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Mental health services in Belgium

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Abstract

Belgium exhibits a complex governmental structure with overlapping yet fragmented healthcare service responsibilities across various levels. The past decade has been characterized with major political reforms, and a continuing road towards deinstitutionalization, enhancing care intensity, and fortifying primary care services. This article provides a concise overview of recent epidemiological trends in Belgium, the organizational landscape of mental healthcare, the roles and financing mechanisms of key institutions and professions, and a selection of specific topics such as euthanasia. Mental healthcare has ascended on the political agenda with a declaration of interest to eliminate a historical underfunding. This is urgent because over one fifth of the adult population struggles with mental issues on a yearly basis, with suicide rates 50 to 60% above the European average. Beyond the individual toll, there is a burning societal impact, reflected in the 7.4 billion euro directly spend within the healthcare sector, alongside substantial additional costs incurred through social security and productivity losses. Policy measures are needed to tackle contemporary challenges such as the attraction, recruiting and retention of skilled healthcare personnel, ensuring equitable remuneration across institutions and professions, and addressing critical areas such as forensic, transcultural, and transition psychiatry.

Keywords | mental healthcare, epidemiology, organization of care

Introduction

Belgium is a West-European high-income country with 11.7 million inhabitants and enjoys commendable health system performance across various indicators. For instance, population satisfaction with availability of quality healthcare tops at 90% compared to the Organisation for Economic Co-operation and Development (OECD) average of 67%. Additionally, 59% of the individuals aged 65 and above reported being in good health, exceeding the OECD average of 46%, and one in four people reported to have a chronic illness which represents a 10 percentage point reduction compared to the OECD average[1,2]. Nonetheless, several areas warrant improvement, including the high prevalence of avoidable hospital admissions, a high heavy drinking prevalence, and a concerning suicide rate of 15.2 deaths per 100,000 population[1,2].

Healthcare expenditures amounts to 11% of Belgium's gross domestic product, which is €4790 per person or €55.5 billion in total[3]. There are no recent and valid Belgian data available on the proportion of healthcare expenditures going to mental healthcare[4], but an often cited percentage suggests around 6%[5,6]. Despite this relatively modest allocation to mental healthcare, a growing recognition among both the public and policy makers of the importance of mental health disorders can be seen. A resolution was adopted in 2020 to increase the allocation of funds to mental healthcare with special focus on enhancing clinical practice and research[6]. A Lancet working group on sustainable development goals argued to increase the mental healthcare budget in high-income countries to at least 10% of the total health budget[7].

A comprehensive overview of the current situation is pivotal to guide the journey towards a fairer mental healthcare budget. This article builds upon Hermans et al.'s 2012[5] overview paper, offering an updated perspective. It provides a scoping overview of the epidemiological status of mental health in Belgium, the organizational structure of mental healthcare, the role of key institutions and professionals, their financing mechanisms, and goes into some of the imminent challenges facing mental healthcare in Belgium. To achieve this aim, data sourced from original peer-reviewed papers, national institute reports, online databases, and reputable websites have been meticulously curated and analyzed.

Epidemiology

Prevalence

In 2012, Hermans et al. indicated a staggering lack of Belgian epidemiological data, prompting reliance on World Health Organisation (WHO) data that was a decade old[5]. In the meantime, an academic research chair to monitor public mental health has been funded by the umbrella organization of Flemish general hospitals, mental health initiatives and social profit facilities in residential care. Their recently published report[8] based on the Composite International Diagnostic Interview[9] showed a 22% yearly prevalence of psychologic disorders in the general adult population in Flanders, marking a 7 percentage point increase over the past two decades. It is important to note that this increase can partially be explained by the broader inclusion of psychological disorders in the screening protocols. The prevalence of depression in Belgium seems to be higher (9%) compared to international standards (5-8%), and has increased slightly over twenty years (6% in 2001-2002). Depression onset tends to occur at a younger age, with about 25% of the population experiencing a depressive episode before the age of 16 years old, with median onset at 24. Comparably, the prevalence of anxiety disorder increased from 7% to 12% over a 20 year time span with a median starting age of 23. Additionally, about 11% suffer from alcohol-related disorders (+3% compared to 2001-2002), often manifesting in adolescence, while externalizing disorders (12%; +5% compared to 2001-2002) equally tend to start early in life[8]. Despite stable diagnostic prevalence rates over time[8], national data from the Health Interview Survey suggest that there was a peak in people at risk of depression and anxiety

disorders during coronavirus disease (COVID)-19-related restrictive measures with lingering effects persisting to the present day[10,11].

The Health Interview Survey 2018 also reported on the prevalence of psychological problems in children and young people (2-18y). Alarmingly, it revealed that 30% of this demographic could presumably be diagnosed with at least one psychopathology, with 40% of these individuals experiencing psychopathological comorbidities. Attention deficit hyperactivity disorder, relation disorders, and behavioral disorders are more common in boys whereas emotional disorders tend to become more prevalent in girls from the age of 15[10].

Burden of disease

Mental and neurological diseases rank as the 3th and 4th leading causes of death among Belgian women and men, respectively[12]. Belgium also has the highest suicide rates amongst the European Union (EU)-14 countries (15.2/100,000 population; m/v ratio 2.8), with suicide rates 50% higher than the EU-14 average in men and 60% higher in women. The excellent Belgian data collection cannot explain this difference entirely: suicide remains problematic[12,13] despite the decrease in age-adjusted suicide rates at the beginning of the 21st century but this decrease flattened after 2010. It is the 4th ranking cause of premature death and the primary reason of potential years of life lost in men (women: 7th cause of death, 4th potential years of life lost). In February 2023, one in ten people reported to have seriously considered suicide in the past year, with rates spiking to 18% among young women aged 18-19. Additionally, 0.4% reported to have made an attempt, a figure that rises to 2.0% among young adults (18-29y)[14].

Mental health issues also take their toll on the job market: unemployment rates have been estimated ten percentage points higher amongst those with mental health problems compared to those without[15]. Moreover, severe mental illness is associated with double the risk of living in poverty[15,16]. Next to the tremendous individual burden, there is major societal cost. The estimated overall mental health related costs accumulate to 5.1% of the gross domestic product, currently exceeding €28 billion. This includes medical expenses within the health system (26.3%), social security costs (28.1%), and costs related to employment and productivity loss (45.5%)[17]. The substantial share of social security costs and labour market costs is not surprising given that 37% of disability benefits and 15% of unemployment benefits has been estimated to relate to mental health problems[16,17].

(Un)met mental health needs

The pervasive epidemiological prevalence of mental health disorders underscores the imperative to address the proportion of people with unmet care needs, sometimes defined as those who lack access to professional ambulant or residential care while fulfilling the criteria for a mental disorder in the past 12 months. Unmet care needs may stem from various factors, including the reluctancy to seek professional help or being on the waiting list. Vulnerable people, such as those living in poverty, homeless, ethnic minorities, or individuals with long-term or complex care needs, as well as minors and the elderly are at risk[18]. Alarmingly, approximately half of Flemish individuals with clinically assessed mental health needs forego healthcare services altogether, while 13.6% of those without clinical needs actively seek help[19].

There is currently an average delay of 10 years before seeking professional support, which is 2 years shorter than two decades ago[8,20]. This delay primarily stems from the lack of feeling the need to go into treatment, the desire to solve problems by oneself, financial concerns, doubting treatment effectiveness, and not knowing where to find the right help[8]. When people actually decide to seek help at private practices of psychiatrists, psychologists or orthopedagogues, half of them get a first appointment within one month and about 75% within three months[21]. However, subgroup analysis showed that 43% endure waits longer than six months to get an appointment

with a psychiatrist[21]. Average waiting time to the first appointment in ambulatory mental health centers is approximately 6-8 weeks, with an additional 7-8 weeks for a subsequent follow-up appointment[22,23]. Considering all healthcare services collectively, the median waiting time is estimated at three months[8].

Medication use

The proportion of adults taking antidepressants has remained relatively stable between 2010 (13.3%) and 2021 (13.7%). However, just like in other European countries, there has been an increase in the number of defined daily doses (DDD). In Belgium, 86.5 DDD per 1000 inhabitants are prescribed daily, considerably more than the EU-14 and EU-27 averages of 77.1 and 64.2 DDD, respectively. Important regional differences can be noted between Wallonia (100.1 DDD), Flanders (82.4 DDD) and Brussels (65.7 DDD). Consumption is highest in women, in individuals with a lower socioeconomic status, and in the elderly[24]. Usage of antidepressants in nursing homes is particularly high, with 48.3% of residents aged 65y or above taking antidepressants in 2021[24].

While antipsychotics prescription in older Belgian individuals (5.5%) align with European norms, these medications are highly prevalent in nursing homes residents (27.3%)[24]. The prescription rate of antipsychotics is higher in Wallonia and Brussels compared to Flanders[25]. Prescription numbers more than doubled between 1997 and 2012 with a clear and continuing shift from first-generation antipsychotics (FGA) to second-generation antipsychotics (SGA)[26], both for the treatment of first episode and recurring psychosis, and due to the superior efficacy and more benign side effects that psychiatrists, general practitioners and trainees seem to attribute to SGA[27]. The prescription shift has been more pronounced in younger doctors, younger patients[26], and in Flanders compared to Wallonia and Brussels[25]. Olanzapine and Risperidone have generally been the most favored drugs[27], with substantial regional differences: Olanzapine has been the preferred drug in Flanders while Prothipendyl has been the number one in Wallonia and Brussels[25]. Off-label use of antipsychotics appeared to be very common[25,26]. The share of depot antipsychotics sales decreased yearly from 14.9% in 1997 to less than 8% in 2011 after which the market share recovered year after year up to 9.8% in 2016[28].

The trend in prescribed DDD of sleep aids and tranquilizers indicates an annual 3% decrease. However, despite this decline, over two million people in Belgium have been prescribed at least one DDD in 2022[29]. Notably, one in eight people have consumed them in the past two weeks[30]. In the first 12 months after first prescription, patients used 124 DDD on average (median of 29 DDD). Especially women and people older than 75 have been described sleep aids and tranquilizers. General practitioners prescribed most of the packages (83%), followed by psychiatrists (6%)[29].

Organization of mental healthcare

Belgium exhibits a complex federal governmental structure with a federal government and federated entities. The federal government oversees nationals matters such as defense and justice. The federated entities consist of three regional governments (i.e., Flanders, Wallonia, Brussels-capital) handling competencies such as urban policy and spatial planning, and three linguistic communities (i.e., Flemish-speaking, French-speaking, German-speaking) responsible for affairs such as culture. The regional and linguistic community levels in Flanders have been merged into one government. Several legislative responsibilities have been fragmented over the federal government and federated entities, public health being of them[31], especially after the 6th Belgian state reform.

Butterfly agreement

The 6th Belgian state reform, also known as the Butterfly Agreement, in 2014 stipulated the shift of certain competences from the Federal state to the Federated entities, but collaboration has

remained essential to effectively address the full spectrum of mental health promotion, prevention, and treatment. For mental healthcare specifically, a historical shift towards more competences for the federated entities was strengthened by the Butterfly Agreement. For a more comprehensive understanding, detailed breakdowns of responsibilities can be found elsewhere[32,33]. In brief, the Federal state remained responsible for the larger part of the regulation and financing of fees for medical and medico-technical services, (psychiatric) hospital budget (and budget of related services), overarching organization rules, pharmaceuticals and health products, healthcare professions and practices, and patient rights. The Federated entities became responsible for (i) (mental) health promotion and prevention; (ii) determination and licensing of (psychiatric) hospitals including quality and safety assessment and accreditation; and (iii) the organization, programming, licensing, financing and control of care types such as psychiatric care homes, mental health centers, initiatives for sheltered living, and most mental health-related rehabilitation centers[32,33].

Towards more community care

Next to the Butterfly Agreement, there has been a shift towards less psychiatric beds and more community care in three waves. Hermans et al.[5] described how a first large reform in 1990 reduced the number of psychiatric beds to enable appropriate sheltering outside psychiatric hospitals for stabilized but chronic patients. In 1999, a second reform was enacted to enhance the diversion of patients from hospitals to community-based facilities. This was achieved by expanding the availability of psychiatric nursing home beds and establishing more places for sheltered living. Meanwhile, the reform also focused on consolidating intensive and specialized treatment at psychiatric hospitals and strengthening collaboration between inpatient and outpatient services.

The third wave started in 2010 with the Article 107 reform of the hospital act enabling the shift of resources from traditional residential care by (temporarily) decommissioning hospital beds to alternative forms of care. The aim was to strengthen community-based care, integrate care, improve social rehabilitation, and reduce the number of psychiatric hospital admissions[34]. This has been operationalized in five so-called 'functions' focusing on (i) prevention, early detection and intervention, (ii) treatment of patients in the home environment, (iii) psychosocial rehabilitation, (iv) intensifying (semi-)residential care, and (v) the development of specific housing facilities (Figure 1)[35].

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A reform of mental healthcare services for adults was initiated, ultimately resulting in 20 adult mental healthcare networks focusing on more community-based care. They are equipped with the task to focus on mental health promotion and prevention, to deliver care as close to the living environment as possible, to improve psychosocial rehabilitation by fostering skills of the patient, to intensify specialized mental health units, and to provide specific living arrangements and residence formulas. Few years later, in 2015, the government initiated a similar reform of mental healthcare services for children and adolescents (0-23y), resulting in 11 mental healthcare networks (Figure 2)[36].

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A critical note within the Article 107 reform is that insufficient capacity for suitable intensive outpatient care for patients with severe psychiatric conditions has been realized. Because of this, stringent conditions were formulated by the sector to justify the inclusion of patients in mobile teams for long-term care[37]. Patients with serious mental illness who require longer hospital stays are confronted with fewer psychiatric hospital beds while mobile teams cannot compensate for the demand for care. As a result, these patients are often patched up briefly during admission

before discharge without adequate post-admission support. The available resources force healthcare professionals to choose between an individually-focused approach with prolonged outreach treatment trajectories if needed, leading to longer waiting lists, or a system-focused approach with shorter, often non-fulfilling trajectories but manageable waiting lists./

Insurance

Belgium's healthcare system operates primarily under a Bismarckian healthcare insurance model. Both employees and employers contribute through compulsory payroll deductions, ensuring widespread access to care. This insurance model accounts for 54.9% of total health expenditures, with governmental schemes covering 22.8%, and voluntary healthcare schemes assisting with out-of-pocket expenses (4.5%), leaving 17.9% directly paid by individuals[3]. Membership to one of the six accredited health insurance funds is mandatory for all residents, and if someone is unable or unwilling to pay, it is possible to enroll in the Auxiliary Illness and Disability Insurance Fund, which is available free of charge. Around 1% of citizens in Belgium do not hold a membership to a health insurance fund (e.g., homeless people), a proportion slightly higher in Brussels Capital Region (1.9%)[38].

Mental healthcare providers

Mental healthcare deliverance can be presented through the World Health Organization's Service Organization Pyramid for an Optimal Mix of Services for Mental Health (Figure)[39]. In the following paragraphs, contemporary formal services (upper three levels of the pyramid) and how these are financed will be presented, starting from the upper level.

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Psychiatric hospitals and Psychiatric departments in general hospitals

There are currently 51 psychiatric hospitals (PH) and 71 psychiatric departments in general hospitals (PDGH) with a focus on adult psychiatry, totaling 17,403 accredited beds and places. However, 2372 of these beds and places (13.6%) are (temporarily) decommissioned based on the previously described Article 107 reform. Per 100,000 inhabitants, there are respectively 105, 21, and 2 accredited beds and places left for residential, day, and night hospitalization. Some regional variances exist, notably with a greater number and more evenly distributed beds in the Flemish region compared to the Walloon region. Importantly, amidst mental healthcare reforms aimed at both deinstitutionalizing and enhancing residential care (staffing) intensity, there has been a sharp reduction in chronic beds (-39.5% over 20 years) and a more modest rise in acute beds (+17.2% over 20 years). Depression and alcohol abuse emerge as primary diagnoses within the latter[36].

Likewise, there are currently 25 PH and 27 PDGH with a focus on children and adolescents (0-23y), totaling 1345 beds and places. Per 100,000 inhabitants, there are respectively 37, 29, and 4 accredited beds and places left for residential, day, and night hospitalization, with a higher concentration of beds in Brussels Capital region, but a similar distribution between the Flemish and Walloon regions. The number of residential beds remained stable over time while day hospitalization tripled over the past 20 years. Autism, adjustment disorder and depression account for almost half of main diagnoses[36].

The two most important revenue streams of hospitals are the federal Budget of Financial Means (BFM) and the remittances of physicians' fees. The BFM covers part of the general operations such as nursing care and the hotel function. However, the BFM underfinances hospitals, and hospital managers therefore make agreements with physicians, who typically work on a self-employed basis (but not per definition), to withhold part of their revenue. Patients pay a lump sum per day,

based on length of stay and social security status. Financial support to invest in infrastructure is the responsibility of the federated entities[40].

Psychiatric nursing homes

A psychiatric nursing home serves individuals with a chronic yet stabilized psychiatric condition or mental retardation, providing them with comprehensive care and support in their daily living. These facilities are staffed by a multidisciplinary professional team dedicated to ensuring the well-being of these residents. The federated entities pay a fixed amount per patient and per day to cover infrastructure, operational and personnel expenses. Care users contribute to the cost through a daily lump sum, based on social status and family situation[40]. In April 2024, there were 45 psychiatric nursing homes (PVT-MSP): 23 in Flanders for 1961 places, 14 in Wallonia for 803 places (including the German community), and 5 in the Brussels Region for 326 places[41-43].

Initiatives sheltered living

Initiatives sheltered living (IBW-IHP) offer recovery-oriented guidance for adults and elderly with a severe, long-lasting psychiatric problem. Care users are offered the option to reside either individually or collectively in specialized facilities. The federated entities allocate a fixed amount per place per day to cover expenses. Not included are medication, psychiatrist and general practitioner fees, as well as accommodation costs[40]. In April 2024, there were at least 76 IBW-IHP: 33 in Flanders for 2938 places, 28 in Wallonia for at least 939 places (including the German community), and 18 in the Brussels Region for 719 places[41,44-46].

Associated with the IBW-IHP, there are psychiatric home care teams (PZT-SPAD) that aim to support and educate patients in their own home environment, to provide coordination across professionals, and to coach first line professionals encountering patients with mental health issues[44].

Mental healthcare centers

Mental healthcare centers (CGG-SSM) provide ambulatory services (prevention, screening and treatment) by multidisciplinary teams consisting of at least a psychiatrist, psychologist, social worker, and an administrative worker. Care users can be referred by health professionals or can sign-up by themselves. The federated entities cover staff and operation costs with a global budget. Care users' contribution per therapy session is fixed but based on social status[40]. Recognition of CGG-SMM is fragmented over several federated entities. In April 2024, there were 110 CGG-SSM. Several CGG-SMM do have multiple antennas bringing care near patients' homes[22,47,48].

Rehabilitation centers

In Belgium, the possibility exists for rehabilitation centers to conclude agreements with the government (also called conventions). These conventions, offering very specific types of mental healthcare, became gradually the responsibility of the federated entities after the 2014 Butterfly Agreement, and may take the form of an ambulant or (partly) residential program (Table 1).

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Mobile "outreach" teams

In the mental healthcare networks for adults, two types of mobile teams have been created in the context of more community-based care following the Article 107 reform described earlier. Multidisciplinary teams deliver intensive, specialized care in the home environment in acute crisis situations (type 2A) or for longer periods (type 2B). The development and implementation of such mobile teams is an ongoing process, with 539 full-time equivalents working in 2A mobile teams following up on 15,174 patients in 2022, a 90% increase compared to 2018. Similarly, 620

full-time equivalents working in 2B mobile teams followed up on 12,985 patients in 2022, a 399% increase compared to 2018. Note that the steep increase can be partly explained by better registration. Presently, mobile teams map the full Belgian territory. In the mental healthcare networks for children and adolescents, 157 and 106 full-time equivalents were working in mobile crisis teams and long-term care teams in 2022[36].

Psychiatrists

Aspiring psychiatrists in Belgium undergo a rigorous selection process to enter the training program, which operates under a quota system for candidate specialists, that defines the number and type of specialist doctors that are allowed to start the profession. Interestingly, this approach contrasts with the observed shortage of adult and child and adolescent psychiatrists in the country. Psychiatry training encompasses a comprehensive curriculum that includes theoretical interuniversity courses covering clinical and legal aspects, along with the completion of a scientific master thesis and a scientific publication in a peer-reviewed journal. Moreover, the training program incorporates a clinical internship component spanning a minimum of five years. Internships take place at multiple institutions, typically completing rotations of at least 6 months duration. While not mandatory, undertaking a four-year postgraduate program in psychotherapy is advisable, providing trainees with additional expertise in therapeutic modalities[49].

Following their training, many psychiatrists align themselves with one or more of the mental healthcare providers outlined earlier, either practicing independently or functioning as an employee. Many psychiatrists also perform consultations in a private practice, either establishing their own practice or collaborating with other healthcare professionals in a formal or informal capacity. There are about 1.7 working psychiatrists per 10,000 inhabitants, which remained stable over the years, but is lower than the EU-14 and EU-27 averages (respectively 2.1 and 1.8/10,000). Some regional differences exist with more psychiatrists living (not necessarily the same as working) in Brussels (3.3/10,000) than in Wallonia (1.6/10,000) and Flanders (1.5/10,000)[24].

Consultations at psychiatrists' private practices are largely reimbursed by a fee-for-service system which is negotiated every two years by medical representatives, the federal National Institute for Health and Disability Insurance (NIHDI), the government and the health insurance funds. Each psychiatrist can choose to (dis)agree with the negotiated agreement (i.e., a convention) that defines the reimbursed and out-of-pocket share per medical act. Psychiatrists who opt to adhere to the agreement set by the NIHDI are entitled to additional financial benefits. Conversely, those who choose not to abide by the agreement have the option to charge patients higher fees, leading to increased out-of-pocket expenses for patients. Some psychiatrists choose to partly agree, depending on the work situation. Psychiatrists' convention rate is remarkable high with 88.5% choosing to be fully convention and 2.9% being partly conventioned, a markedly higher rate compared to other medical specialists in the country [40,50].

Clinical psychologists and clinical orthopedagogues

While the job title 'clinical psychologist' is internationally well-known, this might be less the case for 'clinical orthopedagogue'. The latter autonomously performs acts aimed at the prevention, diagnosis, guidance, and treatment of educational, developmental, learning, behavioral and emotional problems and their psychosocial consequences in children, adolescents and (mainly young) adults and their contexts. Particular attention is paid to pedagogical and broader family and contextual factors that play a role in the emergence and persistence of the aforementioned problems, while clinical psychologists tend to focus more on the individual, although boundaries are often vague. The most frequent target groups are persons with intellectual disabilities, behavioral/emotional problems, and autism spectrum disorder[51].

'Clinical psychologist' and 'clinical orthopedagogue' are protected job titles as of 2016, meaning that a master degree in clinical psychology/orthopedagogy and a visa/recognition by the government are required[52]. For years there have been plans to include a post-graduate internship of one year as a prerequisite for the recognition but there are repeated delays. Starting from the graduating class of 2026, completion of such internships will be a prerequisite for recognition[53].

There are 14.8 recognized clinical psychologists and 2.0 recognized clinical orthopedagogues per 10,000 inhabitants. Some regional differences exist with more clinical psychologists in Flanders (15.4/10,0000) and Brussels (15.9/10,000) compared to Wallonia (13.5/10,000), and more clinical orthopedagogues in Flanders (3.4/10,000) than in Brussels and Wallonia (both 0.2/10,000)[54].

In general, private consultations with a clinical psychologist or an orthopedagogue is almost completely at the expense of the patient: reimbursement for these consultations differs across the different health insurance funds and is tailored based on age, with limitations potentially imposed on both the duration and amount of coverage. Since a few years, as part of the Article107-reform, a growing budget has been allocated by the federal government to almost fully reimburse a limited number of individual and group-based sessions in primary care[55]. This initiative primarily targets individuals with mild to moderate mental health problems. The reimbursement approaches the reimbursement of consultations with a psychiatrist, but patients' out-of-pocket share is lower[40]. However, the budget is limited and some prerequisites exist, making that only 19.1% of registered clinical psychologists and orthopedagogues are licensed to offer a limited number of reimbursed sessions per week[56]. Still, it seems that mental healthcare has become more accessible[55] with more than 315 thousand patients treated in 30 months (Jan/22-Apr/24)[56].

Other important matters

Forensic services

Specialized forensic psychiatric services remain a weak point within the Belgian mental healthcare system. Offenders with a psychiatric disorder find themselves incarcerated in general prisons without access to the necessary psychiatric treatment (Table 2 & 3)[57,58].

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In recent years, authorities have taken significant steps to improve therapeutic care for forensic patients, prioritizing their social integration by establishing reception facilities and expanding service options for extra-penitentiary care. Two Legal (Forensic) Psychiatry Centers (LPCs) recently opened in the Flemish region: Ghent (264 places, opened in 2014) and Antwerp (182 places, opened in 2017). Furthermore, a comprehensive masterplan implemented in 2016 emphasized the creation of 242 specialized places within the regular care network in Flanders. These places cater to individuals with diverse needs, including those struggling with addiction, sex offenders, acquired brain injuries, alcohol-related dementia, mental disabilities, as well as offering 'time out' spaces for individuals whose treatment is temporarily suspended due to behavioral issues. For the French-speaking part of the country, pending the construction of LPCs, a strengthening of the care offer for so-called "temporary" hospital beds has been deployed (136 beds currently funded)[59].

Since October 2002, specialized care systems for forensic patients have been actively promoted, financed and integrated into existing mental healthcare networks, emphasizing collaboration and coordination. There has been a notable expansion in the hospital and residential care offerings for forensic patients, with the number of beds/places increasing from 591 in 2013 to 1,299 in

2023. This expansion includes enhanced support across various settings, including psychiatric hospital beds (n=757), psychiatric care home beds (n=265), sheltered housing beds (n=246), and specific alternative accommodation (n=31).

In the future, the reform will mainly focus in Wallonia on the creation of two LPCs (250 in Wavre and 250 in Paifve). The Marronniers psychiatric hospital in Tournai will be reorganized in a section of forensic psychiatry (250 places) and a section for long stays (120 places). In Flanders, efforts are underway to establish a new LPC with high-security facilities designed for long-term stays, accommodating 120 individuals[59].

Compulsory admission

In 2021 an average of 97,5 involuntary admissions per 100,000 population took place. Involuntary admission rates have increased substantially (63%) over a period of twelve years and differ widely between regions[60]. The current law on involuntary admission of persons with a mental illness from 1990[61] will be replaced in the short-term (vote in chamber of representatives on 25 April 2024) by a completely new law called the "Law on protection imposed on a person with a psychiatric disorder"[62]. Current recovery-oriented trends in social integration and continuity of care, shared decision-making, reduction of coercion, the incorporation of the family and the context, the new law on patient rights, patient rights in accordance with the Convention on the Rights of Persons with Disabilities (CRPD), and children's rights necessitated a complete revision of the legal framework.

The new law describes three necessary conditions to initiate a protective admission: the presence of a psychiatric condition, potential danger to the integrity of oneself or others, and the impossibility of a voluntary appropriate treatment. As a legal measure, a protective observation period and voluntary treatment with conditions can be ordered. The two measures may merge into one another when the circumstances of the disease, the (dis)agreement on voluntary treatment and the capacity to make decisions, require it. The protective admission can take place in a residential facility but not in a family context or the patient's own individual residence[62].

For urgent involuntary admissions, a 48-hour clinical observation period may be introduced by the public prosecutor in order to determine whether the measure must be continued or may be terminated if the clinical condition has substantially improved. Additionally, the patient has the right to a lawyer from the start of the proceedings, and family members or caregivers are always heard by the judge. The duration of an involuntary admission will remain 40 days, but unlike the current law, it can only be extended to the maximum duration of one year[62].

Several amendments to the new law, proposed by the working group established by the ministries of health and justice, were not adopted by the legislature. Among them were a fourth criterion (the potential for sustainable improvement of the psychiatric condition during protective admission) as a necessary condition for establishing the legal status, and the option to conduct initial clinical observation in a general hospital in case of life-threatening somatic co-morbidity.

Another shortcoming in Belgian medical-deontological legislation is the total absence of the concept of compulsory treatment. Physicians are assumed to act as good family persons, making decisions about lifesaving or otherwise necessary treatments when the patient is incapacitated. Even under the current "Law on protection imposed on a person with a psychiatric disorder", it has been chosen not to create a legal framework for this.

Euthanasia

Belgium stands out as one of the few countries where euthanasia is legally permitted for people who are not terminally ill including those suffering from unbearable psychiatric disorders. Prerequisites are that (i) the patient should have decision-making capacity, (ii) there should be a

recurrent and persisting euthanasia request, and (iii) there should be unbearable suffering (iv) caused by an incurable disease. (v) Between the first request and the moment of euthanasia should be at least one month and (vi) two independent doctors of which at least one psychiatrist should give an advice to the doctor performing the euthanasia[63]. However, more stringent deontological due diligence requirements have for instance been formulated by the Flemish Association of Psychiatry[64]. In 2023, approximately 1.4% of all euthanasia cases (48 out of 3423) were attributed to psychiatric disorders such as personality disorders, posttraumatic stress disorder, schizophrenia, or autism serving as the primary underlying cause. Another 1.2% (41/3423) were primarily linked to cognitive disorders such as Alzheimer's disease or vascular dementia[65].

Homelessness

The scarcity in the affordable housing market poses significant challenges for patients and psychiatric centers. Recent unpublished findings estimated the total number of homeless patients in the inpatient setting on an annual basis at 19,5% of the total inpatient population[66]. Homeless patients remain in admission longer than strictly necessary purely because of the lack of housing. On average 13,7% of homeless psychiatric patients in an inpatient setting are referred to a residential care facility, such as a psychiatric nursing home, despite the patients' ability to live independently. Social support organizations even look insistently towards psychiatric facilities to extend the hospitalization as long as a housing solution is not available.

Contemporary and future challenges

Belgium's mental healthcare has many strengths but also faces numerous challenges, some unique to the country and others shared across Europe. A fundamental issue is the shortage of mental healthcare professionals, which hampers efforts to provide appropriate care to all who are in need. Unfortunately, mental healthcare professions are often perceived as less attractive career paths, leading to a scarcity of psychiatrists, among others. Yet, in an era dominated by artificial intelligence, the role of psychiatrists remains indispensable, emphasizing the importance of fair reimbursement to incentivize medical students to pursue this field. Disparities in reimbursement exist, illustrated by the fact that ambulant psychiatrists working in the Netherlands receive more than double the reimbursement compared to their Belgian counterparts. Conversely, there has been a growing interest among students choosing to start studying clinical psychology, encouraged by recent strides in reimbursing private practices. Scientific follow-up of the latter is pivotal, and extension is advised when the evaluation would turn out to be positive.

There are other important mental health professions as well, but equally important is continuing the road of deinstitutionalization and to strengthen community-based mental healthcare. This implies better mental healthcare knowledge and skills of professionals in primary care and in the community, with good communication lines to specialists in mental health and the development of collaborative care models. The implementation and rightful reimbursement of experts by experience could be an added asset as well. Integrated care is a choice that can be made by increasing focus on primary care, by this preventing admission in higher specialized services, which again could shorten waiting lines for patients in desperate need.

In conclusion, while this article has addressed several key challenges facing Belgium's mental healthcare system, there are numerous other important issues that warrant attention. Transcultural psychiatry, for instance, is becoming increasingly relevant as Belgium, like many European countries, is becoming more multicultural which is not yet reflected in mental healthcare. Transition psychiatry is another critical area that demands consideration, as the divide between child and adult psychiatry often leaves adolescents struggling to access

appropriate care. Similarly, forensic care should be reappraised, necessitating a discussion on the shared responsibilities of the departments of justice and public health.

The issue of medication unavailability is also growing in urgency, particularly when there are no suitable alternatives, leaving patients with severe mental illness vulnerable. However, a broader view is necessary, and mental health should be a central focus in all policies, from education to housing. Ultimately, addressing these key areas requires a patient-centered approach with these service-users actively involved in the decision-making progress. By prioritizing mental health and integrating it into broader policy frameworks, Belgium can work towards a more inclusive and effective mental healthcare system.

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Tables

Table 1. Conventions in the field of mental healthcare (April 2024)

Convention no + name	Therapeutic goal	BE	FL	BR	WA
772 Psychosocial adult rehabilitation	Therapeutic guidance to foster autonomy and societal reintegration	37	15	8	14
773 Rehabilitation for addiction problems	Treatment focusing on harm reduction, crisis management, substitution treatment, and ambulant counseling	31	14	6	11
774 Psychosocial pediatric rehabilitation	Therapeutic guidance to foster autonomy, social development and societal reintegration	18	4	3	11
7745 Mother-baby units in psychiatric hospitals	Perinatal psychiatric treatment of mother and development of mother-child connection	3	2	1	0
7746 Autism spectrum disorder reference center	Diagnosis of autism and coordination	9	4	3	2
7845 Rehabilitation for pediatric neuropsychiatry	Treatment of children suffering from neurological disorders.	1	0	0	1
953-965 Ambulatory rehabilitation Centers	Diagnosis and treatment of patients with development or hearing disorders, stuttering, cerebral palsy, and traumatic brain injury.	78	47	10	21

BE: Belgium, BR: Brussels, FL: Flanders, WA: Wallonia.

Table 2. Number of offenders with a psychiatric diagnosis – December 2023

	Belgium	KBM (NL)	CPS (FR)
Conditional release	2191	1341	850
In places of depravation of freedom (General Directorate of Prisons and places of extra-penitentiary placement)	1943	1085	858
Others (Runaways, awaiting appearance at liberty 1st hearing)	208	111	97
Total	4342	2537	1805

Table 3. Psychiatric offenders detained in prison versus other detained. – December 2023

	Convicted	Accused	Psychiatric offenders	Other
Flemish region	3080	1982	557	92
Walloon region	3110	1268	326	45
Brussels region	848	616	111	18
Total Belgium	7038	3866	994	155

Figures: captions

Figure 1. Reorganization of the new mental health model: five functions (adapted from Psy107.be)

Figure 2. Mental healthcare network for adults (left), and children and adolescents (right), reproduced from Ramaeckers et al (2024).

Figure 3. World Health Organization's Service Organization Pyramid for an Optimal Mix of Services for Mental Health