BELGIAN ADVISORY COMMITTEE ON
Bioethics

Opinion no. 61 of 9 March 2015 on the Socialisation of Care

A. Request for an opinion

The following request was made by Mr. J. Reyntens, chairman of the medical ethics committee "Spes et Fides", in a letter dated 24 October 2012 and received on 13 December 2012:

"In article 107 of the Law on Hospitals, the Belgian government is aiming at a reorganisation of the mental health care sector, including a reconversion of residential psychiatric care.

"The ultimate aim appears to be to fight against the psychiatric patient's condition developing into a chronic condition, by allowing him/her to participate in the life of society in an empowering and integrated way. Key concepts in this context are adapted housing and a more personalised outpatient care.

"While the socialisation of psychiatric care undoubtedly contributes to the integration and, as a consequence, possible improvement of the patient, the medical ethics committee "Spes et Fides", which is active in seven psychiatric hospitals in Eastern Flanders that are involved in a pilot project based on the above-mentioned article 107, is concerned that the respect for the ethical principles in care relationships could be compromised.

"This concern prompted the Committee to formulate several observations during its last meetings, which the Committee is pleased to present to the esteemed members of the Belgian Advisory Committee on Bioethics, asking them to adopt and communicate their own point of view on the issue.

"According to the ethics committee "Spes et Fides", important values such as justice, participation and quality of life are threatened for all psychiatric hospitals, due to the possible consequences of the restructuring following from the pilot project based on article 107 of the Law on Hospitals.

"Our observations focus on the following questions:

- To what extent can the chronic psychiatric patient, who is often dysfunctional on a variety of levels and requires extensive support, truly seek this care, given the current shortage of qualified carers and the existing waiting lists in the mental health care sector?
- What if, in the context of treatment involving an established treatment course and for whatever reason, it is impossible to achieve *informed* or *negotiated consent*, in the spirit of the Law on Patient Rights?
- Is society as a whole prepared to fully accept and implement this socialisation, knowing that tolerance towards minorities, in this case those with serious psychiatric disorders, has reduced over time?
- Are the financial implications for the patients and for society sufficiently known and affordable, knowing that international research (including in the Netherlands) points to a substantial increase of costs?

- What impact will the reduction in the number of T-beds have on the admission policy of psychiatric hospitals regarding patients with chronic and complex problems?
- Is there sufficient adapted and affordable housing available for the above-mentioned target group, given that these waiting lists are also extensive, the law is restrictive and costs continue to rise?

“It is therefore all but certain that the reorganisation aimed at by the legislator will lead to better care for people with a serious psychiatric condition.

“The just (re-)distribution of goods and services according to actual needs is a laudable principle which supports the equality of the sick and the healthy, and for which balanced resources should thus be made available. However, participation in the life of society does not only presuppose equal opportunities, but also equal results, which implies that the integration and inclusion be the result of all actors. Furthermore, quality of life presupposes a certain degree of autonomy and is connected to psychological, physical, relational, social and spiritual well-being, in which both objective and subjective elements are recognised and respected.

“Moreover, given the lack of parameters corresponding to the current practice in scientific experiments (or according to the SMART-principle which enables the evaluation of general policy objectives), it is unclear what will happen if the objectives, as described above, are not met, in which case the consequences for the target group – and possibly also for society – risk becoming disproportionate.

“We hope that the above-mentioned observations are capable of inspiring the Belgian Advisory Committee on Bioethics to investigate the issue and, if necessary, to adopt and communicate a point of view.”

B. Article 107 of the Law on Hospitals

Article 107 of the Law on Hospitals allows psychiatric hospitals to utilise up to 10% of the resources that currently go towards caring for inpatients in a different way. It is thus possible for these institutions to use part of their funding for hospital beds to create new forms of care, such as “mobile teams” which care for patients at home as a preventive measure or as an alternative to residential treatment. These multidisciplinary mobile teams are intensive outpatient care teams which go to the patient's home for (sub-)acute psychiatric problems (mobile crisis teams) and chronic psychiatric problems. This project is part of a broader reform of the mental health care sector towards request-directed, rehabilitation-focussed care in which the patient (and his/her wishes, needs, resilience and strengths) is put at the centre, and which is organised in a coordinated network or care system. The aim of care is rehabilitation, empowerment and participation: the disappearance or reduction of symptoms and/or the realisation of quality of life or a meaningful life in society despite symptoms and limitations. This is what is meant by “socialisation of care.” The key to this is the discovery and development of one's own strengths and possibilities, supported by those around one.

The Advisory Committee on Bioethics unanimously supports this ambitious long-term reform project for a wider socialisation of the mental health care sector by means of the development of easily accessible and specialised care in close cooperation with front-line care, so that mental health care becomes more accessible and focussed on rehabilitation.

C. Answers to the questions posed

We will respond to the six questions posed from an ethical perspective.

Question 1: To what extent can the chronic psychiatric patient, who is often dysfunctional on a variety of levels and requires extensive support, truly seek this care, given the current shortage of qualified carers and the existing waiting lists in the mental health care sector?

Article 107 creates a framework in which existing hospital resources in adult psychiatry – and thus carers too – can be utilised differently (for example, the mobile teams). This involves a shifting of but not a decrease in resources. The problem of waiting lists lies more in the outpatient mental health care services than in adult psychiatry departments in hospitals.

Article 33 is more problematic for the reform of the mental health care sector at the level of the communities (Flemish decree of 19 May 1999 on mental health care), which states that mental health care centres are allowed to use up to 10% of their existing resources for the targeted reforms. Outpatient mental health care services do have waiting lists, and a shifting of resources and staff towards prevention, early intervention and mobile teams is certainly not obvious. A reform of the mental health care sector that aims at socialisation should also strengthen traditional outpatient mental health care in addition to developing mobile teams.

Question 2: What if, in the context of treatment involving an established treatment course and for whatever reason, it is impossible to achieve informed or negotiated consent, in the spirit of the Law on Patient Rights?

Mobile teams provide care in the framework of the Law on Patient Rights, and thus take “informed or negotiated consent” into account. A patient who is capable of stating his/her own will or making his/her own decisions can refuse an offer of care; care that is offered according to article 107 is not a form of forced treatment. Mobile teams are nevertheless able to provide care in a regular and repeated way by explaining to the patient and their environment its necessity. From an ethical point of view, the Advisory Committee on Bioethics is of the opinion that mobile teams should have the possibility to offer care in a more assertive way. In this context this is called intervention care.[1] However, even in this context a refusal of care or treatment by a patient capable of stating his/her will should be respected, in accordance with the Law on Patient Rights.

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[1] This can be defined as the social-psychiatric care in which the carer actively intervenes and offers practical help in the life of the patient.

From an ethical and legal point of view, three situations can be distinguished for patients capable of stating their own will or making their own decisions. (1) If the patient gives informed consent, the relevant care and treatment can be administered. (2) If the patient refuses this care, this refusal is respected and of course no care or treatment will be administered. (3) Finally, an ambivalent situation is possible in which neither consent nor a clear refusal is given. In such a case – in the absence of informed consent – no treatment can be started, but there is room for negotiation, repeatedly offering and suggesting care, staying in contact with the patient, etc.

The problem of a possible refusal of care by the patient is not restricted to this project of mental health care socialisation. It also arises outside of the context of article 107, and deserves to be adequately responded to. This includes checking if there is a serious danger and whether the other criteria for forced admission are met (cf. the law from 26 June 1990 on the protection of the mentally ill). In addition, the specific capacity of the patient to state his/her own will or make his/her own decisions should be assessed (regarding this refusal). In certain situations as determined in the Law on Patient Rights of 22 August 2002, the representative of the patient can then give informed consent. Because these situations are not restricted to the mobile teams, they will not be further elaborated on here.

Question 3: Is society as a whole prepared to fully accept and implement this socialisation, knowing that tolerance towards minorities, in this case those with serious psychiatric disorders, has reduced over time?

The Advisory Committee on Bioethics unanimously shares this concern of the applicant, and we are conscious that an important societal stigma exists regarding this vulnerable patient group. However, this goes beyond the issue of article 107, and should be studied as such. The socialisation of the mental health care sector is not only the task of the sector, but also and equally the task of society. This task includes meeting people who are psychologically vulnerable with openness, giving them an equal place, and involving them in home, work and social life.

Question 4: Are the financial implications for the patients and for society sufficiently known and affordable, knowing that international research (including in the Netherlands) points to a substantial increase of costs?

This question regarding the financial implications of article 107 for the patients involved is completely justified and deserving of closer study. Psychiatric patients who are hospitalised long-term in psychiatric hospitals or psychiatric care homes have few costs for their housing, food and medication thanks to a substantial contribution of the public health care system to their hospital invoice. In a socialised form of care, patients have to carry these costs themselves. It is both problematic and paradoxical that in the context of “socialised” care, patients will have to pay more. The Government is striving to make article 107 budget neutral for psychiatric hospitals, but this should also be guaranteed for patients.

The Advisory Committee on Bioethics recommends that academic research be conducted on the financial implications of article 107 for the patients, and that budget neutrality for the patient be adopted as an objective in the further reform of the mental health care sector.

Question 5: What impact will the reduction in the number of T-beds have on the admission policy of psychiatric hospitals regarding patients with chronic and complex problems?

A follow-up study has been planned as part of the reform of article 107, and this question certainly deserves to be included in this study. However, the Advisory Committee on Bioethics shares this concern to a lesser extent for the following reasons. (1) The number of psychiatric beds (pro rata) is particularly high in Belgium. (2) International experience shows that mobile teams prevent, replace and shorten the length of hospitalisation. The mental health care sector is actually faced with the task of optimally (re-)organising the remaining beds depending on care needs, with good regional distribution, coordination, load balancing, and agreements.

Question 6: Is there sufficient adapted and affordable housing available for the above-mentioned target group, given that these waiting lists are also extensive, the law is restrictive and costs continue to rise?

The Advisory Committee on Bioethics shares the concern that a reform of the mental health care sector that aims at socialisation of care, should be accompanied by proper coordination over a number of social domains and policy areas such as: housing policy, employment, social security, etc.

D. Final observations and conclusion

The Belgian Advisory Committee on Bioethics fully endorses the principles of this reform of the mental health care sector and sees no fundamental ethical objections. The existing legal framework for the mental health care sector, which includes the Law on Patient Rights, is sufficiently capable of dealing with the new methods of care such as the mobile teams and is of course fully applicable. The problems of for instance refusal of care and an inability to state one's own will are certainly not restricted to these new modes of care, but also undoubtedly arise in other ways in other contexts, such as the refusal of care at home or in an institution.

In order that this reform lead to better care for the patient, the Belgian Advisory Committee on Bioethics advises that, during the implementation of this reform, sufficient attention and resources be given to the societal acceptance and integration of these patients and the battle against stigmatisation, to the social domains that have to be involved in the socialisation of the mental health care sector (housing policy, employment, social security, etc.), to the budget neutrality of this reform for the patient, to traditional outpatient care as an important pillar in a socialised mental health care sector, and to a reorganisation of the remaining hospital resources in order to meet care needs. The Advisory Committee on Bioethics draws attention to the current situation of the outpatient mental health care centres, which are already struggling to fulfil their tasks. The Committee also recommends that the above-mentioned elements be included in the follow-up study related to this reform.

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This opinion was approved on 9 March 2015 by the plenary gathering of the Advisory Committee on Bioethics, on the basis of a draft prepared by Mr. Paul Cosyns and Mr. Joris Vandenberghe, members of the Committee.

The working documents of the select commission - the question, personal contributions of the members, minutes of the meetings, documents consulted - are kept on file at the Committee's Documentation Centre where they are available to be consulted and copied.

This opinion is available to be consulted at **www.health.belgium.be/bioeth**