MOBILITY IN PSYCHIATRY, AN ALTERNATIVE TO FORCED HOSPITALIZATION?

Gérald Deschietere

*Psychiatric Emergency Unit, Department of Adult Psychiatry, Clinique universitaire Saint Luc,
Université catholique de Louvain, Brussels, Belgium*

SUMMARY

Background: *The number of forced hospitalizations has increased across Europe. One way to reduce these is to set up mobile crisis teams. A reform of psychiatry in Belgium allowed the creation of these mobile teams. These offer an alternative to forced hospitalization.*

Subjects and methods: *196 situations were referred to the mobile crisis team located east of Brussels in 2017. We examined the orientation of these requests according to the applicants and the reasons for them.*

Results: *It appears that the health sector has the best indications for using the mobile crisis team.*

Conclusion: *Access to psychiatric care is of major importance in Western societies. The creation of mobile teams increases this accessibility and should reduce the need for forced hospitalizations. These observations must be confirmed.*

Key words: *mobile team – forced hospitalizations – accessibility – organization of care*

* * * * *

INTRODUCTION

Everywhere in Europe, and sometimes despite recent legislation that is supposed to temper their use, deprivation measures for care are increasing (Salize et al. 2004). In Belgium, various studies have been conducted to explain this trend and this significant development (Benoît 2011). Thus, for the judicial district of Brussels, the number of psychiatric evaluations requested by the judicial world to obtain observation (term enshrined in Belgian law) has increased by more than 150% in 10 years (Deschietere 2011). Access to care is an important issue in this issue. Since 2011 a reform of psychiatry exists in Belgium. She has set up mobile crisis teams. These teams must improve access to care, especially for non-claimant patients. It is an alternative before eventually proceeding to forced hospitalization.

Thus, the role of a rapidly moving mobile team was well defined by a working group of caregivers, managers and political representatives. We can read the conclusions of the working group on mobile crisis teams. This defines the target audience of these teams: adults in crisis with a psychic problem and no other possible intervention modality (http://www.psy107.be/index.php/fr/organe-de-concertation/equipes-mobiles).

The situations taken over in 2017 by the mobile crisis team located in east of Brussels (400,000 inhabitants) were analyzed retrospectively in this perspective. The mobile team intervenes in situations after two analyzes: a first analysis is done at the time of a first phone call. The team verifies that the situation described by the applicant corresponds to the expected intervention. If this is the case, a second analysis is done after consultation with the applicant. This consultation often takes place within 24/48 hours after the phone call. There is therefore a significant reactivity (Johnson 2008). In both cases, the team checks the intervention indications: Is the patient in the area served by the mobile team? There is a crisis in this patient? There is no other way to give access to patient care (Figure 1)?

SUBJECTS AND METHODS

The retrospective analysis of the situations supported in 2017 was conducted on the following items: specifications of the intervention seeker, reasons for refusal of support at different stages and outcomes of the intervention of the mobile team for situations taken care of. The patients were all over 16 years old.

RESULTS

In 2017, 198 situations supported by the mobile team closed.

After the first call, 63 situations were not eligible for the intervention of the mobile crisis team. The main reasons for refusal of care were as follows: patients outside the intervention zone of the mobile team (16 situations), chronic situations (14), abandonment of the request (14), requesting patient (9), possible alternative (6), forced hospitalization of the patient during demand analysis (2), unknown (2).

In these 63 directly reoriented situations, 35 came from families and relatives, 13 came from the health sector, 11 came from the non-health professional sector, 2 applicants could not be identified, 2 were from a patient directly.

After this first telephone analysis, 135 situations led to a consultation at the request of a third party, carried out most of the time within 24/48h.
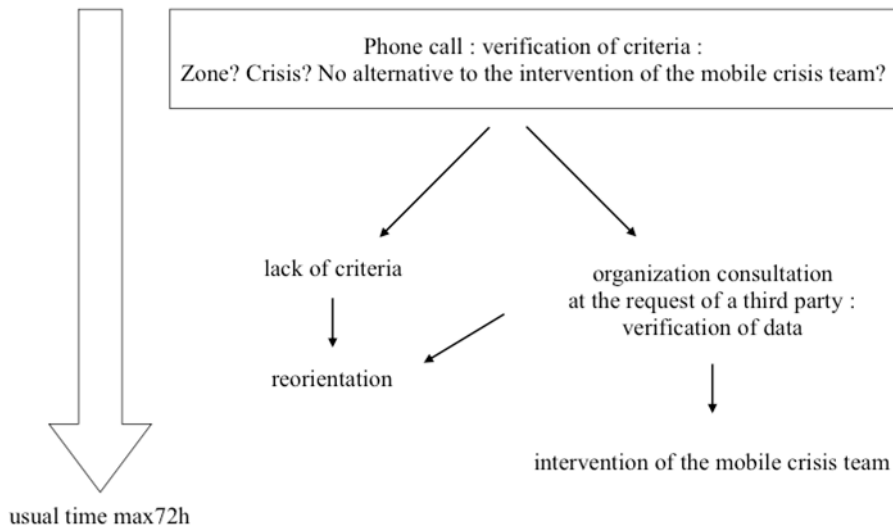
Figure 1. Summary of the steps of the inclusion according to the providers

Table 1. Summary of orientation according to the providers

Step Provider	1. Reorientation after phone call	2. Reorientation after consultation	3. Situations supported by the crisis mobile team	Total per provider
Families	35	28	13	76
Health sector	13	6	64	83
Non Health sector	11	2	15	28
Patient	2	3	0	5
Unknow	2	0	4	6
Total	63	39	96	198

At the end of these consultations, 39 situations were referred to another care device. The reasons for this reorientation are as follows: In 16 situations, patients were applicants; in 10 situations, the applicant was no longer; in 3 situations the patient had been hospitalized (once in a forced setting); in 9 situations the situation was chronic; in one situation, the patient had changed his place of residence and was outside the intervention zone.

In these 39 situations, the applicants were distributed as follows: 28 situations from families and relatives; 6 situations came from the health sector, 3 situations from a patient himself and 2 situations were sent by the non-health professional sector.

This leaves 96 situations supported by the mobile team in 2017, with intervention in the patient's home. Let's re-analyze the sender of these situations: 64 situations came from the health sector; 15 situations came from the non-health professional sector; 13 situations came from a request from families and relatives; 4 of a misidentified applicant.

The outcome of the management by the mobile team is as follows: 15 forced hospitalizations, 39 relayed to the outpatient psychiatric service, 11 hospitalizations granted, 20 situations did not break out in any other care; 11 relays to general medicine.

She took care of 96 patients. 15 of them (15.6%) required the intervention of forced hospitalization in the course of the intervention. In the 102 situations analyzed without support, 3 situations required observation.

Of the 198 situations encountered, here are the applicants: 76 requests came from families and relatives, 83 from the health sector; 28 of the non-health sector; 5 of a patient himself; 6 of a misidentified applicant (Table 1, Figure 2).
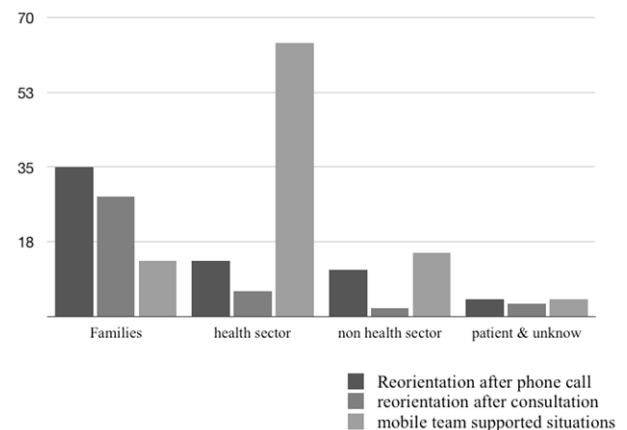

Figure 2. Orientation according to the applicant

DISCUSSION

It is not abnormal to see that the care rate is better when the demand comes from the health sector, as they could probably better verify the absence of alternative care. It is also not abnormal to note that 15.6% of the interventions by the mobile team end with a forced hospitalization given the difficulty of these situations

and that 27% of the situations of the situations taken care of ends with a hospitalization. This means that in more than 70% of situations, despite the fact that the demand comes mainly from the health sector, hospitalization has been avoided. Of course, there should be a prospective study of other determinants of forced hospitalization.

From these results, we can not know what would have happened to the 81 situations if there was no mobile crisis team. Would these patients have been hospitalized forcibly? Would they have access to care in other ways? Impossible to say according to our study. But it is certain that in 81 out of 96 situations (84% of cases) these patients could have had another outcome than forced hospitalization. And that's partly because the family was able to find help other than forced hospitalization. As shown in other studies (Quenum 2017, Zeltner 2018), the mobile team is heavily used by families in contact with a psychologically suffering person. The importance of family demands is an important point in our study, since 38.3% of total requests come from families.

The limit of this study is also the small sample size despite the duration of the data collected over one year. Consideration should be given to collecting this data over several years in order to increase the relevance of the results produced.

It is important to note that some studies undermine this hypothesis that the establishment of mobile psychiatric teams decreases the number of forced hospitalizations (Keown 2011).

CONCLUSION

The study presented here allows to see the data concerning the applicants for intervention of a mobile crisis team in an urban context. It also helps to understand the reasons for not taking charge of psychiatric situations by a mobile crisis team. The interest of naturalistics studies in the psychiatric field is confronted with the complexity of carrying out such studies. More than ever, the question of the accessibility of psychiatric care is a priority issue for public health.

References

1. Benoit G, Burton L, Caels T, Caspar P, Constant H, Daled PF, et al: *La protection de la personne des malades mentaux: éthique, médecine et justice. La Charte, Brussels, 2011*

2. Deschietere G: *Oral communication. Congress of Encephale, January 2011*

3. Keown P et al: *Association between provision of mental illness beds and rate of involuntary admissions in the NHS in England 1988-2008: ecological study. BMJ 2011; 343 doi: https://doi.org/10.1136/bmj.d3736 (Published 05 July 2011)BMJ, 2011*

4. Johnson S, Needle J, Bindman JP and Thornicroft G: *Crisis Resolution and Home Treatment in Mental Health Cambridge University Press, 2008*

5. Quenum Y, Fakra E: *Community treatment outreach teams in Saint-Etienne, France. Annales Médico-psychologiques 2017; 176:70-73*

6. Salize HJ & Dressing H: *Epidemiology of involuntary placement of mentally ill people across the European Union. BJP 2004; 184:163-168*

7. Zeltner L, Fousson J, Stefant P, Luttenbacher C, Boudon J, Pastour N: *Suicidal crisis, trauma, crisis intervention, what adjustments could be proposed? Inf Psyc 2018; 94:247-252*

8. Website: *http://www.psy107.be/index.php/fr/organe-de-concertation/equipes-mobiles*

Correspondence:
Gérald Deschietere, MD
Psychiatric Emergency Unit, Department of Adult Psychiatry,
Clinique universitaire Saint Luc, Université catholique de Louvain
Avenue Hippocrate 10, B1200 Brussels, Belgium
E-mail: gerald.deschietere@uclouvain.be