KEY DATA IN HEALTHCARE

Mental Healthcare

Edition 2021

.be

Colophon

SUBJECT

This report provides an **overview of the functioning of psychiatric hospitals (PH) and psychiatric departments of general hospitals (PDGH) through some key figures.**

EDITORIAL COMMITTEE

The members of the Directorate-General for Healthcare, in particular the 'Data & policy information' unit and the 'Psychosocial health care' unit .

RESPONSIBLE PUBLISHER

Tom Auwers,
Galileelaan 5/2 – 1210 Brussels

CONTACT INFORMATION

federal public service
HEALTH, FOOD CHAIN SAFETY AND ENVIRONMENT

Directorate-General Healthcare
Galileelaan 5/2 – 1210 Brussel

T. +32 (0)2 524 97 97 (Service Center Gezondheid)

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www.health.belgium.be
and **www.healthybelgium.be**

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PREFACE

> "Figures allow for analysis. Today the focus is on the use and development of these data, on their interpretation and their comparability."
>
> **Annick Poncé**

One of the challenges for the Directorate-General for Healthcare (DGGS), as for numerous other institutions, is defining a stronger data strategy. This is multi-faceted: both the technical management of data as well as its accessibility and exploitation. Several initiatives have been set up within the DGGS in this regard. Two years ago, a strategic exercise was carried out: a review of the mission, vision, strategy, organisational structure, capacity building and the management of current data in a progressive approach, taking into account the external partnerships of today and tomorrow. This exercise not only led to the development of a "Data and Strategic Information" service but, above all, it had the benefit of highlighting what is essential.

We have a huge amount of data, especially in the four sectors where the DGGS is active: 'hospitals', 'healthcare professionals', 'urgent medical care' and 'mental healthcare'. In 2019, we decided to publish a periodic summary for each of the four sectors in which we are mainly active. We chose to present the most important key data for each sector in a comprehensible manner.

In our first report, entitled "Key data in healthcare – general hospitals", we presented:

- Key data related to organisation: number of hospitals, types of hospitals, etc.
- Key data related to financing: for example budget and parts of the budget
- Key data related to care: for example types of care and amount of care
- Key data related to quality: for example the number of indicators available to us in terms of quality programmes (pluriannual quality and safety programmes, BAPCOC, BELMIP, colleges of physicians, pharmaceutical platforms, IHAB, P4Q, etc.)

The interest generated by the first edition of "Key data in healthcare" reinforces our belief. We have a wealth of data and this knowledge is for everyone. But such an abundance of knowledge is only valuable if it is shared, and that's what's important: sharing and assimilating the data and taking the time to take something from it to usefully and wisely apply it to our next decisions.

Today's report is dedicated to **mental healthcare**. We take a close look at the functioning of **psychiatric hospitals (PH)** and the **psychiatric departments of general hospitals (PDGH)**. Presenting the figures is the first and modest step in the analysis to provide a comprehensive picture of the structure and functioning of a sector.

We aim to periodically repeat these "key data" so that we can indicate developments and trends. Our ambition is to share these analyses with you and to develop them in the future.

We wish you happy reading,

Annick Poncé
Acting Director- General

INTRODUCTION

The policy regarding mental healthcare (MHC) in Belgium is partly the competence of the communities and regions and partly the competence of the federal government. To encourage cohesion, the Inter-Ministerial Conference on Public Health (IMC Public Health) was set up. The protocols of this IMC form the basis for the various reforms in mental healthcare in Belgium.

The reforms focus on target groups according to their age. As such, the reforms for "Adults" and "Children and Young people" have already been translated into pilot projects in which this new policy is gradually put into practice on a voluntary basis. Ultimately, these projects should result in new regulations and funding. Steps are currently being taken to prepare a new MHC policy for the "Elderly" target group.

Two themes are the guiding principle through these reforms, namely the "**Socialisation of mental healthcare**" and "**Network collaboration**".

Socialisation means that as much care as possible is provided in the patient's immediate environment, including for severe psychiatric disorders. If hospitalisation is unavoidable, the stay should be as short as possible. The follow-up care is transferred to extra-mural care providers as rapidly as possible. This principle implies that the hospital care is intensified.

Network collaboration means that care providers and actors work together to realise personalised care pathways, based on the individual healthcare needs of patients.

This edition of the Key data will not cover the range of care providers that are part of these MHC networks, but we will focus on the effect that this way of working can have on the hospital landscape and the functioning of psychiatric hospitals (PH) and psychiatric departments of general hospitals (PDGH).

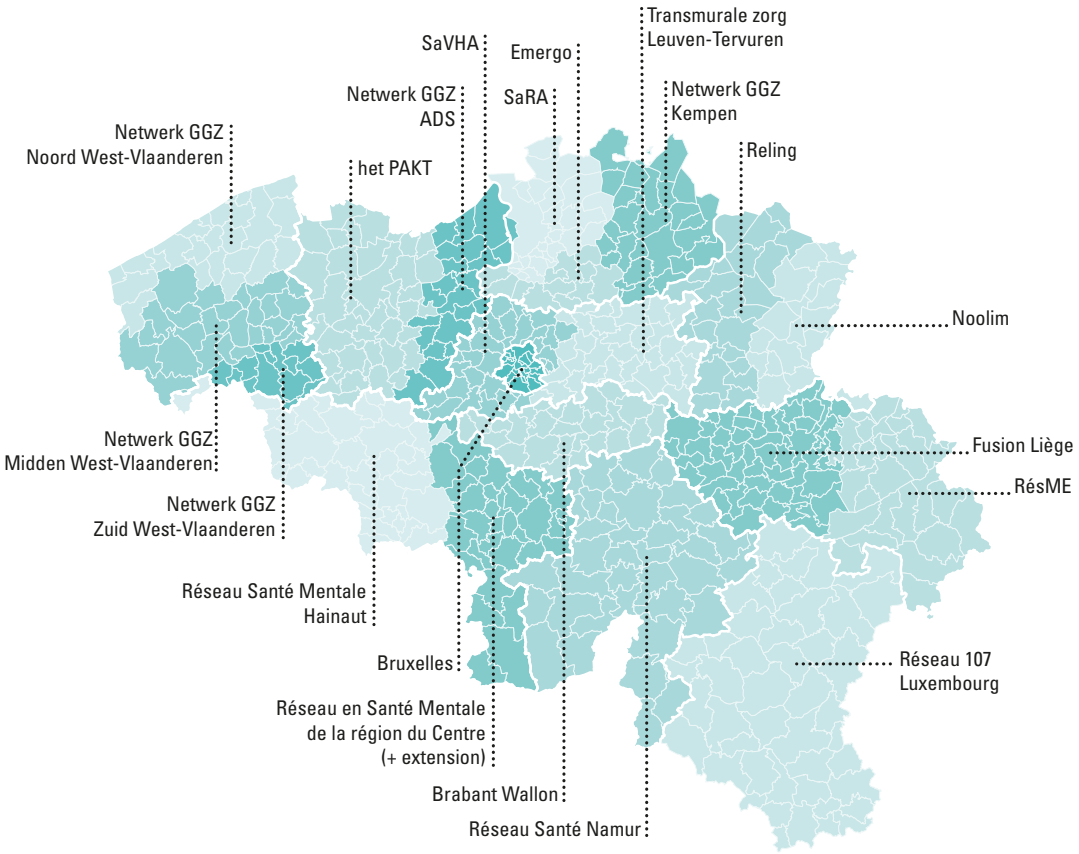
The care offering for "Adults" and "Children and Young people" differ to such an extent, and are on such a different scale, that it was decided to break down the data according to these target groups.

MENTAL HEALTHCARE FOR ADULTS

1. Organisation of the care offering for adults

1.1. Networks in mental healthcare for adults

Ten years ago, the Interministerial Conference (IMC) on Public Health launched the reform of mental healthcare (MHC) for adults. Various pilot projects were launched in which mental healthcare networks (MHC networks) were set up and systematically expanded. An evaluation was made in 2017 and a number of networks were redesigned, which left **20 MHC networks for adults**. Currently, every Belgian municipality is part of one of the 20 MHC networks.



Learn more about the several initiatives in the field of mental health care:

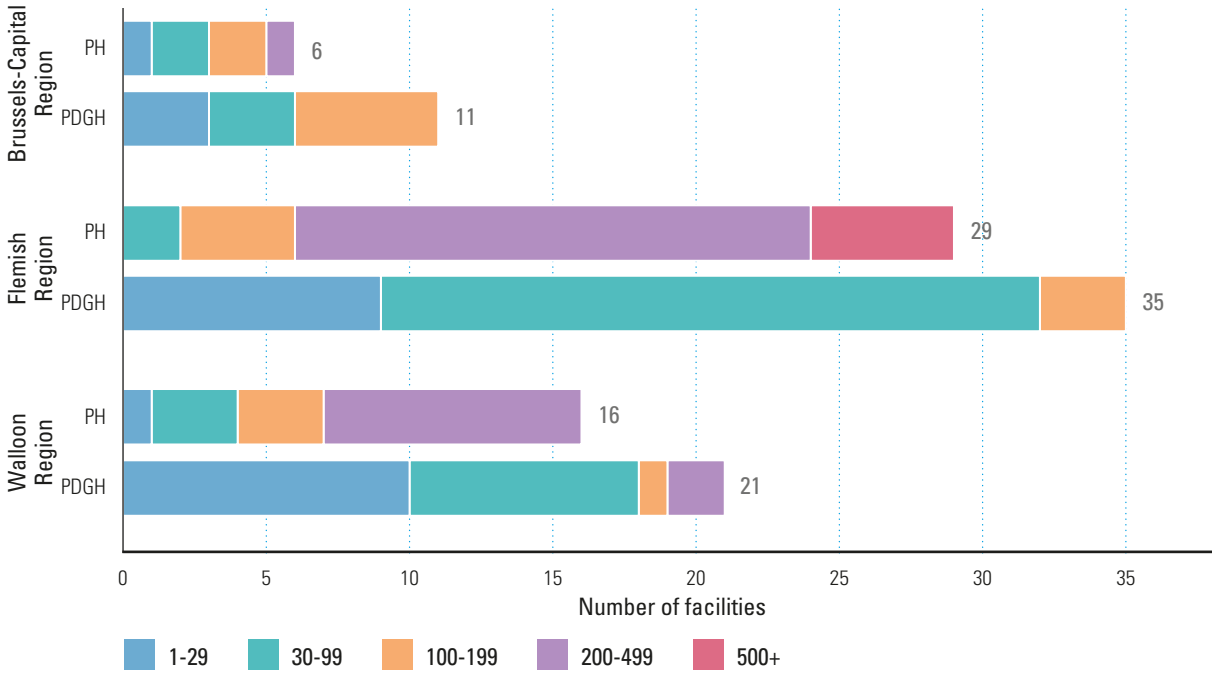
www.psy107.be

1.2. Hospitals

Belgium has **51 psychiatric hospitals (PH)** and **67 psychiatric departments within general hospitals (PDGH)** for adults with psychiatric problems[1].

One third of the PDGH have a limited offering of psychiatric care for adults, and have only between 1 and 30 beds in this regard. Nevertheless, there are 11 general hospitals in Belgium that have 100 or more psychiatric beds for adults. In addition, there are a limited number of PH with a very small number of beds, which often primarily provide day care.

NUMBER OF PH AND PDGH PER REGION BROKEN DOWN ACCORDING TO NUMBER OF BEDS (01/01/2020)



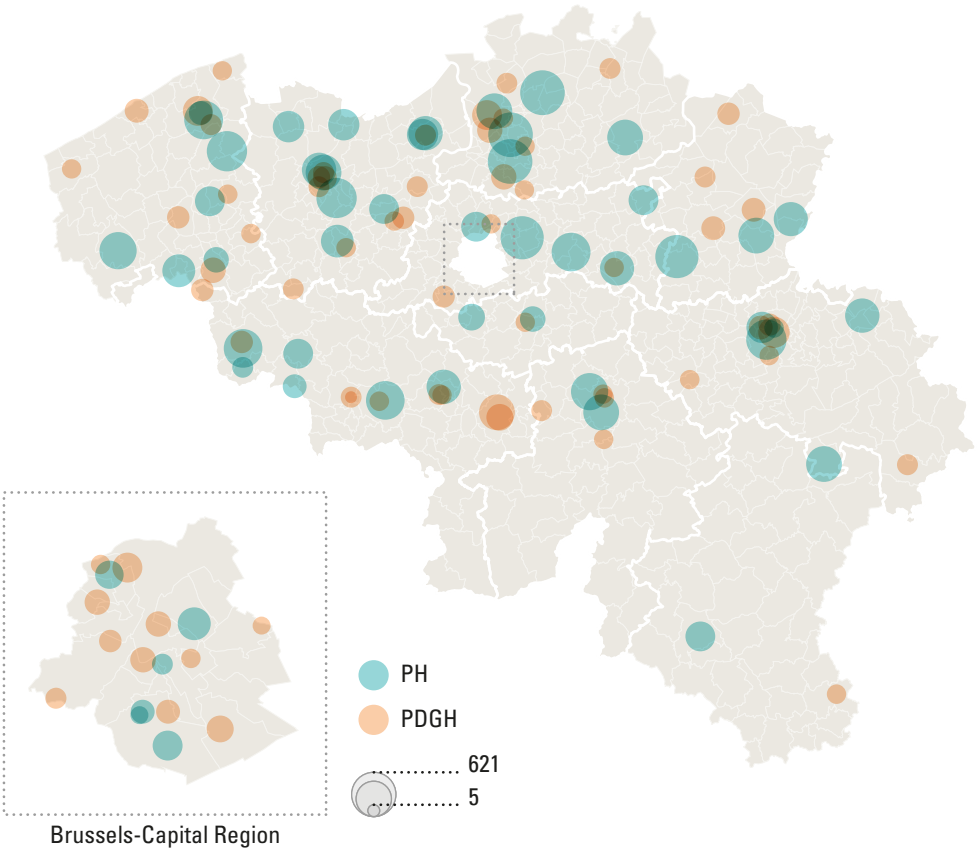
The Flemish region clearly has more PH and PDGH compared to the other regions. It is also the only region to have 5 PH with room for more than 500 patients. In the Brussels-Capital region, there are almost twice as many PDGH as PH. Almost half of the PDGH have 100 beds or more. The Walloon Region also has large PDGH, with two having more than 200 beds.

1 Source: CIC, FPS Health, Food Chain Safety and Environment (1/01/2020)

In addition to the supply, the distribution of PDGH and PH also differs according to the region. In the Flemish Region, the distribution of PH and PDGH for adults is the most balanced. We see concentrations around major cities including Ghent, Antwerp and Leuven. On the other hand, the supply of psychiatric services for adults is rather limited in the Westhoek, the Flemish Ardennes followed by the Pajottenland, and the Kempen region, and the north of Limburg. Nonetheless, we can observe that there is a PH or PDGH at every location within a radius of 50 kilometres.

In the Walloon region, the situation is completely different. Almost all PH and PDGH for adults are on the axis Tournai, Charleroi, Mons, Liège, and Verviers. In addition, there are no PH or PDGH in the districts of Thuin, Philippeville, Dinant, Marche-en-Famenne, Neufchâteau and Bastogne.

DISTRIBUTION OF PH AND PDGH IN BELGIUM
INDICATING THE NUMBER OF BEDS FOR ADULTS (01/01/2020)



1.3. Types of hospitalisation

In psychiatric care, it is possible for a patient to be admitted to a psychiatric service where the patient stays in the institution day and night. This is referred to as residential hospitalisation. In addition, it is possible that a patient stays in the institution only during the day or only at night. This is referred to as partial hospitalisation.

TYPES OF BEDS FOR RESIDENTIAL HOSPITALISATION

Psychiatric institutions are often divided into different units according to the therapy or pathology provided. In each unit, there are a number of recognised beds with a specific code letter reflecting the type of care provided:

- **Beds for acute care (code letter A):** The neuro-psychiatry service for observation and treatment (day and night) of adult patients in need of urgent care;

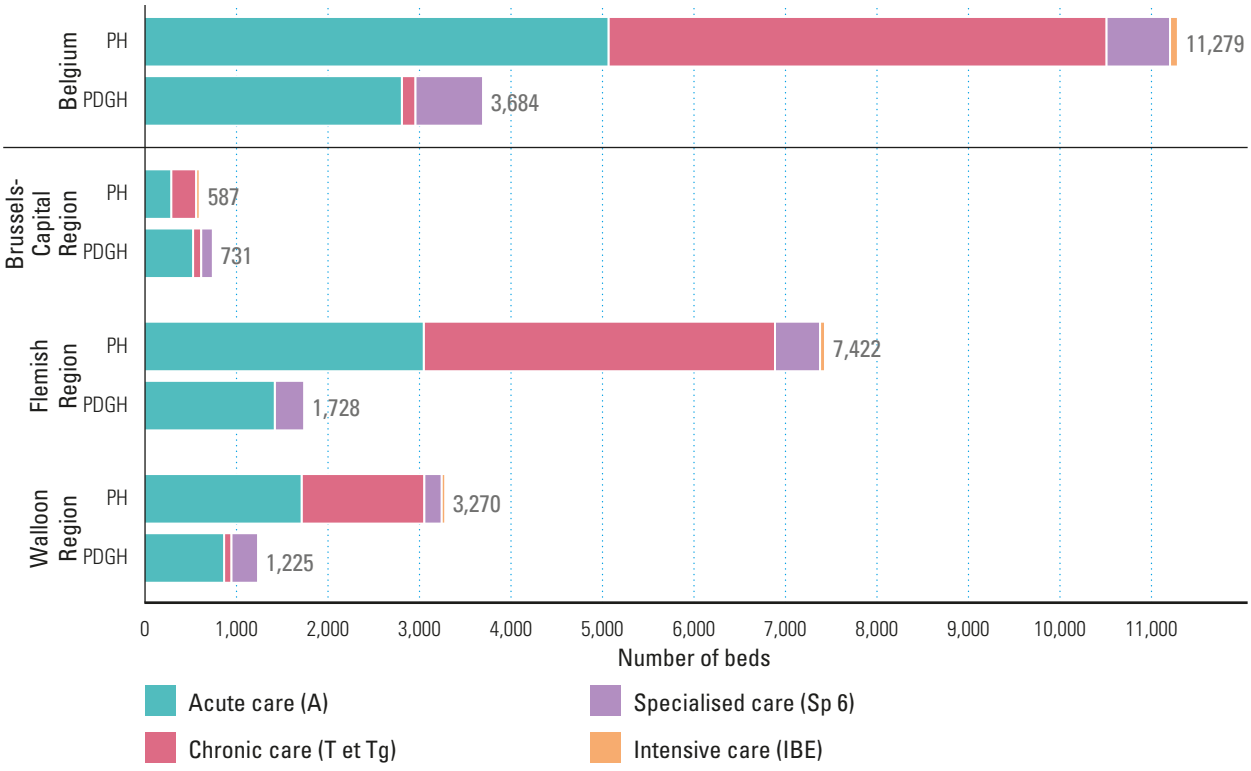
- **Beds for chronic care (code letter T):** The neuro-psychiatry service for treatment (day and night) of long-term and chronic problems in adults, with a focus on social re-adjustment. In this document, beds for the **neuro-psychiatric treatment of geriatric patients (code letter Tg)** are included in this category;

- **Beds for specialised care (code letter Sp 6):** Specialised service for treatment and rehabilitation for patients with psychogeriatric and chronic conditions;

- **Beds for intensive care (code letter IBE: pilot project since 2009):** Intensive treatment unit for adult patients with severe behavioural disorders and/or aggressive adult patients.

The public PH in Geel and Lierneux also have beds and places for "Family placement or psychiatric family care" (code letter Tf). These are atypical of the Belgian hospital landscape and are not covered in this document.

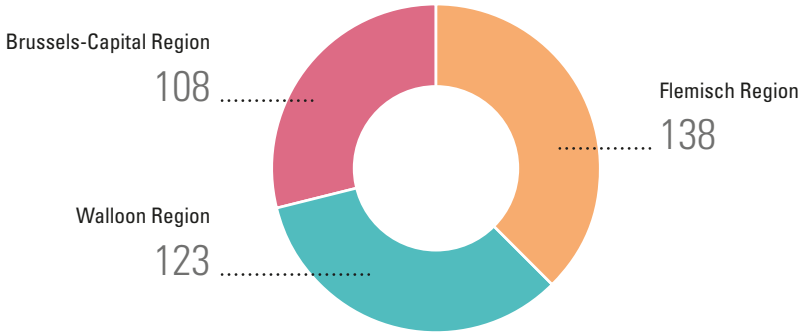
NUMBER OF RECOGNISED BEDS FOR RESIDENTIAL HOSPITALISATION PER REGION AND PER TYPE OF CARE (01/01/2020)



The above figures show the number of psychiatric beds for adults in absolute numbers. We can see that PDGH primarily consist of beds for acute care (code letter A).

We can also see a significant discrepancy between the different regions. However, when the figures are presented in terms of the number of inhabitants, we see that the contrast between the regions is less pronounced, but that the Flemish region is still in the lead with 138 beds per 100,000 inhabitants. On average, Belgium has 130 residential beds in PH and PDGH combined per 100,000 inhabitants.

NUMBER OF RECOGNISED BEDS FOR RESIDENTIAL HOSPITALISATION PER 100,000 INHABITANTS PER REGION (01/01/2020)

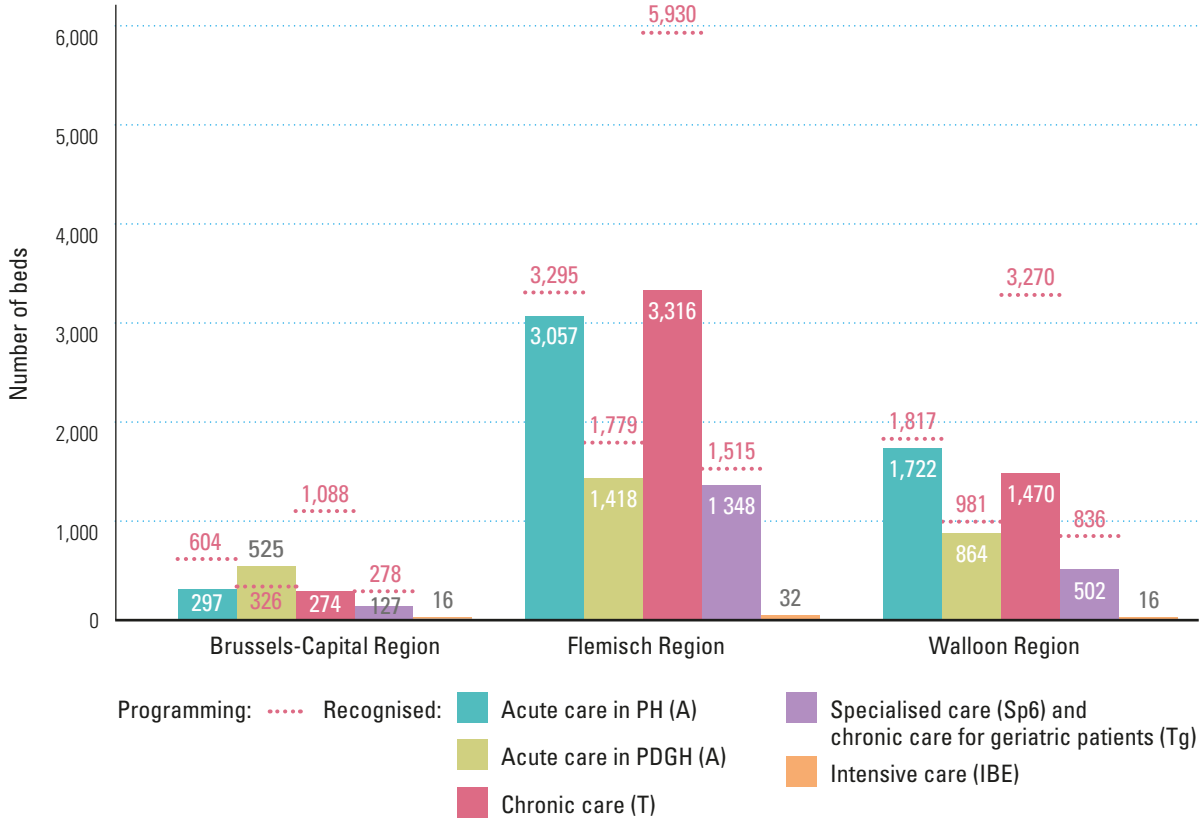


On average in Belgium,
in PH and PDGH altogether,
we have 130 **residential beds per 100,000 inhabitants**

The number of beds and their distribution has grown historically. To achieve an even distribution, the federal government introduced programming criteria.

Code letter	Programming criterion
A (PH)	**0.50** beds per 1,000 inhabitants
A (PDGH)	**0.27** beds per 1,000 inhabitants
T	**0.90** beds per 1,000 inhabitants
Sp6 + Tg	**0.23** beds per 1,000 inhabitants
IBE	**64** beds for Belgium

NUMBER OF BEDS ENVISAGED IN THE PROGRAMMING AND NUMBER OF RECOGNISED BEDS FOR RESIDENTIAL HOSPITALISATION PER REGION (1/01/2020)[2]

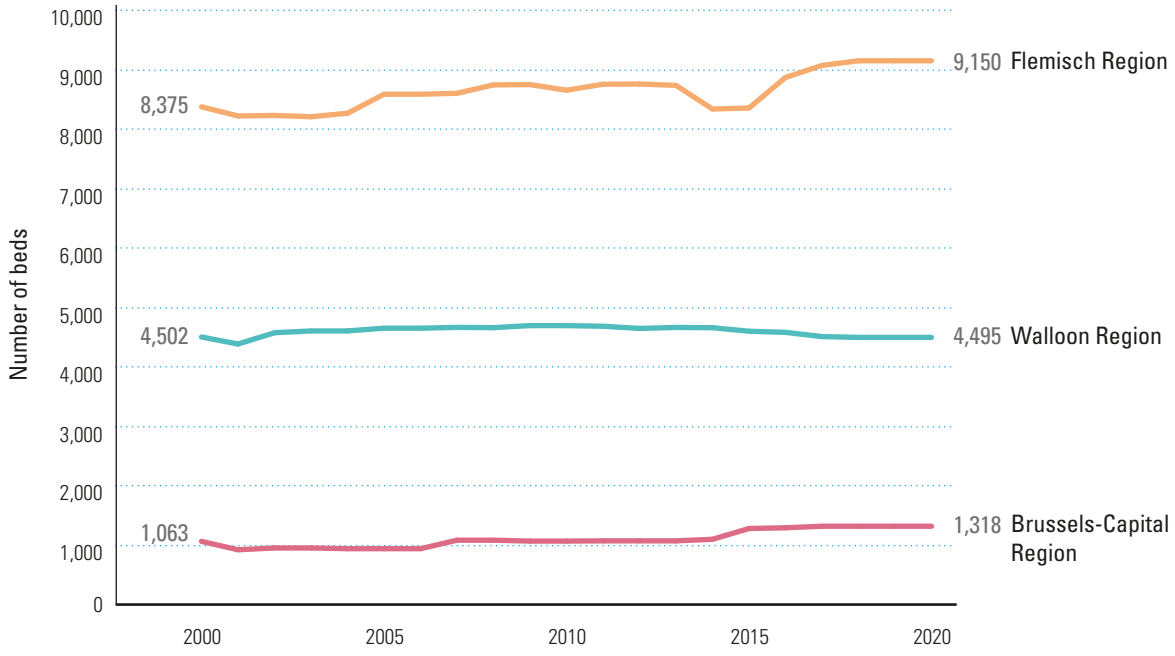


The Brussels-Capital Region has more residential beds for acute care (code letter A) in PDGH per 1000 inhabitants than envisaged by the programming criterion. However, the region has fewer residential beds for acute care (code letter A) per 1,000 inhabitants in PH, which is atypical of the general supply of psychiatric hospital beds.

2 More information on the programming figures can be found on the following website Figures for programming of hospital beds and Explanatory note for programming of hospital beds

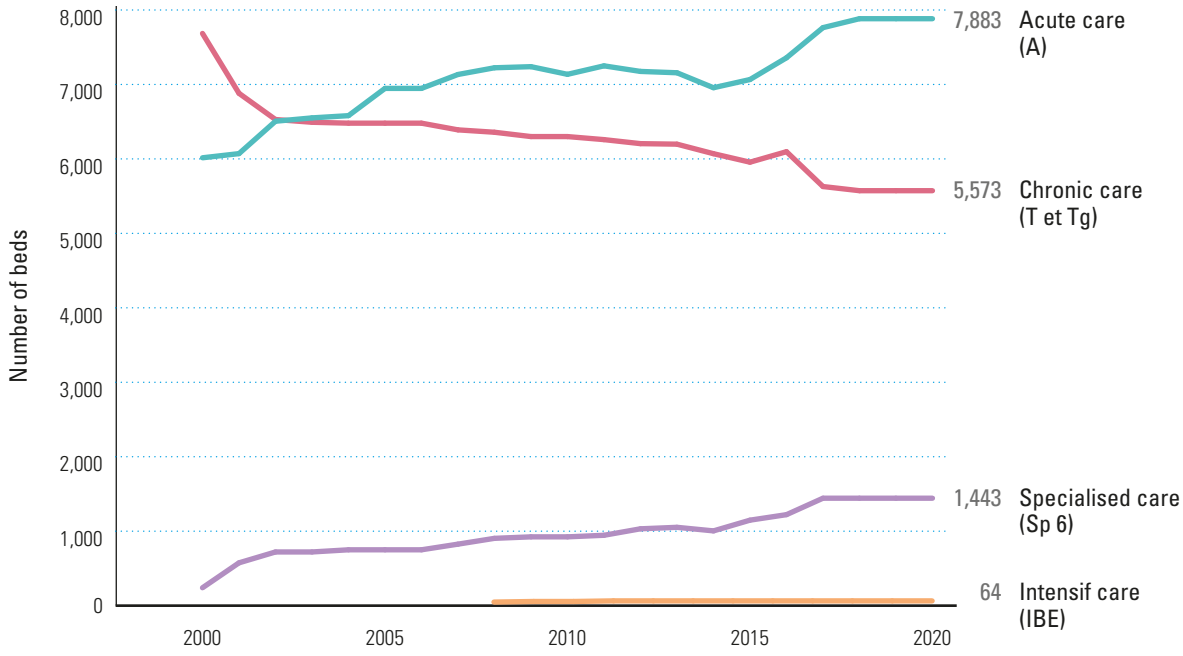
The total number of psychiatric beds for adults in PH and PDGH for residential hospitalisation fluctuates very little over time. If we look at the last 20 years, we see a status quo in the Walloon Region, an increase of 9.3% in the Flemish Region and of 24.0% in the Brussels-Capital Region.

EVOLUTION OF THE TOTAL NUMBER OF BEDS
FOR RESIDENTIAL HOSPITALISATION IN PH AND PDGH



If we look at the evolution of the number of beds by type of care, we see that there was a shift from beds for chronic care to beds for acute care from 2015 on. This reflects the efforts made in the context of the reforms to mental healthcare. This stipulated that no new beds could be created without phasing out the provision of other beds.

EVOLUTION OF THE NUMBER OF RECOGNISED BEDS
FOR RESIDENTIAL HOSPITALISATION BY TYPE OF CARE IN PH AND PDGH



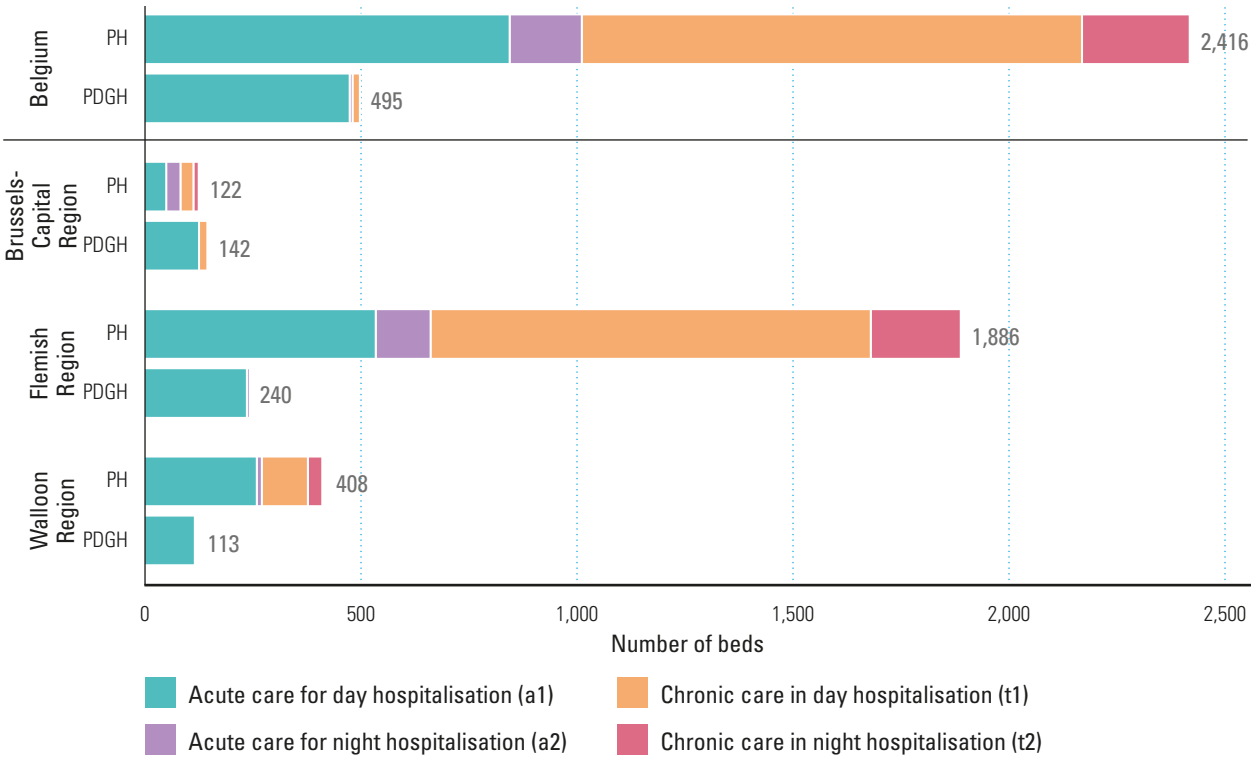
TYPES OF BEDS AND PLACES FOR PARTIAL HOSPITALISATION

For partial hospitalisation, a distinction is made between the following types of beds and places:

- **Places for acute care for day hospitalisation (code letter a1):** The neuro-psychiatry service for observation and treatment for day hospitalisation of adult patients in need of urgent care;
- **Beds for acute care for night hospitalisation (code letter a2):** The neuro-psychiatry service for observation and treatment for night hospitalisation of adult patients in need of urgent care;
- **Places for chronic care in day hospitalisation (code letter t1):** The neuro-psychiatry service for day hospitalisation for adults with long-term and chronic problems;
- **Beds for chronic care in night hospitalisation (code letter t2):** The neuro-psychiatry service for night hospitalisation for adults with long-term and chronic problems;

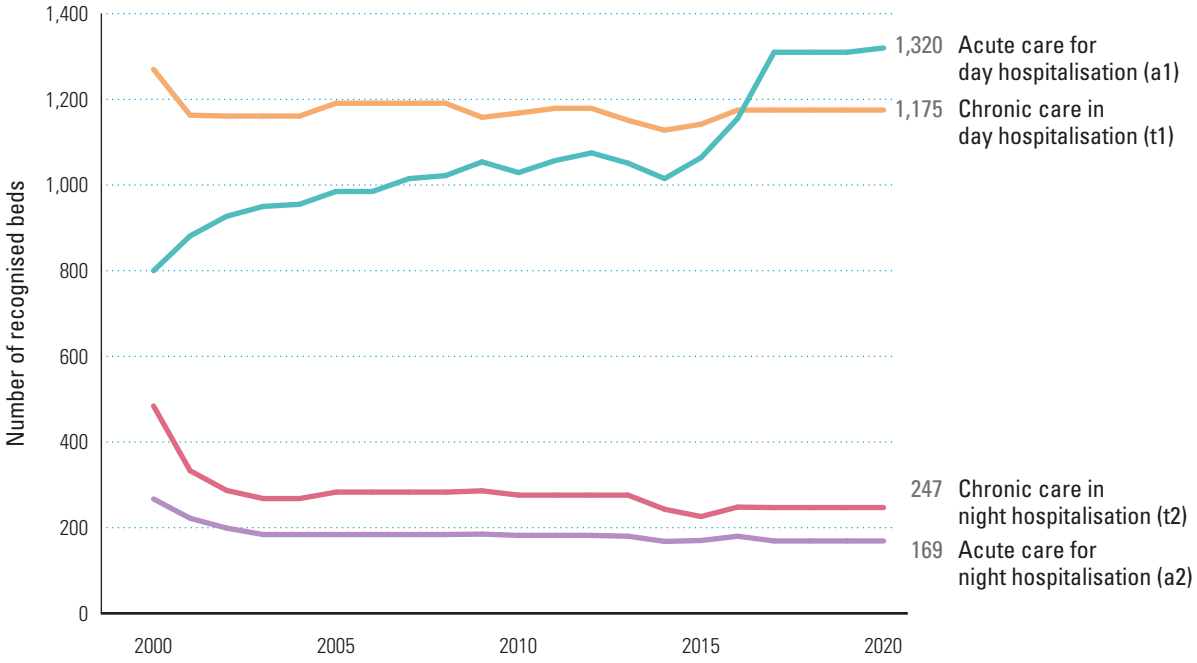
The services for partial hospitalisation are mainly located in the PH. In PDGH, no beds for night hospitalisation are provided, with the exception of 2 beds for acute care in night hospitalisation (a2 beds) in the Flemish Region. For day hospitalisation, the PDGH mainly provides services for acute care (a1 beds). There is only one PDGH in the Brussels-Capital Region that provides 17 chronic care places in day hospitalisation (t1 beds).

NUMBER OF RECOGNISED BEDS FOR PARTIAL HOSPITALISATION PER REGION AND PER TYPE OF CARE (1/01/2020) (01/01/2020)



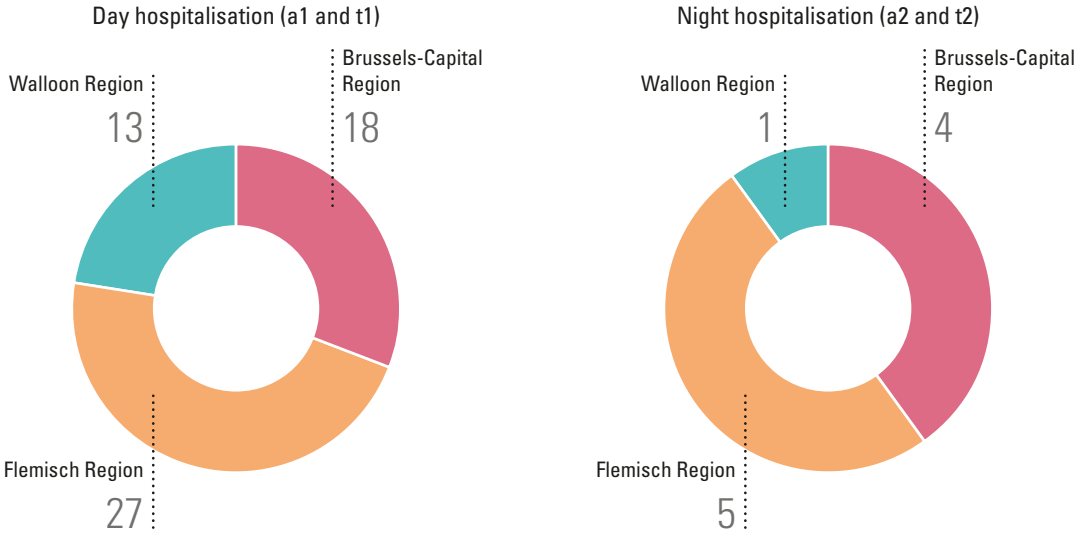
Over the years, we observe a slight decrease in the supply of places in night hospitalisation. The number of places for acute day hospitalisation (a1) is clearly increasing. In practice, this is reflected in an evolution of the supply from more chronic care to acute treatment or day therapy.

EVOLUTION OF THE NUMBER OF RECOGNISED BEDS
FOR PARTIAL HOSPITALISATION BY TYPE OF CARE IN PH AND PDGH



In proportion to the number of inhabitants, more places for partial hospitalisation are provided in the Flemish Region, both for day and night hospitalisation. The provision of both day and night hospitalisation is lowest in the Walloon Region.

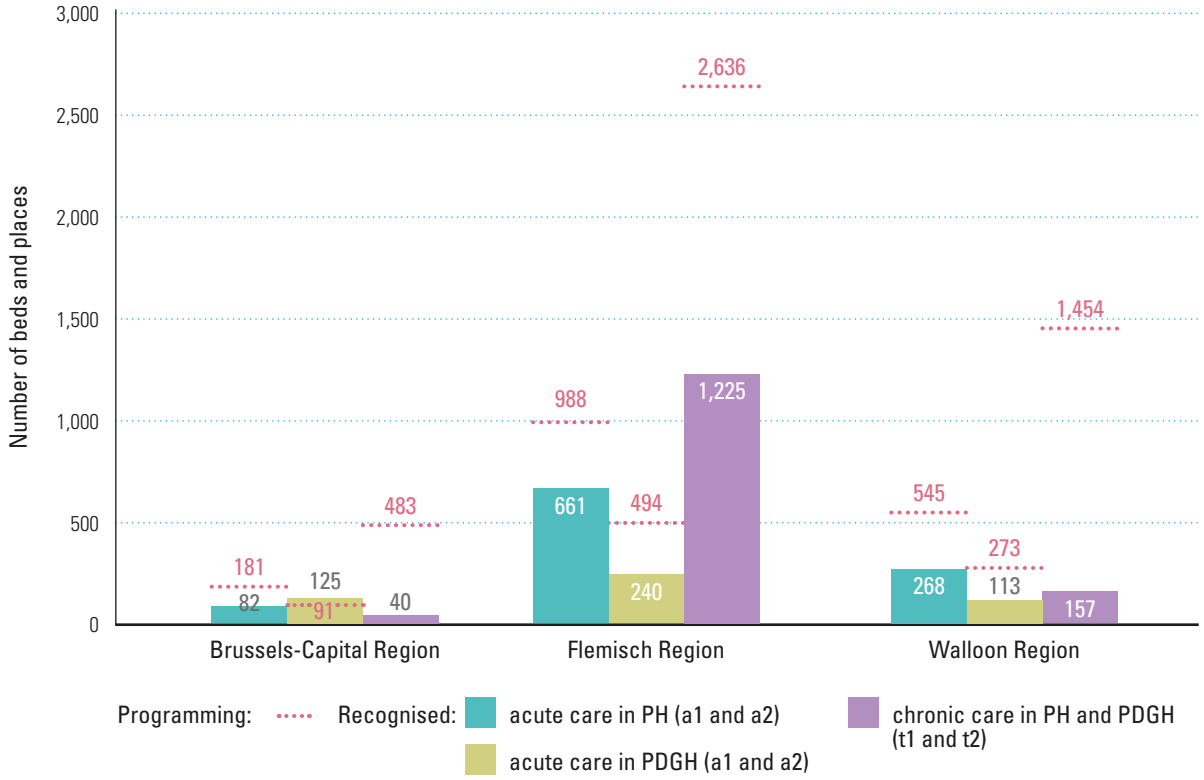
NUMBER OF RECOGNISED BEDS FOR PARTIAL HOSPITALISATION
PER 100,000 INHABITANTS PER REGION (1/01/2020)



In the Brussels Capital Region, we observe that more beds and/or places for day and night hospitalisation are provided in PDGH than described in the programming figures. On the other hand, in PH, only less than half of the beds and/or places are recognised than described in the programming figures.

Code letter	Programming criterion
a1 + a2 (PH)	**0.15** beds per 1,000 inhabitants
a1 + a2 (PDGH)	**0.075** beds per 1,000 inhabitants
t1 + t2	**0.40** beds per 1,000 inhabitants

NUMBER OF BEDS ENVISAGED IN THE PROGRAMMING AND NUMBER OF RECOGNISED BEDS FOR PARTIAL HOSPITALISATION PER REGION (1/01/2020)[3]



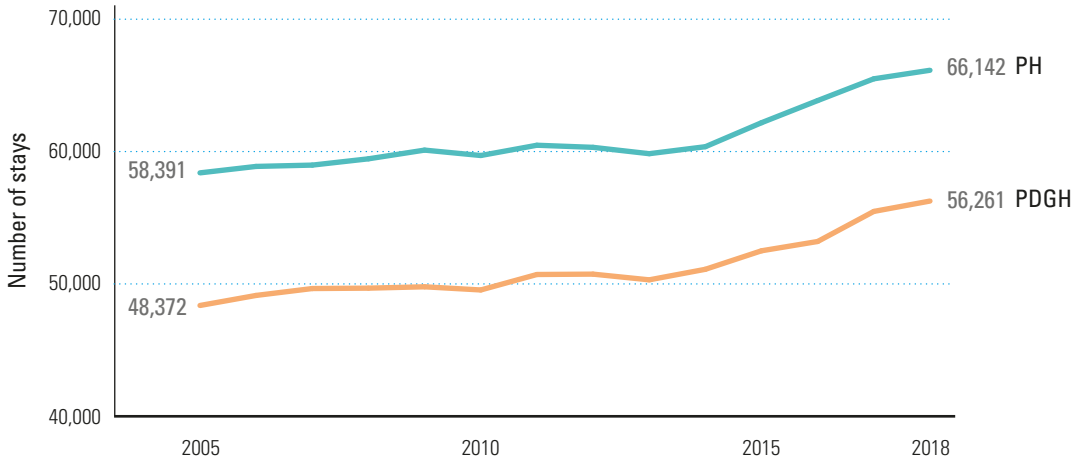
3 More information on the programming figures can be found on the following website Figures for programming of hospital beds and Explanatory note for programming of hospital beds

2. Hospital activities in PH and PDGH for adults

2.1. Hospital stays

In 2018, a total of 122,403 stays (residential and partial) were registered in psychiatric services for adults in PH and PDGH. Of these, 66,142 were stays in PH and 56,261 in PDGH[4],[5]. This means that, in comparison with 2005, the number of stays increased by 13.3% in PH and by 16.3% in PDGH. In addition, we can observe that the evolution of the number of stays in PDGH is almost parallel to that in PH.

EVOLUTION OF THE NUMBER OF HOSPITAL STAYS
IN PSYCHIATRIC SERVICES FOR ADULTS IN PH AND PDGH

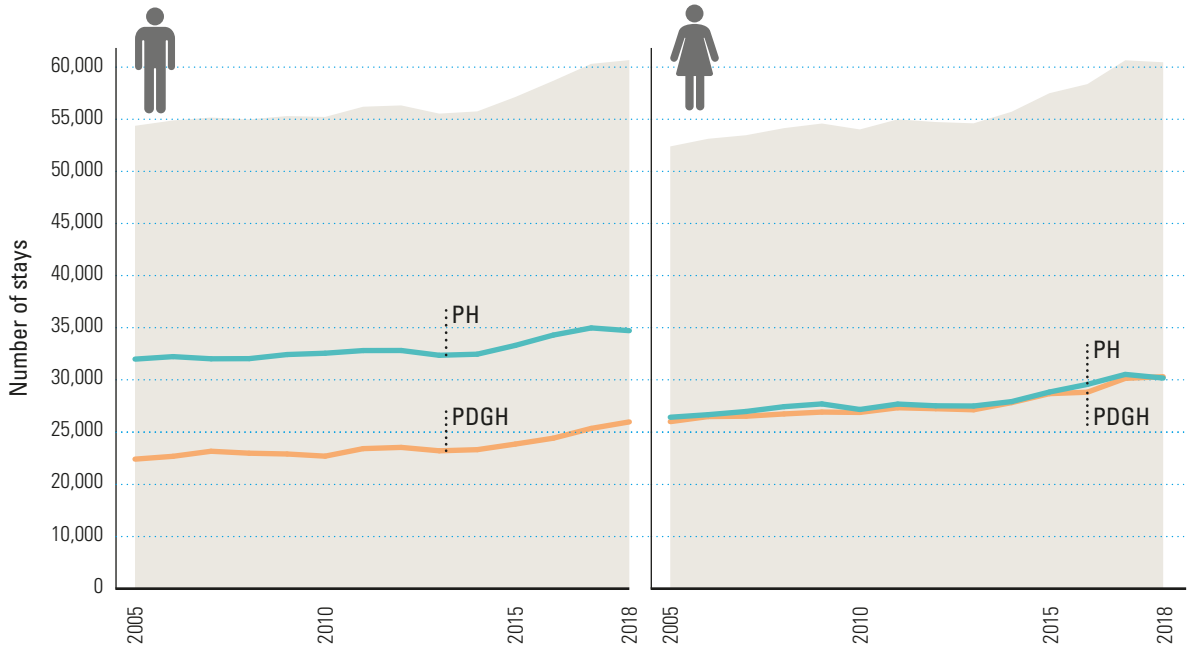


4 Source: Minimum Psychiatric Data (MPD), FPS Health, Food Chain Safety and Environment

5 This concerns the number of registered residential and partial stays in beds for adults (all code letters except K, k1, k2, Tf) in the year in question regardless of the year of admission and regardless of whether the patient has already been discharged.

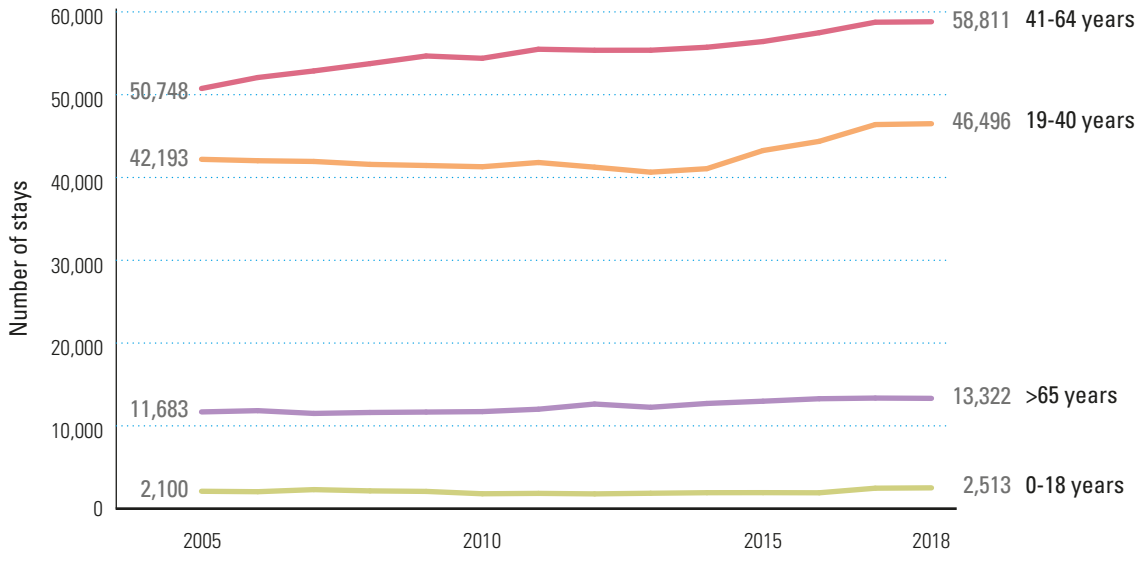
We observe that the total number of stays is the same for men and women. We do however observe a clear difference in the type of facility where a man or a woman is treated for his/her problems. Namely, we see men are more likely to be admitted to a PH.

EVOLUTION OF THE NUMBER OF HOSPITAL STAYS IN PSYCHIATRIC SERVICES FOR ADULTS IN PH AND PDGH BY GENDER[6]



The increase in the number of stays in PH and PDGH is situated within the active population (19-64 years old), whereby we observe a strong increase in the group of 19 to 40 year olds between 2013 and 2016[7].

EVOLUTION OF THE NUMBER OF HOSPITAL STAYS IN PSYCHIATRIC SERVICES FOR ADULTS IN PH AND PDGH BY AGE[8]



6 Stays for which the sex of the patient is not known, have not been taken into account.

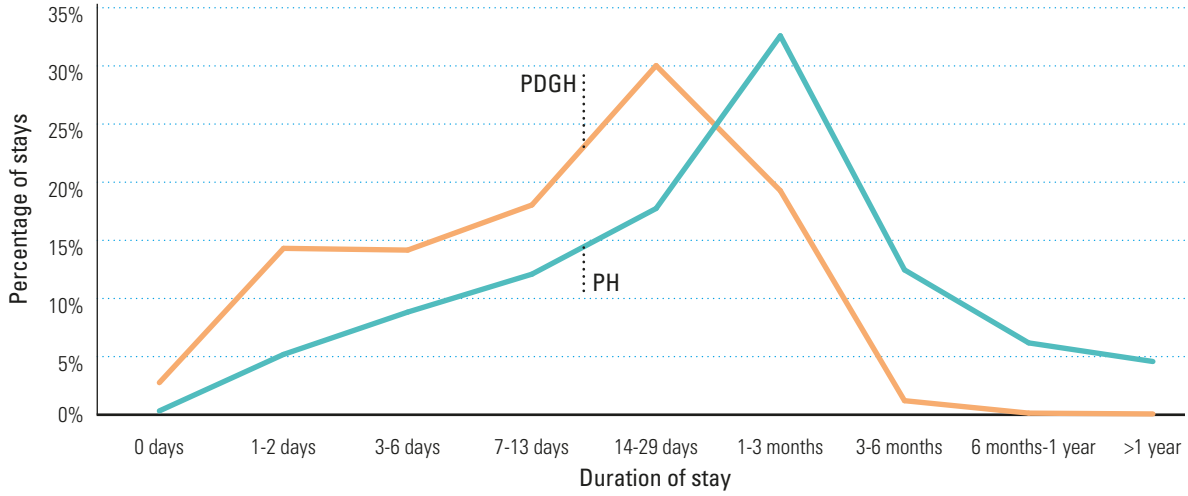
7 For the sake of completeness, the category of 0-18 year olds is also indicated. In exceptional cases, children and young people may be admitted to a psychiatric service for adults. Furthermore, stays in the 0-18 year-old category may be the result of incorrect registration.

8 Stays for which the age of the patient is not known, have not been taken into account.

2.2. Duration of stay

Three quarters of stays in psychiatric services for adults in PH last less than 3 months. Around 14.4% of the stays in the PH last less than one week. In the psychiatric services for adults in PDGH, almost 80% of stays last less than one month. One third of the stays even last less than one week. We can also observe that in PH, few stays end on the same day, while this happens more regularly in the PDGH.

DURATION OF STAY IN PSYCHIATRIC SERVICES FOR ADULTS IN PH AND PDGH



Psychiatric services for adults in PH

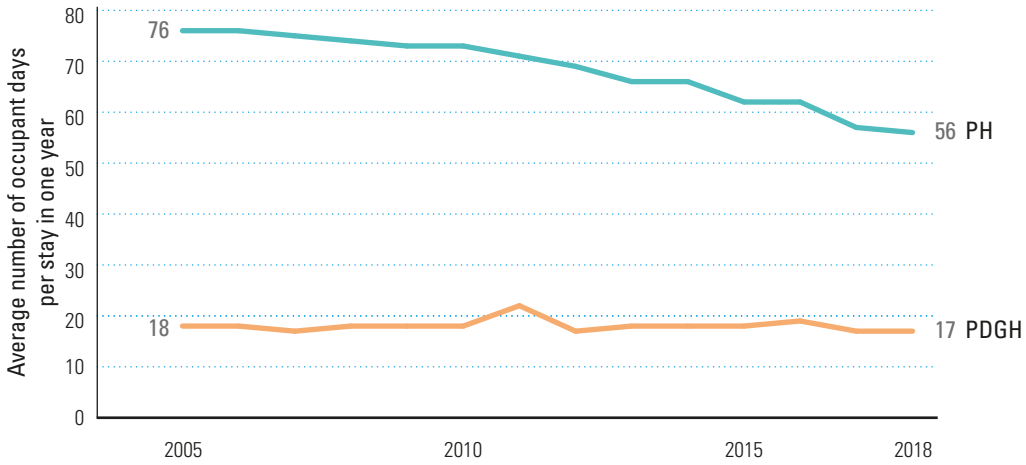
Three quarters of the stays last **less than 3 months**

80% of the stays last **less than one month**

Psychiatric services for adults in PDGH

The average number of occupant days per year[9] in a PDGH is significantly lower than in a PH. This is due to the acute treatment of patients that takes priority in a PDGH. In addition, the average number of occupant days per year remains about the same over the years, while in the PH it is shortened by an average of 20 days (26%) compared to 2005.

EVOLUTION OF THE NUMBER OF HOSPITAL STAYS
IN PSYCHIATRIC SERVICES FOR ADULTS IN PH AND PDGH BY AGE

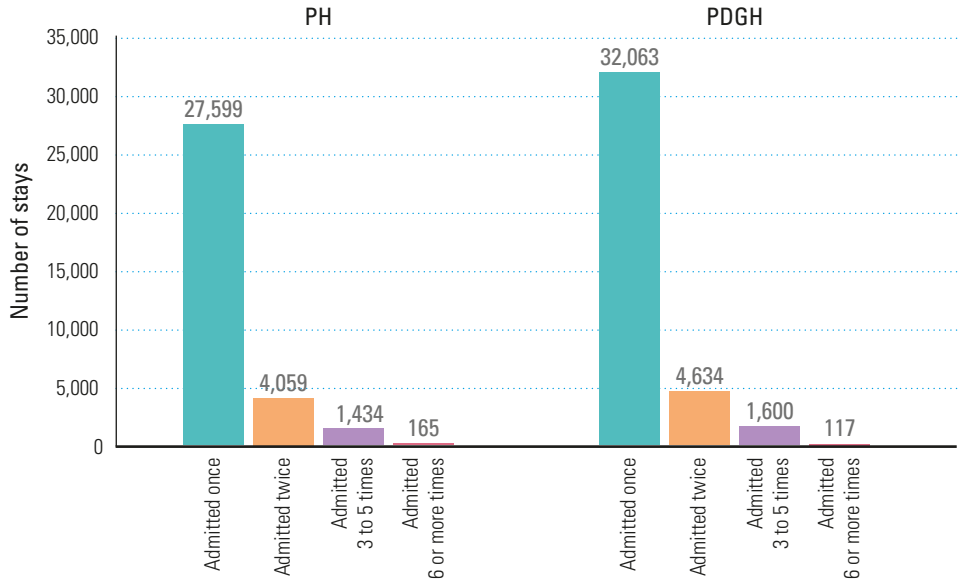


2.3. Readmissions

On the one hand, we observe a reduction in the duration of stay, but on the other hand, we see that, after discharge, patients are readmitted the same year, to the same hospital.

This is usually limited to a single readmission in the same year, but more frequent readmissions are becoming more common.[10]

NUMBER OF REPEAT ADMISSIONS TO PSYCHIATRIC SERVICES
FOR ADULTS IN PH AND PDGH (2018)



9 The average number of occupant days was calculated as the total number of occupant days in relation to the number of hospitalisations in a given year. As a result, this does not relate to the average duration of stay as the number of occupant days in a previous year was not taken into account. For this calculation, both partial and residential stays were taken into account.

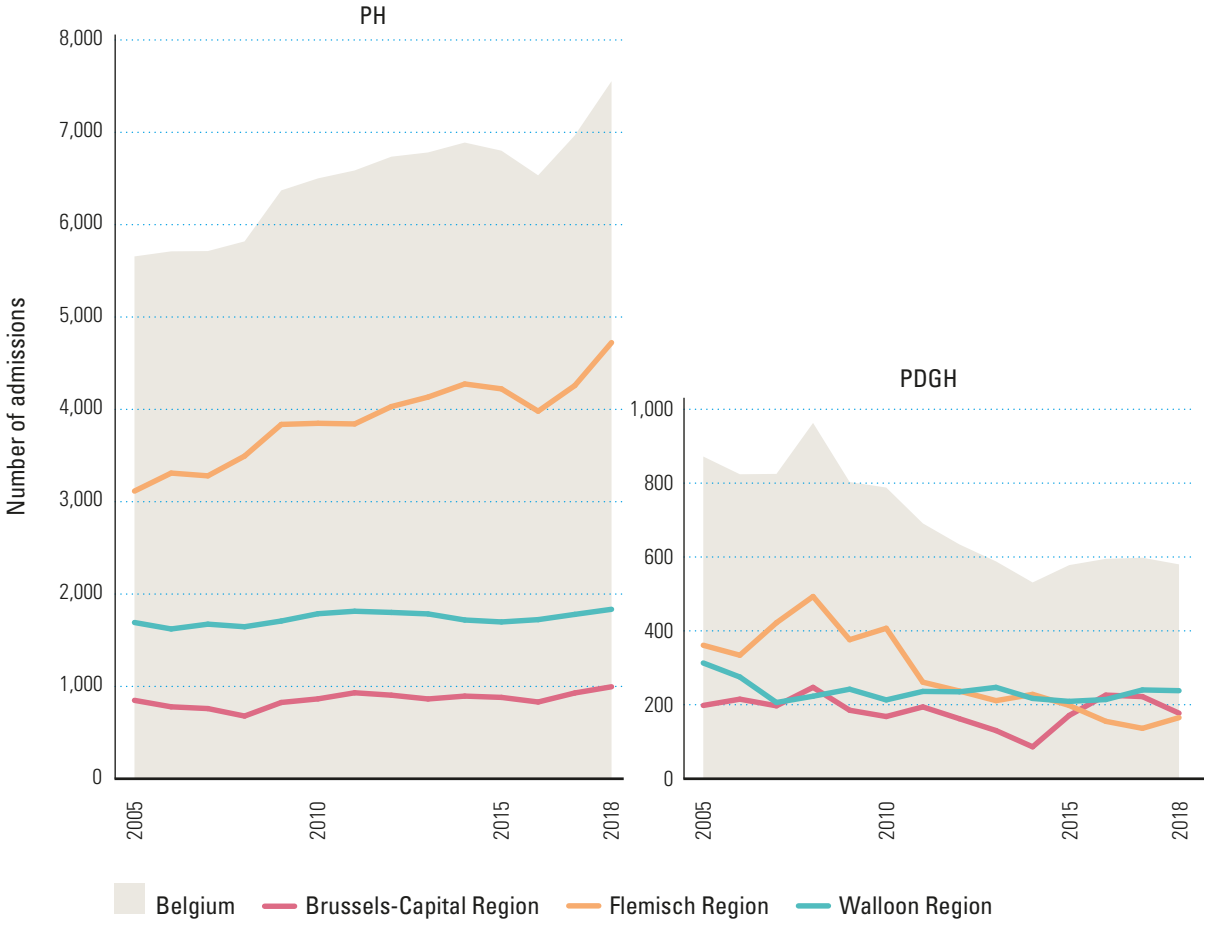
10 It should be borne in mind that there is no unique patient identification number within Minimum Psychiatric Data. As a result, a patient can only be monitored within the same hospital, and readmissions in other hospitals cannot be accounted for. This may result in an underestimation of the number of readmissions.

2.4. Involuntary admissions

An involuntary admission, sometimes called a collocation, is intended as a protective measure. A patient can be ordered into involuntary admission by a magistrate if he or she is a danger to him or herself or to others. These patients are usually admitted to a PH.

The number of involuntary admissions is clearly increasing, especially in the Flemish Region. This observation reinforces our belief that crisis psychiatry, both in outpatient and residential settings, is essential.

EVOLUTION OF THE NUMBER OF INVOLUNTARY ADMISSIONS
IN PSYCHIATRIC SERVICES FOR ADULTS PER REGION IN PH AND PDGH



More information about stays in PH and PDGH:

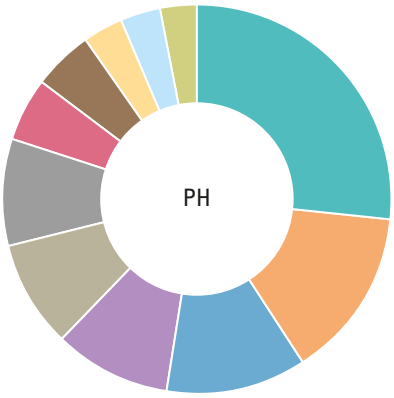
www.health.belgium.be

3. The most common primary diagnosis in PH and PDGH for adults

A diagnosis in the event of psychiatric hospitalisation is rarely unequivocal. There is usually a combination of problems. If we take the primary diagnoses of patients in PH and PDGH as the basis, we find that problems related to the use of alcohol and other psychoactive substances are the most common. This is also the most common secondary diagnosis. A primary diagnosis of a depressive disorder is the next most common primary diagnosis.

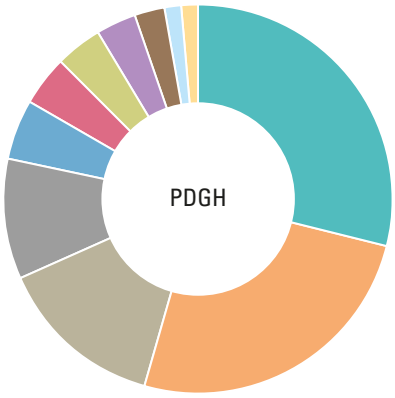
Besides the observation that there are proportionally more admissions to PDGH for depressive disorders, we can see that the top 10 problems for which people are admitted to a PH or PDGH are similar.[11]

PRIMARY DIAGNOSIS UPON ADMISSION OF PATIENTS TO PSYCHIATRIC SERVICES FOR ADULTS IN PH AND PDGH (2018)[12]



66,142

26.7%	Problems caused by the use of alcohol and other psychoactive substances
14.3%	Depressive disorders
11.8%	Psychotic disorders
9.6%	Schizophrenia
9.0%	Adjustment disorders
8.7%	Other disorders
5.5%	Bipolar disorders
4.7%	Personality disorders from cluster A, B and C
3.4%	Delirium, dementia, amnestic and other cognitive disorders
3.3%	Problems predominantly affecting children and young people
3.0%	Anxiety disorder



55,701

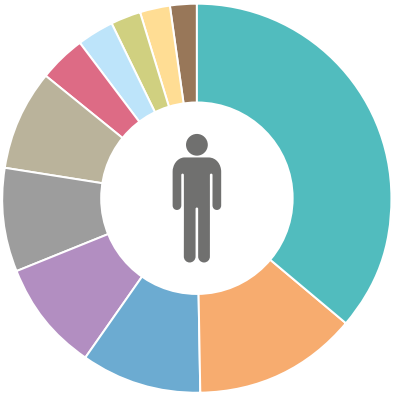
29.1%	Problems caused by the use of alcohol and other psychoactive substances
25.6%	Depressive disorders
13.9%	Adjustment disorders
9.8%	Other disorders
5.1%	Psychotic disorders
4.1%	Bipolar disorders
4.0%	Anxiety disorder
3.1%	Schizophrenia
2.6%	Personality disorders from cluster A, B and C
1.5%	Problems predominantly affecting children and young people
1.1%	Delirium, dementia, amnestic and other cognitive disorders

11 Cluster A personality disorders includes paranoid, schizoid and schizotypal personality disorders, cluster B includes borderline, anti-social, narcissistic and histrionic personality disorders and cluster C includes dependent, avoidant and obsessive-compulsive personality disorders

12 Stays for which the main condition of the patient is not known, have not been taken into account.

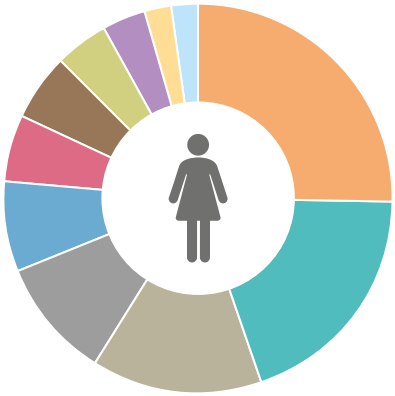
We can observe a clear difference between the problems that occur in men and women. If we take a closer look at the two most common primary diagnoses (Problems related to the use of alcohol and other psychoactive substances and depressive disorders), we see that substance-related problems primarily occur in men, while the depressive disorders are primarily diagnosed in women.

OCCURRENCE OF PRIMARY DIAGNOSES BY GENDER IN PSYCHIATRIC SERVICES FOR ADULTS IN PH AND PDGH (2018)[13]



60,490

36.4%	Problems caused by the use of alcohol and other psychoactive substances
13.6%	Depressive disorders
9.8%	Psychotic disorders
9.4%	Schizophrenia
8.6%	Other disorders
8.3%	Adjustment disorders
3.9%	Bipolar disorders
3.0%	Problems predominantly affecting children and young people
2.5%	Anxiety disorder
2.4%	Delirium, dementia, amnestic and other cognitive disorders
2.1%	Personality disorders from cluster A, B and C



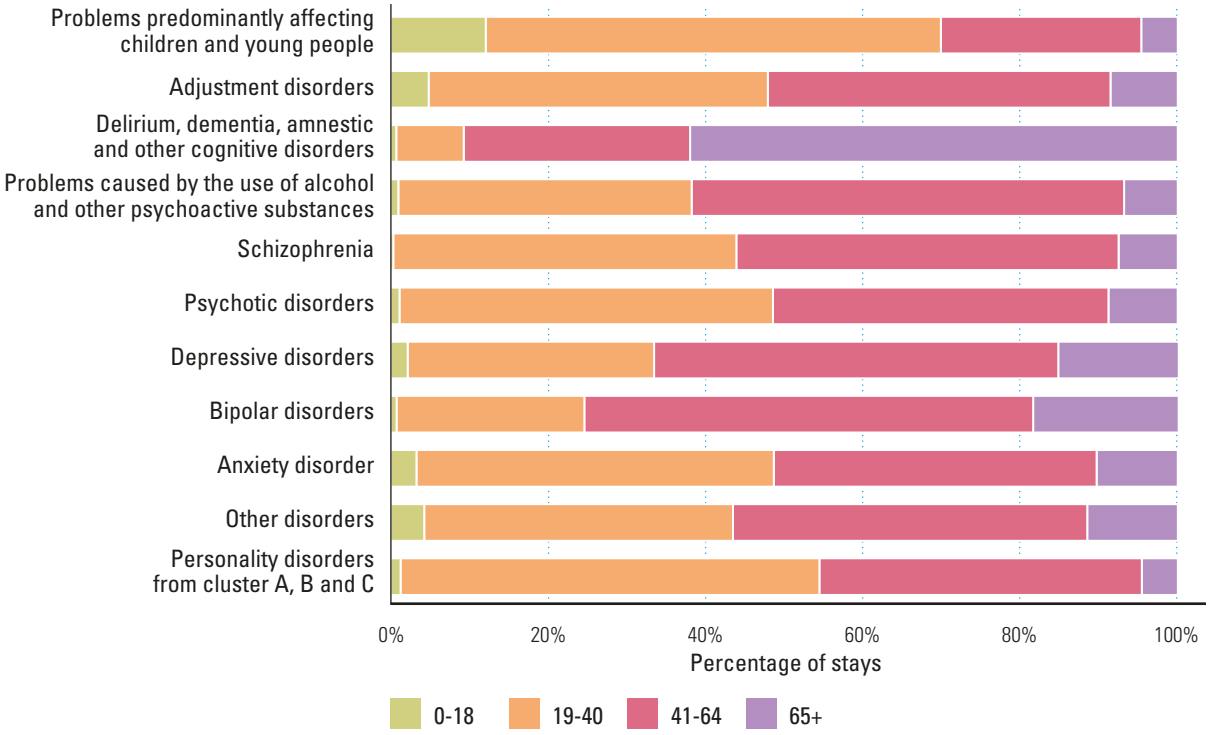
60,092

25.4%	Depressive disorders
19.6%	Problems caused by the use of alcohol and other psychoactive substances
14.2%	Adjustment disorders
9.8%	Other disorders
7.5%	Psychotic disorders
5.8%	Bipolar disorders
5.4%	Personality disorders from cluster A, B and C
4.4%	Anxiety disorder
3.9%	Schizophrenia
2.2%	Delirium, dementia, amnestic and other cognitive disorders
2.0%	Problems predominantly affecting children and young people

13 Stays for which the the main condition and the sex of the patient are not known, have not been taken into account.

We can also see that certain pathologies occur more frequently depending on the age of the patient. Problems predominantly affecting children and young people[14] are most commonly diagnosed in the youngest age groups, whereas delirium, dementia, amnestic and other cognitive disorders are primarily diagnosed in the age group 65 years and older. The primary diagnosis of bipolar disorder is more common in patients of middle age and older.

OCCURRENCE OF PRIMARY DIAGNOSES BY AGE IN PSYCHIATRIC SERVICES FOR ADULTS IN PH AND PDGH (2018)



More information on diagnoses made during admission to PH or PDGH:

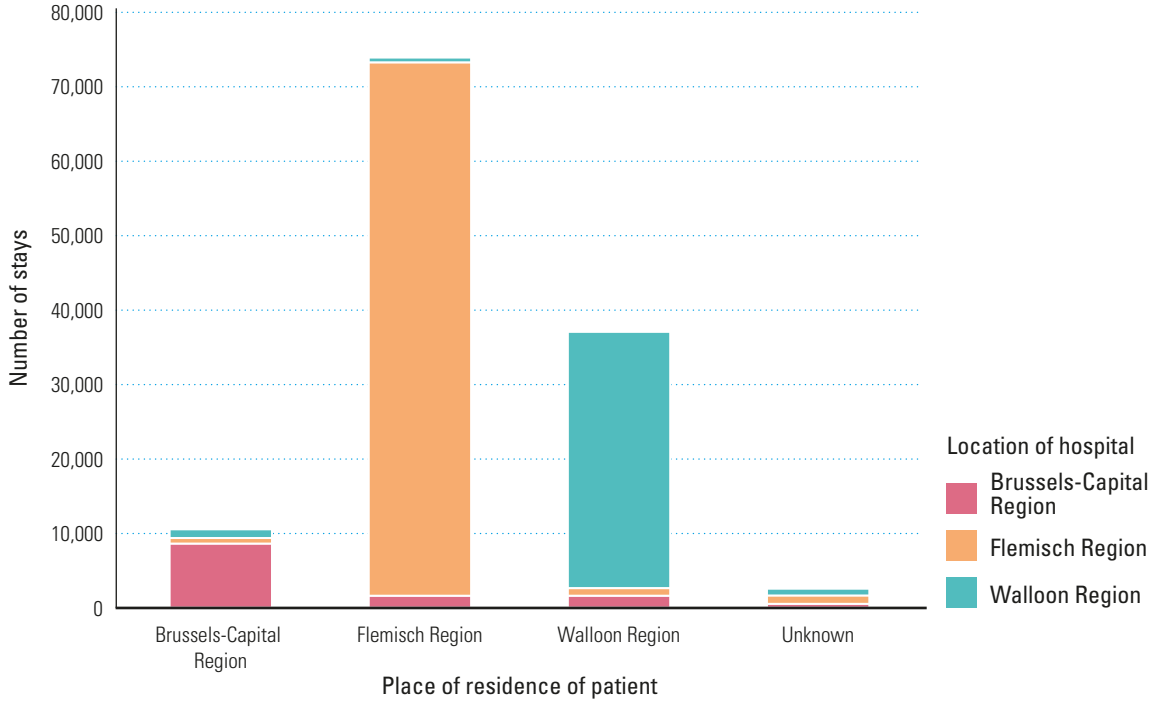
www.health.belgium.be

14 This group includes developmental disorders, autism, attention deficit and behavioural disorders, relationship disorders and other child psychiatric problems.

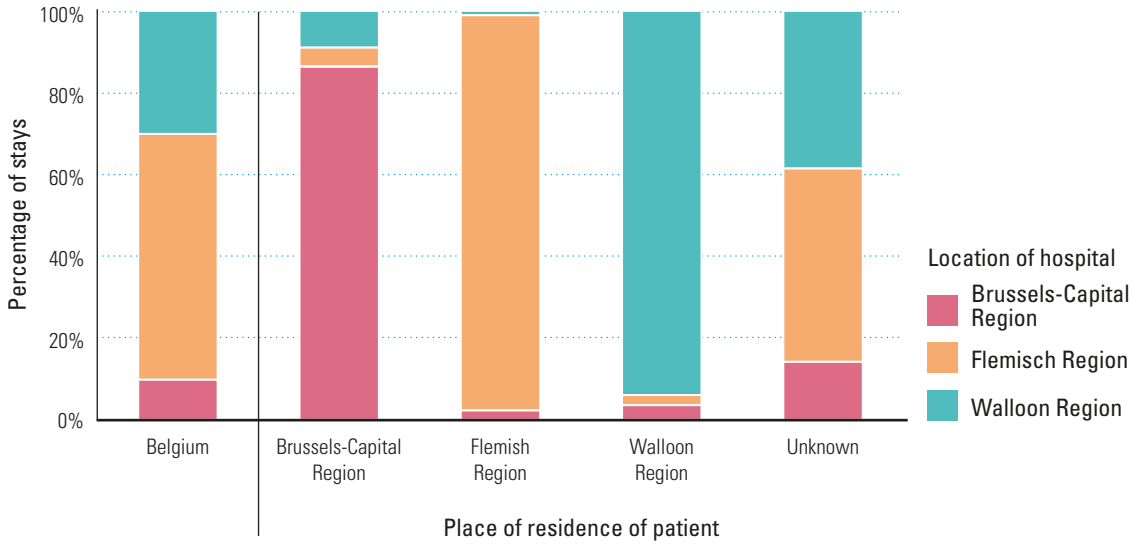
4. Patient flows in PH and PDGH

A psychiatric patient is not necessarily admitted to a hospital (PH or PDGH) in his or her region. For example, it is possible that a patient living in the Flemish Region is admitted to a hospital in the Brussels Capital Region. Hospitals that structurally attract a large number of patients from outside their area could have a greater need for hospital beds as a result.

NUMBER OF STAYS IN PH AND PDGH
PER REGION OF RESIDENCE OF THE PATIENT
AND PER REGION IN WHICH THE HOSPITAL IS LOCATED (2018)[15]

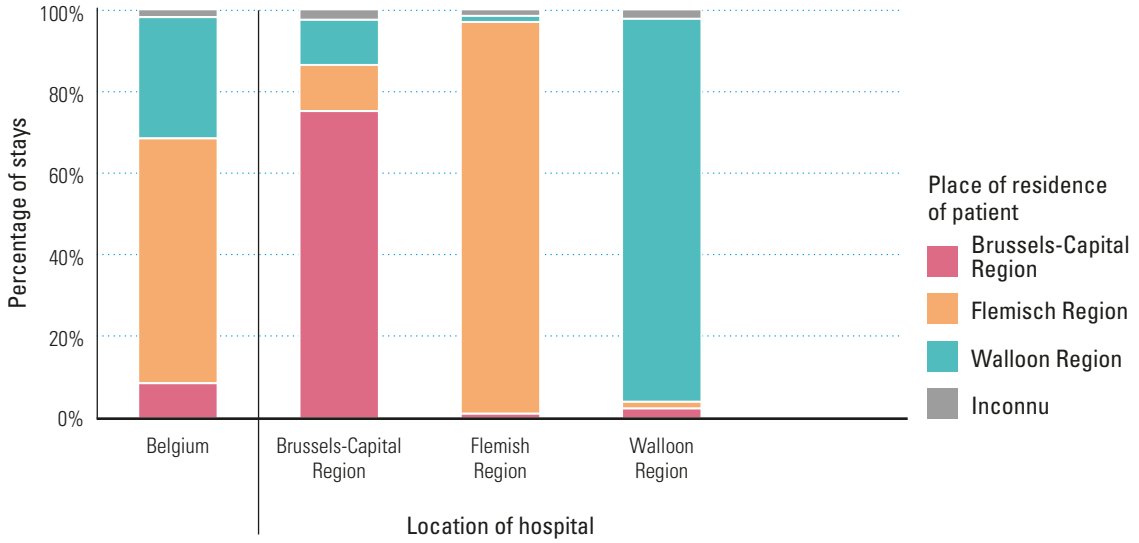


IN WHICH REGION DOES A PATIENT CHOOSE THEIR HOSPITAL?
(SHOWN BY THE REGION OF THE PATIENT'S PLACE OF RESIDENCE)



15 We can see that 1.5% of the patients who were admitted to a psychiatric unit in a PH or PDGH have no known, or no Belgian, place of residence. Each region admits an equal share of this group.

IN WHICH REGION IS THE PATIENT'S PLACE OF RESIDENCE?
(SHOWN BY THE REGION IN WHICH THE HOSPITAL IS LOCATED)



Most of the patients are hospitalised in a hospital within their region. In the Brussels Capital Region, almost one quarter of the patients come from outside the region. The proportion of Flemish or Walloon patients is almost the same.

If Brussels patients are admitted outside the Brussels Capital Region, 8.8% of them go to the Walloon Region and 4.6% to the Flemish Region.

Of the patients from the Walloon Region, 3.6% are hospitalised in the Brussels Capital Region and 2% in the Flemish Region.

Fewer than 2.5% of Flemish patients are hospitalised outside the Flemish region.

More information about patient flows:

www.health.belgium.be

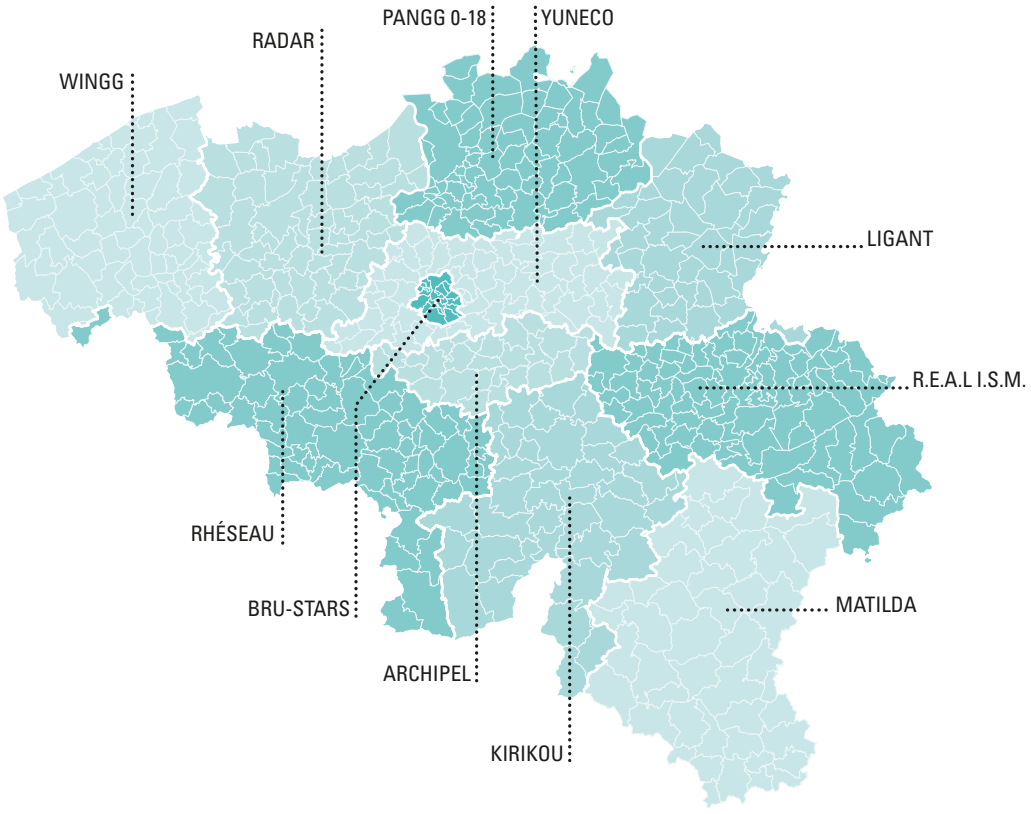
MENTAL HEALTHCARE FOR CHILDREN AND YOUNG PEOPLE

1. Organisation of the care offering for children and young people

1.1. Networks in mental healthcare for children and young people

On 30 March 2015, the Interministerial Conference on Public Health (IMC) approved the "Guide to a new mental healthcare policy for children and young people (GMCY)". Almost immediately, 11 GMCY networks were set up, focusing on children and young people within their area of action.

The areas of action of these networks coincide with the territories of the provinces and the Brussels-Capital Region[16].



16 Although in the German-speaking Community there is a specific pilot project for following-up of children and young people with mental and psychiatric problems financed by the federal government, this does not form a separate GMCY network but is part of REALiSM, the GMCY network of the Province of Liège.

A GMCY network provides a comprehensive and integrated range of services for all children and young people aged 0-23 with mental and/or psychiatric problems. The aim is to respond to the needs of these children, young people and their context or environment as quickly and continuously as possible. Each network consists of all the relevant actors, services, institutions, care providers, etc. of the sectors involved working together and coordinating their policies.

To optimise the care, investments are made in developing various programmes financed by the federal government, namely crisis care, long-term care, intersectoral consultation and liaison (expertise and knowledge exchange) and dual diagnosis (a mental disability combined with psychological problems). More than 300 additional FTEs are made available to the networks[17].

Learn more about the several initiatives in the field of mental health care for children and youngsters:

www.psy0-18.be

1.2. Hospitals

Beds, reserved for children and young people with mental health problems, are recognised under the code letter **K** (residential hospitalisation), **k1** (day hospitalisation) and **k2** (night hospitalisation).

51 hospitals have a department for children and young people with mental health problems

25 PH

26 PDGH

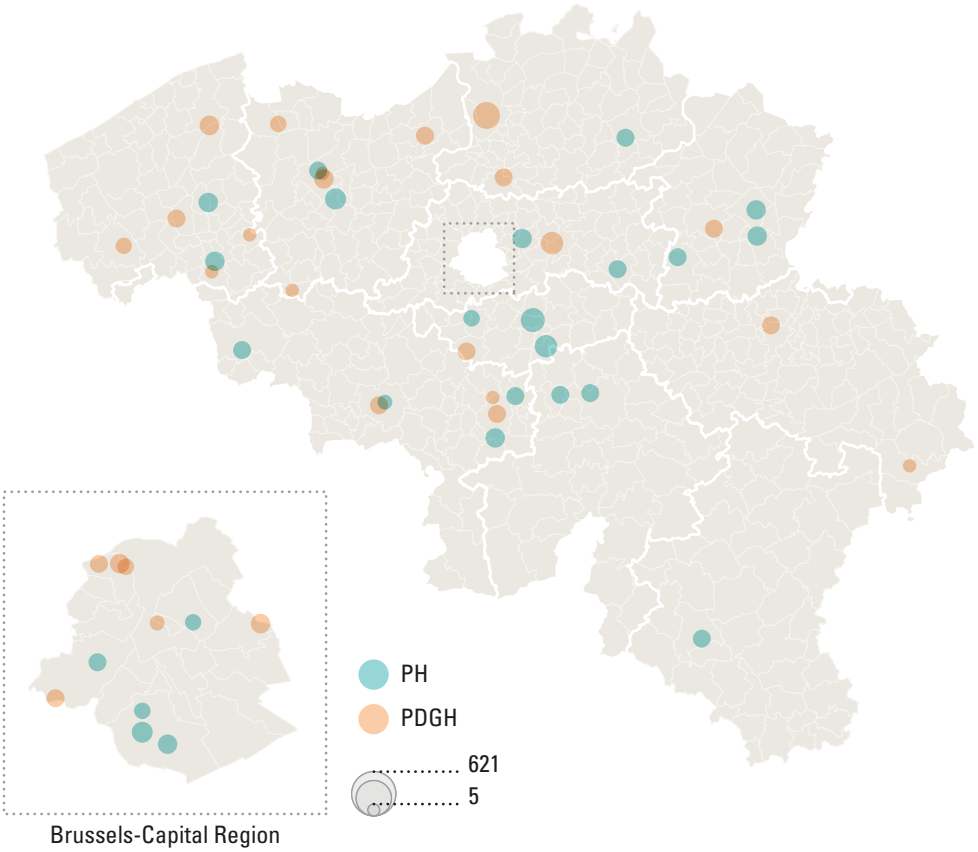
A total of 51 hospitals, including 26 general hospitals with a psychiatric department (PDGH) and 25 psychiatric hospitals (PH) have one of these K-services. Six of these PDGH and 8 of the PH do not have a psychiatric service for adults. In addition, a further three of these PDGH do not have a paediatric department for somatic care, while there is a department for children and young people with mental health problems.

17 This funding is not done by freezing beds (see chapter 'Initiatives regarding alternatives to hospitalisation').

The number of beds in K-services is usually more limited compared to the services for adults. Nevertheless, there are 2 PDGH and 2 PH with more than 50 beds reserved for children and young people (K, k1, k2).

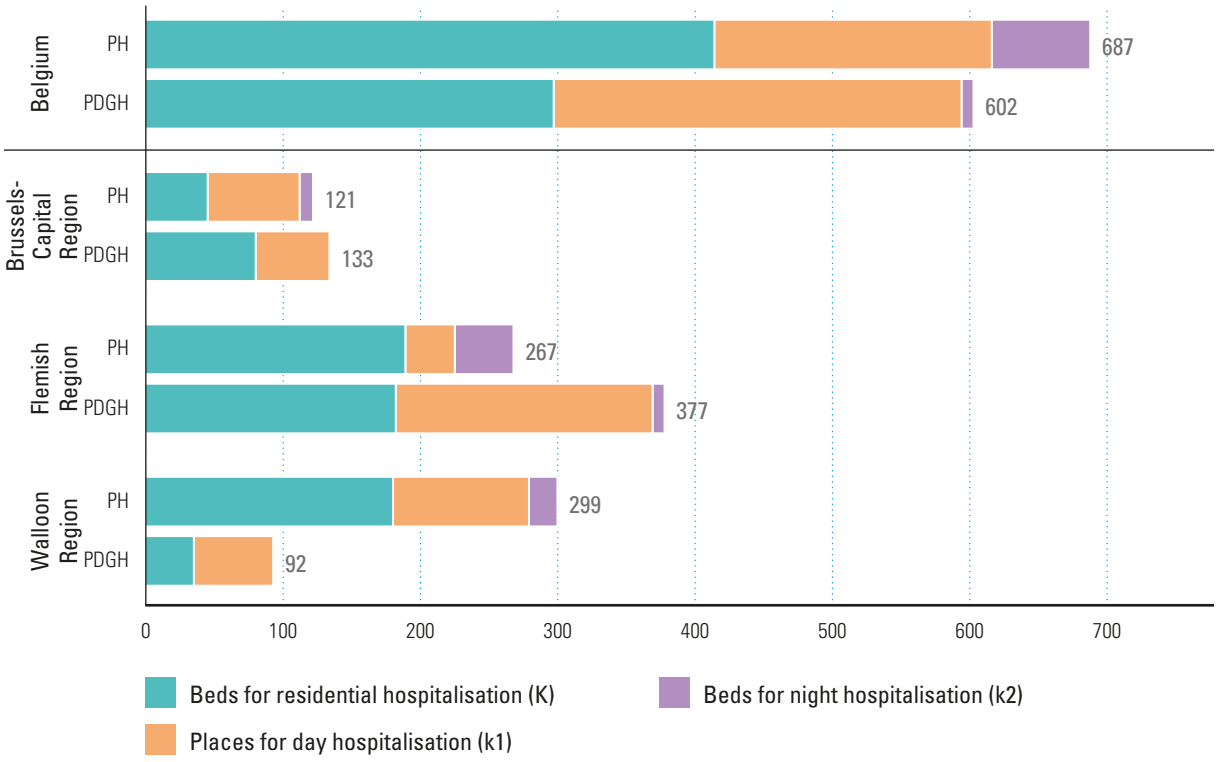
In contrast to the services for adults, psychiatric services for children and young people within PDGH and PH have a better balance in terms of the distribution of bed capacity. In terms of geographical distribution, the concentration of K-services in the regions around Charleroi and Namur and in the province of Walloon Brabant is particularly striking, while the rest of the Walloon Region has a very limited offering.

DISTRIBUTION OF PH AND PDGH IN BELGIUM
INDICATING THE NUMBER OF BEDS FOR CHILDREN AND YOUNG PEOPLE (01/01/2020)



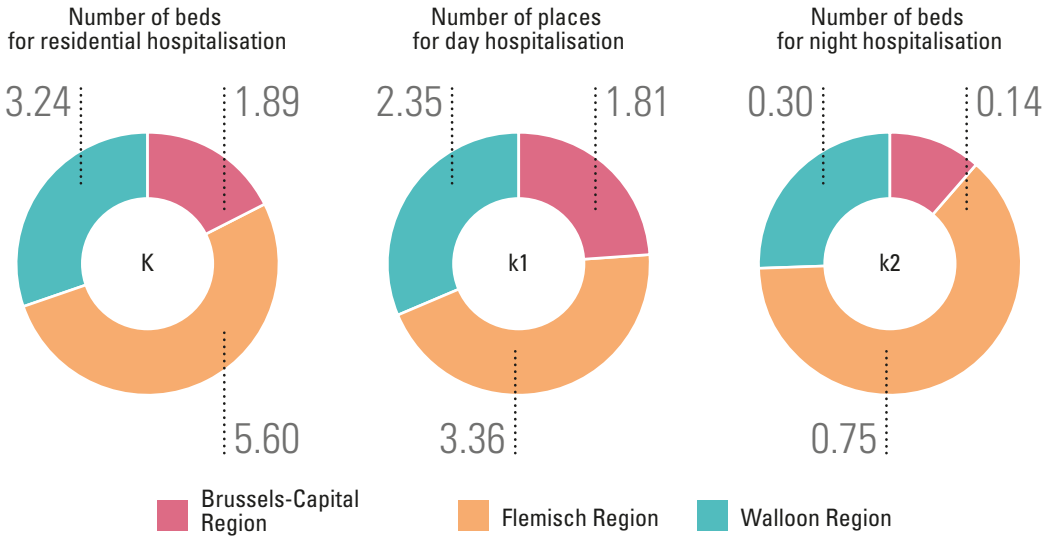
1.3. Types of beds and places for residential and partial hospitalisation

NUMBER OF BEDS AND PLACES FOR RESIDENTIAL AND PARTIAL HOSPITALISATION OF CHILDREN AND YOUNG PEOPLE IN PH AND PDGH PER REGION (01/01/2020)



Compared to the other regions, the beds for child psychiatry in the Walloon Region are primarily located in the PH. In the Flemish Region, there are clearly more places for day admissions in a PDGH than in a PH. As is the case for adults, there are generally fewer places for night hospitalisation compared to places for day hospitalisation.

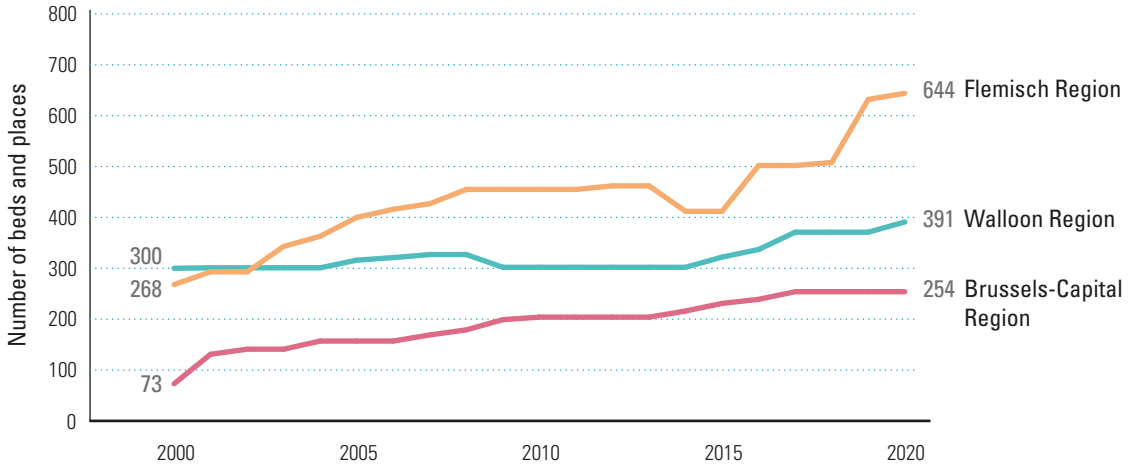
NUMBER OF BEDS AND PLACES FOR CHILDREN AND YOUNG PEOPLE PER 100,000 INHABITANTS



EVOLUTION OF THE NUMBER OF BEDS AND PLACES FOR CHILDREN AND YOUNG PEOPLE

To date, the number of beds for residential hospitalisation has increased, even though there are already more beds recognised per 1,000 inhabitants than described in the programming figures. The number of beds and places for day and night hospitalisation (code letters k1 and k2) is also increasing but, unlike residential beds (code letter K), there is still programming room for this in the Walloon and Flemish Regions.

EVOLUTION OF THE TOTAL NUMBER OF BEDS AND PLACES FOR CHILDREN AND YOUNG PEOPLE IN PH AND PDGH (K, k1 AND k2)



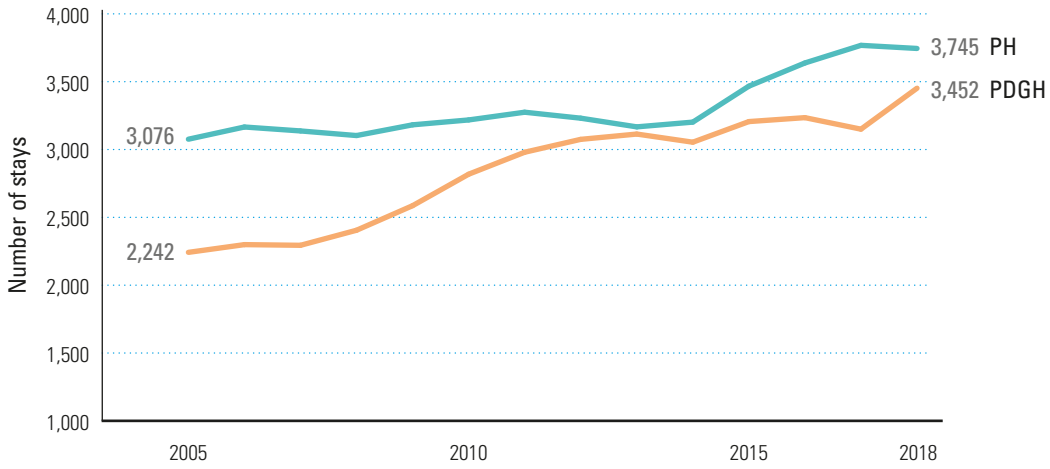
This trend may indicate an increased need for care for children and young people with mental health problems. An adaptation of the programming criteria would therefore not appear to be unjustified. Care for young people in particular merits special attention. Under the current regulations, young people from the age of 15 can be admitted to adult psychiatry. Yet this target group is so specific that a solution within juvenile psychiatry should be prioritised. Experts refer to a transition age that can last up to the age of 23. However, for the programming, only the number of children up to the age of 14 is taken into account.

2. Hospital activities in PH and PDGH for children and young people

2.1. Hospital stays

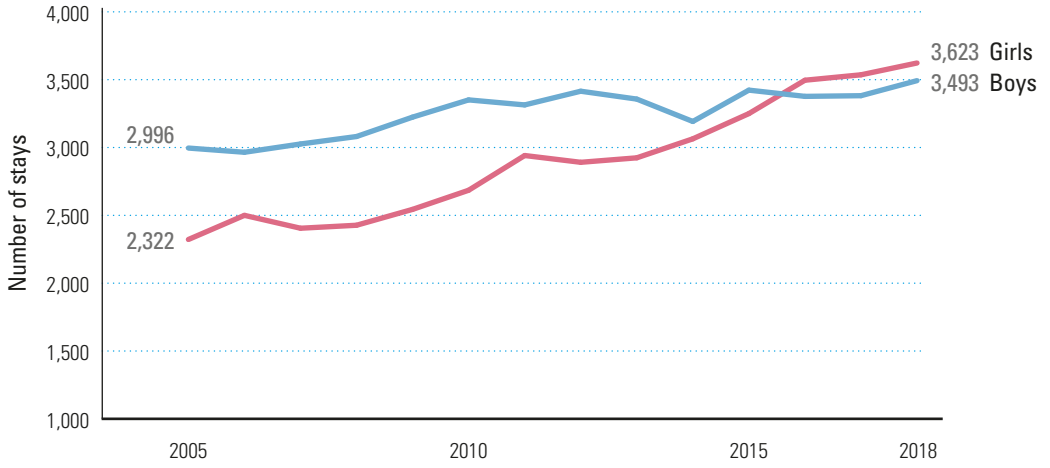
The number of stays in psychiatric services for children and young people (K, k1 and k2) has been increasing sharply in recent years, both in PDGH and PH[18],[19].

EVOLUTION OF THE NUMBER OF HOSPITAL STAYS IN PSYCHIATRIC SERVICES FOR CHILDREN AND YOUNG PEOPLE IN PH AND PDGH



We can also see that more boys were admitted initially. In recent years, we have seen a steady increase in the number of admissions of girls, to such an extent that in 2018 more girls than boys were admitted to PH and PDGH.

EVOLUTION OF THE NUMBER OF HOSPITAL STAYS IN PSYCHIATRIC SERVICES FOR CHILDREN AND YOUNG PEOPLE IN PH AND PDGH BY GENDER[20]



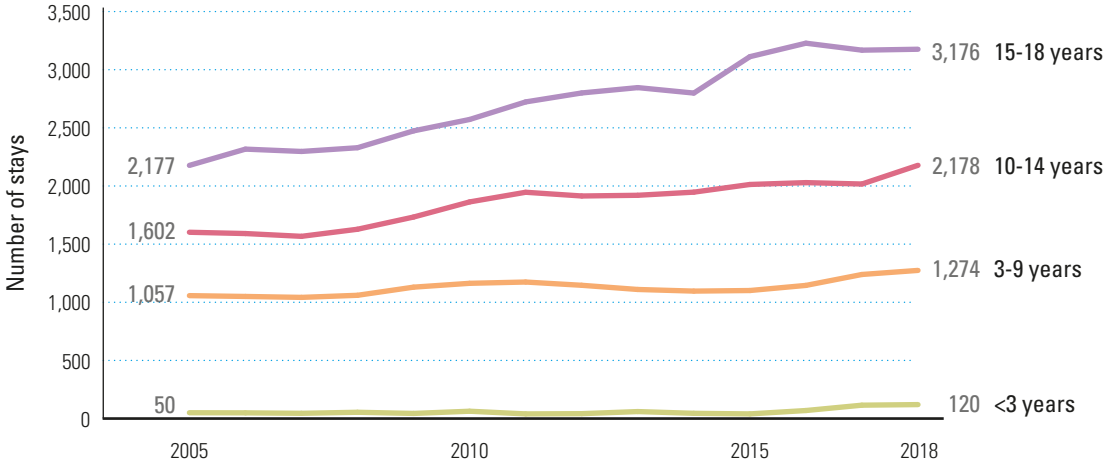
18 Source: Minimum Psychiatric Data (MPD), FPS Health, Food Chain Safety and Environment

19 This is the number of registered residential and partial stays in beds for children (code letter K, k1, k2) in the relevant year, regardless of the year of admission and regardless of whether the patient has already been discharged.

20 Stays for which the sex of the patient is not known, have not been taken into account.

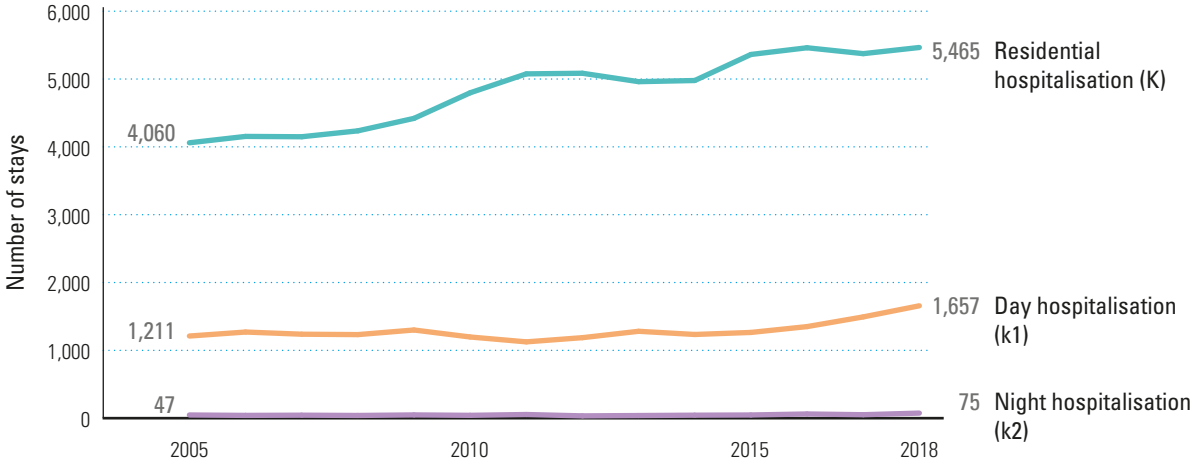
Most admissions are in the age categories 10-14 and 15-18 years old. Although young people are allowed to be admitted to adult psychiatry from the age of 15, a service for children and young people (K, k1 or k2) is still often preferred. In certain cases, a patient is still admitted to a psychiatric service for children and young people even after their 18th birthday. It is assumed that this transition age is acceptable up to 23 years old.

EVOLUTION OF THE NUMBER OF HOSPITAL STAYS IN PSYCHIATRIC SERVICES FOR CHILDREN AND YOUNG PEOPLE IN PH AND PDGH BY AGE[21][22]



It is striking that children and young people increasingly need residential psychiatric care.

EVOLUTION OF THE NUMBER OF STAYS IN PSYCHIATRIC SERVICES FOR CHILDREN AND YOUNG PEOPLE IN PH AND PDGH BY TYPE OF HOSPITALISATION



We can observe an increase in both the number of residential admissions and the number of day admissions (k1), whereby the child or young person often stays at home during the weekend.

There are only a few admissions where the child or young person is only in hospital in the evening and at night, but otherwise attends a day programme outside the hospital (k2).

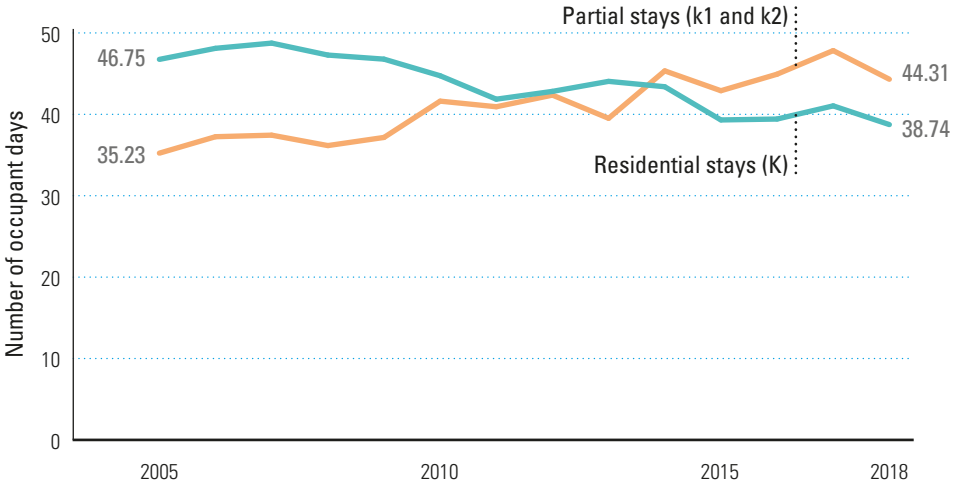
21 Note: Number of stays of persons older than 18 are not included in this graph. In exceptional cases, it is possible that persons older than 18 stay in a psychiatric service for children and young people. It is also possible that these stays have been registered incorrectly.

22 Stays for which the age of the patient is not known, have not been taken into account.

2.2. Duration of stay

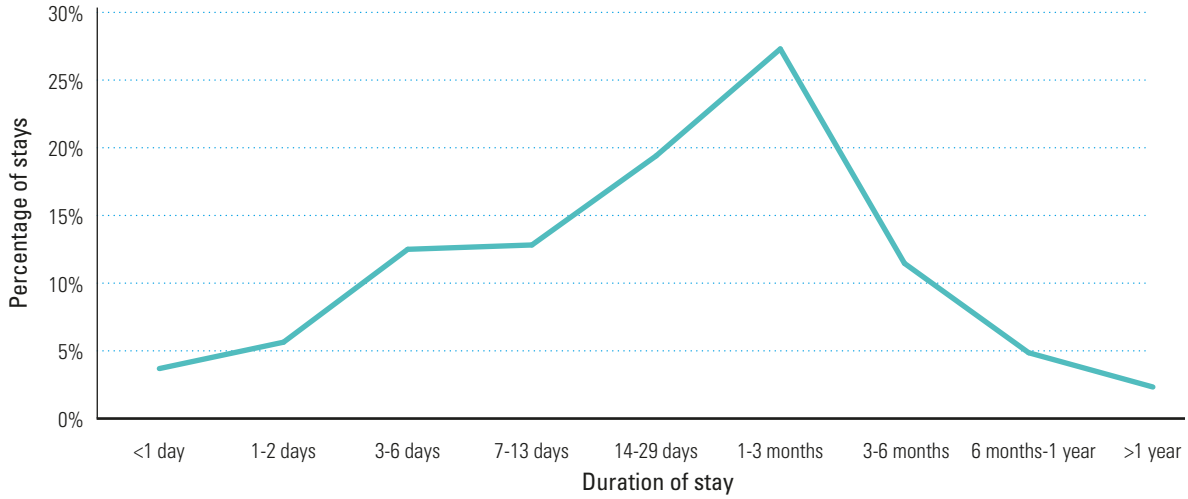
Although the number of admissions is increasing, we see - as is the case in adult psychiatry - that the average number of occupant days in a given year for a residential hospitalisation in a K-service is decreasing. On the other hand, we can see that the average number of occupant days in a year of day or night hospitalisation is increasing.

EVOLUTION OF THE AVERAGE NUMBER OF OCCUPANT DAYS PER STAY IN A YEAR IN A PSYCHIATRIC SERVICE FOR CHILDREN AND YOUNG PEOPLE IN PH AND PDGH



More than 80% of all ended stays for children and young people in PH and PDGH are shorter than 3 months. 2.4% stay longer than a year.

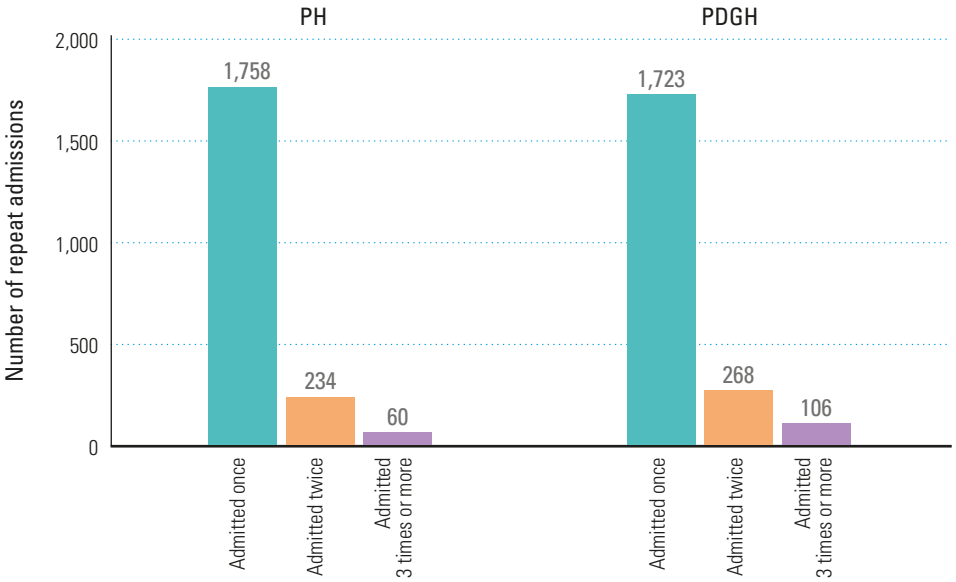
DURATION OF STAY IN PSYCHIATRIC SERVICES FOR CHILDREN AND YOUNG PEOPLE IN PH AND PDGH



2.3. Readmissions

Around 16% of the children and young people discharged from a PDGH or PH were readmitted to the same hospital the same year[23].

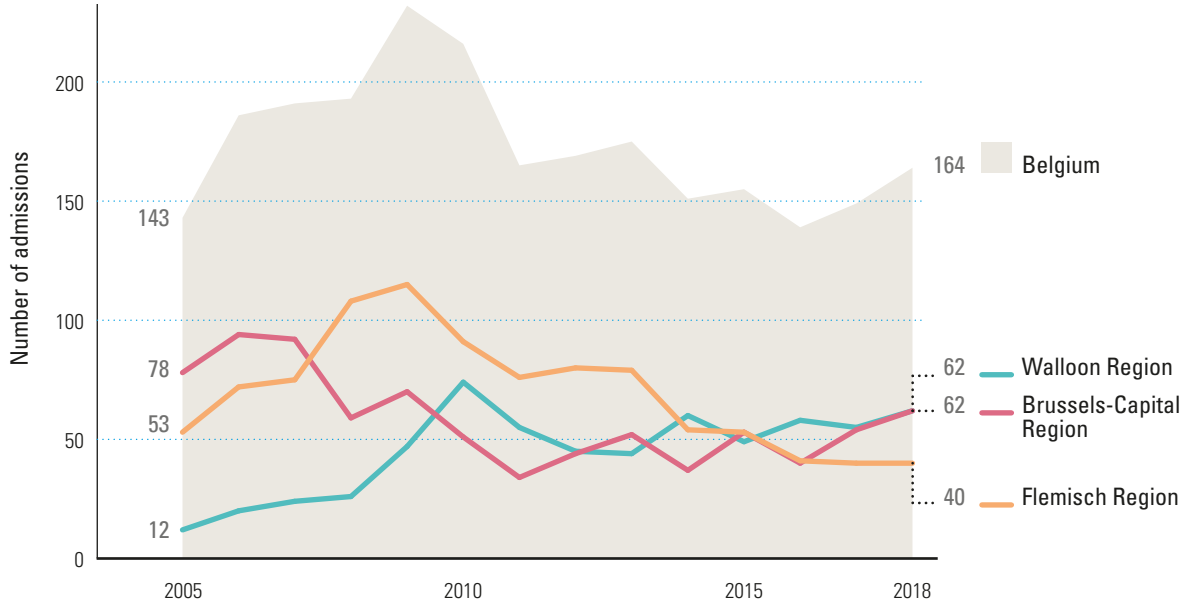
DURATION OF STAY IN PSYCHIATRIC SERVICES
FOR CHILDREN AND YOUNG PEOPLE IN PH AND PDGH



2.4. Involuntary admissions

Of the 7,197 admissions for children and young people in 2018, 164 were involuntary admissions (2.28%). This legal measure is increasingly applied in the Walloon Region, but shows a decreasing trend in the Brussels Capital Region and the Flemish Region.

EVOLUTION OF THE NUMBER OF INVOLUNTARY ADMISSIONS
IN PSYCHIATRIC SERVICES FOR CHILDREN AND YOUNG PEOPLE
PER REGION IN PH AND PDGH



23 Figures are only available for readmissions to the same hospital, which may lead to an underestimation of the actual number of readmissions.

INITIATIVES REGARDING ALTERNATIVES TO HOSPITALISATION

We stated earlier that the reform of MHC in Belgium aims to prevent hospitalisation as much as possible and, when hospitalisation is unavoidable, it should be as short as possible.

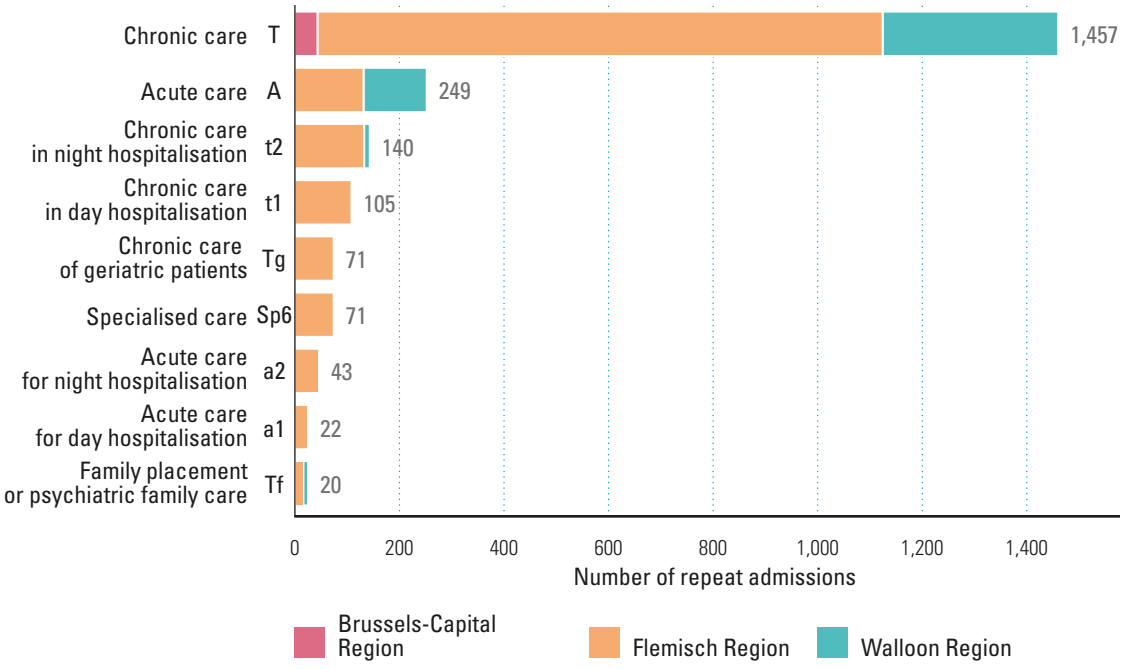
For this to be successful a number of alternatives are available to patients.

1. Decommissioning or freezing of beds

The MHC reform for adults is often called "Project 107", referring to the article 107 of the Hospital Act which states that "The King may provide for specific funding methods to enable, on an experimental basis and limited in time, the prospective and programme-oriented funding of care circuits and networks".

In concrete terms, this means that hospitals can temporarily decommission some of their beds or freeze them. This 'bed freeze' is on a voluntary basis following consultation between the network partners and subject to approval by the federal government. Approval implies a budget guarantee for the hospital that decommissions beds. As of 1/01/2020, 2,178 beds were decommissioned.

NUMBER OF BEDS DECOMMISSIONED PER REGION (01/01/2020)[24]



24 Source: Psycho-social Healthcare Service, FPS Health, Food Chain Safety and Environment

The staff freed up by the decommissioning of the beds can be deployed in alternative care. In practice, these are mobile teams for specialised care in the home environment (see 1.1.) or more staff is deployed to residential care (see 1.2.).

2,178 beds were **decommissioned** in favour of **mobile teams** and intensified health care

1.1. Mobile functions

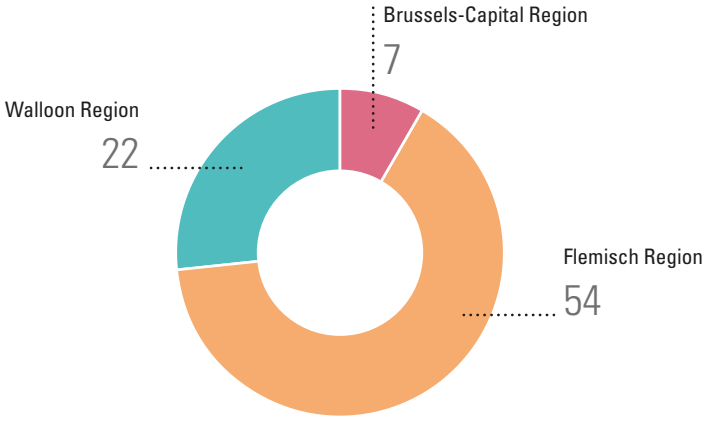
A stay in a psychiatric hospital (PH) or in a psychiatric department of a general hospital (PDGH) is often a stressful event. Patients find themselves in a strange, clinical environment with unfamiliar neighbours and caregivers, and they temporarily lose their social contacts. As such, it is important that, firstly, the residential admission is as short and as intensive as possible, and secondly, that the necessary after-care can be provided quickly and efficiently.

The aim of the MHC reform is to bring care as close to patients as possible, and respond to their needs and preferences in the best possible way. To this end, multidisciplinary mobile teams were set up to provide specialised care in the home environment of patients with severe psychiatric disorders.

Rapid intervention by the crisis team means that treatment can be started in the home environment, whereby hospitalisation may be avoided.

After several weeks of care by the crisis team, a long-term care team can take over the aftercare. This is also possible immediately after an admission. This makes it possible to keep the hospitalisation period as short as possible, so that the link with the patient's home environment can be restored more quickly.

NUMBER OF CRISIS TEAMS PER REGION (01/01/2020)[25]



25 Source: Psycho-social Healthcare Service, FPS Health, Food Chain Safety and Environment

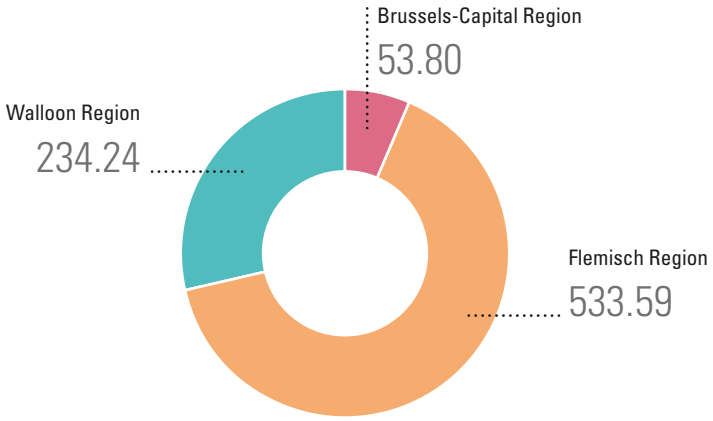
In **2018**, 8,894 patients have been supervised by a **crisis team** and 8,204 patients by a **long-term care team**[26]

Both the crisis team and the long-term care team came about through the application of Article 107 of the Hospital Act, the so-called bed freeze. The staff that no longer need to be deployed to treat patients admitted to a residential setting can be deployed in one of these mobile teams.

We stated above that the healthcare landscape was split up into MHC networks. Each healthcare facility within the same geographical area is part of the MHC network. The collaboration can take various forms. For example, it may be the case that partners (even without a bed freeze) make staff available to the mobile teams.

The facilities within each MHC network are not proportionally distributed. Some networks simply do not have enough resources to create sufficiently large mobile teams on their own. In such cases, the networks can receive a financial intervention from the federal government to recruit additional staff.

NUMBER OF FTES PER REGION (01/01/2020)[27]



1.2. Residential intensive treatment units HIC and IC

In crisis situations, talking to a care worker from a mobile crisis team or from a mental healthcare centre (MHCC) is sometimes not enough to treat mental health problems. Admission and treatment in a PH or a PDGH is then the most appropriate solution.

Here, a multidisciplinary team of specialised care workers works with the patient to work out an appropriate treatment plan (for both acute and chronic problems) and prepares the return home and follow-up care.

A crisis admission is possible in an intensive care unit (IC) where both an individual and a group therapeutic programme are provided, as short as possible, but as long as necessary.

26 Source: annual reports 'Article 107' pilot projects

27 Source: Psycho-social Healthcare Service, FPS Health, Food Chain Safety and Environment

If the severity of the problem is such that admission to IC does not meet the needs, an HIC unit (High & Intensive Care) is an alternative. The patient stays in a secure room, in a peaceful environment with the possibility of working with one-to-one treatments, with a focus on restoring autonomy and self-reliance. In any event, coercive measures should be avoided as much as possible.

2. First-line psychological function (FLP)

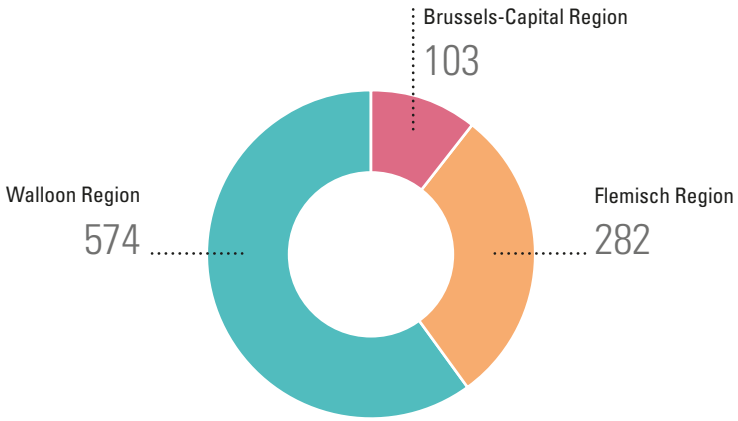
In April 2019, a pilot project was set up in which doctors can refer patients with mild and moderately severe mental health problems to a clinical psychologist or clinical remedial educationalist for short-term, first-line psychological treatment that is largely reimbursed by the health insurance fund.

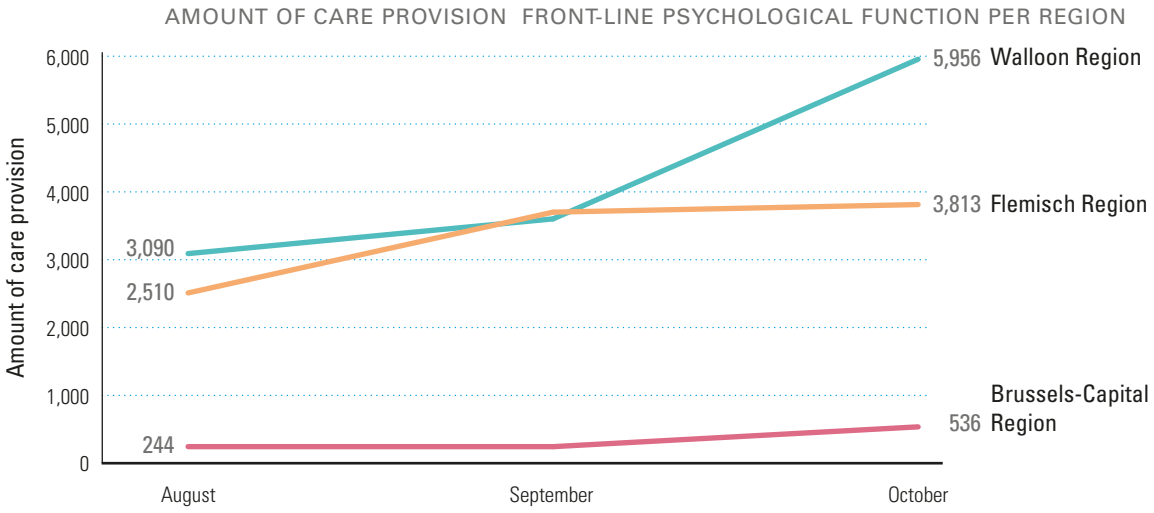
Initially, this was only envisaged for the 18 to 64 age group. Since 2 April 2020, the sessions have been refunded for people in all age groups.

The treatment consists of a series of individual discussion sessions. After an intake interview with a diagnosis of the patient's psychological problems, treatment sessions are organised which are aimed at general psychological care, solution-focused treatment, etc. In addition, if the patient requires more intensive, long-term counselling, the care worker can refer the patient to another care provider who may or may not work at an advantageous rate.

Mild and moderately severe mental health problems are defined as mental health problems related to anxiety, depressed mood, moderate to serious alcohol abuse or misuse of sleeping pills and sedatives. For young people, these can include behavioural or social problems and addiction to screens. The project is still in the start-up phase.

NUMBER OF PROVIDERS OF FRONT-LINE PSYCHOLOGICAL CARE PER REGION (01/11/2020)



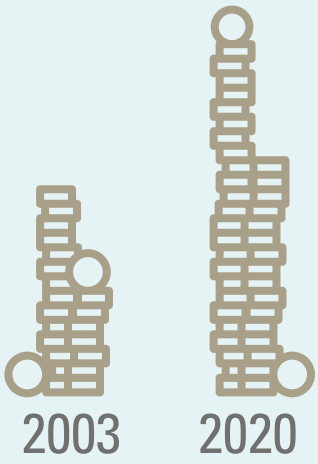


Recently, an agreement was reached in the IMC Public Health, primarily on strengthening the care offering in front-line health care. Indeed, on 2 December 2020, the Protocol agreement on the coordinated approach to strengthening the mental healthcare offering in the context of the COVID-19 pandemic was concluded. The agreement sets out several priority target groups, such as children and parents in vulnerable families, young adults, and people with pre-existing mental health problems. Additional recurrent budgets were set aside for this enhancement. Intensive consultations are being held with the sector on how to use these resources efficiently.

FINANCING OF PSYCHIATRIC HOSPITALS

This chapter focuses on the financing of psychiatric hospitals (PH). The financing of other institutions in mental healthcare is not covered in this document.

Budget for psychiatric hospitals almost **doubled since 2003**

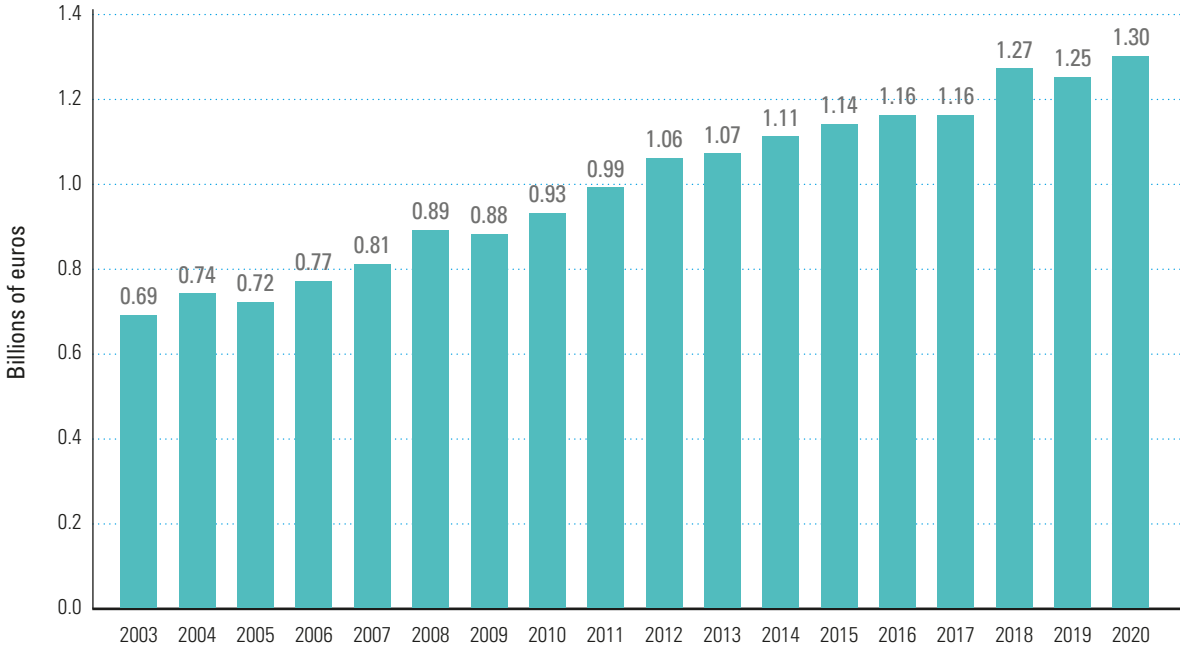


As regards the PH, the main sources of funding are the **Budget of Financial Resources (BFR)** on the one hand, and doctors' fees on the other. In addition, there are also reimbursements for pharmaceutical and consumable products, NIHDI flat-rates and room supplements.

We will look at BFR in more detail. This consists of a budget for infrastructure and equipment, a budget for operating costs and one for corrections or catch-up amounts.

The total budget for the PH in 2020 was €1.30 billion, which is roughly double the 2003 budget of €0.69 billion. The amount allocated to PH corresponds to 6.8% of the total budget for general hospitals (€18.66 billion)[28]

EVOLUTION OF THE BUDGET FOR FINANCIAL RESOURCES (BFR) OF PSYCHIATRIC HOSPITALS



Learn more about the financing of psychiatric hospitals:

www.health.belgium.be

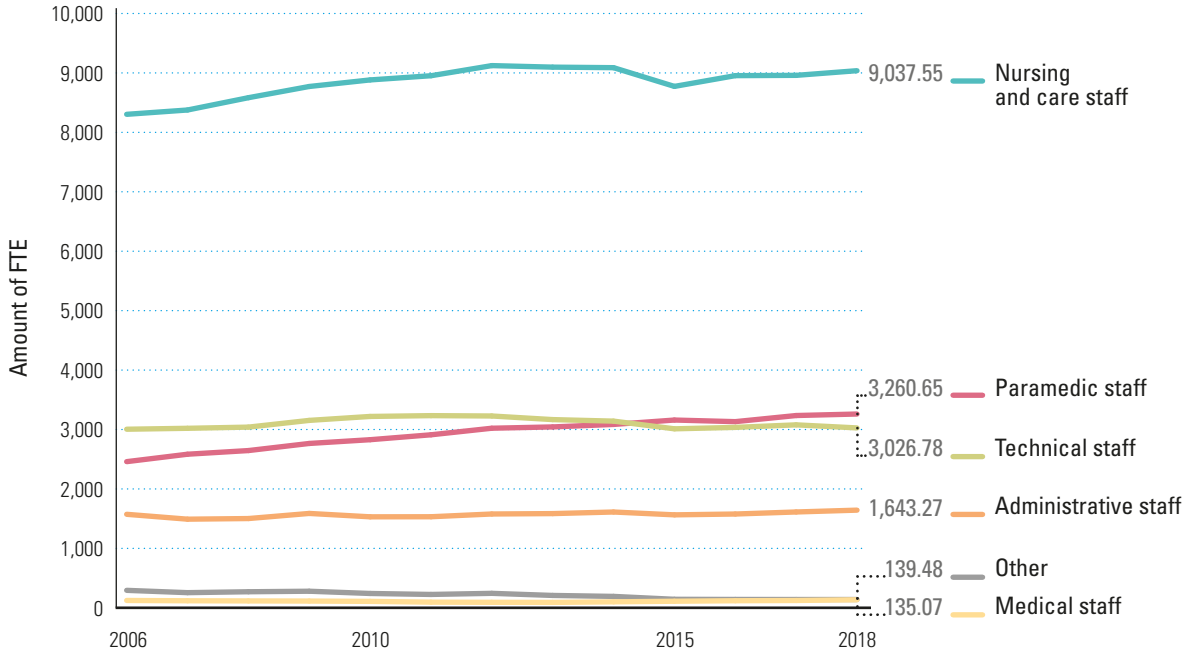
28 Source: Budget for Financial Resources, FPS Health, Food Chain Safety and Environment

STAFF IN PSYCHIATRIC HOSPITALS

Since 2006, the number of FTE in psychiatric hospitals (PH) has increased by 9.4%.[29]

More than half of the staff members can be found in the "nursing and care staff" category.

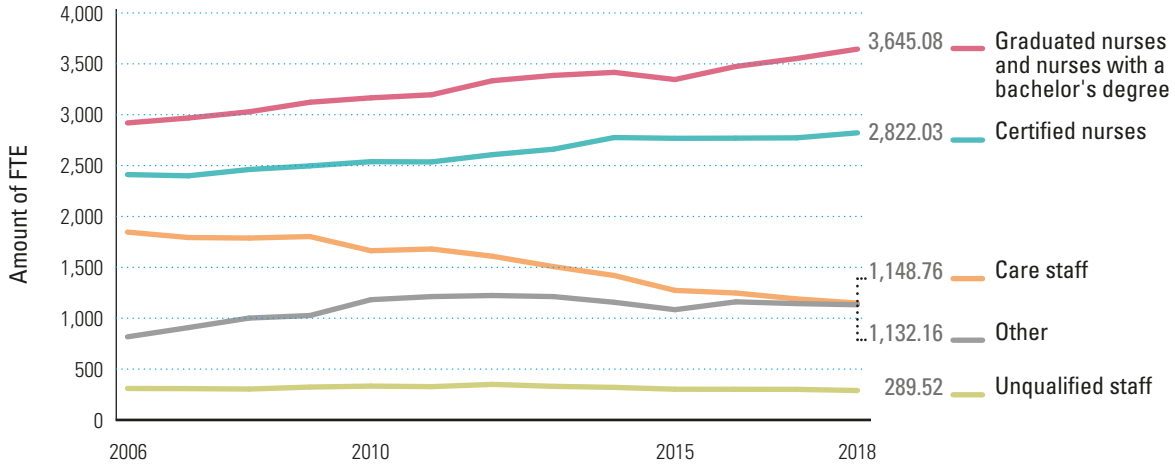
EVOLUTION IN THE NUMBER OF FTE IN PSYCHIATRIC HOSPITALS BY TYPE OF PROFESSION



29 Source: Finhosta, FPS Health, Food Chain Safety and Environment

If we look at the qualification of the nursing and care staff, we find that 71% of them are nurses. We see that the number of healthcare staff is decreasing and the number of graduates or bachelors is increasing.

EVOLUTION IN THE NUMBER OF FTES
OF NURSING AND CARE STAFF



FORENSIC CARE

1. Internment

In 2013, there were 1,169 inmates staying in a Belgian prison. The figure has since fallen to 609.

Internment is a legal security measure ordered by the criminal court for persons with mental illness who have committed a crime but who are deemed by the criminal court judges to have not been in control of their actions, and who also pose a danger to society. This criminal internment measure should not be confused with the civil-law involuntary admission, in which no crime has been committed.

It was standard practice for many years for inmates to stay indefinitely in the psychiatric departments of correctional institutions or even ordinary prisons. Because the care provided in these institutions was inadequate, Belgium was regularly criticised by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. Ultimately, the Belgian State received various convictions from the European Court of Human Rights

> Decrease from **1,169** to 609 **mental detainees** in Belgian prisons **since 2013**

Under this EU pressure, the governments invested in forensic care and, following new investments by the Ministers of Justice and Health, the so-called "Masterplans" came into being.

The 'Masterplan for Internment' focuses on forensic psychiatric care. It states that every inmate has the right to a place in an appropriate structure. As such, investments were made to set up Forensic Psychiatric Centres (FPC). An FPC is responsible for the reception of internees in a forensic care programme implemented in networks. The forensic psychiatric centres cooperate with regular psychiatric hospitals (PH) in this regard.

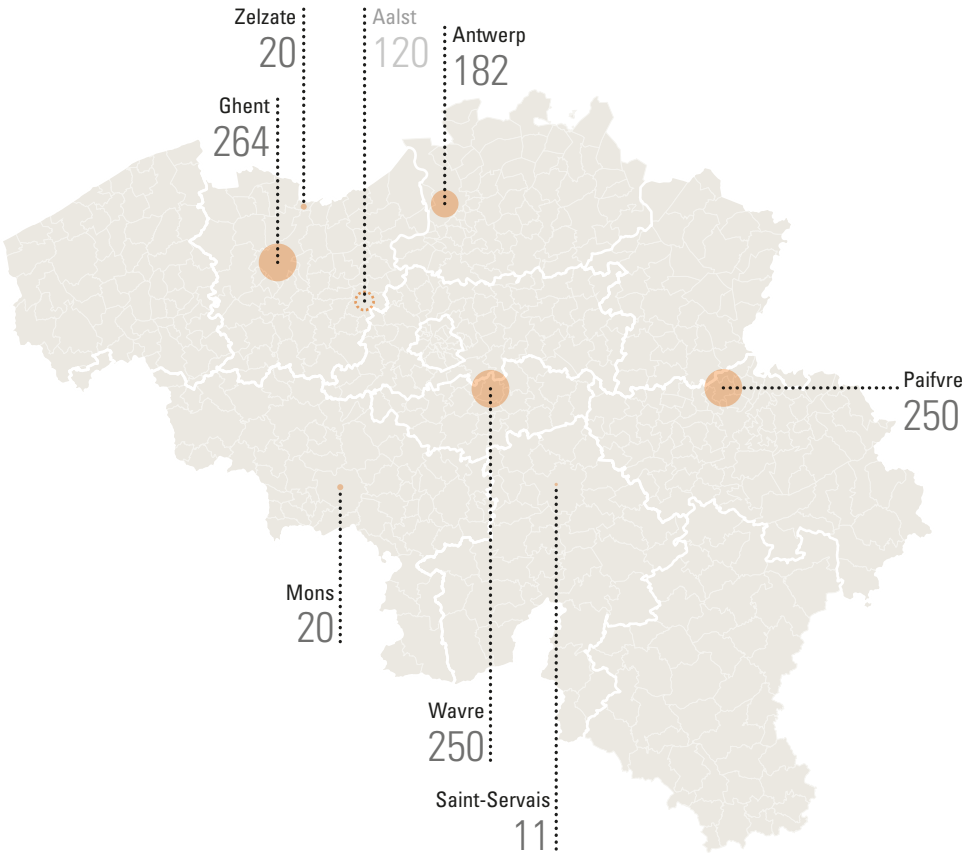
In 2014, the first FPC, which accommodates 264 male patients, became operational in Ghent. Three years later, in 2017, a second FPC opened in Antwerp, where 182 patients can be accommodated, 18 of whom female.

The Walloon region has 2 FPC, one in Paifve and one in Wavre, each with 250 places. Finally, a "Long Stay FPC" is planned in Aalst, which will be able to house 120 inmates.

For women inmates, with both a high-risk[30] and a high-security[31] profile, the special unit Levanta was set up in the psychiatric centre Sint-Jan-Baptist in Zelzate. Levanta has room for 20 women inmates, including 2 crisis beds. The Hôpital Psychiatrique du Beau Vallon in Saint-Servais and Le Chêne aux Haies in Mons, with their special units of 11 and 20 beds respectively, can also take care of such patients.

The other facilities for inmates in the regular PH are generally "Medium Risk / Medium Security". They receive a staff upgrade for taking care of these inmates.

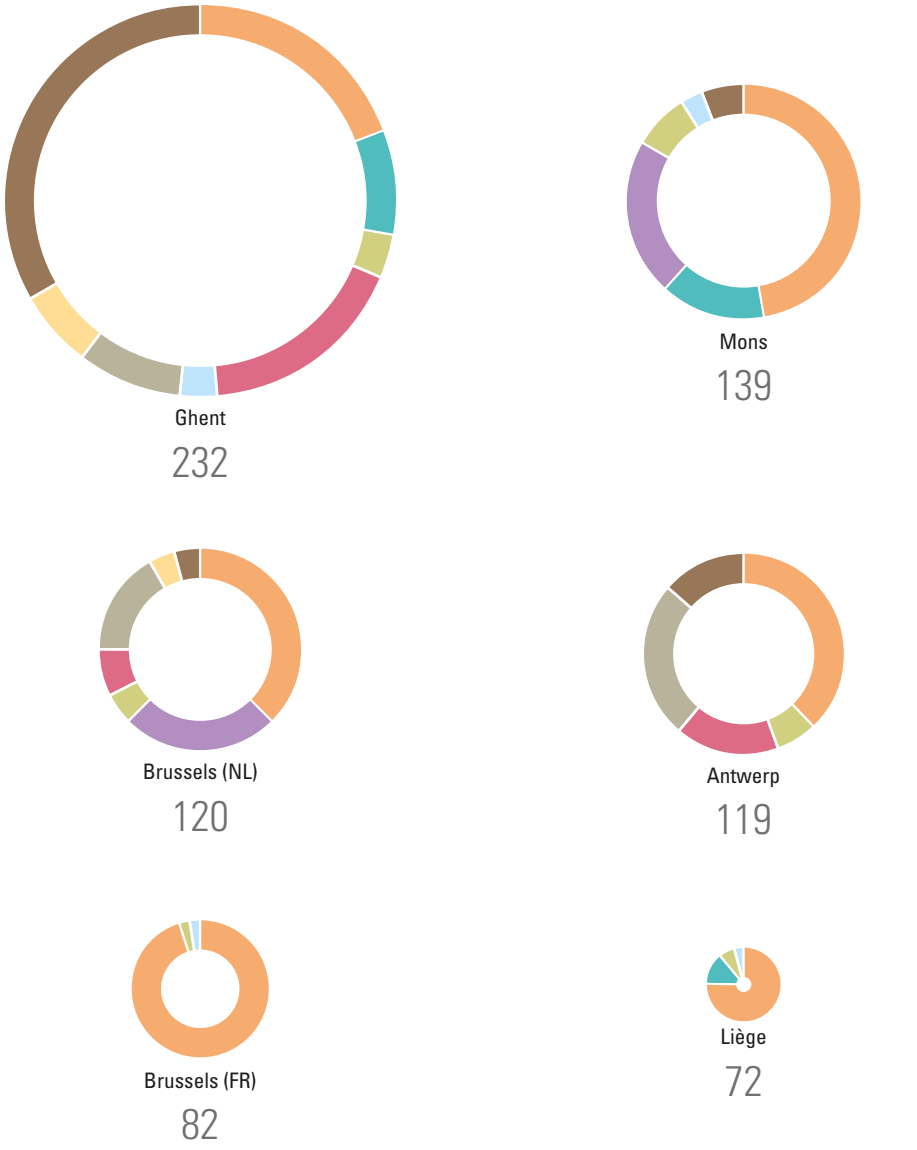
OVERVIEW OF FORENSIC MENTAL HEALTH CARE IN BELGIUM



30 Risk of recidivism

31 Need for security

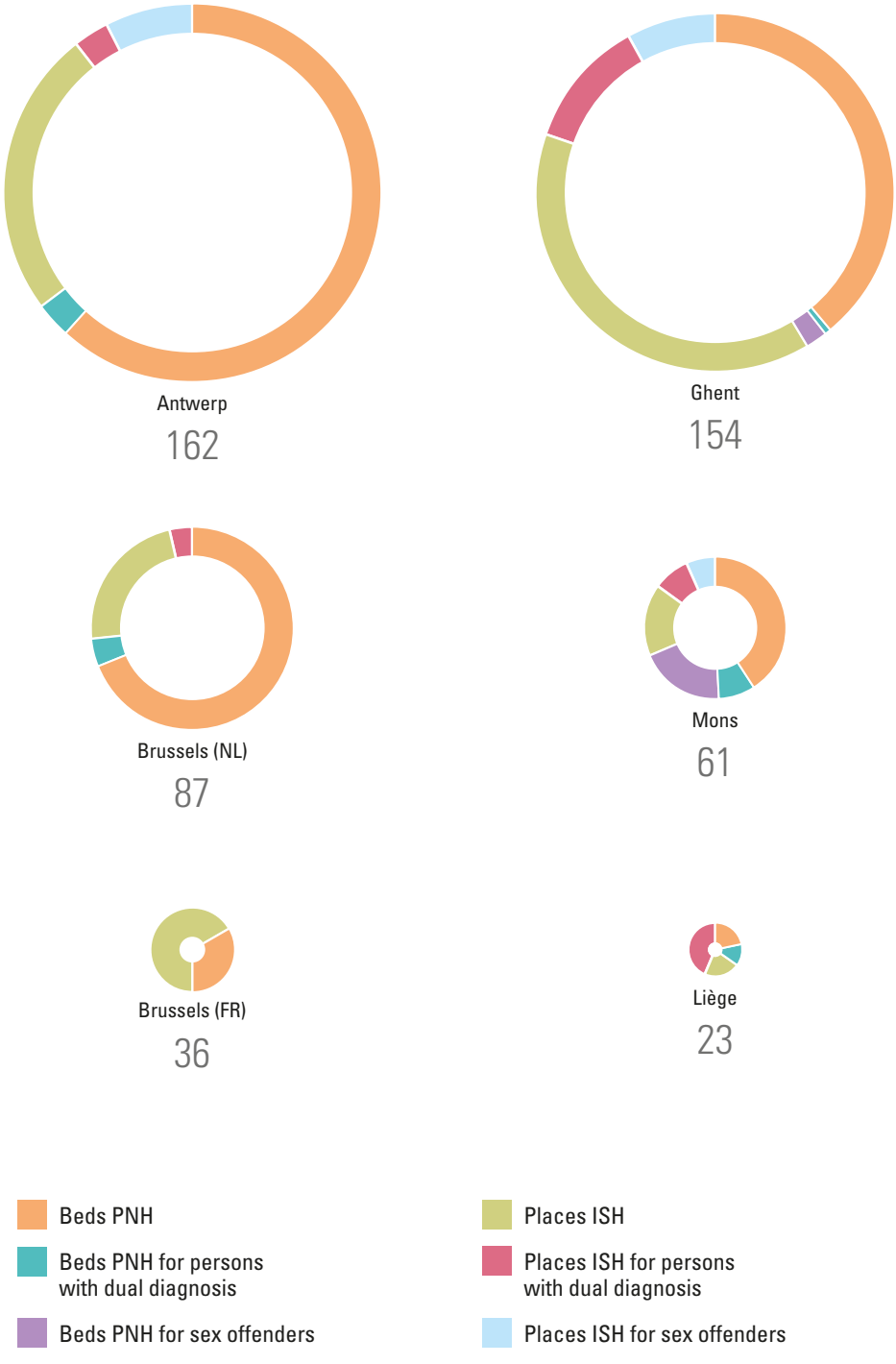
NUMBER OF BEDS IN PH RESERVED FOR A SPECIFIC TARGET GROUP BY COURT OF APPEAL[32]



32 Source: Psycho-social Healthcare Service, FPS Health, Food Chain Safety and Environment

A staff upgrade is also granted in psychiatric nursing homes (PNH) and initiatives for sheltered housing (ISH), for a number of beds or places for the reception of inmates.

NUMBER OF BEDS IN INITIATIVES FOR SHELTERED HOUSING (ISH) AND PSYCHIATRIC NURSING HOMES (PNH) TO ACCOMMODATE INMATES, BY COURT OF APPEAL[33]



33 Source: Psycho-social Healthcare Service, FPS Health, Food Chain Safety and Environment

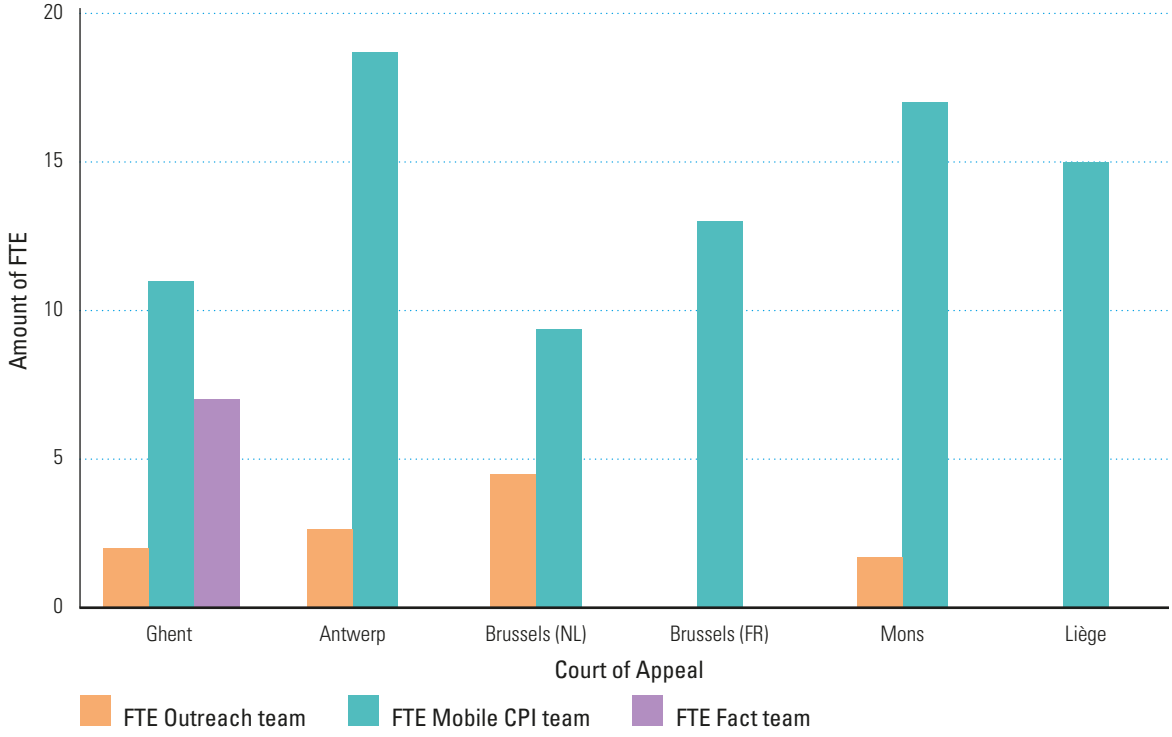
Finally, an outpatient care offering for inmates is being set up:

- **Outreach** is a specific form of extra-mural follow-up and can take place before hospitalisation (psychiatric department of a prison, Institution for the Protection of Society) or after (outpatient care network).

- The **mobile team 'Care programme for inmates'** must guide inmates towards integration in regular care, and draws up a tailor-made care plan for each inmate, in cooperation with the judiciary. The team provides orientation advice, ensures follow-up and gives support to partners in health care, the judiciary, etc. The courts of appeal of Ghent, Antwerp, Brussels (N and F), Mons and Liège have each appointed 1 full-time coordinator.

- A **Fact team (Flexible Assertive Community Treatment)** focuses on people with severe psychiatric disorders and offers treatment and support in various areas of recovery, by reducing psychological and somatic symptoms, promoting social functioning and participation and achieving personal recovery and quality of life.

NUMBER OF FTE IN OUTPATIENT CARE FOR INMATES BY COURT OF APPEAL[34]



Besides care facilities outside prison walls, initiatives have been developed to enhance the quality of care in psychiatric departments of prisons and the internment law has been amended to provide for a more flexible judicial and implementation procedure that better meets the specific care needs of inmates.

34 Source: Psycho-social Healthcare Service, FPS Health, Food Chain Safety and Environment

2. Specialised care for young people with psychiatric problems who are subject to a court order (For K)

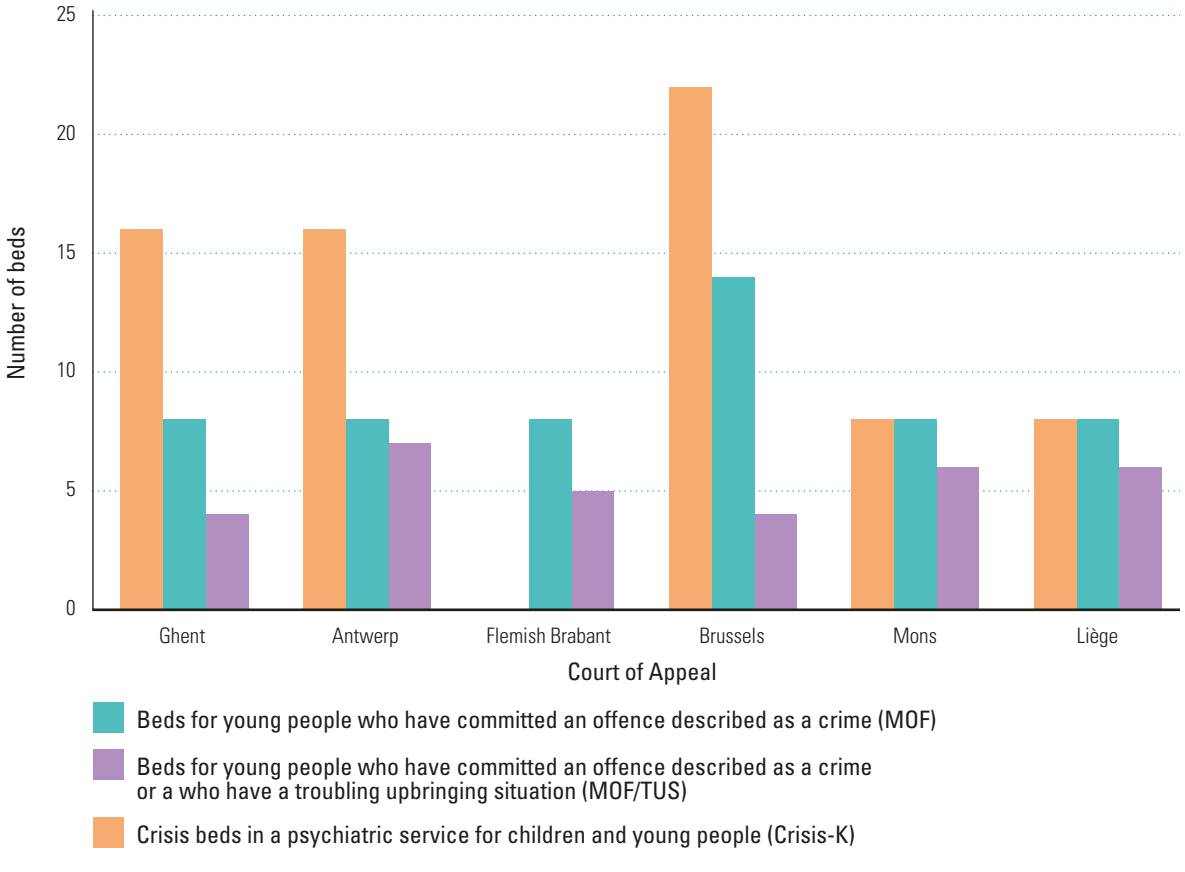
The pilot project "For K" provides, for each Court of Appeal, for the development of a care pathway specifically for young people with psychiatric problems who are subject to a court order.

156 beds for youngsters under judicial control having a psychiatric problem

Intensive treatment units have been set up for young people who have committed an offence described as a crime (MOF in Dutch) or for young people with a troubled upbringing situation (TUS).

Moreover, each project has a number of K-crisis beds that are not counted in the number of recognised K-beds.

NUMBER OF BEDS PER COURT OF APPEAL IN THE CONTEXT OF THE "FOR-K" PROJECT[35]



In Brussels, this provision is complemented by a form of Sheltered Housing (8 places) for young people with psychiatric problems with a court order.

35 Source: Psycho-social Healthcare Service, FPS Health, Food Chain Safety and Environment

CARE FOR ADDICTION

In the chapter "The most common primary diagnosis in PH and PDGH for adults", we already indicated that substance-related disorders (Alcohol, Medication, Drugs) are the main primary diagnosis for patients admitted to PH and PDGH. In addition, drug-related disorders are often listed as secondary diagnoses in other diagnoses. The FPS Public Health has a number of ongoing projects to tackle this problem:

TREATMENT DEMAND INDICATOR (TDI)

TDI is the registration of treatment questions relating to alcohol abuse or dependence on illegal drugs. Every year, around 115 hospitals register 20 epidemiological variables. This mandatory registration (RD 15/10/15) is organised within a European framework (EMCDDA) and is managed by Sciensano. The funding for this was included in the Budget for Financial Resources (BFR).

More information regarding this project:

workspaces.wiv-isp.be

SUBSTANCE ABUSE CRISIS UNITS

Nine crisis units each with 4 beds accommodate patients in crisis for a limited period of 5 days. An intensive and multidisciplinary team (11 FTE) cares for around 3,500 patients annually. A specific feature of this project is that the follow-up is done by case management, and that there is a certain affinity with the target group of patients who use psychoactive substances.

"DRUGS AND DETENTION" PILOT PROJECT

Despite the daily efforts of care providers and the intense efforts of the Judiciary, drug and medication use in Belgian prisons remains high. The situation is not healthy in any sense of the word. Indeed, drug use entails various health risks and can place significant pressure on prison security. According to recent international survey studies, an estimated 20 to 45 percent of all prisoners use illegal drugs in prison, with very similar figures in Belgium.

As such, at the Interministerial Conference on Public Health on 20 November 2017, the Federal Minister of Health proposed the development of an adapted drug assistance model for prisoners. To this end, pilot projects were launched in December 2017 in the prisons of Sint-Gillis/ Berkendael, Hasselt and Lantin. Experience gained on the ground will be used to develop a broad assistance model that includes all steps, from screening and early detection to motivational discussions and treatment.

In each of the three prisons, additional care staff have been recruited and the existing care and prison staff have received additional training, so that prisoners with a drug problem can receive more personalised support. Furthermore, inmates are now systematically screened for drug use upon arrival, so that they can be guided to the right help more quickly if necessary. The relevant care workers inside and outside the prison walls are also in close contact with each other, which helps to ensure the continuity of care.

Three non-profit organisations specialised in drug assistance provide support on the ground: iCare (Sint-Gillis/Berkendael), CAD Limburg (Hasselt) and Fédito Wallonne (Lantin).

BELPEP (BELGIAN PSYCHOTROPICS EXPERTS PLATFORM)

BelPEP is a multidisciplinary platform consisting of 3 expert working groups which aims to promote the rational use of psychotropics in Belgium. A comprehensive vision paper provided an overview of the history, status, context, various problems and priorities of the platform.

More information on the comprehensive vision paper:

www.health.belgium.be

Below is a brief list of some of the actions that have already been taken:

- Various tools have been developed to support professionals in their practice. For example, two websites were set up to collect recent scientific information:
  - A website on the diagnosis and treatment of ADHD (www.trajet-tdah.be)
  - A website related to the proper prescription of sleep medications and sedatives (www.slaapenkalmeermiddelen-hulpmiddelenboek.be).

- Online training (www.e-learninghealth.be) in the LOKs[36] is provided to GPs on the rational use of benzodiazepines, but also on the best ways to manage depression. (https://www.domus-medica.be/vorming for the Dutch-speaking offering, https://dmgulb.be/formation-specifique/ for the French-speaking offering).

36 Local quality group: a group of doctors or pharmacist-biologists who share and critically evaluate their medical practice in order to improve the quality of care.

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HEALTH, FOOD CHAIN SAFETY
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