



Depression scorecard: Belgium

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About the depression scorecard project

The depression scorecard is a tool that aims to support the assessment of national-level performance in key aspects of policy, delivery and care for people with depression. The framework that underpins the scorecard was developed based on an international literature review and consultation with an expert advisory group.

The scorecard framework has been applied initially to four countries: Belgium, France, Italy and Romania, with findings summarised in individual scorecard reports. National-level findings were developed based on in-depth literature review and interviews with leading national experts in depression.

This scorecard focuses on Belgium.

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Depression: why it matters

Depression is the most common mental health condition affecting people today.¹ The World Health Organization estimates that depression affects a staggering 4.3% of Europeans – 40 million people.² In light of the psychological effects of the COVID-19 pandemic, this number may now be even higher.³

Depression has a devastating impact on the lives of those affected, their families and societies more broadly. It is associated with numerous negative outcomes throughout a person's life, including poorer academic performance, reduced earnings, chronic illness, diminished quality of life and a higher chance of death.^{4,5} It is the leading cause of suicide,² contributing to up to 60% of all suicides worldwide.⁶ Up to 15% of people with untreated depression may die by suicide.¹ Stigma associated with depression may exacerbate suffering and prevent people from seeking and receiving quality care for their illness.⁷⁻⁹ Depression also places a significant socioeconomic toll on European countries.

9.4%

of people living in Belgium are living with depression^{10*}

€20.7 billion

cost of mental health (direct and indirect) annually^{14§}

20.7 per 100,000

people in Belgium died from suicide or self-harm in 2017^{11*} compared with a European average of 12.9.^{12‡} Global estimates indicate depression may have contributed to up to 60% of these deaths⁶

Belgium has 17 psychiatrists

per 100,000 inhabitants, which reflects the EU average^{13*}

5.1%

cost of mental health to annual GDP (direct and indirect expenditure), compared with 4% in the EU overall^{14§}



Depression in Belgium

Belgium's healthcare system is complex and fragmented, with competencies divided between the federal and community levels, and further complicated by the regional governance structure.¹⁵

Against this background, it is perhaps no surprise that Belgium faces serious challenges in offering integrated care for people with depression.¹⁶ Federal policy change has led to the deinstitutionalisation of mental health care, bringing services into the community.^{17 18} However, this may have contributed to disjointed delivery of care due to the organisation of services into siloed networks and care circuits.^{15 16 18}

Globally, it is estimated that depression may contribute to up to 60% of suicides;⁶ this is particularly poignant in Belgium, which has one of the highest rates of suicide among Organisation for Economic Co-operation and Development (OECD) countries.¹⁹ Belgium also faces some of the highest costs in the European Union (EU) for poor mental health, including direct spending on health and social systems, as well as indirect costs from employment and productivity losses.¹⁵ Depression affects more than one million people in Belgium;¹⁰ however, it is thought that – even before the COVID-19 pandemic – the burden of disease was underreported.⁹ Belgium also has a high rate of antidepressant use, but many people taking antidepressants may not have any other care plan to support them in managing their depression.⁹

The government's willingness to address depression and improve the quality and efficiency of mental health care is indicated by a number of key federal-level policy initiatives. These include Reform 107, which aims to reduce the number of residential beds and bring mental health care into the community, involving experts-by-experience at all levels of mental health care.^{15 20} The reform included age-specific strategies, as well as policy efforts to increase the integration of eHealth (tools and services that use information and communication technologies in healthcare services) across the country.^{15 21} However, monitoring and evaluation of depression programming is inconsistent across the country, severely hampering service planning and understanding of best practice.^{15 22} As such, Belgium's recent prioritisation of mental health is promising, but effective implementation is likely to continue to be impeded by excessive fragmentation of competencies and care.¹⁵



Assessing depression management: the scorecard

This scorecard was developed to highlight to policymakers where change is most needed to improve the management of depression in Belgium. It is our hope that this document may galvanise policymakers to work in close partnership with all stakeholders to reverse

the course of depression in Belgium, taking a comprehensive and preventive approach to address it in all its complexity.

The scorecard focuses on four key areas, identified as priorities for improvement:

1

Joined-up and comprehensive depression services

Integrated care – that is, a patient-centred system that supports the person with depression throughout their lifetime and with continuity across the health system – is essential to delivering adequate support and treatment. Integrating mental health services into wider health and social care services is convenient and can increase treatment rates, improve comprehensiveness of care and reduce overall costs.²³

2

Data to drive improvements in depression care

Collecting and analysing robust and up-to-date data on depression is essential for ensuring the right services are available for everyone who needs them. Monitoring patient outcomes helps to identify and inform good practice, and may give hope to service users that their mental health can improve.²³ Data on services can support clinicians, policymakers and people with depression to better understand what treatment options are available and accessible. More transparent data will also facilitate shared learning across all domains of depression care. New digital tools may have the potential to facilitate documentation for transparency and research purposes while retaining the anonymity of the user.²³



3

Engaging and empowering people with depression

It is essential that people with depression – along with their families, friends and carers – are actively empowered to participate in depression care plans at all stages. Empowerment involves a person gaining information and control over their own life as well as their capacity to act on what they find important, which in turn will allow them to more optimally manage their depression.²⁴ Peer support, whereby a person who has previously experienced depression offers empathy and hope to others in the same position, can assist both people with depression and their peer supporter in their recovery.²⁵ Social systems, patient advocacy groups and other civil society organisations with access to underserved communities are critical in ensuring that mental health services reach everyone, including those who have 'slipped through the net'.²³

4

Harnessing technology to improve access to care

Digital platforms such as those which facilitate remote therapy sessions and online prescription requests, as well as other depression-focused software, smartphone applications and virtual platforms, can allow greater choices of treatment for people with depression while supporting them to take more control of self-managing their condition. While virtual sessions cannot replace in-person therapy, they may be a flexible option to support people with depression between regularly scheduled visits. Health and social services may also use digital tools to facilitate data collection and monitor care.^{26 27} In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.²⁸



Summary scorecard for Belgium

Joined-up and comprehensive depression services

Is depression included in either the national health plan or a specific plan for mental health?



Is there a government lead on mental health, with cross-ministerial responsibility to support a 'mental health in all plans' approach?



Is collaboration between primary care and mental health services supported and incentivised/encouraged/facilitated?



Are there guidelines on depression care developed jointly by primary care and psychiatry?



Is a range of therapeutic options reimbursed and available to people with depression, such as psychotherapy, counselling and cognitive behavioural therapy?



Are depression services available and tailored for at-risk groups?

- Young people
- Older people
- People in the workplace
- Homeless people



Data to drive improvements in depression care

Are data on people with depression systematically collected by the health system?



Are data on mental health services being used for planning?



Are patient-reported outcomes being measured systematically?



No



Somewhat



Yes



Engaging and empowering people with depression

Do guidelines or care pathways for depression recognise the importance of patient empowerment?



Do guidelines on depression recognise the role of families and carers in making decisions on the planning and delivery of care?



Were patient and carer representatives involved in the most recent national plan or strategy covering depression?



Do carers have access to financial aid to help them support their loved ones with depression?



Is peer support recommended in depression care guidelines?



Are peer support roles reimbursed?



Are there national associations advocating for the rights of:

- people living with depression?
- carers of people living with depression?



Harnessing technology to improve access to care

Can patients access depression support remotely (via telephone or the internet) in addition to services delivered face-to-face?



Do professional societies or guidelines recommend the use of remote services alongside face-to-face services?



Is remote support for depression reimbursed?



Are people with depression able to use telephone or online platforms that allow them to renew their prescriptions from home?



Joined-up and comprehensive depression services

In recent years, Belgium has implemented significant reforms in mental health care

Reform 107, a policy shift to deinstitutionalise mental health care and implement a network-based community approach to care (see **Case study 1**), was instituted in 2010.²² The initiative began in 2002 with a joint declaration from Belgium's ministers for health seeking to offer mental health care through collaborative care networks and care circuits; this declaration also identified three target groups: adults, older people, and children and adolescents.^{15 17} In 2010, mental health care reform for adults was launched, and reform specific for children and adolescents began with a 2015 national plan.^{17 29} As of the writing of this report, reform specific to older people is forthcoming.³⁰

Belgian policymakers seem to recognise the significant burden of mental illness in the country. They secured significant additional funding of €200 million for mental health care in late 2020, in response to the additional need identified due to the global pandemic, and they successfully recommended that this funding recur.^{31 32} A pilot project has begun which offers broader reimbursement for first-line care from clinical psychologists without the need for a referral.³² The national health insurance scheme has also increased reimbursement of remote consultations for people seeking mental health care.³²⁻³⁴

Case study 1. Reform 107 policy shift: a major deinstitutionalisation of care

Reform 107 is a mental health policy initiated in 2010 to shift Belgium's psychiatric care from one of the most heavily institutionalised in the world towards comprehensive community-based care.^{15 17 22}

This major shift was financed in part by freezing hospital bed capacity in institutions and redirecting those funds towards community care.¹⁵ The result of this has been a significant reduction in long-term hospitalisation for mental health conditions, and shorter duration of admissions.²² Mobile teams working in the community, including mobile crisis teams for acute care and mobile teams for chronic mental health problems,²² have a high satisfaction rate.^{15 35}

While challenges remain in Belgium's organisation and delivery of mental health care, many of these may be unique to the country's federated health system, which is highly fragmented. Reform 107 is a strong model for other countries looking to make a similar shift out of hospitals towards community-based care, especially those which can harmonise systems across the country to ensure consistency of offering and continuity of care.

Competencies and responsibilities for mental health care are fragmented, leading to gaps in care for people with depression

The shift to primary care in the community has been broadly welcomed, but has come with persistent challenges of fragmentation, mixed competencies and heterogeneous implementation.^{8 18 35} This has left many people in need still falling through gaps in care.³⁶ Critics argue that the policy may be over-ambitious in seeking to apply one model of care to cover every person with every degree of need.^{18 36} Continuity of care management across the health system and over time has not been prioritised.

In addition to the complex ministerial organisation of health at the federal and community levels across Belgium, part of the challenge in organising standardised care with clear competencies may be that the country does not have federal clinical guidelines on treating depression across primary, secondary and tertiary care.^{8 9} Guidelines for depression care were developed by general practitioners in Flanders,³⁷ but these are not consistently used and most clinicians use guidelines from the Netherlands or UK.⁹

Referral rates are also unclear between primary and secondary care, with communication between different parts of the health system overall representing a significant challenge.^{8 9 35 38} In the absence of formal guidance, patient management between these tiers appears to function largely on an ad hoc basis, with some networks and circuits much stronger than others.^{8 9}

This can lead to unacceptable variations in the quality of care that people with depression receive, and poorer outcomes as a result of suboptimal management and lack of communication between healthcare providers.

Despite government prioritisation of depression and mental health, challenges remain

Psychiatric disorders including depression may be seen as a lower priority than other conditions, especially with many primary care physicians having very little time to consult with each patient.⁹ Some clinicians may be treating their patients exclusively with antidepressants,^{8 9} while failing to offer psychotherapy and to follow up on effectiveness or consider a long-term, comprehensive approach to care and recovery.

Outside of the health system, there is some acknowledgement of mental health in other sectors such as the employment, social support and judicial sectors.¹⁵ However, there do not appear to be any major initiatives to actively address the risk and challenge of depression in a whole-systems manner.

People with depression can access consultations and a range of therapies, but waiting lists and co-payments present barriers to access

People with depression can self-refer to community mental health centres, but these are often stretched beyond capacity, leading to long waiting times.^{35 38} Belgium has a relatively strong response for acute crises but falls short in providing the longer-term care that is needed for people with chronic depression.^{36 38} The structure of disparate networks and care circuits has also left people with depression dissatisfied with freedom of choice in mental health care.¹⁵

Reimbursement for depression services was until recently considered inadequate,^{9 32 35} and the system insufficiently transparent.⁸ However, the national health insurer has made permanent the reimbursement and provision of telemedicine which was temporarily expanded during the COVID-19 pandemic.³² Yet sessions are limited and some co-payments are still required,³²⁻³⁴ which may present a barrier to lower-income groups.³⁹ The new pilot programme to broaden reimbursement for first-line psychological care may not include all clinicians due to budgetary constraints.³²



Data to drive improvements in depression care

There are large gaps in data on the scale of depression and on key mental health care indicators, challenging policymakers to plan services that meet users' needs

Belgium does not have a mental health patient registry or similar database to systematically monitor and evaluate treatment outcomes for people with depression,¹⁵ nor is there any federally led data collection across the country's mental health system.²² Basic quantitative indicators related to depression are collected across Belgium, such as on suicides and psychiatric hospital beds,^{15 22} but these alone cannot give a full picture of the challenge of depression across the country.

Uptake of eHealth tools such as unique patient identifiers and electronic patient records is slow, despite promotion by the Belgian government.^{21 35 38} Unique patient identifiers are particularly useful in chronic illnesses like depression, where data are difficult to collect over the long term and there is a shortage of information across domains including epidemiology, long-term outcomes and treatment effectiveness. These identifiers can provide invaluable (anonymised) long-term data to inform planning for treatments, service delivery and policymaking. They can also support effective sharing of information among different healthcare professionals to support continuity of care.

Some communities and networks do promote data collection among providers, but reporting is not mandatory and there is no coordination to ensure comparability across the country.

Together, these challenges have contributed to a significant knowledge gap in understanding the effectiveness and acceptability of depression care in Belgium.^{15 19 22} As a result, best practice is not being elevated and disseminated.

Patient-reported outcomes and other qualitative data are not being collected, limiting people's ability to make informed decisions about their care

Despite the importance of understanding effectiveness of interventions and services, neither the national government nor the federated entities are systematically collecting patient-reported outcomes or other qualitative measures on satisfaction with service use.⁹ This deprives people with depression and their carers of informed decision-making on their treatment plans. It also reflects a lack of prioritisation of the patient experience.

There have been some efforts by patient-oriented organisations on mental health and depression to coalesce online information on the range of available treatment options.⁴⁰⁻⁴³ However, there is no complete, centralised resource outlining even this basic information.⁹

Engaging and empowering people with depression

Belgium has acknowledged the importance of including people with depression, their families and carers in policymaking and care

Patient and carer representatives were key stakeholders in the development of Reform 107,²² which aimed to reorganise care around the needs of mental health service users.¹⁷ However, there is variability across communities in the integration of patient involvement in service delivery, with the Flemish region typically seen as stronger in this domain^{8 15} (see **Case study 2**).

Case study 2. Experts-by-experience in Flanders

The Flemish mental health system has placed particular value on 'experts-by-experience' and includes them at many levels of care, planning and policy.^{8 9} One of Belgium's largest networks of mental health hospitals includes carers, former patients and their family members on its board of directors.²⁵ These individuals are valued not only for policy planning purposes but also to provide information to patients and help services increase user satisfaction.¹⁵ Some commentators believe that people with depression may actually receive more benefits from experts-by-experience than from clinicians, perhaps because experts-by-experience are uniquely positioned to offer hope and empathy.^{8 23}

Stigma remains a barrier to care for depression

Despite government investment in campaigns to reduce stigma, the challenge persists.³⁸ Self-stigma – internalisation of negative perceptions around mental illness – stops many people from seeking the care they need.^{8 9} Unconscious discrimination against people with mental (as opposed to exclusively physical) health needs may also play a role in hindering clinicians from providing optimal care to people who do seek support.^{8 9} An expert interviewed for this work felt that this may, in part, explain why so many people are prescribed antidepressants in primary care yet do not receive adequate follow-up or coordinated referrals to specialist care.⁹

Despite the recognised value of patients and carers, there are no publicly funded patient organisations focusing specifically on depression

Belgium's lack of depression-specific patient organisations may be because, due to funding constraints, civil society has found it more efficient to advocate under a broader mental health umbrella. The Flemish and French communities each have a society dedicated to carers of people with mental illness,^{44 45} and there are numerous initiatives in place to promote better mental health and reduce stigma.^{40 46 47} One patient association in Flanders, Ups & Downs, offers support to people with depression and bipolar disorder, as well as their families.⁴¹ However, its work is not supported by any funding from the Belgian or Flemish governments.⁴¹ More could be done to support patient associations in their vital work as educators, advocates and support systems for people with depression.



Harnessing technology to improve access to care

The federal plan to expand the use of digital tools for health could support improvements in care for people with depression

Clinicians have received financial incentives and technical support to promote and facilitate uptake of digital tools including electronic patient dossiers, electronic prescriptions, electronic invoicing and more.²¹ The most recent iteration of the federal policy (Plan d'actions e-Santé 2019–2021 / Actieplan e-Gezondheid 2019–2021)⁴⁸ included the launch of eHealthMonitor, a recurring survey on knowledge and use of eHealth applications in Belgium.⁴⁹ The findings may help to improve policymakers' understanding of needs and gaps in the relatively new field of eHealth, and identify barriers to optimal uptake of these tools.

Beyond applications, people with electronic records may access their personal information on an online health portal, [MaSante.be](https://ma.sante.be) / [Mijngezondheid.be](https://mijngezondheid.be).⁵⁰ Electronic prescriptions are also being standardised: in January 2020, it became mandatory for all medications to have an electronic prescription, and in June 2021 patients should be able to go to their pharmacist for medication without needing to bring physical proof of their prescription.⁵¹ These initiatives are positive steps towards making it easier for people with depression to collect their medication and better understand their treatment history, which in turn will empower them to better engage in future decision making regarding their care.

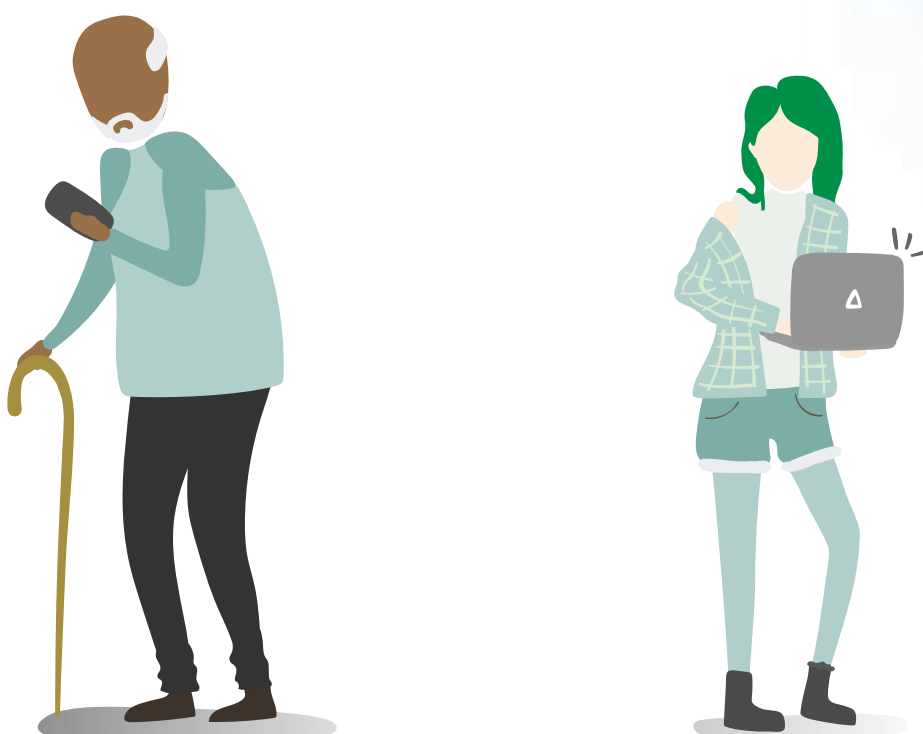


Despite prioritisation, technical support and training, barriers to uptake of digital tools persist

General practitioners report that poor functionality, technical difficulties, perceived high cost of use vs. benefit, and concerns around data loss from IT crashes are among the challenges they face in integrating eHealth tools into their practice.²¹ Some clinicians have questions over privacy use and General Data Protection Regulation (GDPR) compliance.³⁵ More must be done to address these concerns and ensure that secure and user-friendly systems are available and contribute to managing depression. Reassurance is needed for both healthcare professionals and people with depression before digital solutions will be fully integrated into care pathways.

COVID-19 has led to improved access to virtual consultations

In light of the pandemic's negative impact on mental health, the national health insurer is facilitating greater access to virtual consultations with psychologists. Since before the pandemic, some practitioners have been offering online consultations through the website [Psy.be](https://www.psy.be).⁵² Each practitioner may choose what types of services to offer, and costs may vary by practitioner and network.¹⁵



Conclusion and recommendations

Belgium's prioritisation of mental health care, including depression, indicates political and social will to improve the care and treatment of the millions of people living with depression. The country's flagship mental health policy, Reform 107, has made important strides in moving care from institutions to communities, but a lack of capacity is putting the system under tremendous strain.

'Belgium's healthcare system is generally well-performing and people with depression should be able to easily access the help they need – but this is not always the case.'

Professor Bernard Sabbe,
Psychiatry and Medical Psychology
University of Antwerp

Furthermore, Reform 107 has not facilitated a patient-centred, coordinated approach to depression across primary, secondary and tertiary care. Fragmentation and communication challenges remain one of the most significant gaps, with competencies spread across the federal and federated levels and numerous ministers of health. A lack of harmonisation on data collection, coupled with an absence of qualitative data on programme effectiveness or patient-reported outcomes, results in a system rife with gaps and overlaps, which is short on efficiency and elevation of learnt best practice.

Yet with policies to increase the use of digital tools for depression care, reimbursement adjustments in light of the need presented by the COVID-19 pandemic, and a particular emphasis on child and adolescent mental health, Belgium's approach to depression has some strengths which must be promoted and reinforced.

Priority recommendations

Joined-up and comprehensive depression services

- Develop and promote uptake with training support of federal clinical guidelines to identify and harmonise best-practice treatment of major depressive disorder across primary and secondary care, improving referral pathways and outcomes, and reducing solely pharmaceutical approaches to care.
- Establish systems, support and incentives in each region to facilitate improved communication and coordination between community mental health centres, primary care and specialist care and systematically evaluate the delivery and integration of depression care across these groups.
- Further expand reimbursement of non-pharmaceutical interventions for depression supported by evidence, and increase investments in multidisciplinary primary care centres to facilitate better and more efficient community care and coordination with secondary and tertiary care.

Data to drive improvements in depression care

- Mandate standardised data collection on depression, including clinical, occupational, programme evaluation and patient-reported data. This should include use of unique patient identifiers to support continuity of care and observation of long-term outcomes. These data can then be used by policymakers and healthcare managers to effectively plan, monitor and evaluate services for people with depression.
- Collect data on effectiveness, acceptability and adherence to available treatments for depression and make this information available for people with depression and their carers, to help inform patient-centred care decisions.

Engaging and empowering people with depression

- Establish mechanisms to link people with depression, their families and carers with local associations and resource centres that can provide ongoing support, and ensure these have appropriate funding to deliver their role as educators, advocates and support systems.
- Expand awareness-raising on depression and mental health to reduce stigma, including a specific focus on internalised stigma and unconscious discrimination, and encourage people with depression to seek care.
- Expand engagement of people who have lived with depression, as well as their carers and families, in hospital boards and at all levels of decision-making on mental health care.

Harnessing technology to improve access to care

- Ensure software, platforms and other digital tools are user-friendly for both healthcare professionals and people with depression, to facilitate their safe uptake and integration into care in line with data protection regulations.
- Extend as permanent the national health insurer's new reimbursement policies on remote consultations, and increase the number of sessions a person can access per year.
- Expand use of digital tools that facilitate coordinated, multidisciplinary care, including integrated electronic medical records and technologies facilitating joint consultations and interdisciplinary meetings.

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