Key data in healthcare

Mental healthcare

Health
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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

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CONTENT

FOREWORD

Dear Reader,

In this new edition of Key Data in Healthcare, we will provide an update on the topic of 'Mental Healthcare' that was highlighted for the first time in 2021.

The main goal of mental healthcare policy is to provide appropriate counselling, support and/or care to persons with mental and psychiatric problems as soon as possible. Supporting and developing the mental resilience of citizens is a common thread throughout the various forms of counselling and care.

The mental healthcare (MHC) services in our country are very diverse, extensive and complex. There are a wide range welfare and health services that people with mental health problems can access: psychologists, psychiatrists, general practitioners, community health centres, centres for general welfare work, mental healthcare centres, sheltered housing initiatives, psychiatric nursing homes, psychiatric hospitals, psychiatric wards in general hospitals, and so on. Depending on the severity of the problem, people may be referred for more specialised assistance. It has been noted that this referral is not always a smooth process. Fragmented political competences hinder the most optimal organisation of care.

In the past, policies in both acute and more long-term care were based on a strict distinction between different services. This distinction took little account of the actual needs of patients. Based on this observation, the competent authorities chose to develop more community-orientated mental healthcare, based on the needs of persons with mental health problems and starting from their specific living and working environment.

By making all institutions, services and initiatives in the mental healthcare sector work together as effectively as possible in networks and care circuits, the aim is to guarantee a continuous and adapted mental healthcare offering. Demand-driven mental healthcare seeks to avoid residential admissions as much as possible and to keep stays in residential settings as short as possible when admission is unavoidable. In this regard, residential care takes on a more intensive character.

The path of socialising care is being continued and expanded. With this in mind, a protocol agreement on the coordinated approach to strengthening the provision of primary psychological care was concluded during the Interministerial Conference on Public Health (IMC) on December 2 2020. This agreement was mainly about strengthening the supply of care in primary care to provide readily accessible and affordable care. In accordance with the perspective of 'Public mental health', available resources and scientific knowledge, the emphasis is on group care, early intervention, and early detection. The individual with a mental health complaint receives personalised care based on a distributed, integrated, collaborative, proactive and multidisciplinary care offering. Local accessibility of care and to healthcare providers is a central element of this convention.

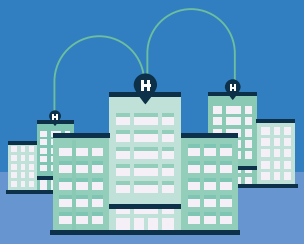
In this updated edition of Key Data, we focus on the one hand on the offering and activity in psychiatric hospitals (PH) and psychiatric departments of general hospitals (PDGH) both for children and adolescents and for adults. We will zoom in further on the organisation regarding the care of patients. A subsequent chapter highlights some mental healthcare reform initiatives. Finally, a number of policy projects are explained that aim to provide specific target groups with tailored care offerings. This includes projects relating to addiction treatment, eating disorders, victims of sexual violence and cross-cultural mediation.

We hope you enjoy reading this new edition.

Sabine Stordeur,

Director-General Healthcare

01 MENTAL HEALTHCARE FOR ADULTS



There are 20 mental health networks for adults.

The number of collocations has increased by 37.4% over the past 10 years.

In 2021, there were almost 120,000 stays for adults in PH and PDGH.

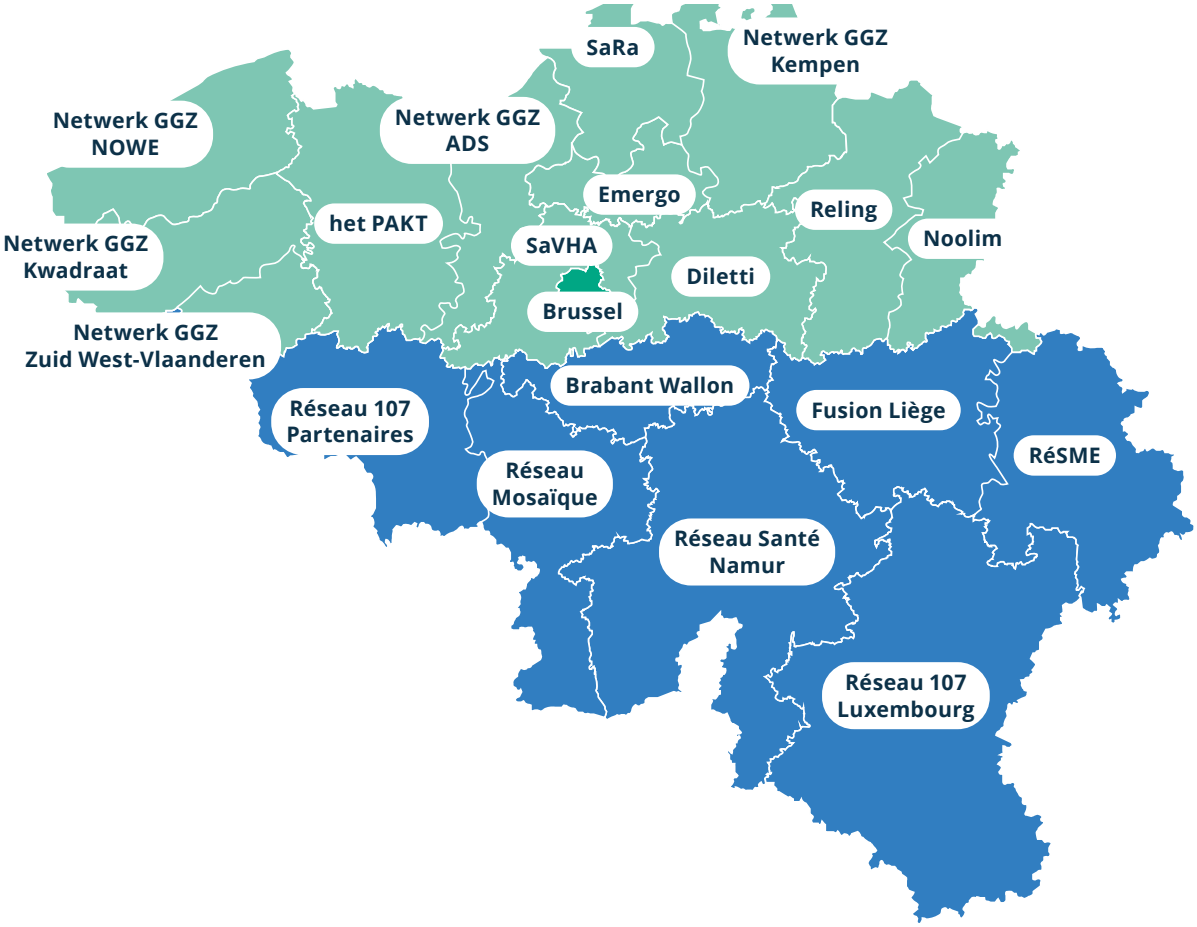
Alcohol, cannabis and heroin are the most common substances among those in treatment for substance use.

Depressive disorders are the most common in PH and PDGH.

MENTAL HEALTHCARE FOR ADULTS

Networks in mental healthcare for adults

With the signing of the 'Guide to Improved Mental Health Care through the Realisation of Care Circles and Care Networks' by all competent Ministers, the Interministerial Conference (IMC) Public Health kicked off the reform of adult mental healthcare in 2010.[1] Various pilot projects were launched in which mental healthcare networks (MHC networks) were set up and systematically expanded. An evaluation was carried out 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.



1 It has already been stated that the care offering for the elderly should be a continuation of the reform for adults and consequently be expressly chosen to be an addendum/an update guide 2.0 to the already existing guide for adults so that it is responsive for all adults.

The new networks expand on 5 functions within an area of operation they define, namely:

1. Mental health promotion, prevention, early detection and intervention
2. Mobile treatment teams

   that travel to the patient's home or elsewhere in the living environment. These teams focus both on persons in a (sub)acute condition and those with previous chronic, psychological or psychiatric problems. A mobile team can also act immediately, providing intensive and on-the-spot care in crisis situations. In other words, the mobile service can provide a complete alternative to hospitalisation in several situations.
3. Psychosocial rehabilitation
4. Teams focused on psychosocial rehabilitation offer programmes aimed at fostering skills to enable someone to function as autonomously as possible in daily life, socially, professionally and culturally.
5. Intensive specialised residential mental health units
6. Specific living arrangements and residence formulas

A policy for working towards a more community-based mental health care was deliberately chosen because it can be seen that home-based care, possibly combined with short intensive residential care, leads to better outcomes for patients and their families.

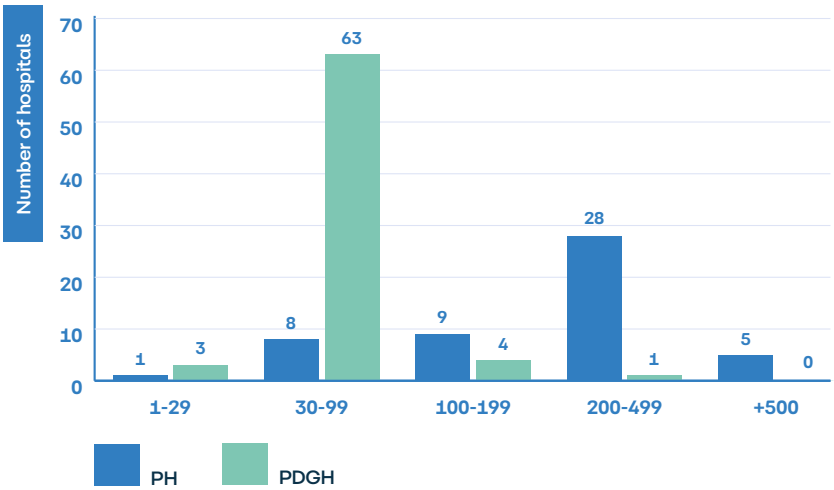
What follows highlights some topics for which the federal government has jurisdiction, whereby we analyse the offer and activity in PH, PDGH, and in relation to internment. Finally, the nature of treatments in the context of substance abuse is discussed.

Learn more?
www.psy107.be

Offer and activity in PH and PDGH for adults

Psychiatric hospitals (PH) and psychiatric departments within general hospitals (PDGH) are part of the mental healthcare networks. The organisation and activity of these institutions is outlined below.

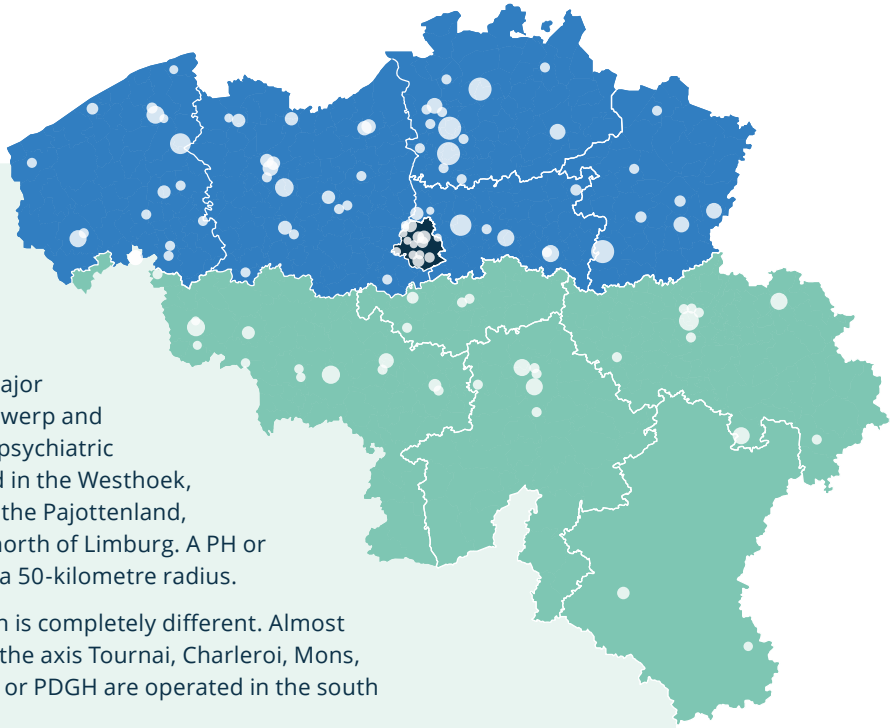
Number of hospitals according to number of accredited beds for adults with psychiatric problems (01/01/2023)



Distribution of hospitals

In Belgium are 71 PDGH and 51 PH serving adults with psychiatric problems.[2] Almost 90% of the PDGH have less than 100 adult beds. In contrast, 80% of the PH have more than 100 beds.

2 Source: FPS Public Health Central Institution File (CIC), situation at 01/01/2023.



The distribution of PH and PDGH for adults is the most balanced in the Flemish Region. We have concentrations around major cities including Ghent, Bruges, Antwerp and Leuven. Meanwhile, the supply of psychiatric services for adults is rather limited in the Westhoek, the Flemish Ardennes followed by the Pajottenland, and the Kempen region, with the north of Limburg. A PH or PDGH can always be found within a 50-kilometre radius.

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. Hardly any PH or PDGH are operated in the south of the country.

Types of beds and places for residential and partial hospitalisation

Psychiatric institutions are often divided into different units according to the therapy or pathology provided. In each unit, a number of accredited beds are available with a specific index reflecting the type of care provided.

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.

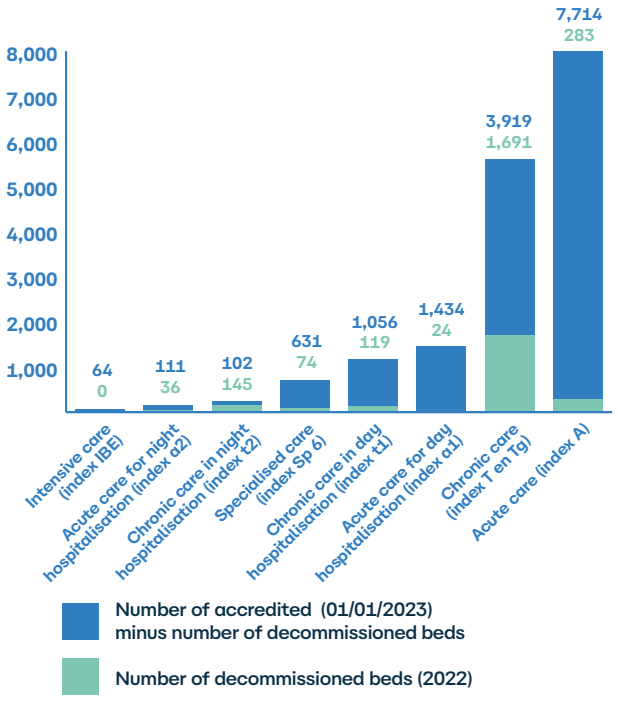
Residential hospitalisation

- Beds for acute care (index A): The neuropsychiatry service for observation and treatment (day and night) of patients aged 15 and over in need of urgent care;
- Beds for chronic care (index T): The neuropsychiatry 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 neuropsychiatric treatment of geriatric patients (index Tg) are included in this category;
- Beds for specialised care (index Sp 6): Specialised service for treatment and rehabilitation for patients with psychogeriatric and chronic conditions;
- Beds for intensive care (index IBE): Intensive treatment unit for adult patients with severe behavioural disorders and/or aggressive adult patients.

Partially hospitalisation

- Places for acute care for day hospitalisation (index a1): the neuropsychiatry service for observation and treatment for day hospitalisation of adult patients in need of urgent care;
- Beds for acute care for night hospitalisation (index a2): the neuropsychiatry service for observation and treatment for night hospitalisation of adult patients in need of urgent care;
- Places for chronic care in day hospitalisation (index t1): the neuropsychiatry service for day hospitalisation for adults with long-term and chronic problems;
- Beds for chronic care in night hospitalisation (index t2): the neuropsychiatry service for night hospitalisation for adults with long-term and chronic problems.

Number of accredited adult beds (01/01/2023) and number of decommissioned beds



17,403 accredited beds and places

On January 1, 2023, there were 17,403 accredited beds and places in psychiatric services for adults in PH and PDGH. Nearly 80% of this supply consists of accredited residential beds for acute and chronic care (A, T and Tg).[3]

A proportion of accredited beds (13.6%) were decommissioned. After all, 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.

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

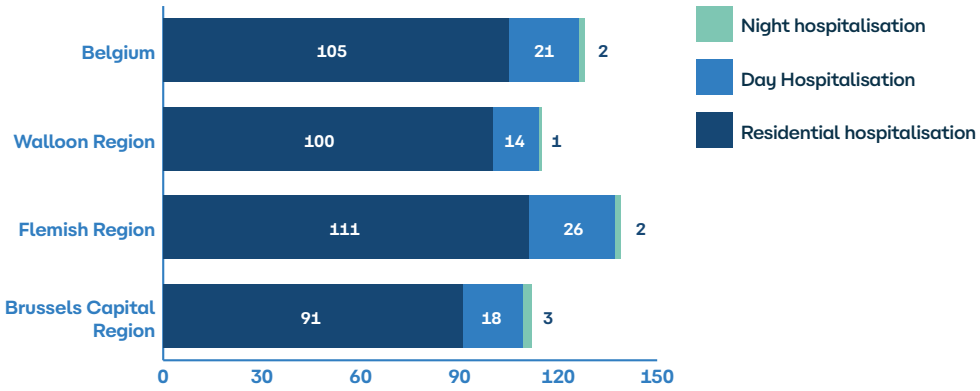
This is possible based on Article 107 of the Hospital Act which states that (translation) "The King may provide for specific funding methods to enable, on an experimental basis and limited in time, the prospective and programme-orientated funding of care circuits and networks". Mental health reform is often referred to as 'Project 107' due to these regulations.

The staff freed up by the decommissioning of the beds can be deployed in alternative forms of care provision. In practice, these are mobile teams for specialised care in the home environment or more staff are deployed to residential care.

The highest proportion of beds were decommissioned from among chronic care beds (58.7% in t2, 30.1% in T and Tg).

Relative to population, the Flemish region has the largest supply of psychiatric care in PH and PDGH with 111 residential care beds, 26 day hospitalisation places and 2 night hospitalisation beds per 100,000 inhabitants, respectively. This equates to a total of 139 beds per 100,000 inhabitants in the Flemish Region.[4] In the Brussels Capital Region and the Walloon Region, the total supply is smaller, with 112 and 115 beds and places per 100,000 inhabitants, respectively.

Number of accredited beds and places minus number of decommissioned beds for adults per 100,000 inhabitants



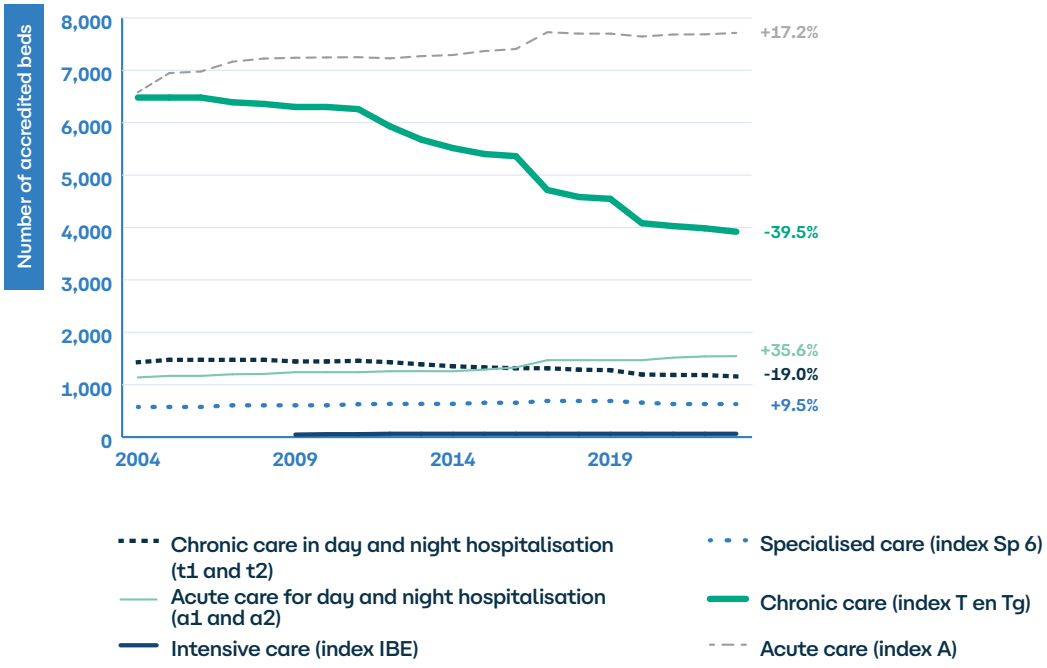
4 Source: STATBEL. Structure of the population, situation at 01/01/2023. Accessed on 01/10/2023, from https://statbel.fgov.be/en/themes/population/structure-population

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 residential, chronic care to beds for acute care. This reflects the efforts made in the context of the reforms to mental healthcare, stipulating that no new beds could be created without phasing out other accredited beds.

We have noted a 6.4% decline in adult psychiatric beds over the past 20 years.[5] The foremost decrease of 39.5% can be seen in chronic care beds (T, Tg). The number of beds and places for chronic day and night hospitalisation also fell sharply (19%). Both decreases arose as a result of both the decommissioning of beds via Section 107 and the disappearance of registration.

In addition, we have seen an increase for both acute and specialised beds (A by 17.2% and S6 by 9.5%). The number of places for acute day and night hospitalisation (a1 and a2) is clearly increasing (+35.6%). In practice, this is reflected in the change in the offering from more chronic care to acute treatment and day therapy.

Evolution in the number of accredited beds and places for adults in PH and PDGH minus number of decommissioned beds



5 This involved deducting the number of decommissioned beds from the number of accredited beds.

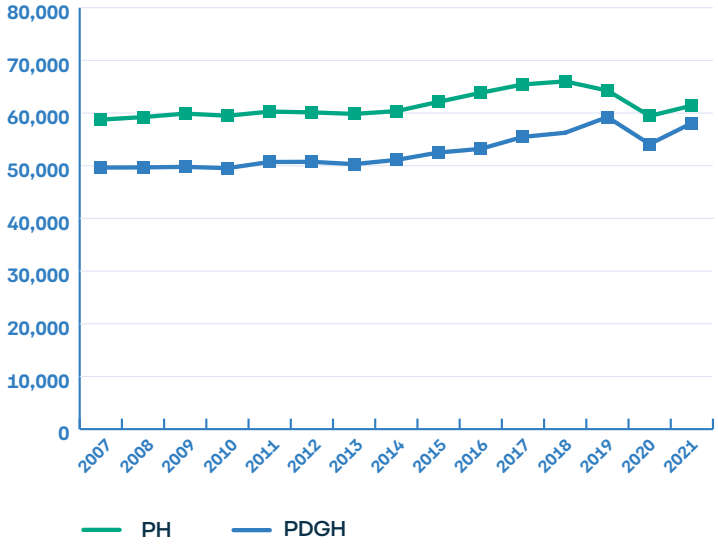
Characteristics of hospital stays

In 2021, a total of 119,501 stays (residential and partial) were accredited in psychiatric services for adults in PH and PDGH.[6] Of these, 61,412 were stays in PH and 58,089 in PDGH. From 2007 to 2019, we observed an increasing trend that was interrupted as a result of the measures taken in the context of the COVID-19 pandemic.

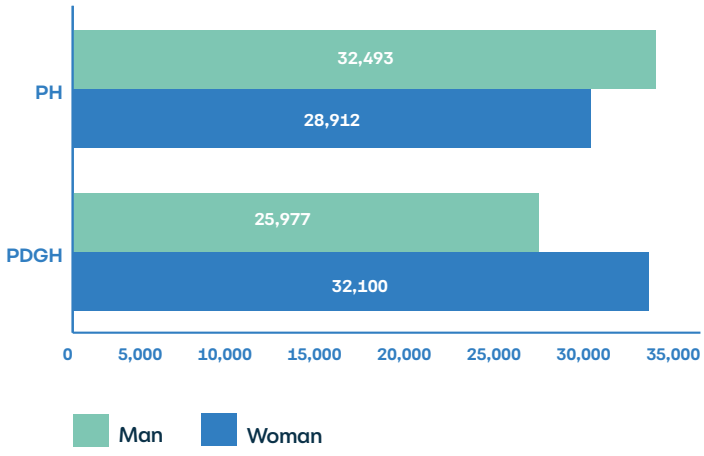
Nevertheless, there is a 4.5% increase in the number of stays in PH and 17.0% in PDGH over the period from 2007 to 2021.

6 Source: FPS Public Health Minimal Psychiatric Data (MPD); This concerned the number of accredited residential and partial stays in beds for adults (all code letters except K, k1, k2, Tf, Tfb, Tfp, Z and VP) in the year in question, regardless of the year of admission and regardless of whether the patient had already been discharged.

Evolution in the number of hospital stays in psychiatric services for adults in PH and PDGH



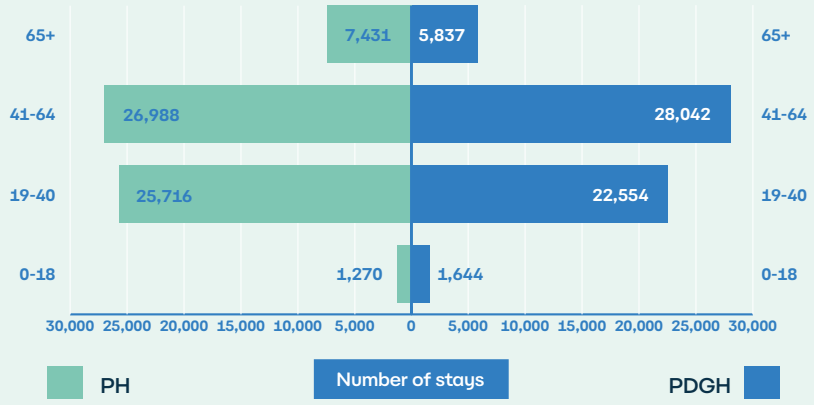
Number of stays of men and women in PH and PDGH in 2021



In 2021, 58,470 men and 61,012 women stayed in PH and PDGH.[7] Therefore, both genders accounted for almost an equal number of stays. We can, 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 that more women are admitted to a PDGH, whereas more men are admitted to a PH.

7 The gender of the patient was unknown for 19 stays in 2021.

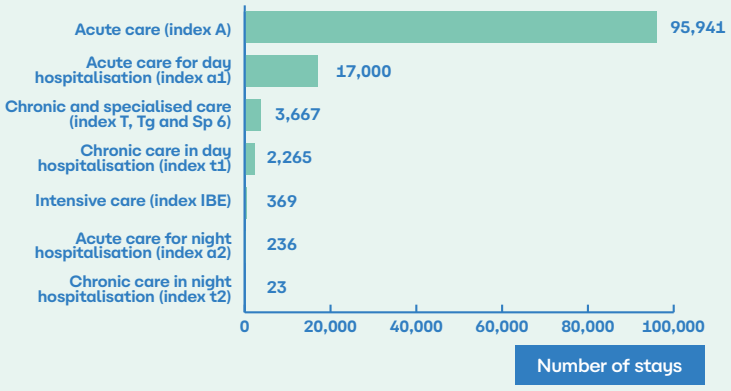
Number of stays by age group in PH and PDGH in 2021



46.06% of stays in adult services in PH and PDGH concern patients between 41 and 64 years old.[8] 40.40% concern patients between 19 and 40 years old. The distribution in PH and PDGH is similar.

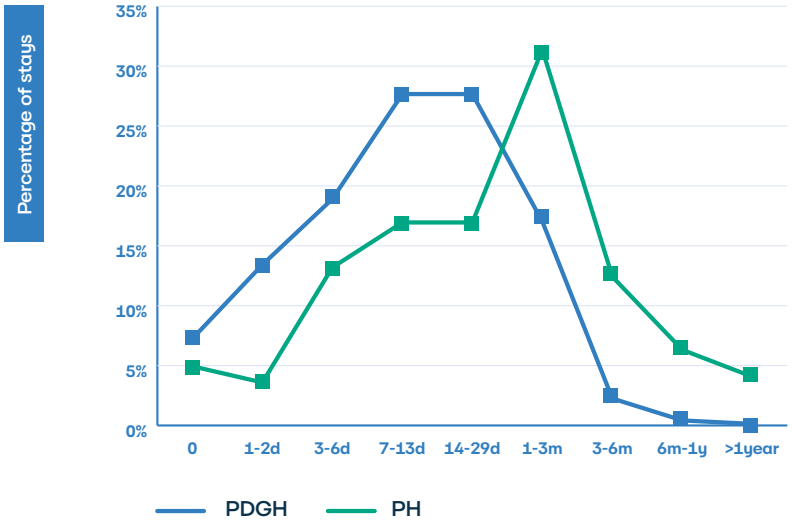
8 For the sake of completeness, the category of 0-18 year olds is also stated. In exceptional cases, children and adolescents may be admitted to a psychiatric service for adults. Furthermore, stays in the 0-18 year old category may be the result of incorrect registration.

Number of stays by type of hospitalisation in 2021



80.2% of stays take place in residential acute care services (A), while 14.2% take place in acute services for day hospitalisation (a1). This figure has doubled over the last 15 years.

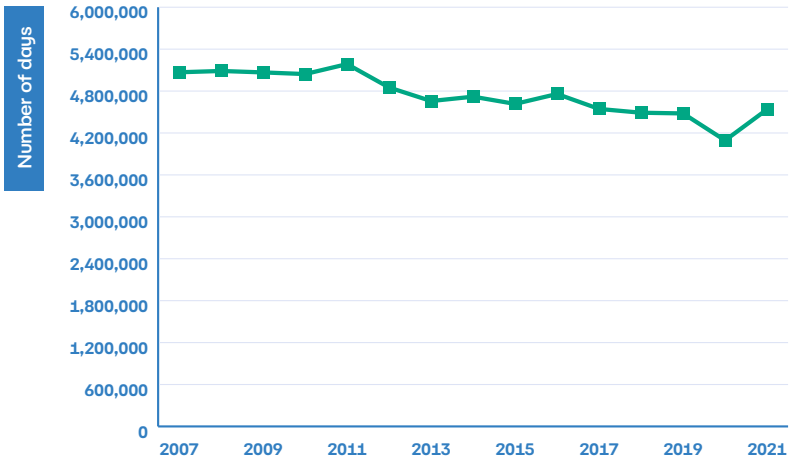
Duration of stay in psychiatric services for adults in PH and PDGH in 2021



A stay in an adult psychiatric service in a PH is generally longer than a stay in a PDGH.[9] Almost 80% of the stays in the latter last less than one month, while one third of the stays in PH last between one and three months.

9 Only partial and residential stays that had ended in 2021 were considered in this calculation.

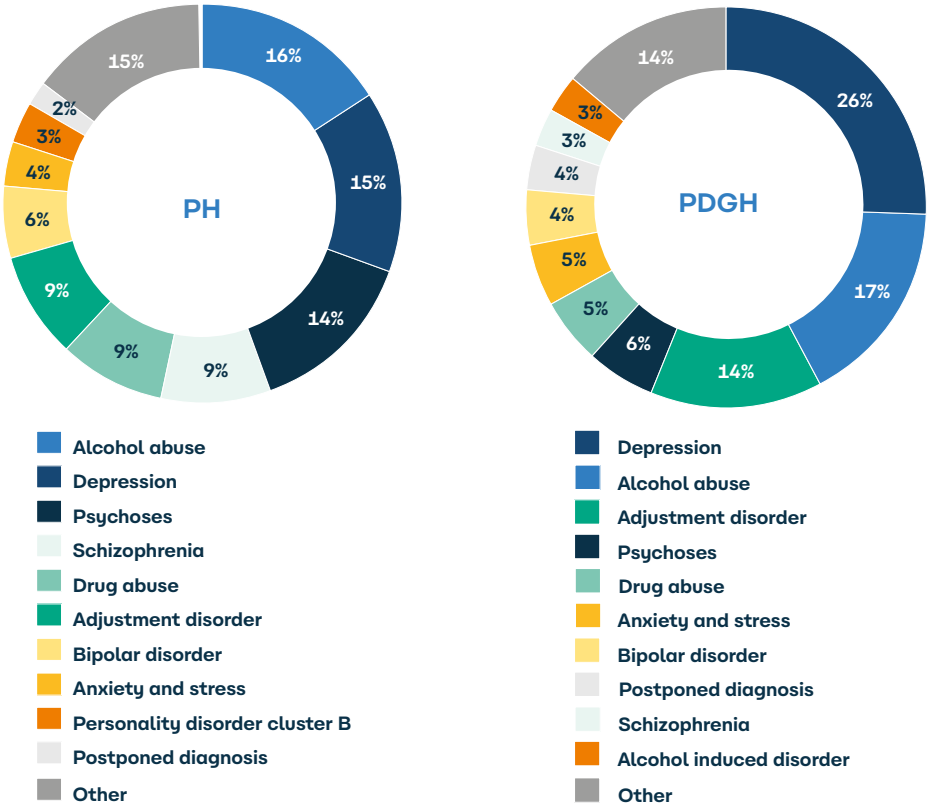
Evolution in the number days spent in PH and PDGH in adult psychiatric services



The number of days of hospitalization in PH and PDGH in adult psychiatric services decreased by 10.5% between 2007 and 2021 from 5,068,824 to 4,537,628 days.

More information about the characteristics of hospital stays:
https://www.health.belgium.be/fr/activite-de-soins-au-sein-des-etablissements-psychiatriques

Top 10 main diagnoses in 2021



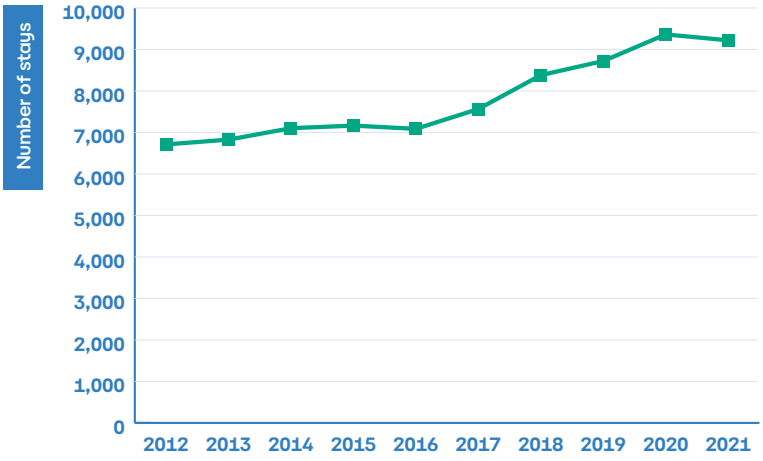
A diagnosis in the event of psychiatric hospitalisation is rarely unequivocal; there is usually a combination of problems. If we take the main diagnoses of patients in PH and PDGH as the basis, we find that depressive disorders were the most common in 2021. Two-thirds of these stays took place in a PDGH. A main diagnosis of problems related to alcohol abuse follows in second place.

More information about diagnoses made during admission to PH or PDGH:
https://www.health.belgium.be/fr/prevalence-des-pathologies-dans-les-etablissements-psychiatriques

Involuntary stays

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.

Evolution in the number of (continued) involuntary stays



The number of involuntary admissions has increased by 37.4% over the past 10 years.[10]

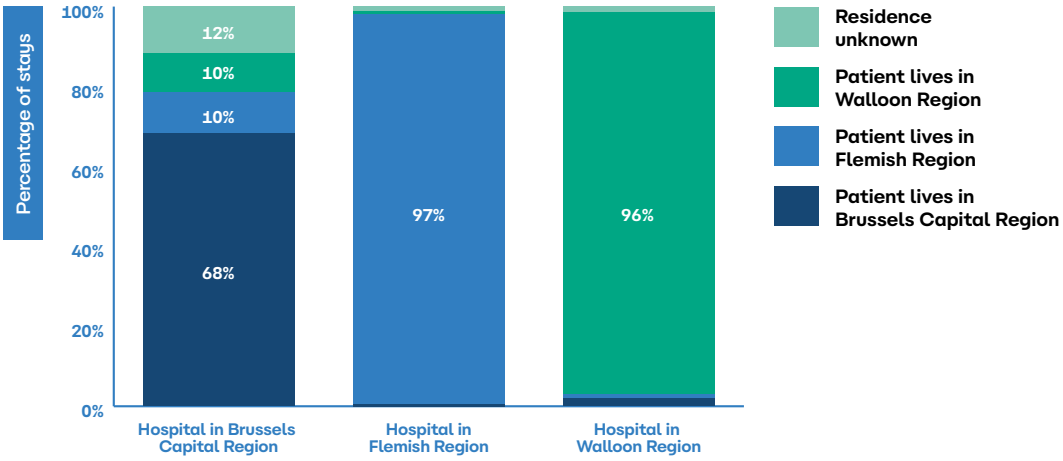
10 Source: FPS Public Health. Minimal psychiatric data (MPD); All new (ended and non-ended) stays for the year in question were selected (year stated = year of admission)

More information about stays in PH and PDGH:
https://www.health.belgium.be/

Patient flows

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 systematically attract a large number of patients from outside their area could have a greater need for hospital beds as a result.

Percentage of patient stays by patients' place of residence and region of hospital in 2021



Most patients are hospitalised in a hospital within their region. In hospitals in the Flemish and Walloon regions, the figures are 97.4% and 95.6%, respectively. In hospitals in the Brussels Capital Region, 10.2% of patients come from the Flemish Region and 10% come from the Walloon Region. The place of residence is unknown for 11.5% of stays.

More information about patient flows:
https://www.health.belgium.be/

Offer and activity regarding internment

Care pathway for internees

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 internment measure under criminal law should not be confused with involuntary admission under civil law, whereby no crime has been committed.

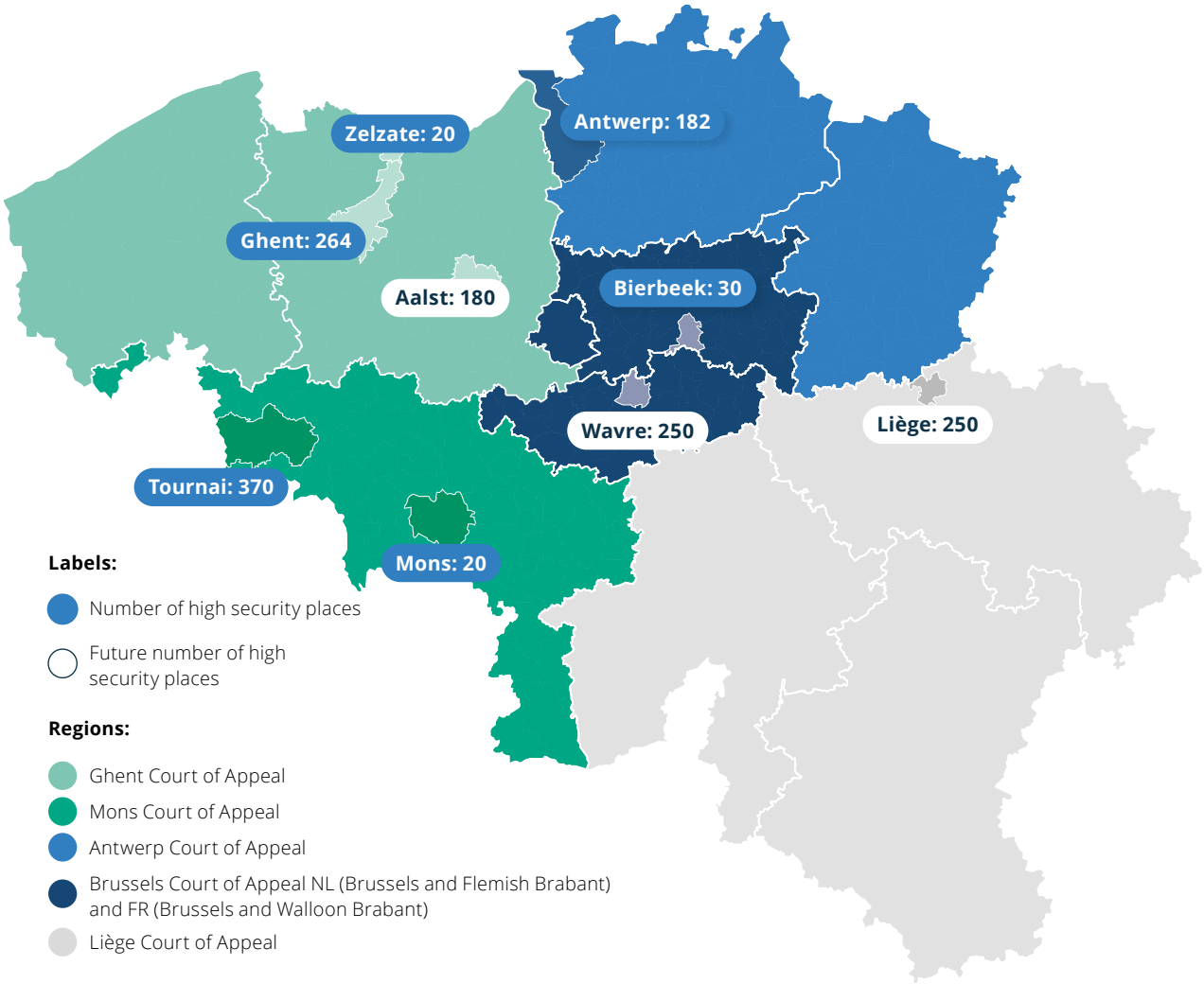
It was standard practice for many years for internees to stay indefinitely in the psychiatric wards or society protection departments of correctional institutions. As the care provided in these institutions was inadequate, Belgium was regularly the subject of criticism by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. Ultimately, the Belgian State had numerous rulings pronounced on it by the European Court of Human Rights.

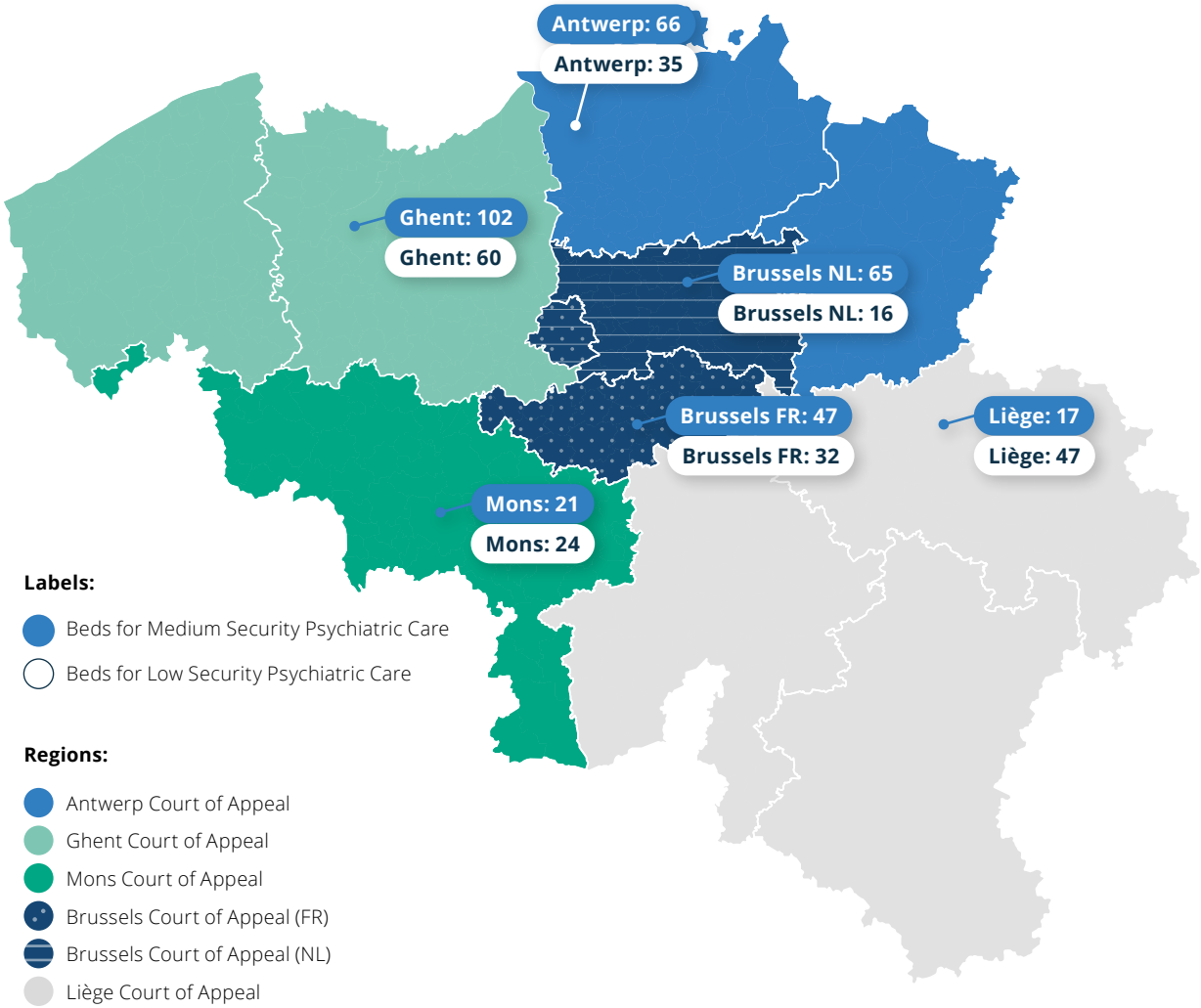
Under this pressure from within Europe, the governments invested in forensic care and the 'Masterplans', as they were known, came into being. The 'Masterplan for Internment' focuses on forensic psychiatric care. This stipulates that every internee is entitled to appropriate care.

As part of mental health reform in 2014, a care pathway was developed for internees thanks to the launch of networks organised by the Court of Appeals (CoA). Network collaboration means that care providers and actors work together to realise personalised care pathways, based on the healthcare needs of patients.

The residential care offering for internees can be broadly divided by security level:

- High security care facilities provide care for internees with high risk profiles and high security needs;
- Medium security facilities/departments provide care for internees with moderate risk profiles and increased security needs;
- Low security facilities provide care for internees with low risk profiles and low security needs.

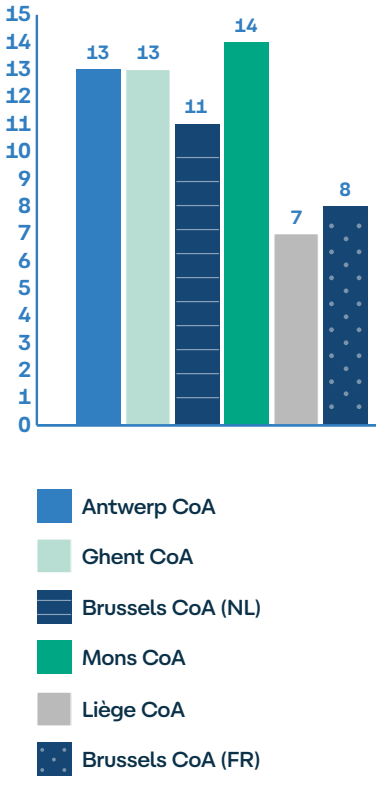




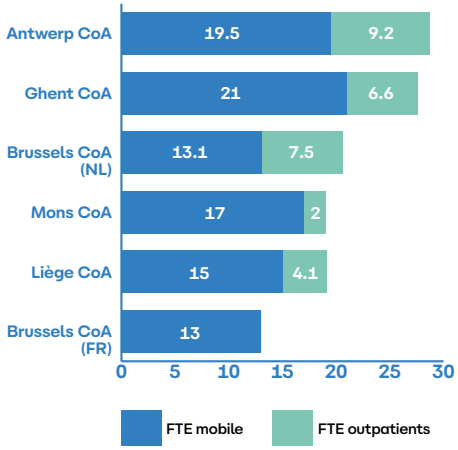
Crisis and time-out initiatives were also launched, and investments were made to expand outpatient and mobile care services and alternative housing specifically for the target group of internees.

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 internees.

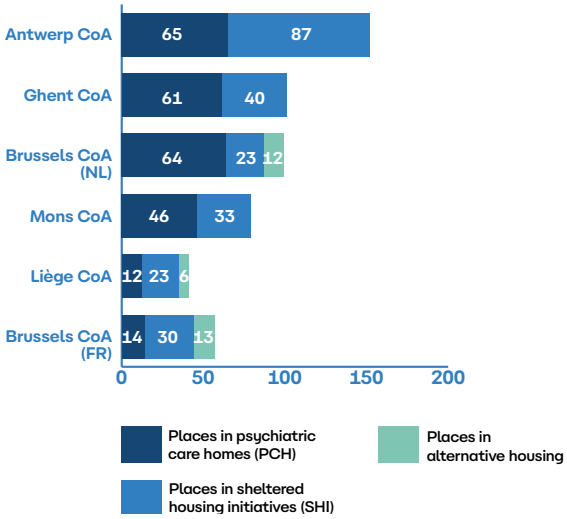
Number of crisis and time-out beds



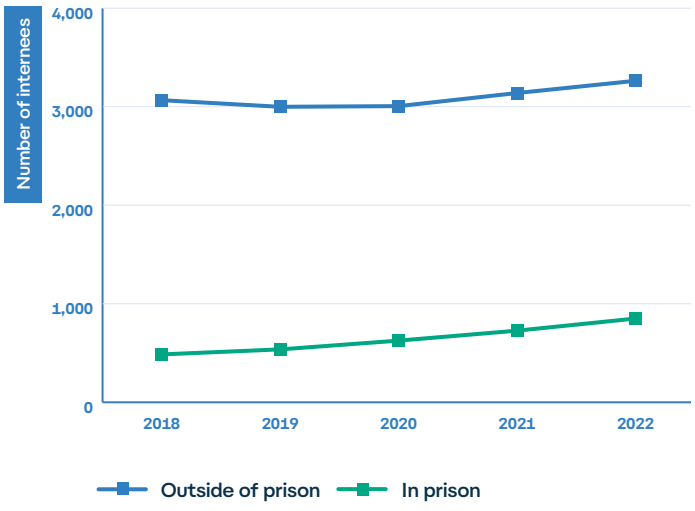
Number of FTE for mobile and outpatient care for internees



Number of places for internees in PCH, SHI and alternative housing



Evolution in number of internees inside and outside prison



An average of 83% of internees stayed in a facility outside prison from 2018 to 2022. This equated to 3,263 people in 2022. Around one fifth of internees were placed in a Belgian prison. This equated to 486 people in 2018. This number rose to 850 by 2022.[11] This increase is mainly due to an increase in orders for internment.

11 Source: Chamber of Society Protection

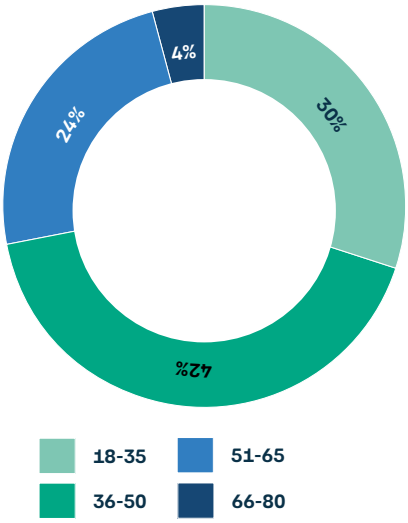
More information:
https://www.internement.be/

Profile of the internees in a FPS health-funded care facility (excluding FPC)[12]

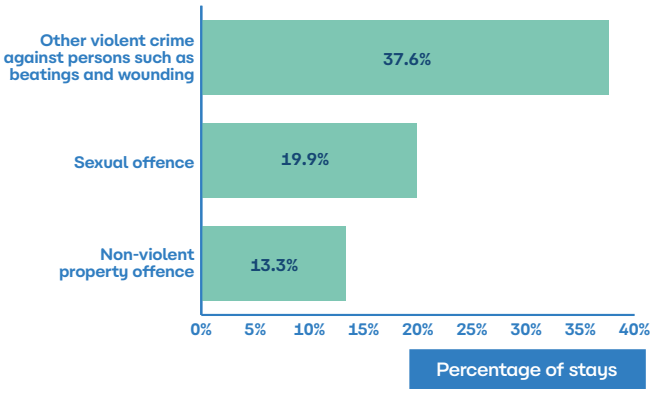
In 2020, there were 2,174 internees receiving treatment/support in a FPS Public Health-funded care service for this target group (excluding care capacity in forensic psychiatric centres (FPC)). These patients are cared for outside prison. The average age was 43.

12 Delannoy, D., Jeandarme, I., Pham, T., Pouls, C. (2023). Onderzoeksrapport Zorgtraject geïnterneerden [Research Report on Care Pathway for Involuntarily Committed Patients – 2020. Gent. Accessed 1 October 2023, from https://www.researchgate.net/publication/362889778_Onderzoeksrapport_Zorgtraject_geinterneerden_-_2018; this refers to in FPS Public Health-funded care capacity (excluding Forensic Psychiatric Centres (FPC))

Percentage of internees by age group

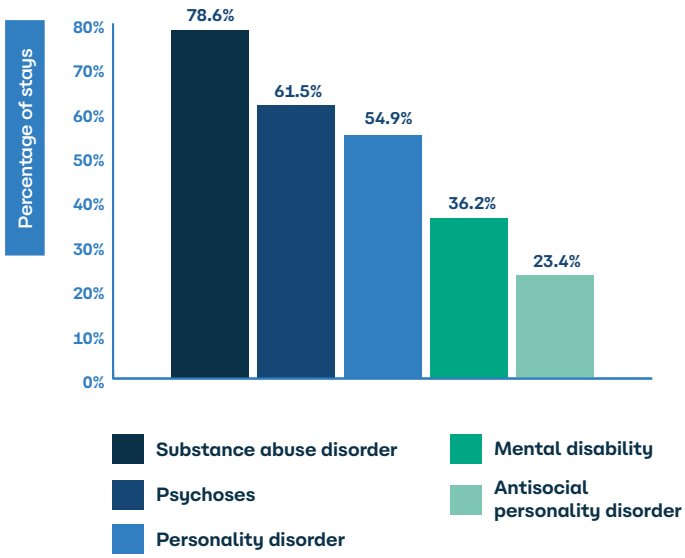


Top 3 most common offences among internees



More than one third of internees committed a violent crime against people, including beatings and wounding and unruly behaviour. Almost 20% committed a sexual offence and 13% were committed for a non-violent property offence.

Top 5 most common diagnoses among internees



More than two thirds (78.6%) of internees had substance abuse problems. Other common diagnoses were psychoses (61.5%) and personality disorders (54.9%).

In addition, over one third of involuntarily committed patients (36.2%) were also diagnosed with a mental disability.

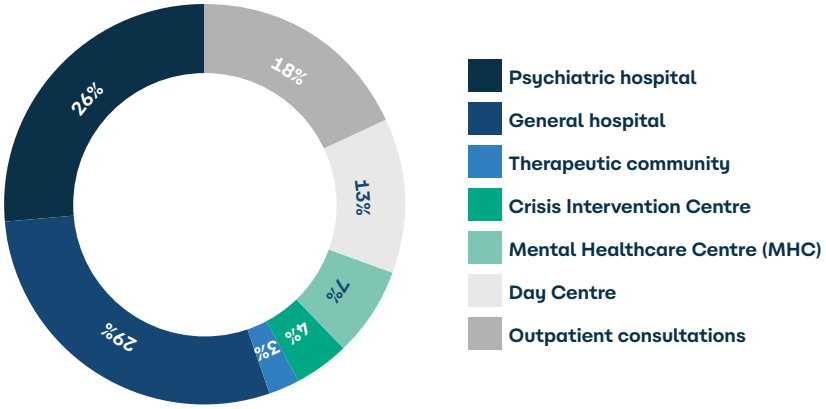
About 80% of the cases involved two or more comorbid disorders.

Treatments for substance abuse

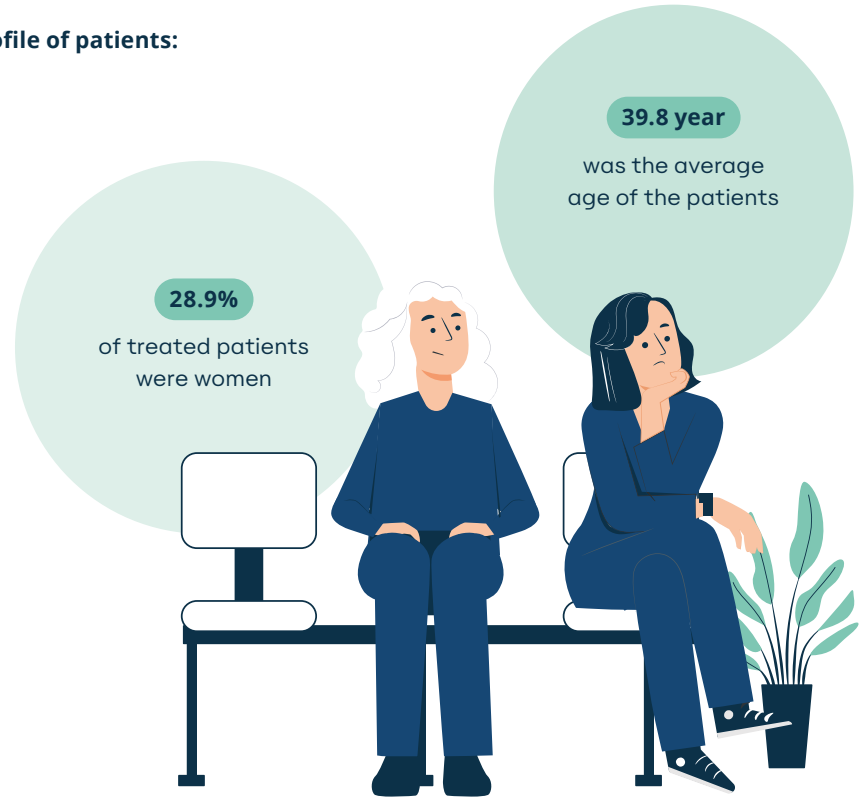
More than 26,000 new treatment episodes aimed at addressing substance abuse were recorded in 2021. This concerns the treatment of approximately 15,000 different individuals.

Two thirds of treatments (62.1%) took place in a residential context such as a psychiatric hospital, general hospital, crisis intervention centre or therapeutic community.

Number of treatment episodes in 2021 by facility type



Profile of patients:



The top three substances reported as the main substance differ according to the type of contact:

RESIDENTIAL

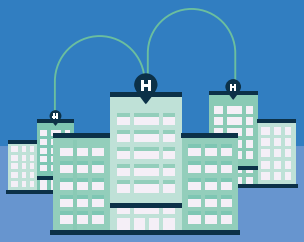
1. 66.8% Alcohol
2. 7.4% Cannabis
3. 5.5% Cocaine

OUTPATIENT

1. 25% Cannabis
2. 23.6% Alcohol
3. 13.1% Heroin

Learn more?
Treatment Demand Indicator Register in Belgium | sciensano.be

02 MENTAL HEALTHCARE FOR CHILDREN AND ADOLESCENTS



11 mental health networks for children and young people

There are 1,345 beds and places in child and adolescent psychiatric services accredited in Belgium on 01/01/2023.

Replace with: The number of stays in child and adolescent psychiatric services in PH and PDGH increased by 50.1% in 15 years.

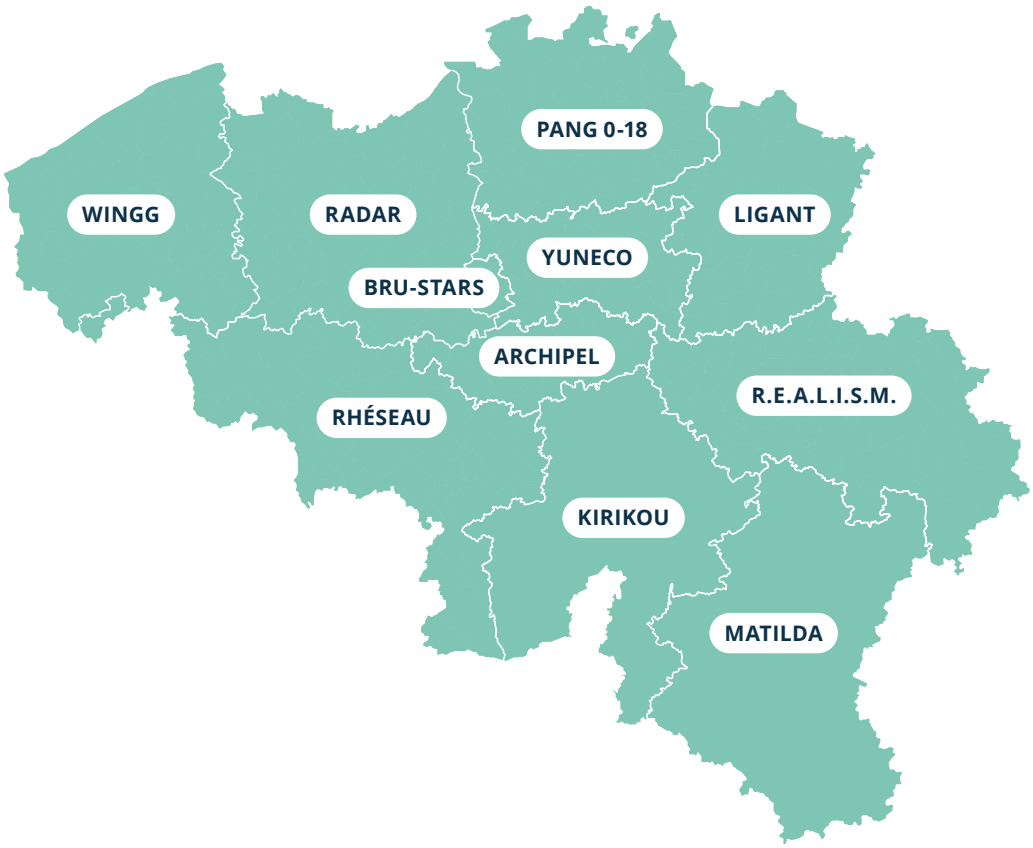
Almost two-thirds of stays in PH and PDGH are 13- to 17-year-olds.

MENTAL HEALTHCARE FOR CHILDREN AND ADOLESCENTS

Networks in mental healthcare for children and adolescents

On March 30 2015, the Interministerial Conference on Public Health (IMC) approved the "Guide to a new mental healthcare policy for children and young people (MHCY)". This drew the outlines of a comprehensive and integrated mental health policy for children and adolescents.

It is a comprehensive policy, on the one hand because it covers health promotion and prevention, to primary care and outpatient care, through to highly specialised residential care, and on the other hand, because it is intended for all children and adolescents aged 0 to 23 years. It is integrated because it seeks the seamless collaboration of facilities and providers from mental health, broader healthcare and societal aspects.



Eleven networks were set up almost immediately under the MHCY Guide, focusing on children, adolescents and young adults. The areas of operation of these networks correspond to the territories of the provinces and the Brussels-Capital Region.[13]

13 In the German-speaking Community, through a specific pilot project, a network is currently being created that will provide follow-up and care for all age-based target groups: children, adolescents, adults and the elderly.

The aim is to respond to the needs of these children and adolescents and their context or environment with the fastest and most continuous care 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 assistance, the MHCY networks are developing a number of programmes and modules funded by the federal government.

More specifically, it concerns:

- **Programmes of crisis care and long-term care** in which places for short-term care and acute treatment of adolescents in a non-life-threatening crisis situation with associated case management are provided in addition to a mobile offering.
- There is also investment in expertise and knowledge exchange between all actors involved regarding:
  - individual children, adolescents and their context;
  - specific sub-target groups of adolescents
  - concerning all children and adolescents within the MHCY area of operation.
- We can then consider this to be an **intersectoral consult and liaison programme and learning networks**.
- In addition, **dual diagnosis modules** are being established in which customised care pathways are provided for children with intellectual disabilities combined with psychological problems, including crisis offerings and time-out options.

In addition, child and adolescent psychiatric hospital services, as well as forensic psychiatric units for adolescents, have also been **strengthened with the addition of more staff**. They not only contribute to the optimal operation of those services but also provide 'bridging functions' of care delivery and care transmission. This means that young patients are supervised even before their admission to a psychiatric hospital service and their departure is prepared from the start of admission.

To curb patient flow to these services, **liaison teams** are also deployed. They consist of psychiatrists, psychologists and psychiatric nurses, and provide counselling and care in non-psychiatric hospital services, e.g. paediatrics and emergency departments. They also provide support to caregivers in these non-psychiatric hospital services.

The MHCY networks are also given the means to realise **innovative projects** within cross-programme sites, ranging from additional forms of liaison where teams with psychiatric expertise provide care in non-psychiatric hospital services to the creation of pilot projects for adolescents in transition up to age 23.

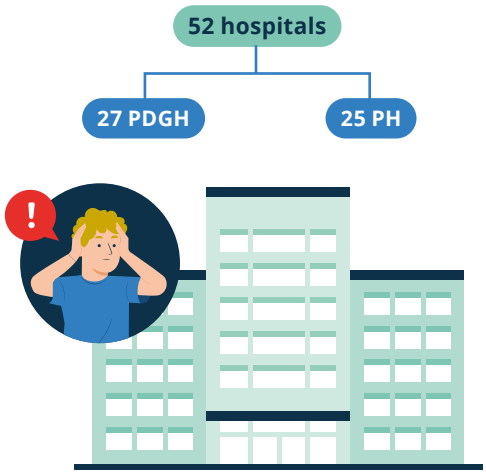
More than 700 additional FTEs are being made available to the networks in order to realise all of these programmes, modules and projects.

Finally, the MHCY networks are driving the expansion of psychological care offerings in primary care for children and adolescents (see below).

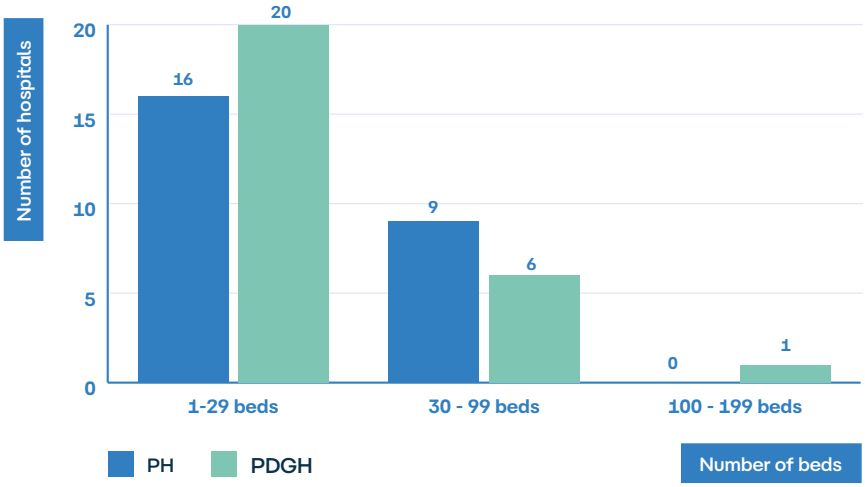
Offer and activity in PH and PDGH for children and adolescents

Distribution of hospitals

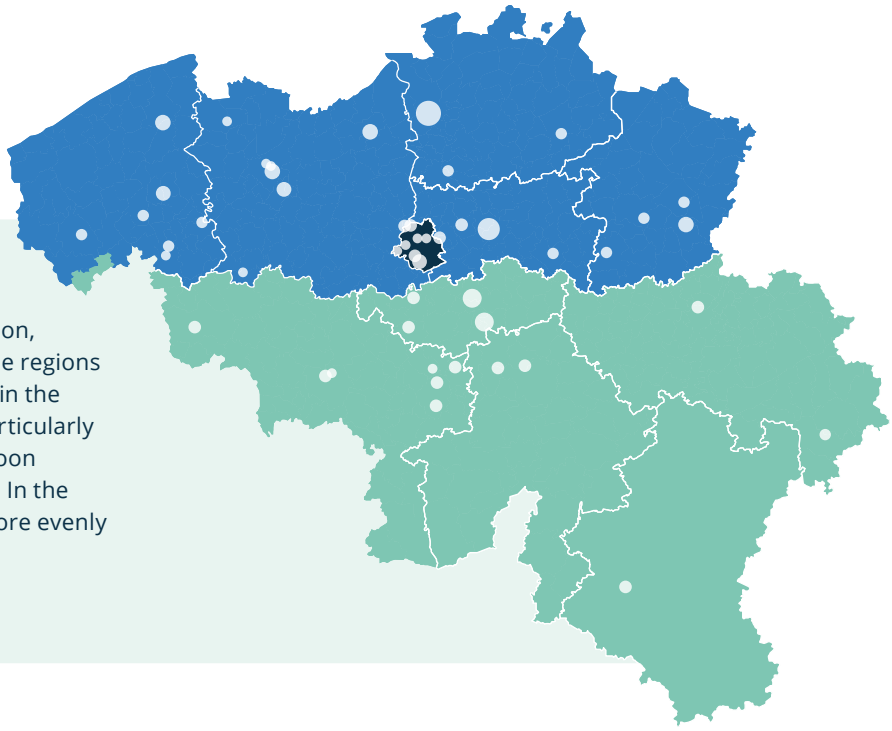
A total of 52 hospitals, including 27 general hospitals with a psychiatric department (PDGH) and 25 psychiatric hospitals (PH) have a child and adolescent psychiatry service.



Number of hospitals according to number of accredited beds or places for adults with psychiatric problems 01/01/2023

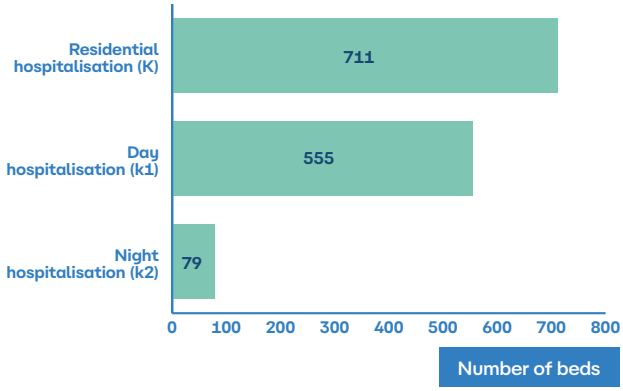


The number of beds or places in these services is usually more limited compared with the services for adults. Notwithstanding the above, there is 1 PDGH with more than 100 beds or places. In contrast to the services for adults, psychiatric services for children and adolescents within PDGH and PH have a better balance in terms of the distribution of bed capacity.



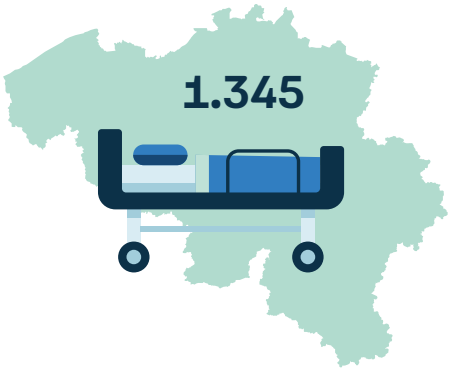
In terms of geographical distribution, the concentration of services in the regions around Charleroi and Namur and in the province of Walloon Brabant is particularly striking, while the rest of the Walloon Region has a very limited offering. In the Flemish Region, supply is again more evenly distributed.

Number of accredited beds and places in child and adolescent psychiatric services on 01/01/2023

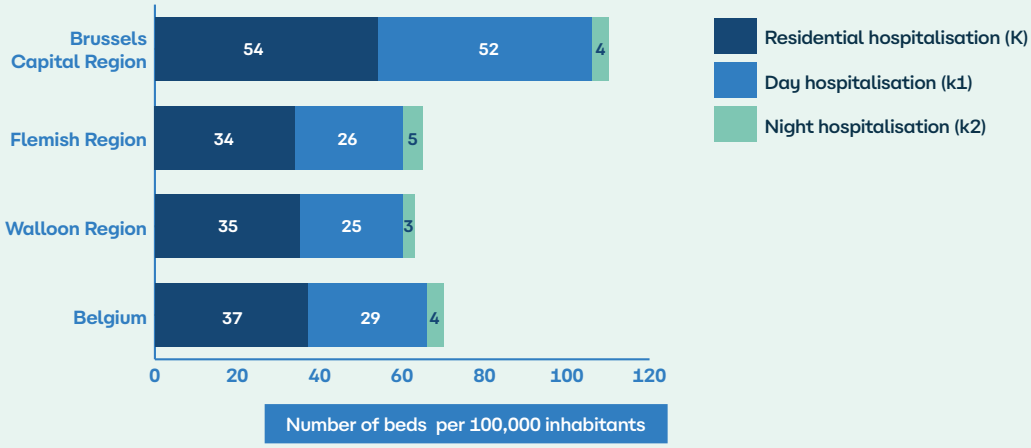


Types of beds and places for residential and partial hospitalisation

There were 1,345 beds and places in child and adolescent psychiatric services recognized in Belgium on 01/01/2023. This includes 711 beds for residential hospitalisation (index K), 555 places for day hospitalisation (index k1) and 79 beds for night hospitalisation (index k2).



Number of accredited beds and places for children and young people per 100,000 inhabitants



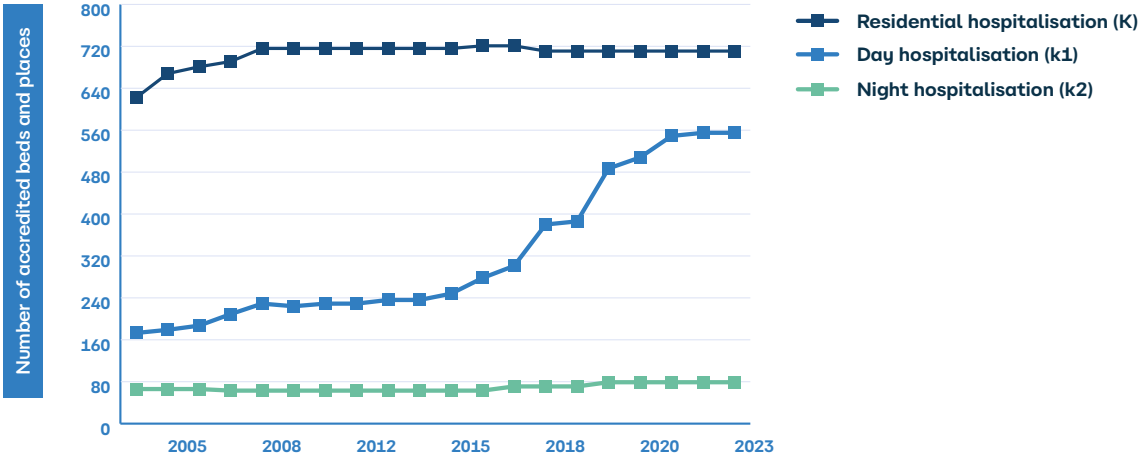
The Brussels Capital Region, with 110 beds, has the most accredited beds per 100,000 inhabitants.[14] In the Flemish Region, 65 beds and places are accredited per 100,000 inhabitants, while this figure is 63 beds for the Walloon Region.

14 Source: STATBEL. Structure of the population, situation at 01/01/2023. Accessed on 01/10/2023, from https://statbel.fgov.be/fr/themes/population/structure-de-la-population; only the number of inhabitants below the age of 15 were taken into account.

The number of places for day hospitalisation (k1) for children and adolescents has tripled from 173 to 555 in the last 20 years. The number of accredited residential beds (K) and night hospitalisation beds (k2) remained stable.

Considered separately of political decisions in the past, this trend may indicate an increased need of care for children and adolescents with mental health problems, and especially a need for forms of (short-term) admission that are less severe than full hospitalisation. An adaptation of the programming standard would therefore not appear to be unjustified. Care for adolescents in particular merits special attention. However, under the current regulations, adolescents from the age of 15 can be admitted to adult psychiatric services in hospital. Even so, this target group is so specific that a solution within child and adolescent psychiatry should be prioritised. Experts recognise a transition age that can last up to the age of 23. However, for the purpose of designing programmes, only the number of children up to the age of 14 is taken into account.

Evolution in the total number of beds and places for children and adolescents

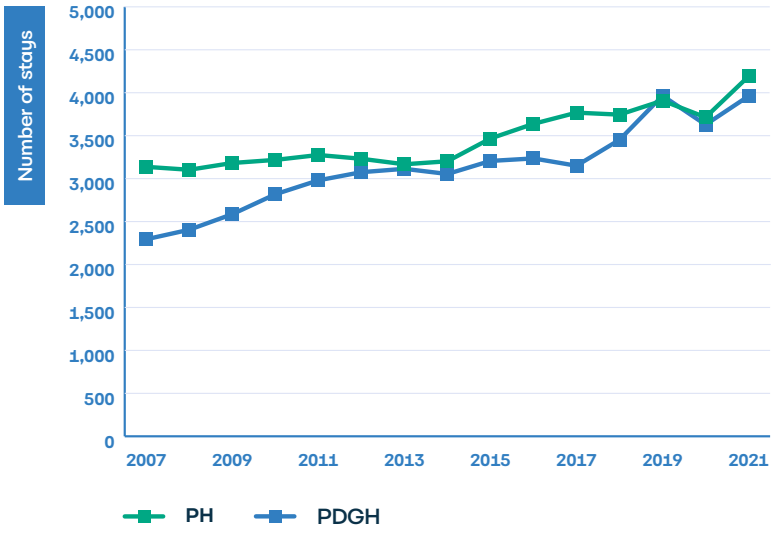


Characteristics of hospital stays

In 2021, there were 8,152 stays in PH and PDGH in child and adolescent psychiatric services.[15] The stays are evenly distributed across the institutions. The number of stays increased by 50.1% from 2007 to 2021. The largest increase was observed in PDGH (72.7% vs 33.6% in PH). We noted a decrease in the number of stays in 2020 due to the measures taken in the context of the COVID-19 pandemic.

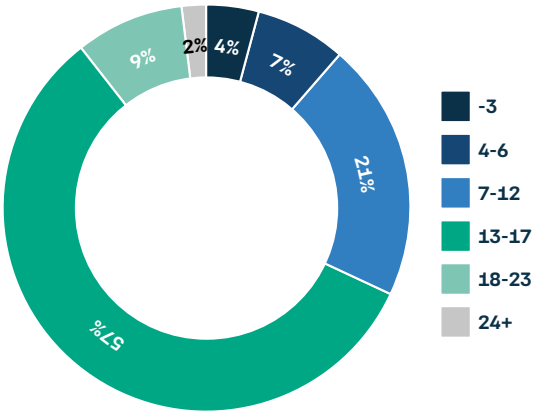
15 Source: FPS Public Health, Minimal Psychiatric Data (MPD). This is the number of accredited residential and partial stays in beds for children (index K, k1, k2) in the relevant year, regardless of the year of admission and regardless of whether the patient had already been discharged.

Evolution in the number of hospital stays in psychiatric services for children and young people in PH and PDGH

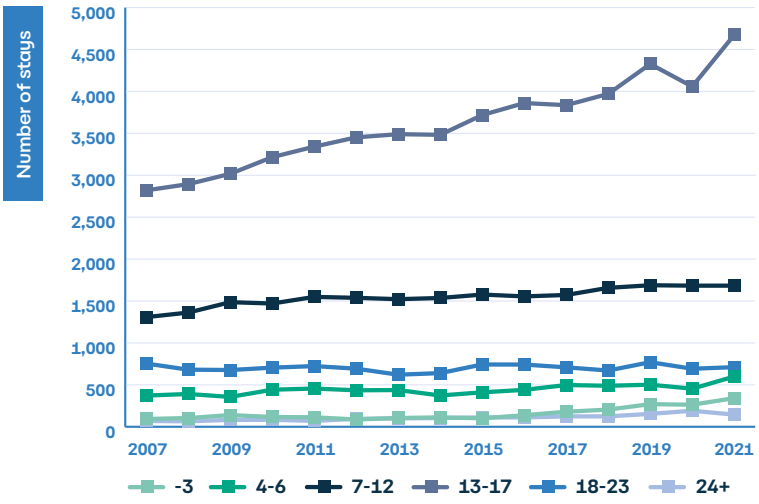


57% of patients in child and adolescent psychiatric care in PH and PDGH in 2021 were female. More than half of the stays in these services were in the 13–17 age group (57%). Although adolescents older than 15 years can be admitted to adult psychiatry, a service for children and adolescents (K, k1 or k2) is still often preferred. In certain cases, a patient can still be admitted to a psychiatric service for children and adolescents even after their 18th birthday (11%). It is assumed that this transition age may continue to 23 years old. Nevertheless, in 2021, we still observe 145 stays by people older than 24 years (2%).

Number of stays in child and adolescent psychiatry services by age group in 2021

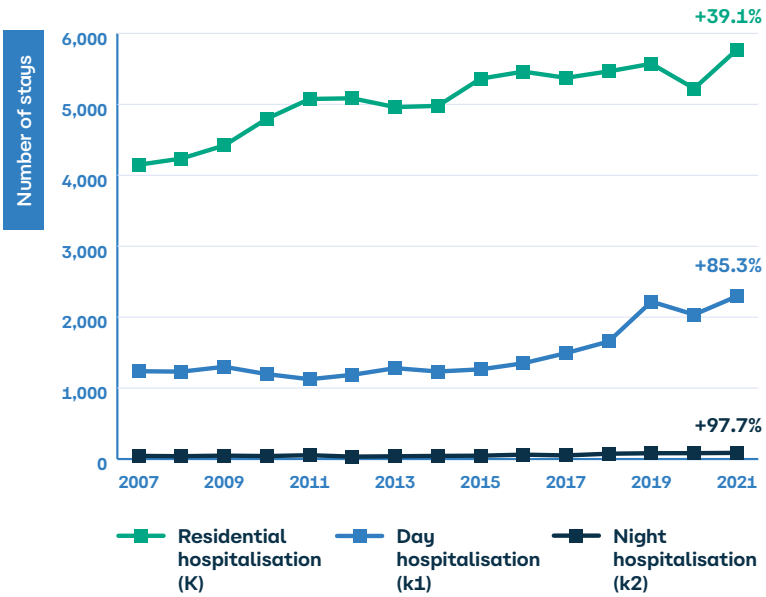


Evolution in the number of stays in child and adolescent psychiatry services by age group



In the period from 2007 to 2021, we see that the number of stays by children aged 0 to 3 tripled. The stays by children and adolescents in the 13-17 age group increased by more than half. The number of 18 to 23-year-olds staying in child and adolescent psychiatric services decreased by 5.7%.

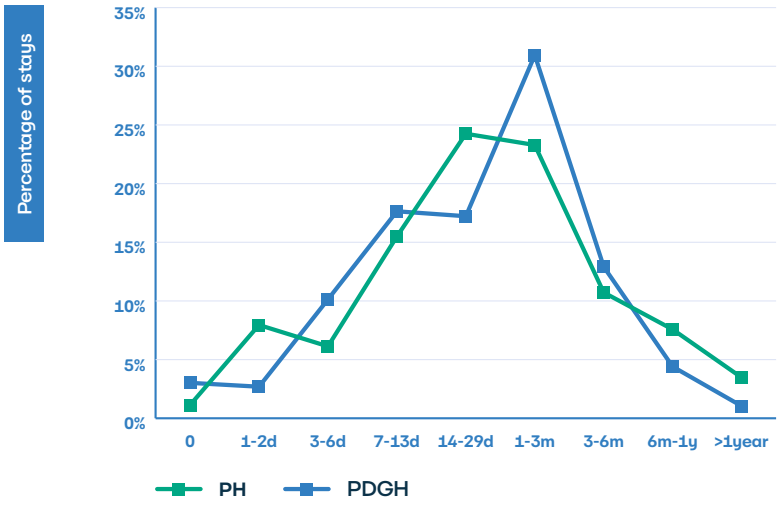
Evolution in the number of stays in PH and PDGH by type of hospitalisation



The last 15 years have seen an increase in all forms of stays in child and adolescent psychiatric hospital services. We have observed an increase of 39.1% in the number of residential stays and almost a doubling in the number of day hospitalisations (k1), where the child or adolescent stays at home at night and on weekends.

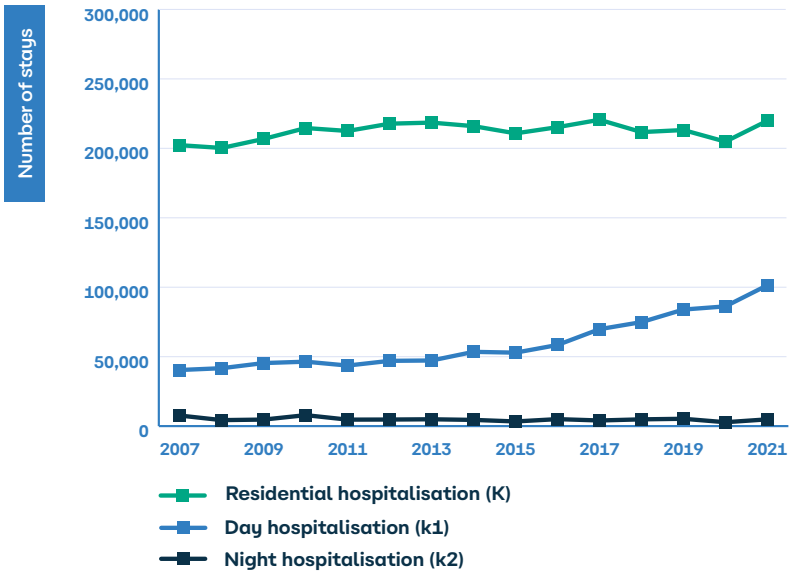
There are few stays (87 in 2021) in which the child or adolescent stays in the hospital only in the evening and at night (k2).

Duration of stay in psychiatric services for children and adolescents in PH and PDGH in 2021



Around 80% of stays in a child and adolescent psychiatric service in PH and PDGH last less than 3 months.

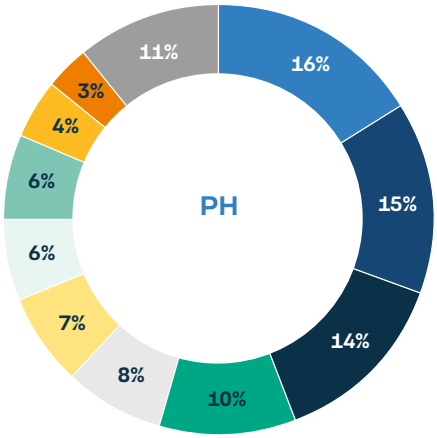
Duration of stay in psychiatric services for children and adults in PH and PDGH in 2021



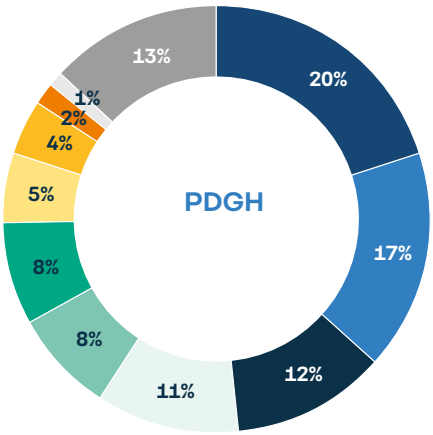
From 2007 to 2021, we saw an increase in the total number of inpatient days for residential hospitalisation (8.7%). For day hospitalisation, the number of stays more than doubled (151%). Due to increased pressures in child and adolescent psychiatric services, it was decided in 2021 to increase staffing levels for these services and to create liaison teams to supervise and treat adolescents with mental health problems admitted to non-psychiatric hospital services.

Based on the primary diagnosis given to patients in PH and PDGH in the psychiatric wards for children and adolescents, we can see the following top 3 diagnoses in 2021: adjustment disorders, autism spectrum disorder and depressive disorders. Stays with one of these 3 main diagnoses represent 44.3% and 48.5% of all stays in PH and PDGH, respectively.

Top 10 main diagnoses in 2021



- Autism
- Adjustment disorder
- Depression
- Postponed diagnosis
- Developmental disorder
- Relationship disorder
- Attention/behavior disorder
- Anxiety and stress
- Eating disorder
- Psychoses
- Other



- Adjustment disorder
- Autism
- Depression
- Attention/behavior disorder
- Anxiety and stress
- Postponed diagnosis
- Relationship disorder
- Eating disorder
- Psychoses
- Developmental disorder
- Other

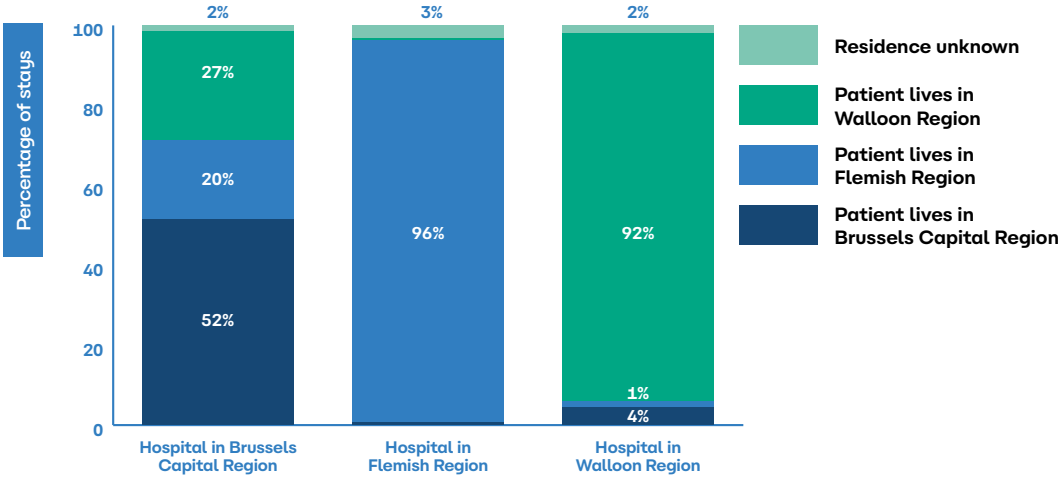
More information about diagnoses made during admission to PH or PDGH:
https://www.health.belgium.be

Patient flows

As is the case with stays in adult psychiatry services, patients in child and adolescent psychiatry services are not necessarily admitted to a PH or PDGH in their own region.

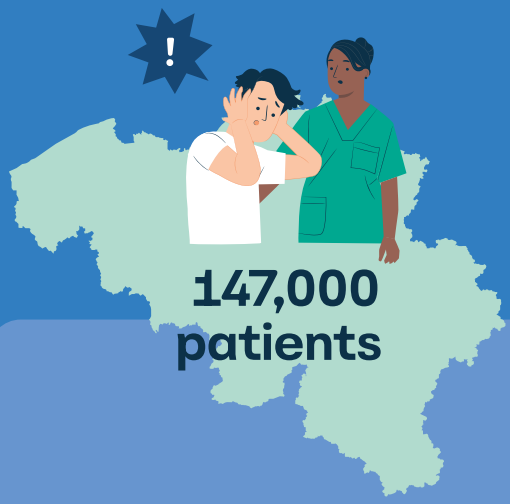
In hospitals in the Flemish and Walloon regions, 95.6% and 92.1% of patients respectively are domiciled in the same region. Only half of the patients from the Brussels Capital Region are admitted to hospitals there. Almost one fifth of patients there are from the Flemish Region and 27.1% are from the Walloon Region.

Percentage of patient stays by patients' place of residence and region of hospital in 2021



More information about patient flows:
https://www.health.belgium.be/

03 MENTAL HEALTHCARE REFORM INITIATIVES



Approximately 147,000 patients are treated annually under the convention on primary psychological care in Belgium.

Care is brought as close as possible to people by mobile teams providing specialised care in the home environment.

More intensive, psychiatric care through creation of intensified psychiatric care units and 'High Intensive Care' model

MENTAL HEALTHCARE REFORM INITIATIVES

We stated earlier that the mental healthcare (MHC) reform in Belgium aims to prevent hospitalisation as much as possible. If hospitalisation is nevertheless unavoidable, the stay should be as short as possible.

To succeed in this objective, a number of initiatives were launched, including mobile operations, primary psychological function and intensification of residential care provisions.

Mobile functions

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.

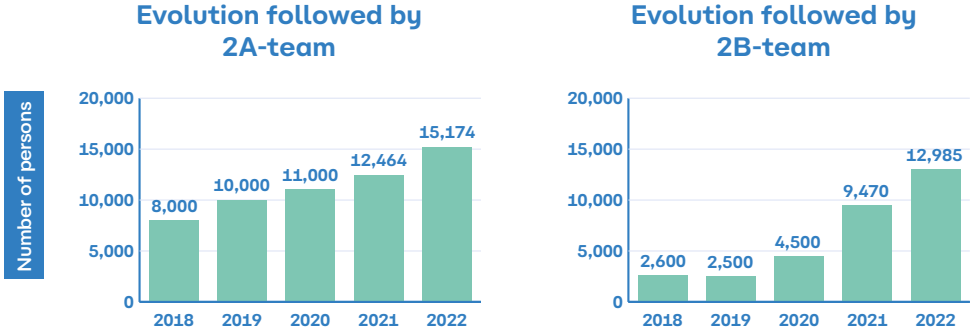
Rapid intervention by the crisis team means that treatment can be started in the home environment, potentially avoiding hospitalisation.

After several weeks of care from the crisis team (known as the 2A team in the adult mental health networks), aftercare can be taken over by a long-term care team responsible for rehabilitation and recovery (2B team in the adult mental health networks). 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, work and learning environments can be restored more quickly.

In 2022, 157 FTEs were active in the mobile crisis teams and 106 FTEs in the long-term care teams of the MHCY networks. In the adult mental health networks, there were 539 FTE active in 2A teams and 620 FTE active in 2B teams in 2023.

The 2018 - 2022 evolution indicates that the number of individuals for both the 2A and 2B adult mobile teams show an upward trend[16].

16 For the MHCY networks, no figures can be made available at this time.



Psychological care in primary care

In April 2019, a pilot project was launched in which doctors can refer patients with mild and moderately severe mental health problems to a clinical psychologist or clinical remedial education provider for short-term, first-line psychological treatment that is largely reimbursed by the health insurance fund. The objective of this is to provide psychological care early and in individuals' nearby environments.

The treatment consists of a series of individual discussion sessions. An intake interview with diagnosis is followed by treatment sessions. In addition, if the patient needs more intensive, long-term support, the provider may refer the patient.

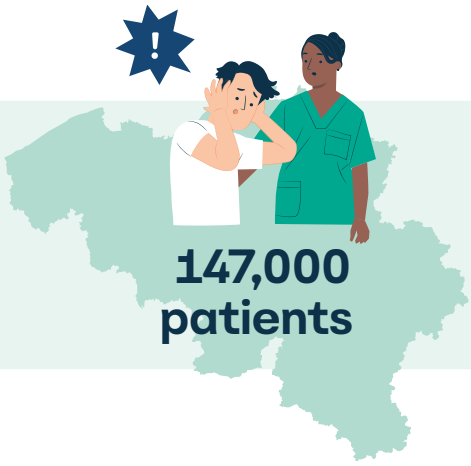
Mild and moderately severe mental health problems are defined as mental health problems related to anxiety, depressed mood, alcohol abuse or abuse of sleeping pills and sedatives. For adolescents, these can include behavioural or social problems and addiction to screens (smartphone, tablet, laptop, etc.).

In 2020, an agreement was reached in the IMC Public Health, primarily on strengthening the care offering in front-line healthcare, which provided a recurrent budget of 200 million euros.

The agreement sets out several priority target groups, including children and parents in vulnerable families, young adults and people with existing mental health problems. The goal concerns prevention, early detection and early intervention of mild to moderately severe problems through 2 psychological functions:

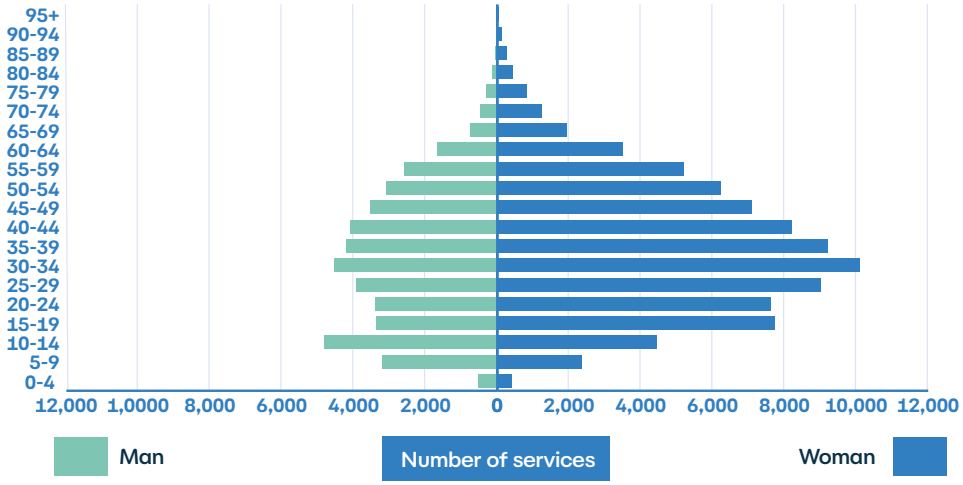
- resilience-enhancing function
- treatment function of moderate intensity.

Approximately 147,000 patients are treated annually under the convention on primary psychological care in Belgium.



In 2022, we found that almost twice as many services under the convention for primary psychological care are billed for women. People who use this type of assistance come mainly from the active population. Among men, we see a high peak in the 10 to 14 age group.

Number of services billed under the first-line psychological care convention, broken down by gender in 2022



The innovative project is built on a few key pillars to keep the threshold of access to care as low as possible.

- Public health
- Population management
- demand-driven work
- Multidisciplinary and intersectoral cooperation and integration
- Group interventions
- On-location work

A scientific study was recently completed (EPCAP) showing that primary psychological care is effective and efficient: there is an improvement in general functioning, plus there is a reduction in absenteeism, a strengthening of resilience, and a decrease in the waiting time to seek help.

More information
EPCAP research report

More information
Primary and specialised psychological care in a mental health network - NIHDI (fgov.be)

Residential intensive treatment units HIC and ID

If deemed necessary, more intensive psychiatric care should be offered for more severe mental illness.

To this end, 2 models have been developed:

1. **ID model**

   This involves the creation of a unit for intensified psychiatric care. Here, high-quality, intensified care is realised through the adaptation of care methods on the one hand, and through the adaptation of architecture (low-stimulus rooms, comfort rooms, etc.) or care organisation (smaller living units, etc.) on the other hand.

2. **High Intensive Care (HIC) model.**

   This is a new care organisation model based on the combination of intensified service and increased intensified operations. A ward consists of two smaller adjoining 'high care units', supplemented by a separate 'intensive care unit'. The patient never stays there alone, but is always accompanied by someone from the care staff.

   HIC units need to provide better and more humane care for people admitted in crisis. Furthermore, the objective is to reduce aggression and suicidality and further reduce the number of coercive and restrictive measures, such as isolation and fixation.

   At least 1 HIC service should be provided in each mental health network within a crisis care pathway. The already existing 9 HIC projects have been expanded to 28 HIC services since 2022.

The ultimate goal of intensifying residential care is to roll out a crisis care pathway throughout Belgium. Each network should review its existing crisis care offerings and then roll out a crisis care pathway according to the stepped care principle. This consists of the collaboration of various players in the network: specifically, HIC services and ID services and the outpatient network including the mobile crisis team and emergency services. Cooperation between these partners is being strengthened.

More information
https://www.psy107.be/index.php/fr/organe-de-concertation/groupe-du-travail-intensification

04 QUALITY AND INNOVATION

According to the 2018 Sciensano Health Survey, alcohol consumption is a potential hazard for 14% of the Belgian population.

A Belgian study found that nearly 60% of inmates used drugs before their incarceration.

11% of the adult population shows signs of an eating disorder.

3,287 sexual assault victim registrations by 2022.

QUALITY AND INNOVATION

Care for addiction

The use of drugs and alcohol in Belgium

The use of psychoactive substances and addiction problems are a public health issue, since the use of these substances poses a risk to the individual health of the user, among other things. Affected individuals must be able to access quality care services without being stigmatised or facing discrimination. To address these issues, the federal government has initiated several projects in various sectors:

- Care model for drug-using prisoners
- Tackling inappropriate use of psychopharmaceuticals
- Addressing substance abuse in hospitals
- Raising awareness among healthcare professionals

Below we take a closer look at some of these projects. The goal of these projects is to counter the problems caused by drug use and promote the health and well-being of individuals. Through collaboration with various agencies and professionals, these projects strive to provide early identification and intervention, treatment, reintegration and social support for those facing drug-related problems. Through concerted efforts, the government seeks to reduce the harmful effects of drug use and promote a safer and healthier society.

60%

of inmates used drugs before their incarceration

Care model for drug-using prisoners

Despite the daily efforts of care providers and the intense efforts of the FPS Justice, drug and medication use in Belgian prisons remains high. Drug use entails various health risks and can place significant pressure on prison security. A Belgian study[17] found that almost 60% of inmates used drugs before their incarceration, which is higher than the international average of 50%.[18]

As part of the penitentiary healthcare reform, the FPS Public Health, in collaboration with the FPS Justice, funded an adapted care model for incarcerated drug users through a pilot project in three prisons in 2017:

- Brussels Penitentiary Complex
- Hasselt Prison
- Lantin Prison

17 Favril, L., & Laenen, F. V. (2018). Predictors of drug use during detention: data from 1,326 inmates from 15 prisons in Flanders. PANOPTICON, 39(4), 296–312. https://biblio.ugent.be/publication/8577366

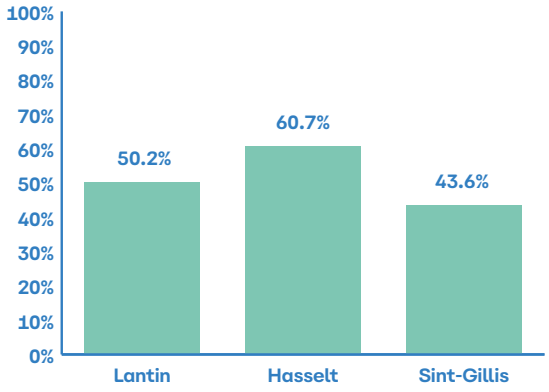
18 Mundt, A. P., Baranyi, G., Gabrysch, C., & Fazel, S. (2018). Substance use during imprisonment in Low- and Middle-Income countries. Epidemiologic Reviews, 40(1), 70–81. https://doi.org/10.1093/epirev/mxx016

Three non-profit organisations specialising in providing assistance to drug users are receiving funding to provide additional training, expertise and staffing support to the three prisons.

In each of these 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 be given 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.

- In Belgium's largest prison, Lantin, no fewer than 1,447 inmates were screened over a 12-month period, of whom 50.2% reported using drugs and 12.8% of these drug users were included in the pilot project.
- Hasselt is a smaller and more modern prison with a special drug-free ward where inmates who choose to stop using drugs can be admitted. In this prison, 303 inmates were screened and 184 (60.7%) of them reported using drugs from which 46.2% opted to participate in the project.
- We have similar data for Saint-Gilles, where 43.6% of those screened were found to use drugs and 109 inmates were followed for 12 months in the project. Inmates in Saint-Gilles are currently being transferred to Haren prison.

Percentage of drug users compared with number screened persons



Cannabis is the most commonly used substance in the three prisons, followed by cocaine and heroin.

In total, this pilot project has already screened thousands of inmates and offered around 1,500 care pathways. In addition to its original tasks, the project will now focus on post-detention aftercare, the involvement of front-line psychologists and peer support. In March 2023, the FPS Health launched a call to expand the pilot project to seven other prisons. The project will again be monitored by a group of scientific experts and an 18-month training course will be provided to support the prisons. This takes place on the initiative of the NIHDI.

Tackling inappropriate use of psychopharmaceuticals

Belgium continues to have the largest population of users of psychopharmaceuticals. Psychopharmaceuticals are drugs used in the treatment of psychiatric disorders and psychological problems. These drugs can be classified into several groups: antipsychotics, antidepressants, narcotics and sedatives, and stimulants such as Rilatine.

In 2022, it was estimated that more than 3 million Belgians were taking at least one psychopharmaceutical. This is 1 belgian out of 4. Narcotics and sedatives are the most commonly used.[19]

Psychotropic treatments are not always adapted to patients' needs, are often unjustifiably prolonged, poorly monitored and rarely questioned. Psychotropic drugs may be necessary in some cases, but only at the right dose and for the right length of time. If possible, chronic use should be avoided, to prevent unnecessary side effects and, in the case of certain types of psychotropic drugs, dependence or addiction. It's also crucial to stop taking them gradually if their value is no longer proven.

The Belgian Psychotropics Experts Platform (BELPEP) aims to promote the appropriate use of psychopharmaceuticals such as antidepressants, narcotics and sedatives in Belgium. This includes proper prescribing and follow-up of treatment. We note that some patients are prescribed psychopharmaceuticals when there may be non-drug alternatives, while others are not prescribed a psychopharmaceutical when one might be essential for optimal treatment of their condition.

19 Source: IQVIA Belgium Le Marché Pharmaceutique Belge- National Sell In Audit for the period 2018-2023; and Regional Sell Out Patient data for the period 2022

More information about BELPEP:
https://www.health.belgium.be/fr/sante/organisation-des-soins-de-sante/qualite-des-soins/bonnes-pratiques/belgian-psychotropics

An awareness campaign was launched by the FPS Public Health in September 2023, targeting general practitioners, pharmacists and psychologists. The goal of this campaign is to draw attention to the proper use of psychopharmaceuticals, where open dialogue with patients and information sharing among healthcare professionals are essential. Attention is being drawn again to resources such as clinical guidelines, training courses and an online handbook to facilitate this dialogue.

The key messages are:

- Psychopharmaceuticals are not without risk to health and can cause many side effects.
- Psychopharmaceuticals may be useful in certain cases, but for an appropriate duration and especially
- Health professionals have a crucial role to play: to inform, raise awareness, diagnose, motivate, guide and so on.
- Collaboration between health professionals working with the patient is essential to promote rational use of psychopharmaceuticals.
- Prescriptions should be reviewed regularly to prevent chronic use, and if possible, phased out.

More information:
https://www.usagepsychotropes.be

Alcohol care pathway in general hospitals

Alcohol consumption poses risks to both the physical and psychosocial health of users. It can cause various diseases as well as accidents. According to Sciensano's Health Survey in 2018, alcohol consumption is a potential hazard for 14% of the Belgian population.[20]

It is recommended to limit alcohol consumption to no more than 10 standard units per week (1 standard glass = 1 unit = 10 grams of pure alcohol) and not to consume alcohol daily. It is estimated that about 20% of all patients admitted to general hospitals exhibit harmful or risky alcohol use.

In 2009, the pilot project 'Tools & alcohol care pathway' was launched in general hospitals on the basis of the observation that alcohol-related problems were still under-recognised in general hospitals. The goal of this project is to improve the detection and treatment of people with alcohol-related problems through training and awareness of healthcare personnel and by developing an alcohol care pathway that strengthens collaboration.

The benefits for the hospitals where the project has been implemented are numerous. Healthcare providers are paying more attention to alcohol use in their daily practice, thanks in part to many resources such as brochures, guidelines, posters, care pathways, abstinence scales, and so on. Patients are referred more quickly and treatment of alcohol-related withdrawal symptoms is more effective.

On the basis of the positive results, the project has been expanded to 15 general hospitals.

20 L. Gisle, S. Demarest, S. Drieskens. Health Survey 2018: Alcohol use. Brussels: Sciensano. Accessed on 1 October 2023, from www.gezondheidsenquete.be

Learn more:
https://www.health.belgium.be/fr/sante/organisation-des-soins-de-sante/hopitaux/projets-specifiques/dispositif-alcool

Eating disorders

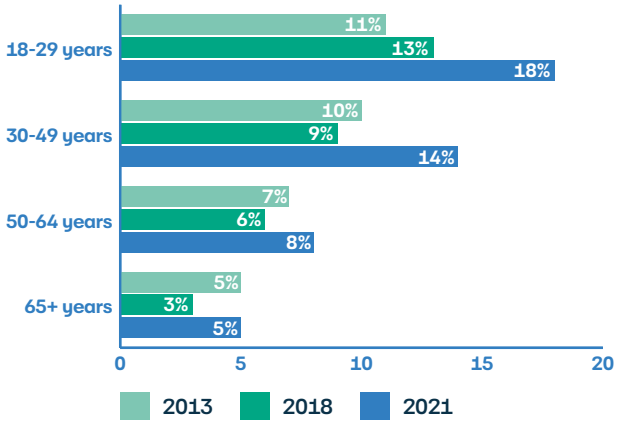
Findings

Results from the sixth COVID-19 Health Survey in April 2021 indicated that 11% of the adult population shows signs of an eating disorder (up from 8% in 2013 and 7% in 2018).[21]

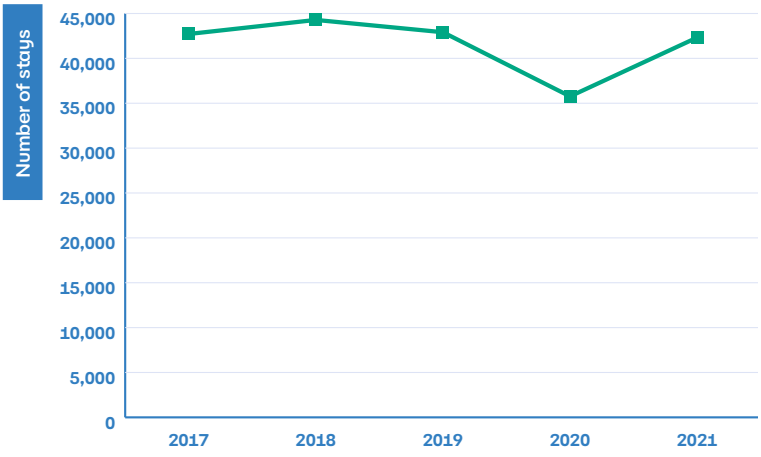
These signs are most common in the 18 to 29 age group and more common among women (13%) than men (9%).

21 Sixth COVID-19 Health Survey. First results (2021). Brussels: Sciensano. Filing number/2021/14,440/29. Accessed 1 October 2023, from https://doi.org/10.25608/r4f5-1365

Evolution of the percentage of individuals aged 18 and older showing signs of an eating disorder



Evolution in number of hospital stays in psychiatric and general hospitals due to eating disorders



More than 40,000 hospital stays related to an eating disorder are recorded annually in general and psychiatric hospitals.[22]

Eating disorders are associated with a heavy disease burden, have a strong impact on all life domains, and are associated with suicide risk. One third of deaths among persons with eating disorders are due to suicide. At the same time, we can see that the care offered to young people with an eating disorder varies greatly from place to place and that care programmes that have been started are sometimes interrupted because specific follow-up care is not or hardly available near the living and learning environment of young people.

22 In 2020, we saw a decrease because of COVID-19 pandemic measures and because of the temporary suspension of registration of diagnoses in Minimal Psychiatric Data (MPD).

New policy initiatives

The Interministerial Conference on Public Health (IMC) agreed on December 14 2022, to develop a transversal care model of eating disorders as an example of integrated care. This model is based on the specific proposals of the Committee on the New Mental Health Policy for Children and Youth (COMMHCY).

It clearly states that there is a need in Belgium for a population-orientated care organisation.

- This should, on the one hand, support children and adolescents so that mental problems – and, more specifically, eating disorders – can be prevented.
- On the other hand, early detection mechanisms are also best developed for the first signs of eating disorders and quality and accessible care is tailored when needed.

Such care organisation leads to more health gains, greater well-being, less suffering and lower social costs.

To achieve this objective, a care pathway will be developed for children and adolescents with eating disorders. As a complement to the initiatives within the states, this involves:

- **Training** of primary care providers around eating disorders so that they learn to recognise signs of an eating disorder, dare to intervene or to enable them to refer.
- Further development of **specialised psychological and dietetic care** for adolescents with eating disorders, preferably as part of a multidisciplinary collaboration with general practitioners, psychologists and psychiatrists. Cooperation and consultation will be actively encouraged in this regard.
- **Support for outpatient care** with expertise through multidisciplinary outpatient support teams, known as MAST teams. Their job will be to support outpatient providers so that young people can be supervised and treated in their own environment for as long as possible. If needed, they can provide specific training and peer supervision to assistance providers. In difficult pathways, they will be responsible for care coordination and may also take steps to address gaps in care provision in terms of policy, as well as helping to look for solutions within the framework of the mental health networks.
- **Increasing the flexibility of intensive offerings** and having more options and variations of assistance forms developed to provide better tailored care. This mainly involves various forms of part-time treatment and (intensive) multi-family therapy (MFT and iMFT)

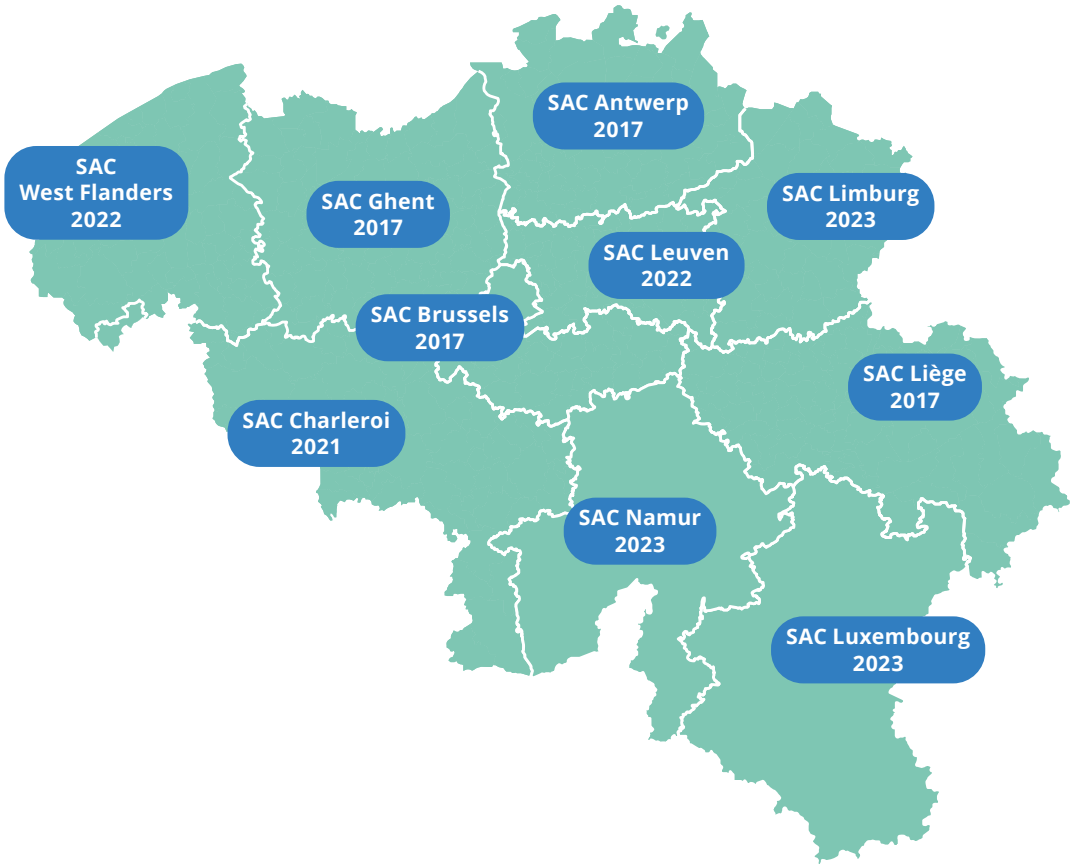
The new care pathways for children and adolescents with eating disorders will be implemented from 2024.

Sexual Assault Centres

In Belgium , official police statistics show that around 11 rapes per day were reported to police in 2021. However, according to the 2018 Security Monitor, around 82% of sexual assaults and rapes go unreported and are therefore not included in police and Justice statistics. The most recent prevalence survey in Belgium in 2021 shows that 16% of women and 5% of men have been victims of rape in their lifetime.[23] This violence has a significant impact on victims' mental, sexual and physical health and requires integrated medical, medico-legal and legal care.

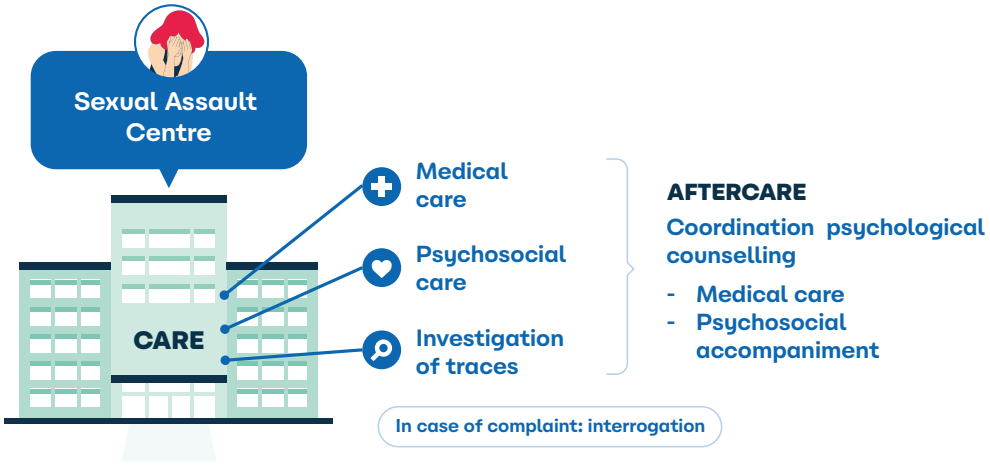
Sexual Assault Centres were established in Belgium to provide a response and assistance to victims of sexual violence and to implement Article 25 of the Istanbul Convention. In late 2017, three Sexual Assault Centres were opened in the judicial districts of Brussels, Liège and East Flanders. In 2021, two new centres were opened: one in Antwerp and one in Charleroi. Centres in West Flanders and Leuven opened in 2022 and in 2023 centres opened in Namur, in Luxembourg and Limburg. Located in a hospital, these SSG are funded by the Institute for Gender Equality and by the FPS Public Health.

23 Zorgcentra seksueel geweld: het model ZSG [Sexual Assault Centres: the SAC model] (2021 edition). Brussels: Institute for the equality of women and men. Accessed on 1 October 2023, from https://zsg.belgium.be/nl



Each SAC welcomes victims 7 days a week and 24/7 and has forensic nurses, a psychologist, a doctor, a coordinator and an administrative assistant.
The centre works with police vice inspectors, who have a room at the SAC to file reports. The SAC also works with prosecutors to follow up on reports[24].

24 Zorgcentra seksueel geweld: het model ZSG [Sexual Assault Centres: the SAC model] (2021 edition). Brussels: Institute for the equality of women and men. Accessed on 1 October 2023, from https://zsg.belgium.be/nl



More information:
https://cpvs.belgium.be/fr

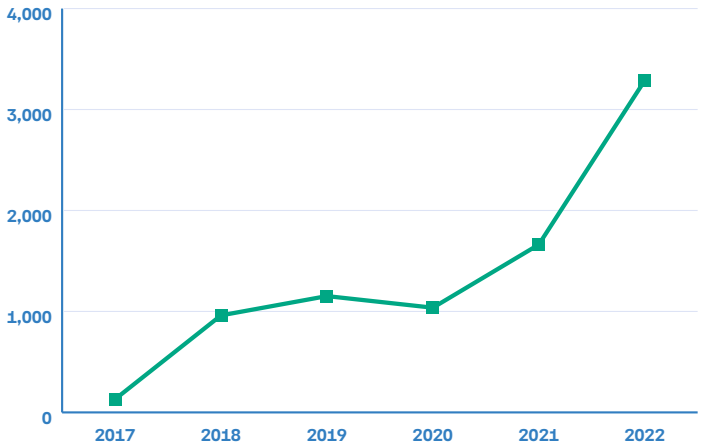
Some figures[25] :

3,287 reports

by sexual assault victims in 2022

25 Fomenko E., Baert S. & Keynaert I. (2022). Zorgcentra seksueel geweld in België: Evolutief rapport 2021 [Sexual Assault Centres in Belgium: Progress report 2021]. Ghent University- ICRH. Accessed on 1 October 2023 at https://www.icrhb.org/nl/publicaties/8755724

Evolution in number of reports of victims of sexual violence



Intercultural mediation

What is intercultural mediation?

Intercultural mediation is a set of activities to minimise the effects of language barriers, socio-cultural differences and tensions between ethnic groups within healthcare settings. The goal is to offer equal access and quality of care for all patients regardless of their migrant background. Intercultural mediators act as interpreters, clarify misunderstandings, offer explanations of cultural differences and assist both care providers and patients during the care process. In exceptional cases, such as in cases of racism or discrimination, they act as patient advocates. Currently, 113 intercultural mediators are active.

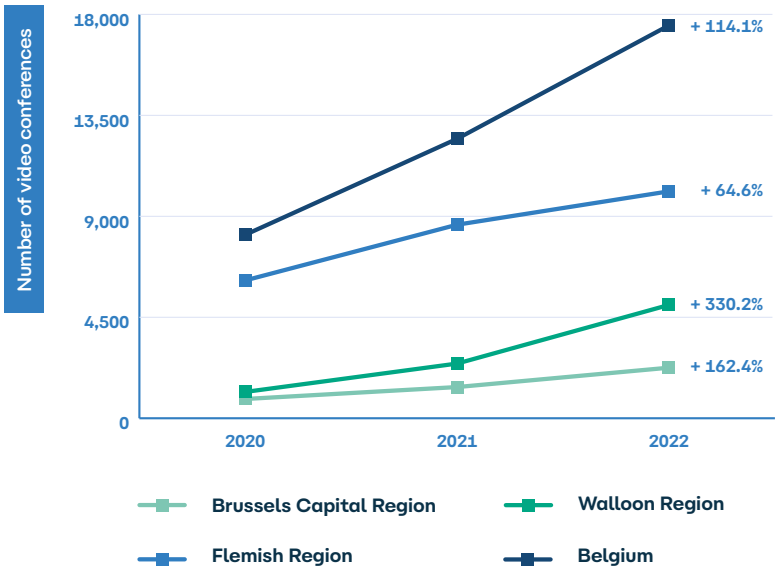
On-site intercultural mediation takes place in 40 general and 8 psychiatric hospitals, as well as in a network of 28 community health centres.

Intercultural mediation via videoconferencing

In addition to on-site intercultural mediation, an offering of intercultural mediation via videoconference was created. This uses an app developed for this purpose and care providers can use the app to reserve a mediator for an intervention via video. Twelve languages are continuously available, including Turkish, Russian and several variants of Arabic. Recently, Ukrainian and languages from Afghanistan (Dari, Pashto, Urdu) were made available. Healthcare providers can also request interventions in less commonly requested languages such as Italian and Bosnian-Serbian-Croatian.

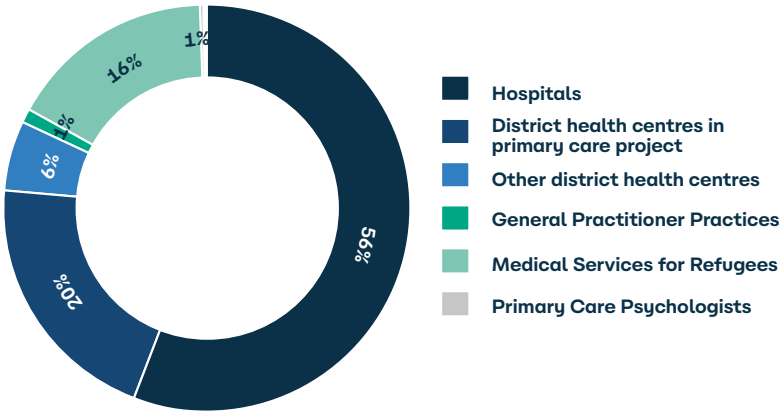
Assistance providers are increasingly using intercultural mediation via video. Currently, more than 250 healthcare facilities use this service. The total number of interventions via video more than doubled from 8,178 to 17,511 from 2020 to 2022.

Evolution in number of video conferences for intercultural mediation



The majority of these videoconferences, around 56%, take place in hospitals. The offer of intercultural mediation via videoconference is now available to general and psychiatric hospitals, general practices, community health centres, medical services of reception structures for asylum seekers and front-line psychologists.

Number of interventions per type of institution



Intercultural mediation in the mental health sector

Intercultural mediation is also used in mental health services, although it is still relatively limited. In 2022, 327 video interventions were conducted in 8 psychiatric facilities. Mental healthcare providers stress that intercultural mediation makes it possible to provide better care to people who were previously hard to reach. Taking into account the higher incidence of mental health problems among people of migrant background, this is an important development. This is all the more true since, as a result of a series of geopolitical crises (Syria, Afghanistan, Ukraine), we have experienced and are experiencing a significant influx of potentially traumatised asylum seekers.

More information
Guide for Intercultural Mediation in Health Care

More information
What are the roles of intercultural mediators in health care?

CONCLUSION

Mental healthcare currently offers a wide variety of options. In the creation of this care offering, we strive to meet the diverse needs in terms of mental healthcare for children, young people/adolescents as well as adults and the elderly. Our goal is to provide care that is consistent with each patient's environment, taking into account their individual needs and the unique context of their environment.

In doing so, we encourage the cooperation of the various care actors within the mental health networks so that children, adolescents and adults with mental health problems can be helped quickly according to their individual needs. We realise that the strength of the healthcare system lies in collaboration and the flexibility to evolve with changing needs.

Partly by investing in psychological care in the 1st line and partly by investing in crisis and long-term care teams, liaison functions and residential intensive treatment units, we seek to provide a mental health care offer for everyone's needs.

In this way, we aim to develop a stepped integrated mental health care system of care consisting of coordinated evidence-based services that increase or decrease in intensity depending on each person's needs. The care pathway may begin at any service and people may require recurring episodes of counseling or treatment at different levels in the stepped system. We are aware that many components of such a tiered system of care are already present in the current supply of care, but there are also still gaps. The challenge for the future is to fill those gaps in order to best meet needs and, as mentioned above, to strive for better cooperation between all actors and services in order to achieve optimal continuity of care.

Health
Food Chain Safety
Environment