by a 2b team?
	How to define our working areas in a more optimal way?
	What are possible levers for achieving our (potential) target group?
	What can help us to work in a more efficient and targeted manner with our limited staff resources?
	How can we improve the hospital – outpatient continuity, and with which organisational measures?
	Mustn't a mobile team find its ground in the light of the experiences in the field?
	How can we support a larger number of persons (more than 15) per WTE, and at the same time offer good quality support?
	How can we use our (travel)time more efficiently?
	Do we, as a mobile team type 2b, focus sufficiently on the SMI (serious mental illness or disorder) target group?
	How to control the balance between in- and outflow?
	How individual workloads remain tolerable, and how to convert multidisciplinary vision into practice?
	Limits of an assertive approach ('meddle care')
2A+2B	How to remain involved when the client tends to loosen contact with the team?
2A	Isn't it just natural that mobile teams will meet people avoiding care or refusing to engage with services, and that sufficient time should be invested in creating a therapeutic alliance?
2B	How to get an assertive outreach care on its feet?
	How to work with a user in absence of a demand and in denial, for whom the network is challenging us and for whom we sense a need to be followed by the team?
	How to prevent and/or avoid saturation of the team regarding the cases followed by the team?

	Useful practice supporting instruments important for starting up and further development/ deployment
2A+2B	Do we appeal enough to the family and the network around the client, do we do this in a sufficiently coherent way?
	How can we efficiently exchange information with other services or professionals?
2A	How to find out one is still working within the context of crisis intervention?
	Is it recommended that mobile teams type 2a and 2b receive direct requests from the family, so without interference of a professional referral?
	What are useful instruments to approve communication between the members of a mobile teams?
	How to improve the efficiency of the communication and daily to do's regarding the whole caseload of the team?
	How can we work out a treatment plan in an efficient way?
	How can we support as good as possible our multidisciplinary consultation with practically useful tools?
	How to improve the objectivity and increase justification of our observations?
	How can we integrate HONOS within a treatment / support plan?
	How to optimise our work by developing appropriate tools for practice?
	How to work with the entourage and how to integrate them in the treatment?
	How to ensure an objective assessment for each client with mental health disorders referred to the mobile crisisteam ?
	How can we ensure that home workers can continuously dispose of working tools?
	What is the best possible way to organise our consultation moments, so we can take full advantage of them in supporting our daily practice?
2B	How can we assure that the duration of a follow-up by the team is limited in time?
	How to avoid that part of the caseload stays under the radar (out of sight)?
	How to manage demands in a structured and smoothly way, and how to disconnect them from our weekly team meetings?
	How to find a better balance between meeting time and client-oriented work?
	Are there any good practices available that illustrate how an intranet application can become a practice supportive tool for a mobile team?
	What procedure is used for new demands or requests?
	How can we still improve our daily practice by using practical and targeted tools?
	How can we organise the consultation around the FACT board more efficiently, in order to create more space for moments of intervision and supervision?
	Are there any good practices available that illustrate how an intranet application can become a practice supportive tool for a mobile team?
	How to take into account the distraught families, having a complicated relationship in a situation where there is no help demand for a young adult or adolescent with a psychological problem?
	How to introduce and share new daily practice supporting instruments as a team?
	How to improve the evaluation of needs and problems in the home situations (for instance before discharge from hospital)?
	How to optimise an intensification (up-scaling) of the care for a client in such a way that all team members are informed?
	How do we achieve a proper and an efficient information transfer?
	How can we optimise the co-operation with the professional and non-professional network?
	Why is it very important for a mobile team to have good communication tools at its disposal?

	Practical organisation
2A	How to make more “psychiatrist-time” available when psychiatrists already spend much time in briefings, meetings?
2B	How can we make our briefings more to-the-point and efficient?
	How to promote an effective communication concerning all the clients belonging to the active caseload ?

Table 7 Problem solving questions, theme ‘Hospitalisation’

	Role, place and function of the hospital
2A	How to manage our involvement with post-treatment conditions, ‘control of users in our service delivery’?
	How can we, as partner within a network, increase co-operation?
2B	How can we prevent admissions to hospital and shorten periods of hospital stay?
	Interventions at or before the front door (of emergency units, psychiatric units, psychiatric emergency units), gatekeeping
2A	Is it an utopia that a 2a-team would fulfil a gatekeeping role?
	Decision process (leading to an admission, avoiding an admission to hospital)
2A	To what extent is the unavailability of hospital beds an obstacle to a mobile team with a crisis function?
	How can we, as a concerned ambulatory network, improve coordination to prevent unnecessary hospital admissions?
	Is it possible to inform doctors, working in an emergency room, better about the involvement of an mobile crisis team before they make the decision to hospitalise a person?
2B	How can hospitalisation be facilitated by the mobile team?
	Role of the mobile team when the user is admitted to hospital: in-reach in residential units, early discharge
2B	How can we assure that the duration of a hospital admission is limited in time and how to avoid relapse (readmissions)?
	What do we have to do when a person belonging to the caseload is admitted to hospital?
	How to integrate treatment in the home situation and treatment in a residential setting? x 2
	How to communicate in an optimal way with hospital services in case the user is admitted?
	How can we stay involved in case of a hospital admission of one of our clients, and how to secure continuity?
	Interferences with MH-act (coercive interventions)
2A	What is the most appropriate way to start a coercive admission to hospital for a patient followed by the mobile crisis team?
	Useful in facilitating coordination between mobile teams and hospital
2A	Who is coordinating the care for the patient within the network and can propose an intervention by the 2a-team?
	What kind of intervention could we possibly deliver in the emergency units ?
2B	How to collaborate properly, in a relevant way, with the hospitals?
	How a mobile team can help to reduce the duration of a hospitalisation?

Table 8 Problem solving questions, theme 'crises and risk'

	Perspectives (point of view: patient, environment, professional)
2A	What are possible handles for short term interventions that make it possible to establish a therapeutic relation enabling continuity of care?
	How to achieve reassuring effects during a crisis?
	How to perceive crisis in a living environment (in the community)?
	Perspectives of the professional: vulnerability, aggression, personal safety
2A	In case of a suicidal attempt, how can we ensure a debriefing and a moment of evaluation (after a few weeks)?
2B	What can you do if one of the team members is faced with aggression during a home visit?
	Risk assessment
2A	How to assess a crisis, a suicide risk?
	How a 2a-type of mobile team can work effectively?
	How can we assess risks in a more objective way?
	Crisis assessment
2A	How to assess patients more rapidly (and more efficiently) ?
	How to estimate that a certain situation is a crisis situation that should be met by a 2a-team ?
	Crisis management
2B	How to improve crisis management with the use of appropriate tools ?
	Crisis communication
2A	How to improve communication between all stakeholders in a crisis situation?
	How can we more rapidly obtain a view when dealing with a crisis situation?
2B	How can we ensure that each team member has up to date information, and what communication tools should be used?
	How to talk about a possible relapse with the client (how to announce this possibility and prepare the client for it)?
	Coordination 2a and 2b
2B	Is a closer co-operation possible between our mobile crisis teams and our 2b-teams?

Table 9 Problem solving questions, theme 'role of the psychiatrist'

	Clinical / medical responsibility
2A+2B	How to develop care plans on time (quicker than today)?
2A	How to guarantee that every client referred to a mobile crisisteam is seen by a psychiatrist?
	Clinical leadership
2A	Is there any chance it is going to work without a psychiatrist?
	Collaboration with GP's
2B	How can we keep a better overview on medication?
	Is there a way to ensure that both GP and psychiatrist are informed about the prescribed medication?
	Collaboration with psychiatrists working external to the mobile team ("treating psychiatrist")
2B	Is it a good idea that hospital psychiatrists could temporarily get in charge for the follow up of a patient that is allocated to the mobile team?
	Number of hours/week available for the team, number of WTE psychiatrist (full-time, part-time..)
2A	Is it necessary that each patient, followed by the 2a-team, is seen by a psychiatrist? It this realistic, feasible, desirable?
	How to provide a contact with the psychiatrist more rapidly?

	Should there be a weekly home visit by the psychiatrist?
	How can we quickly (preferably within 72uur) respond to a crisis situation, whether or not referring quickly and dealing efficiently with doctors hours?
	What could be the immediate impact of a daily presence of a psychiatrist on a few essential aspects of the functioning of a mobile crisisteam (such as a rapid response when the demand arrives, a clear treatment plan at the moment of inclusion in the team)?
	How can we make our consultation moments more productive and efficient?
	How is the psychiatrist function defined in an acute mobile team?
2B	How to align the team functioning with the limited availability and mobility of the team psychiatrist?
	how can we improve and modify the involvement of the psychiatrist, that is limited in hours and rather supervisory?
	Is there a possibility that, within a period of time, the final direction will be the responsibility of the psychiatrists attached to the 2B team?
	Could the psychiatrist of a mobile team (type 2B) become the treating psychiatrist?
	Home visits by psychiatrists (as a team member)
2A+2B	How to increase the accessibility of consultations with the psychiatrist?
2A	How to arrive at a common vision between the psychiatrist and the team regarding the state of the patient?

Table 10 Problem solving questions, theme 'valorisation of expertise by experience'

	Expert by experience as a team member
2B	What role (s) may experienced workers / experts by experience perform within the new approach of psychiatric home care?
	How to introduce this, how to put the first step?
2B	How can we integrate efficiently an expert by experience into our mobile team?
	Formation, training, specific role as a member of a mobile team
2B	How can we support the process of growth in our team regarding the issue of expertise by experience?
	How can we avoid that an expert by experience becomes a professional worker ?
	Family, carers: integrating their expertise in mobile teams
2A	How can we mobilise the environment of the patient so they can make a contribution to the treatment?

Table 11 Problem solving questions, theme 'specific problems in combination with mental health problems

	Mental health problems in combination with substance use, addictions
2B	How to make time for useful moments of supervision about individual cases?
	Personality disorders
2B	To what extent we can expect a certain specificity (specialisation) of a mobile team, and how to develop it?
	Integration of specific competences, expertise in mobile teams
2B	Are there any limits integrating home treatment and treatment in a residential setting, for example, when it comes to specific expertise?
	Problem related exclusion criteria
2A+2B	How, as a mobile team, can we deal with the diversity of psychiatric disorders that we meet on the field?

Table 12 Problem solving questions, theme 'the acute care pathway'

	Which activities, how (modalities), an acute care pathway programme
2A	What interventions can we propose to a patient in crisis?
	How to respond to and manage the absence of a crisis bed reserved for our users?
	Shouldn't each project 107 have its own crisis beds accessible for a mobile team crisis team?
	How to achieve that certain inclusion criteria (no minors) and therapeutic view will less obstruct the working with the context?
	Actors involved (services, professionals), "who"
2A	How to improve the collaboration with police and medical emergency services?
	Can a GP continue to play a central role when a mobile crisis team works, very intensively and for a brief period, with the context in order to avoid an admission to hospital?
	Other functions psy107, than function 2, involved in the acute care pathway
2B	What could improve our taking charge of patients in the acute care pathway ?
	How can we adjust our care duration to the current ambulatory provision?
	How can we improve care transfer to professionals continuing the pathway?
	How can clients be removed briefly, and quickly and efficiently, from the home situation without launching a battery of care but with the support of mobile teams? How can referrals become less complicated?
	Exchange of information in the acute care pathway
2A	What kind of information is exchanged in the network ?
	How to improve the receipt of demands, how to run this more smoothly?
	How to communicate efficiently with GP's?
	Sharing of information in the network and professional secrecy: is a joint tool for the whole network helpful for the user?
	Coordination of an acute care pathway
2A	When a referral to hospital must be considered, how to limit the duration of the hospitalisation?
	How can we obtain a more efficient triage for referrals to a mobile crisis team so that the clients are more rapidly guided to the right service?
2B	How to increase the permanency (accessibility, on call, on duty) outside the office hours?
	How can we improve our interventions for care resistant persons ?

Table 13 Problem solving questions, theme 'the continuing care pathway'

	Which activities, how (modalities), continuing care pathway programme
2B	How to guarantee a recovery project?
	How can we guarantee a shelter/time-out, outside a hospital setting?
	Is it a good strategic decision for mobile teams to lower their thresholds in the start-up phase, by being for example physically present at locations that serve a gateways?
	How to deal, as a mobile 2B-team, with the "final completion" of our intervention?
	Actors involved (services, professionals), "who"
2A	Which diversity of shelter type places are possible for persons with mental problems, who are in crisis and don't need hospitalisation?
2B	Can a mobile team release a client step by step? And how?
	It is recommended to redirect patients who stayed for a long period in a hospital, first to an alternative residential housing – care combined service, before get to work with them in the natural home environment?
	How can we find new and more regular point of support for social isolated clients, after finishing the interventions of the mobile team?
	How can we facilitate integration of clients in the community?
	Is there a way to improve the flow through the system of our clients?
	How can we activate clients, often with schizophrenic problems, and stimulate them to encounter?
	Exchange of information in the acute care pathway
2B	How to simplify the exchange of information, how to make this more accessible and rapidly available for every professional ?
	How can we improve the transfer of information and the cooperation between partners?
	Can we organise consultations around the client (meetings to discuss the client) by telephone?
	How to monitor the follow-up of the possible side effects of taking anti-psychotic medication?
	How can we become less dependent on individual communication with the client?
	How can we improve the communication between partners within the network?
	How to improve the co-operation between the various network partners, within the framework of the communitisation of care?
	Coordination of an acute care pathway
2A+2B	What can we do to improve the follow up of the medication compliance of the user?
2B	Is it wishful to charge a team member of a mobile team to accompany a person who is a resident in a sheltered housing (SH) initiative? Or is this something that SH has to do itself?
	How can we work effectively with the doctors (attending doctors, in this case, GPs)?
	How can we involve partners in the mental health scene in a better way, in order to alternate more rapidly between different services?
	How can we encourage and more often benefit from the consultation around the psychiatric patient?
	Is it possible to include depot follow-up and laboratory controls using the fact-board of mobile teams?
	Can the mobile crisis team and the 2b-teams have more crisis beds at their disposal in case of crises of their clients?

Table 14 Problem solving questions, theme 'cultural diversity'

	Languages (spoken by team members, cultural diversity in team composition)
2A+2B	Shouldn't we take the cultural diversity that we meet on the field into account in the composition of a mobile team?

4 NEXT POSSIBLE STEP

Continuing a mutual learning

Collecting the feedback and making it accessible was meant to stimulate and to document a mutual learning process between Belgian mobile teams. The initial idea was to organise thematic inter-vision sessions: group meetings with representatives of Belgian mobile teams, reducing the list of problem solving questions to FAQ's, Frequently Asked Questions regarding the daily functioning and practice of mobile teams, to see if the reflexions on FAQ's can bring Belgian teams to a consensus on some key-ingredients to be met by 2a- and 2b-mobile teams, and why they should be met, and to present the results of these reflexions to experts from other countries who were actively involved in the formation programme for Belgian mobile teams.

An alternative is to analyse the collected documentation with representatives of the teams, to select FAQ's related to recognisable problem situations, and to check whether one or more Belgian mobile teams are making progress regarding some of the described to do's. As a sequel to the internships of learning places abroad, Belgian teams could be helped to search for Belgian beacon sites where possible answers can be found for difficulties faced by most of the teams to respond to some critical key-ingredients.

A mutual learning process could be continued, as a long term structured practice exchange between mobile teams. This process can be facilitated, by making the bridge between the finalised formation programme based on expertise from abroad, by a short term investment by the FPS-Health in putting the process on track, by exploring the best possible framework containing a user-friendly web based tool and a solid construction in terms of organisation and coordination, formal engagements of motivated professionals and employers in order to guarantee a sustainable support for the mutual learning. If these conditions are met, then the contribution of the FPS-Health in facilitating the next step can be limited in time, and the mobile teams could take charge to this continued mutual learning.

Where considered necessary and useful, crossing borders and reinforcing connections between expertise in Belgium and other countries, should still be maintained.

5 DETAILED OVERVIEW OF ACTIVITIES PER PROJECT

	LEUVEN-TERVUREN				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012	17 April	Remmers Van Veldhuizen	1	GGZ Noord Holland Noord	6
	6 Sept.	Kevin Heffernan	2	GGZ Noord Holland Noord	6
			3	EPSM Lille Métropole	2
2013			4	Stoke-on-Trent	2
2014	7-9 July	Kevin Heffernan, Harry Gras			
	9 Dec.	Jo Volle, Victor Gronstad, Mervyn Morris			
		N days local support = 12			**N days internship = 64**
					N Participants = 16
					Mean cost per participant = 415,54 Euro

	GGZ DE KEMPEN				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012	17 April	Kevin Heffernan	1	Birmingham (BSMHFT)	2
	6 Sept.	Harry Gras			
2013					
2014	13-15 Oct	Kevin Heffernan, Harry Gras	2	Aalesund	2
	7-9 July	Kevin Heffernan, Harry Gras	3	GGZ Breburg	2
2015			4	GGZ Noord Holland Noord	1
		N days local support = 8			**N days internship = 30**
					N Participants = 7
					Mean cost per participant = 799,02 Euro

	HET PAKT (GENT-EEKLO)				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012	19 Nov.	Harry Gras	1	Birmingham (BSMHFT)	2
2013			2	E.R.I.C. (CH Charcot Plaisir)	2
			3	EPSM Lille Métropole	3
			4	EPSM Lille Métropole	2
2014	17-20 Nov 11-12 Dec	Mervyn Morris, Kevin Heffernan			
2015			5	GGZ Noord Holland Noord	7
		N days local support = 8			**N days internship = 53**
					N Participants = 16
					Mean cost per participant = 473,12 Euro

	GGZ NOORD WEST-VLAANDEREN				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012	17 April	Atie Dekker, Mervyn Morris	1	GGZ Noord Holland Noord	2
	20 Nov.	Rokus Loopik, Harry Gras			
2013			2	Birmingham (BSMHFT)	3
2014			3	GGZ Mondriaan	3
		N days local support = 2			**N days internship = 38**
					N Participants = 8
					Mean cost per participant = 582,59 Euro

	REGION HAINAUT				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012	18 April	Laurent Defromont	1	CHUV Lausanne	4
			2	Birmingham (BSMHFT)	2
2013	30 Jan.	Jean-Luc Roelandt	3	EPSM Lille Métropole	4
	23 May	Jean-Luc Roelandt			
2014	26-29 Aug	Laure Zeltner, Mervyn Morris	4	E.R.I.C. (CH Charcot Plaisir)	2
2015			5	E.R.I.C. (CH Charcot Plaisir)	2
		N days local support = 8,5			**N days internship = 50**
					N Participants = 14
					Mean cost per participant = 528,78 Euro

	RESEAU SANTE NAMUR				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012	6 Sept.	Pascale Ferrari	1	E.R.I.C. (CH Charcot Plaisir)	2
			2	CHUV Lausanne/HUG Genève	2
2013					
2014			3	ABM ULHB Wales	4
		N days local support = 1			**N days internship = 40**
					N Participants = 8
					Mean cost per participant = 726,54 Euro

	BRUXELLES EST				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012	17 April	Philippe Huguelet	1	EPSM Lille Métropole	3
			2	E.R.I.C. (CH Charcot Plaisir)	2
2013			3	EPSM Lille Métropole	2
	N days local support = 1		**N days internship = 24**		
			N Participants = 7		
			Mean cost per participant = 427,58 Euro		

	FUSION LIEGE				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012	20 Nov.	Frédéric Mauriac	1	E.R.I.C. (CH Charcot Plaisir)	2
2013	24 April	Mervyn Morris	2	CHUV Lausanne	4
	9-12 Dec	Frédéric Mauriac, Matthias Lippuner, Mervyn Morris	3	E.R.I.C. (CH Charcot Plaisir)	2
			4	GGZ Altrecht (Utrecht)	2
	N days local support = 8		**N days internship = 42**		
			N Participants = 10		
			Mean cost per participant = 681,73 Euro		

	HAINAUT OCCIDENTAL				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012	18 April	Jean-Luc Roelandt	1	EPSM Lille Métropole	3
2013			2	CHUV Lausanne	4
			3	Birmingham (BSMHFT)	2
			4	E.R.I.C. (CH Charcot Plaisir)	2
2014	23-26 Sept	Frédéric Mauriac, Maud Lapeire	5	EPSM Lille (SIIC)	2
	N days local support = 7		**N days internship = 50**		
			N Participants = 13		
			Mean cost per participant = 413,93 Euro		

	IEPER-DIKSMUIDE				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012			1	EPSM Lille Métropole	2
2013					
2014			2	GGZ Mondriaan	2
			3	E.R.I.C. (CH Charcot Plaisir)	2
		N days local support = 0			**N days internship = 25**
					N Participants = 6
					Mean cost per participant = 534,13 Euro

	ZUID WEST-VLAANDEREN				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012			1	EPSM Lille Métropole	2
2013			2	GGZ Noord Holland Noord	3
2014			3	Birmingham (BSMHFT)	2
			4	Aalesund	2
			5	GGZ Noord Holland Noord	4
		N days local support = 0			**N days internship = 49**
					N Participants = 13
					Mean cost per participant = 530,85 Euro

	PRIT (ZUID WEST-VLAANDEREN)				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012					
2013	30 May	Mervyn Morris	1	EPSM Lille Métropole	2
2014	3-6 Feb	Mervyn Morris	2	Birmingham (BSMHFT)	2
	18-20 May	Kevin Heffernan	3	GGZ Noord Holland Noord	4
2015			4	Aalesund	3
		N days local support = 7			**N days internship = 43,5**
					N Participants = 11
					Mean cost per participant = 442,14 Euro

	RELING				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012	17 April	Philippe Delespaul			
	17 Oct	Mervyn Morris, Atie Dekker			
2013			1	GGZ Noord Holland Noord	4
			2	Birmingham (BSMHFT)	2
2014	26-29 Aug	Laure Zeltner, Mervyn Morris	3	Birmingham (BSMHFT)	2
			4	GGZ Breburg	2
	N days local support = 2		**N days internship = 43**		
			N Participants = 10		
			Mean cost per participant = 518,52 Euro		

	NOOLIM				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012					
2013			1	GGZ Noord Holland Noord	4
2014			2	GGZ Noord Holland Noord	4
			3	Birmingham (BSMHFT)	4
			4	GGZ Mondriaan/GGZ Orbis	4
	N days local support = 0		**N days internship = 70**		
			N Participants = 16		
			Mean cost per participant = 500,39 Euro		

	HERMES PLUS				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012					
2013	31 May	Mervyn Morris	1	EPSM Lille Métropole	2
			2	EPSM Lille Métropole	3
			3	GGZ Noord Holland Noord	2
2014	7 Feb	Mervyn Morris	4	Birmingham (BSMHFT)	2
	7-10 July	Mervyn Morris, Roberto Mezzina	5	Trieste	2
	N days local support = 8		**N days internship = 42**		
			N Participants = 11		
			Mean cost per participant = 494,49 Euro		

	REGION DU CENTRE				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012					
2013			1	EPSM Lille Métropole	2
			2	E.R.I.C. (CH Charcot Plaisir)	2
			3	EPSM Lille Métropole	2
2014	7 Feb	Mervyn Morris	4	EPSM Lille Métropole (SIIC)	2
	7-10 July	Mervyn Morris, Roberto Mezzina	5	CHUV Lausanne	2
2015	10-13 Mrs	Frédéric Mauriac, Cristina Garcia	6	Birmingham (BSMHFT)	4
	N days local support = 6		**N days internship = 53**		
			N Participants = 14		
			Mean cost per participant = 460,32 Euro		

	HALLE-VILVOORDE-BRUSSEL				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012					
2013			1	EPSM Lille Métropole	3
			2	GGZ Noord Holland Noord	3
2014			3	Birmingham (BSMHFT)	3
2015			4	GGZ Noord Holland Noord	4
	N days local support = 0		**N days internship = 43,5**		
			N Participants = 13		
			Mean cost per participant = 518,44 Euro		

	SaRA				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012					
2013					
2014			1	Birmingham (BSMHFT)	4
			2	GGZ Altrecht (Utrecht)	3
			3	GGZ Altrecht (Utrecht)	2
			4	Birmingham (BSMHFT)	3
	N days local support = 0		**N days internship = 52**		
			N Participants = 12		
			Mean cost per participant = 667,30 Euro		

	RéSME – RESEAU DE SANTE MENTALE DE L'EST				
	LOCAL SUPPORT		INTERNSHIPS		
	Date	**Expert**	**No.**	**Place**	**N Part.**
2012					
2013					
2014			1	CHUV Lausanne	4
			2	CHUV Lausanne	4
			3	EPSM Lille Métropole	6
			4	EPSM Lille Métropole	6
		N days local support = 0			**N days internship = 67,5**
					N Participants = 19
					Mean cost per participant = 499,38 Euro

TABLES

For basic materials (shared learning experiences): www.mobileteamsconnecting.eu