

Mental Health of Belgian Population: update 18/12/2021

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1. Background

In The Mental Assessment Group (MAG) report, we aim to describe the current mental health state of the Belgian population through a short description of the results and conclusions of studies and reports that allow us to describe the evolution throughout the pandemic. We have compiled the findings according to mental health indicators.

Mental health is defined by the WHO as a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2001). Mental disorders are defined as those reaching the clinical threshold of a diagnosis according to psychiatric classification systems including disorders such as depression, anxiety, bipolar disorder and schizophrenia. Fewer data are available on mental disorders and consequently we use here indicators of mental health disorders such as, use of medication, consumption of psychological and psychiatric care. Finally we also give some more health economic related data on sickness absence and unemployment,...). We present data per age- or specific group depending on the availability.

The report is updated on a regular basis. These results are being used by the GEMS in their advice, in which key findings concerning the motivation and mental health problems are summarized. Each version of this document includes studies that have had a recent update. For other studies and their results we advise you to check the earlier versions of this report. If you dispose of good quality Belgian data and would like to contribute to this report, we invite you to send a short abstract of your study, together with key figures to Prof. dr. Lode Godderis (lode.godderis@kuleuven.be).

2. Executive summary

During the COVID-19 crisis, our mental health is under pressure especially in periods with increasing restrictive measures and uncertainty, particularly among younger people. Based on the current available data, the findings of long-term studies (Motivation Barometer and the Great Corona Study) showed that after a steady increase in well-being since the measures were relaxed before the summer, which levelled off from September on. Since the end of September the GHQ-12 has taken a turn for the worse in December, especially in students and adults under 45. Apart from the students, people working in the culture & event sector, as well as education and health care workers are badly affected by the sequence of events that took place between the penultimate GCS wave in late September and early December 2021. Younger individuals, females and those suffering from co-morbidity report lower well-being, as was also the case in pre-COVID times. Given the selective nature of sampled participants in these large-scale questionnaires, vulnerable groups may be under-represented.

Despite good follow-up data on mental disorders are lacking, we can estimate the impact of the crisis by using data of agency and care providers. For children, young adolescents, and their families the “Opgroeien” agency provides consultations in crisis and urgent care is needed. The dispatch for crisis situations has been receiving more questions every month, and even more so since the beginning of the COVID-19 crisis. The number of consults has known a steep rise in 2021 and since September 2021 numbers are rising again due to a rise in

questions concerning mental health. Since March 2021 the applications for crisis youth aid has never been higher, with in March an all-time high of 588 unique minors that were referred to crisis youth aid. Most cases are about mental health problems, with a lot of questions about suicide. Especially complex situations that have been difficult for a while, seemed to go into crisis. In July and August 2021 the numbers stabilized, but seem to be rising again since September 2021. There are especially more requests for crisis help in mental health care facilities for young adolescents.

Similar notices and indications arrive from the field, reporting a shortage of beds to treat eating disorder patients and young people with general psychiatric disorders, with waiting lists being 4 times longer than during pre-corona times (5-8 months). Also, child psychiatric services (for ambulatory care and hospitalisation) as well as students psychological support services report getting saturated, with long waiting lists as a consequence. The situation in the child psychiatric mental health sector is currently again very worrying. It takes up to two or even three months to get an appointment for a consultation with a child psychiatrist and a similar period for hospitalization in a child psychiatry department. Consequently, it is essential to take measures to avoid the overcrowding and to slow down the emergence of new requests for care.

When looking at the working population, data of Group Idewe suggest an impact of COVID-19 on the different indicators of well-being in workers. Hence, there seems to be a small increase in burnout risk, while intention to stay and satisfaction seem to decrease. Regarding the psychological well-being of health care workers, especially in ICU, the evidence of their being at risk of exhaustion and moral distress was well documented in 2020¹. On the other hand, the psychological well-being of mental and social health workers remains yet an under investigated issue.

With increasing circulation of the virus, more and more workers drop out. When looking at data of ACERTA, the alarming signals about short sick leave in the healthcare sector are being supported by the numbers, with a noticeable peak in numbers since September 2021. This peak can be noticed across all sectors. These data support the reports of closing classes, schools, departments of hospitals, workplaces and institutions due to a lack of personnel. This is an important issue to consider when considering which measure to take or not to take. Hence, the economic continuity can be put in danger when appropriate measures are not being taken to prevent the further transmission of the virus among the working populations. This puts also additional strain on the remaining workers.

¹ Bruyneel, Arnaud ; Smith, Pierre. Comparison of the prevalence of burnout risk between ICU and non-ICU nurses during the COVID-19 outbreak in French-speaking Belgium. *Intensive & critical care nursing*, 66, p. 103086 (2021). doi:10.1016/j.iccn.2021.103086.

Butera S, Brasseur N, Filion N, Bruyneel A, & Smith P. Prevalence and associated factors of burnout risk among intensive care and emergency nurses before and during the COVID-19 pandemic: A cross-sectional study in Belgium. *Journal of Emergency Nursing*, Published: September 02, 2021. DOI:<https://doi.org/10.1016/j.jen.2021.08.007>

Tiete J, Guatteri M, Lachaux A, et al. Mental Health Outcomes in Healthcare Workers in COVID-19 and Non-COVID-19 Care Units: A Cross-Sectional Survey in Belgium. *Front Psychol*. 2021;11:612241. Published 2021 Jan 5. doi:10.3389/fpsyg.2020.612241

Eveline Van Steenkiste, Jessie Schoofs, Shauni Gilis & Peter Messiaen (2021) Mental health impact of COVID-19 in frontline healthcare workers in a Belgian Tertiary care hospital: a prospective longitudinal study, *Acta Clinica Belgica*, DOI: [10.1080/17843286.2021.1903660](https://doi.org/10.1080/17843286.2021.1903660)

In this report we also included an analysis of medication data provided by Farmaflux and health expenditure data provided by RIZIV/INAMI. Taking all medication use together (psycholeptics and psychoanaleptics), the data indicate that in comparison to 2019, the average defined daily doses (DDD) per patient in 2020 increased which continue to increase in 2021. While the average DDD use, and the use per patient increased, the number of unique patients (PAT) using psycholeptics or psychoanaleptics grew less strongly, stayed constant, or dropped. The higher medication use per patient can be explained by a higher medication use for existing patients, for example because they had more complaints because of the measures, or because of reduced psychiatric healthcare use as suggest during COVID.

The total healthcare expenditures for psychiatrists and child psychiatrists fell below previous years from April to July 2020 (first wave), in October 2020 and January 2021 (second and third wave). This was also the case for consultations, visits and advice at doctors' offices. Looking in more detail, from March 2020 onwards there is a lower expenditure on therapies, psychotherapies, and pediatric psychiatric consultations in comparison with previous years. If distance consultations (which started in April 2020) are factored in, the gap stays apparent between March and June 2020. However, since March 2021 the expenditures rise above levels of previous years when taking into account the distance consultations.

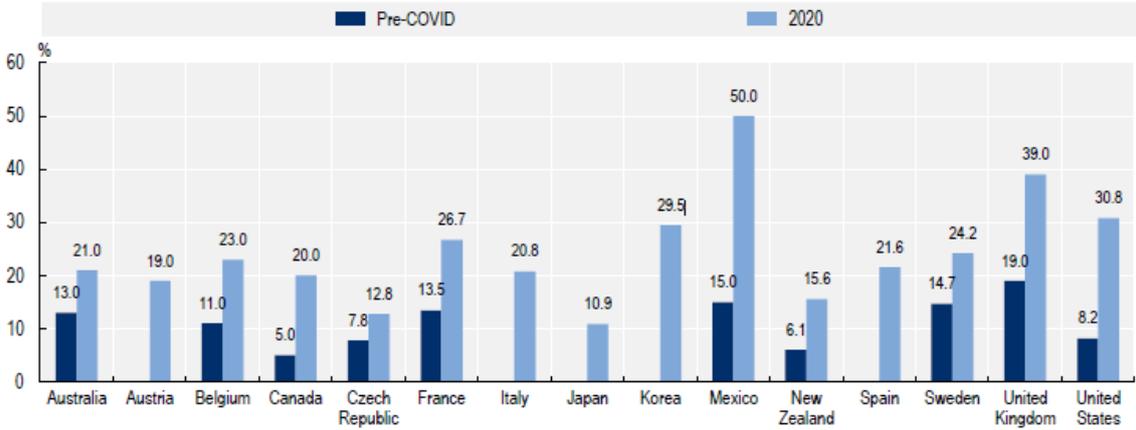
On a larger, worldwide level, OECD urges to respond effectively to the impact of the COVID-19 crisis on population mental health, integrated and cross-sectoral policies to improve mental health support (preventively and in the care sector) are needed. A recent article published by The Lancet supports these findings and states that taking no action to address the burden of major depressive disorder and anxiety disorders should not be an option.

3. Mental health and disorders

3.1. Mental Health Impact of COVID-19

In May 2021, the Organisation for Economic Co-operation and Development (OECD) published a report about the mental health impact of the COVID-19 crisis². The mental health of the population has worsened significantly during the pandemic. From March 2020 onwards, the prevalence of anxiety and depression has significantly increased (see figures 1 and 2). Periods when the highest rates of mental distress were reported correlated with periods of intensifying COVID-19 deaths and strict confinement measures.

National estimates of prevalence of anxiety or symptoms of anxiety in early 2020¹ and in a year prior to 2020

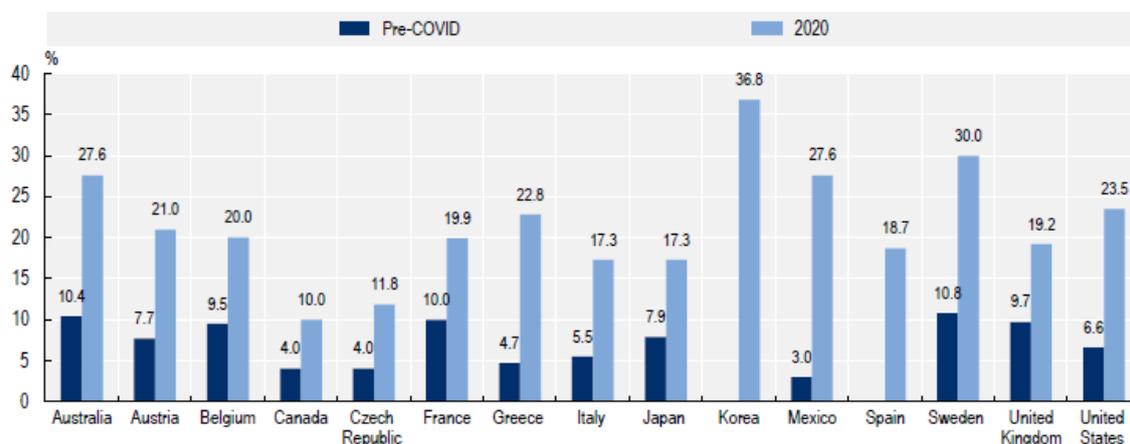


Note: ¹To the extent possible, 2020 prevalence estimates were taken from March-April 2020. The survey instruments used to measure anxiety and population samples differ between countries, and therefore are not directly comparable, and some surveys may have small sample sizes and/or not use nationally representative samples. Differences in the openness of populations to discussing their mental state also hampers cross-country comparability. Where possible, surveys using the GAD-7 instrument have been selected. 2013 data for Sweden uses a cut-off of '8' for the GAD-7, while most other studies use a cut off of ≥ 10 . Source: National sources: Australia [2017-18](#) and [2020](#); Austria [2020](#); Belgium [2018 and 2020](#); Canada [before COVID](#) and [2020](#); Czech Republic [2017 and 2020](#); France [2017 and 2020](#); Italy [2020](#); Japan [2020](#); Korea [2020](#); Mexico [2019-20 and 2020](#); New Zealand [2016-17](#) and [2020](#); Spain [2020](#); Sweden [2013 and 2020](#); the United Kingdom [2019 and 2020](#); the United States [2019 and 2020](#).

Figure 1: Prevalence of anxiety increased significantly in 2020

² OECD Policy Responses to Coronavirus (COVID-19). Tackling the mental health impact of the COVID-19 crisis: An integrated, whole-of-society response. 12 May 2021. Retrieved from: <https://www.oecd.org/coronavirus/policy-responses/tackling-the-mental-health-impact-of-the-covid-19-crisis-an-integrated-whole-of-society-response-0cfa0b/#:~:text=The%20COVID%E2%80%9119%20crisis%20has,to%20health%20services%20%E2%80%93%20fell%20dramatically>

National estimates of prevalence of depression or symptoms of depression in early 2020¹ and in a year prior to 2020



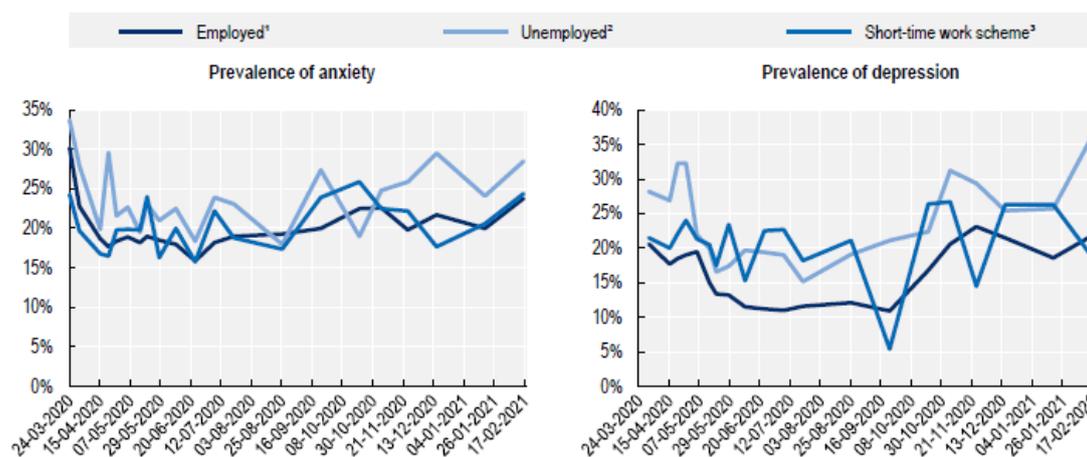
Note: ¹To the extent possible, 2020 prevalence estimates were taken from March-April 2020.

The survey instruments used to measure depression differ between countries, and therefore are not directly comparable, and some surveys may have small sample sizes or not use nationally representative samples. Differences in the openness of populations to discussing their mental state also hampers cross-country comparability. Where possible, surveys using the PHQ-9 instrument have been selected. 2020 data for Sweden uses a cut-off of '11' for the PHQ-9, while most other studies use a cut off of ≥ 10 .

Source: National sources Australia [2017-18](#) and [2020](#); Austria [2014](#) and [2020](#); Belgium [2018 and 2020](#); Canada ['before COVID' and 2020](#); Czech Republic [2017 and 2020](#); France [2017](#) and [2020](#); Greece [2014](#) and [2020](#); Italy [2014](#) and [2020](#); Japan [2013](#) and [2020](#); Korea [2020](#); Mexico [2019-20 and 2020](#); Spain [2020](#); Sweden [2013](#) and [2020](#); the United Kingdom [2019 and 2020](#); the United States [2019 and 2020](#).

Figure 2: Prevalence of depression increased significantly in 2020

During 2020, the risk factors for poor mental health – financial insecurity, unemployment, fear – increased, while protective factors – social connection, employment and educational engagement, access to physical exercise, daily routine, access to health services – decreased. Across countries, the mental health of unemployed people and those experiencing financial insecurity was worse than that of the general - a trend that pre-dates the pandemic but seems to have accelerated in some cases (see figure 3).



Note: ¹'Travail' ²'Chomage' ³'Chomage partiel'. Results are based on a survey with a small sample size (2 000 total respondents by survey wave) which may drive sharp drops and falls in some survey waves.

Source: Santé Publique France, Enquête CoviPrev, <https://www.santepubliquefrance.fr/etudes-et-enquetes/coviprev-une-enquete-pour-suivre-l-evolution-des-comportements-et-de-la-sante-mentale-pendant-l-epidemie-de-covid-19>.

Figure 3: Anxiety and depression are more prevalent among the unemployed in France

To respond effectively to the impact of the COVID-19 crisis on population mental health, integrated and cross-sectoral policies to improve mental health support are needed. OECD therefore proposes to assure access to existing mental health services either in-person or via telemedicine, or both, and to increase access to evidence-based services, including alternatives to mental health promotion programs in schools or workplaces. Employers must contribute to supporting the mental health of employees, including those who have been on job retention schemes. Policymakers should look further at the implications of long-term teleworking on mental health, and countries should consider scaling-up mental health support for jobseekers through public employment services.

These findings and recommendations are further supported by a recent article published by The Lancet³. The authors conducted a systematic review of 5683 unique data sources reporting on the prevalence of major depressive disorder and anxiety disorders during the pandemic. 48 data sources met the inclusion criteria. Two COVID-19 impact indicators were found to be associated with increased prevalence of major depressive disorder and anxiety disorders: daily COVID-19 infection rates and reductions in human mobility. Females and younger age groups were more affected by the pandemic than males and older age groups.

The authors conclude that the pandemic has created an increased urgency to strengthen mental health systems in most countries. Mitigation strategies could incorporate ways to promote mental wellbeing and target determinants of poor mental health and interventions to treat those with a mental disorder. Taking no action to address the burden of major depressive disorder and anxiety disorders should not be an option.

3.2. Children and adolescents

3.2.1. Youth aid

The Flemish agency “Opgroeien”⁴ (growing up) is a Flemish organization that consists of “Kind en Gezin” (child and family), “Jongerenwelzijn” (youth welfare) and part of “Vlaams Agentschap voor Personen met een Handicap” (Flemish agency for persons with disabilities). They provide advice, support, guidance, shelter or help for children and young adolescents while growing up. Every month they update the number of applications for crisis youth aid, youth support centers and other youth aid services. In March 2020 and March 2021 there was a noticeable peak in applications. Also in June 2021 there were more applications than in 2020 and 2019. Besides an increasing demand because of mental health problems, we need to take into account that postponed care is probably being caught up as well (decrease in 2020 vs 2019 in every month March-November), against a rising trend pre-Covid observable also in the Jan-Feb data.

³ Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. Published online October 8, 2021 [https://doi.org/10.1016/S0140-6736\(21\)02143-7](https://doi.org/10.1016/S0140-6736(21)02143-7)

⁴ <https://www.opgroeien.be/>

Evolutie aantal aanmeldingen per maand (n=unieke minderjarigen)

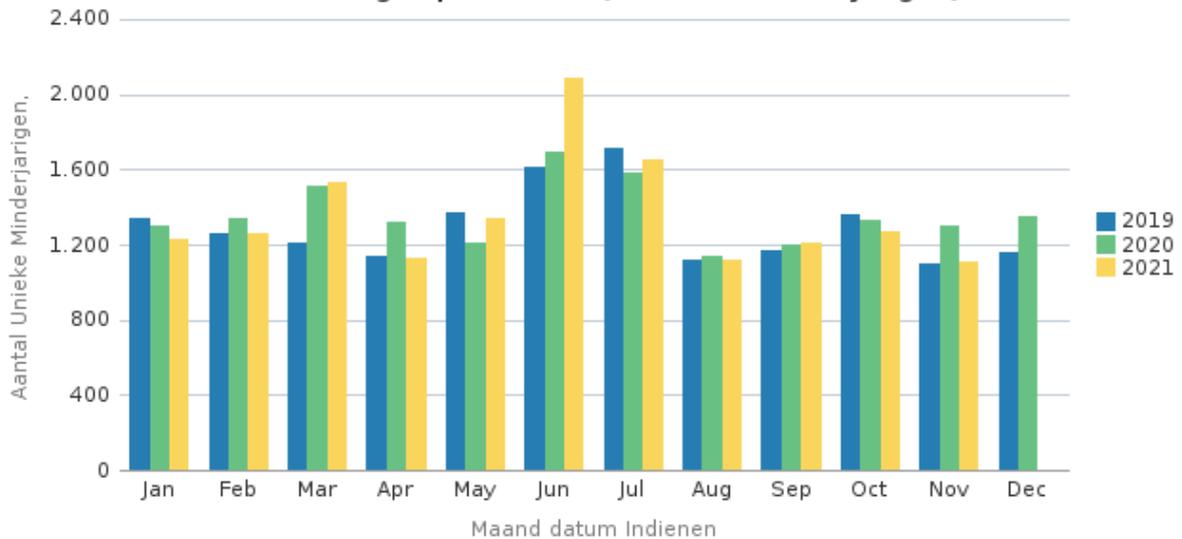


Figure 4: Number of applications for not directly accessible youth aid

One of the steps in youth aid is crisis youth support for children, young adolescents, and their families when in crisis and urgent care is needed. The dispatch for crisis situations has been receiving more questions every month, and even more so since the beginning of the COVID-19 crisis. The dispatch center first looks for a solution within the environment of the minor. If this is not possible, the dispatch center decides to provide a consult. During a consult, it is estimated if the situation needs further (crisis) youth support, mental health care support or both. The number of consults has known a steep rise in 2021, with a record of 756 consults in March 2021. In April 2021 and May 2021, the numbers were around the same level as in 2019, but are still higher than 2020. In June 2021, the numbers are higher than in 2019 and 2020. From July 2021 on, the numbers stabilized to the levels of previous years. Since September 2021 numbers are rising again. On one hand, this seems to be mainly due to a rise in questions concerning mental health. On the other hand, over the three years the months May and October have been characterized by a re-occurring high demand.

Aantal unieke trajecten

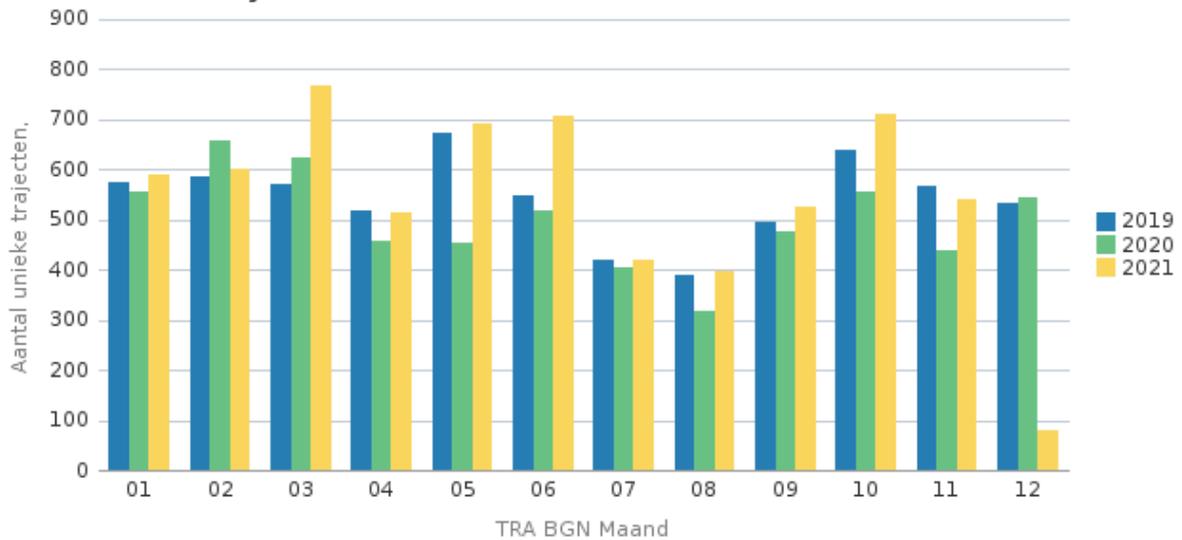


Figure 5: Number of provided consults after demand for crisis support at the dispatch center (note: numbers of 12/21 not complete).

When looking at the number of demands for crisis support where it was decided that crisis youth aid was necessary, there has been a record in applications. Even before the COVID-19 crisis began there were many applications, but since March 2021 the applications have never been higher, with in March an all-time high of 588 unique minors that were referred to crisis youth aid. Most cases are about mental health problems, with a lot of questions about suicide. Especially complex situations that have been difficult for a while, seemed to go into crisis. In July and August 2021 the numbers stabilized, but seem to be rising again since September 2021. There are especially more demands for crisis help in mental health care facilities for young adolescents.

Aantal unieke cliënten

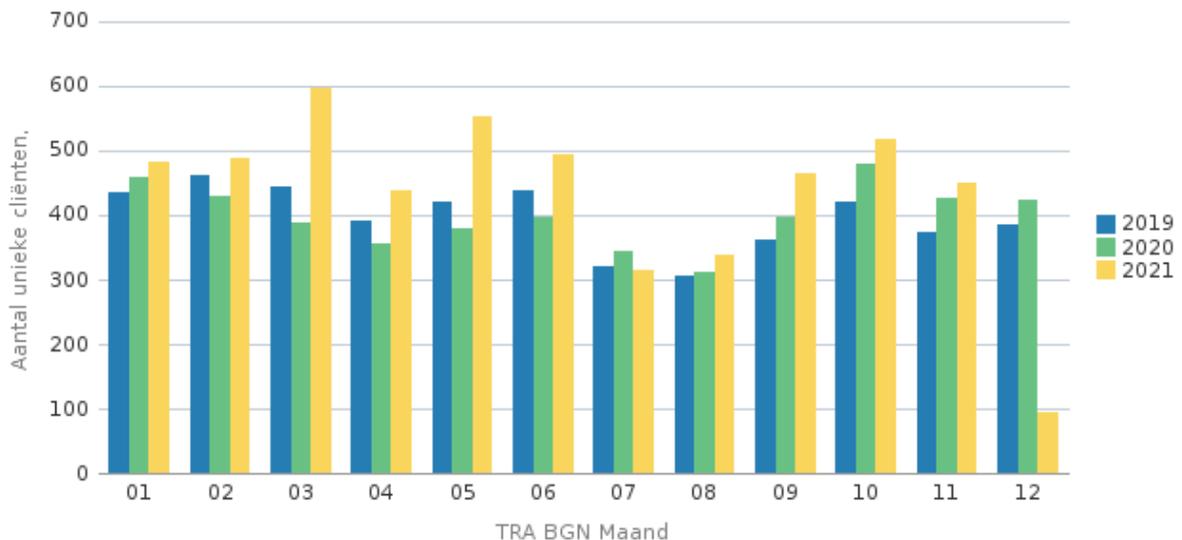


Figure 6: Number of unique minors who are being referred to crisis youth aid every month. (note: numbers of 12/21 not complete)

When voluntary support is difficult or not possible, youth support centers can provide care for children, young adolescents, and their parents. With regard to the number of minors who

applied for help at one of the youth support centers, in March 2021 they noted the second highest number of applications ever (512 unique minors). Only in March 2020, right before the start of the COVID-19 crisis there was a higher number (556 unique minors). Since April 2021 the numbers seem to stabilize again to the numbers of 2019, but there are some regional differences. In September 2021 there was a peak (especially for the regions of East-Flanders and Limburg), but since October 2021 numbers dropped below 2019.

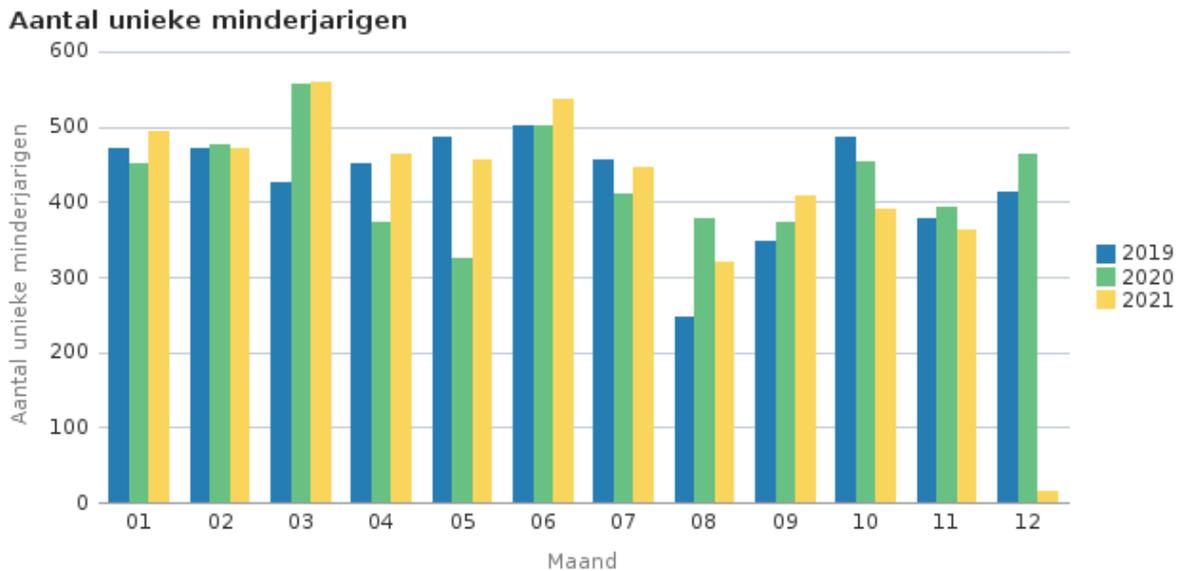


Figure 7: Number of unique trajectories for minors for whom an application was made for support at a youth support center every month. (note: numbers of 12/21 not complete)

3.2.2. Child psychiatry

Child psychiatric mental health sector is currently saturated. It takes up to two or even three months to get an appointment for a consultation with a child psychiatrist and a similar period of time for hospitalization in a child psychiatry department. The data recorded within the Unit for adolescents of the Hospital Centre le Domaine-ULB in Braine-l'Alleud, which has 15 beds including 3 crisis beds, has proven to give a picture of what is generally encountered in all classic child psychiatric hospital structures. A strong increase in requests for care is occurring since the end of September 2021, as shown in the following graph, which represents the evolution of requests within the unit for adolescents at Le Domaine over time.

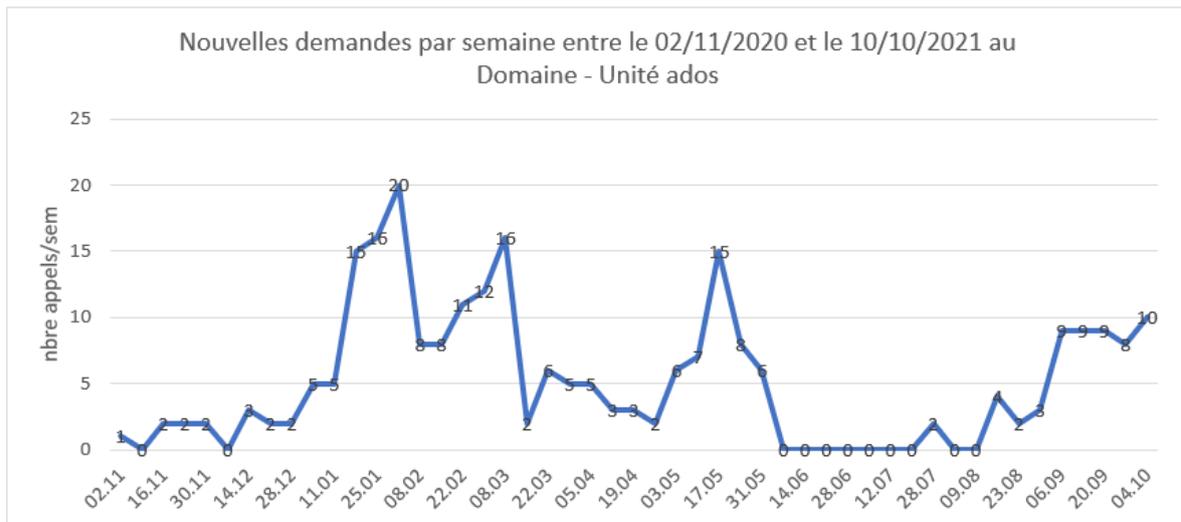


Figure 8: Number of requests for care per week (adolescents)

The first wave of massive psychological decompensation among young people appeared in January 2021, which quickly saturated the entire child psychiatric mental health care system. A new peak appeared in May 2021 and corresponded to the resumption of face-to-face classes on 10 May 2021. At that time, the school resumption took place without any arrangements for the pupils coming out of the crisis, with maximum school stress due to the continuation of the end-of-year exams, while the psyche of the young people was already strongly impacted. This led to further decompensation and requests for follow-up, and further overburdened the already overburdened care system.

Requests then slowed down during the summer, which was particularly calm, allowing the child psychiatric hospitals to be relieved of their workload and reducing the waiting lists. On the other hand, outpatient follow-up remained at a relatively high level. Since September 2021, requests for outpatient follow-up and hospitalization in child psychiatry have again been rising in at a much higher rate than during a traditional academic year. The effects of the pandemic and the health measures added to the school stress are noticeable.

The graph shows what such an increase in demand can do to a ward. The length of stay is generally 2-3 months, except for the crisis beds which allow for immediate care (when there is space) but are interrupted after 2 weeks to make room for the next patient. In the adolescent unit of the Domaine, which has 15 beds in total, there is a turnover of about 5 patients per month for the classic beds and 5 patients per month for the crisis beds. In the last month they had 36 new requests for hospitalization, which immediately saturated the beds but also the waiting list. They had to announce a 3-month waiting period to the families and professionals who contact them today for a classic hospitalization. If the demand continues at the same rate, the waiting list will grow by one month for every week that passes. The evolution of saturation is exponential. Only the crisis beds are still available because they do not create a waiting list, otherwise they will soon no longer be able to meet the definition of the crisis and the initial project. But demand exceeds supply: this month they received 10 requests for crisis beds for 6 available places.

If they had been able to respond to all the calls and offer the hospital care that corresponds to the demand on the ground, their occupancy would have caused a bottleneck comparable to that illustrated in the graph "Evolution of needs between 2 November 2020 and 10 October 2021". The red line "saturation" corresponds to the occupation of all the places available in the service, including the provision of additional beds in pediatrics until 31 December 2021 via the liaison program as part of the intensification of child psychiatric care. The blue "new requests" columns show the number of new requests made to the service per week. The orange "fictitious occupation" curve represents the number of patients present in the ward if they had been able to hospitalize them all, taking into account those leaving (after an average stay of 2 months). This curve corresponds to the real needs and shows how hospital services cannot meet the current needs. It also shows the disaster to come if this demand continues at the current level.

The program to intensify child psychiatric care has made it possible to hire 2 additional FTEs in the Domaine, which are devoted, among other things, to support patients on the waiting list in the context of the "In" and "Out" function. This additional staff will not be sufficient to meet all the demands. The beds now available in the pediatric department of the Chirec hospital in Braine-l'Alleud, with which they work closely, only inadequately and very summarily reinforce the current supply of crisis beds in terms of quality of care and support.

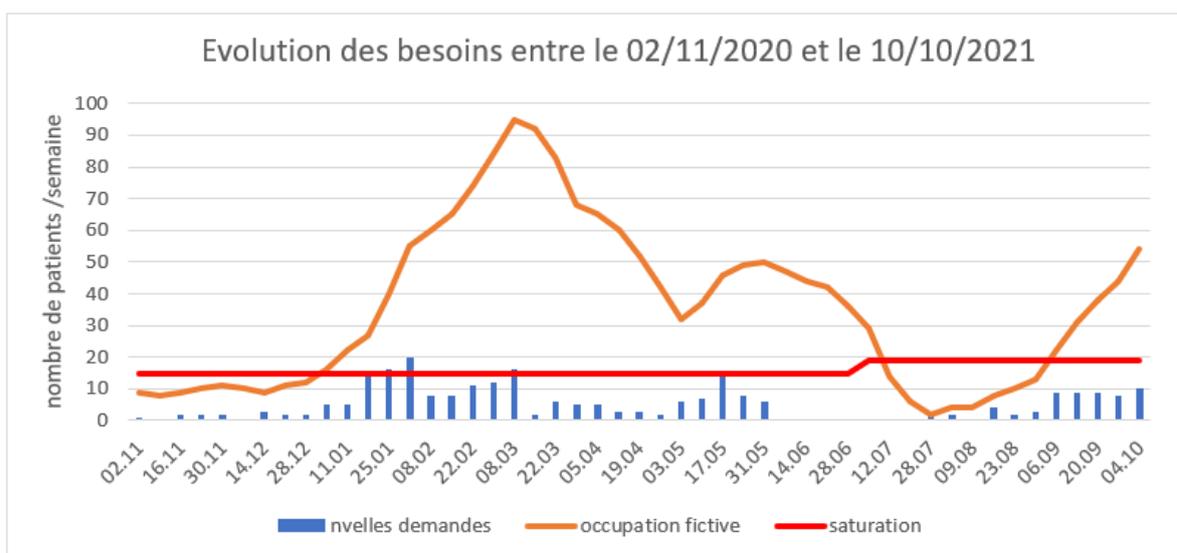


Figure 9: Evolution of needs

The next very worrying factor is the degree of saturation of outpatient child psychiatry, which was not as problematic at the beginning of the January 2021 wave. At that time, outpatient clinics were able to make up for the lack of hospital places for about a month. Today, patients arrive at the hospital because, among other things, the waiting time for a child psychiatric consultation is such that the situation has time to deteriorate, and hospitalization becomes necessary.

The lack of accommodation in the youth welfare sector for children and adolescents requiring out-of-home care also contributes to hospital overcrowding. Moreover, these situations of waiting for placement often lead to longer than average hospitalizations, occupying beds for up to 6 months, whereas the care itself no longer requires hospitalization.

Faced with a saturated mental health care system in child psychiatry, it is now essential to take preventive measures to avoid the continuation of this overcrowding and to slow down the emergence of new requests for care. The child psychiatry sector will not be able to cope alone with the impact of health measures on young people. Our young people are not in danger of saturating the intensive care units, but they are overflowing child psychiatric care. It is essential to protect them from the deleterious effects of health measures and to support their socialization. It is essential to change the discourse addressed to them and to stop considering them as dangerous: they are now the ones who are most at risk and need the benevolence and attention of all adults.

3.2.3. Eating disorders in adolescents

In Flanders, the knowledge center for eating disorders (Kenniscentrum Eetexpert⁵) provides residential and outpatient care. Their first goal is early detection, prevention, and guidance to specialized care if necessary. In Flanders, there are five specialized residential eating disorder-teams, from which two focus on adolescents younger than 15. There are approximately 80 beds, combined with (daytime) therapy and specialized outpatient programs.

In October 2021, 'post'-COVID-19, the waiting lists for admission in residential care are four times as high as before COVID-19. Most patients have to wait two to four months for an intake, and five to eight months for admission. Some centers even decided to stop intakes (temporarily) until the waiting lists get shorter. For both younger patients (<15y) and patients older than 15 there is a capacity- and intensity problem.

Due to the increased need for care in COVID-times, the ambulant network also has a capacity problem. Kenniscentrum Eetexpert is therefore working on a capacity expansion both for specialized dieticians as for psychologists. The acute problem, however, is the lack of possibilities to refer to residential care. Therefore, to keep the ambulant network operational, Kenniscentrum Eetexpert urges to ensure additional support from centers for mental health care and to create a buffer in the residential care through rapid short-term admission capacity and daycare services for patients and their parents.

3.3. Motivation barometer

Since the beginning of the lockdown, the well-being and motivation of the population have been ongoingly monitored within the motivation barometer. Across 97 waves (latest update 06.12.2021), more than 330.000 individuals from varying age groups have filled in a brief online questionnaire. The latest wave was gathered in early December (N = 3993) completed the questionnaire and yielded a mix of participants coming from different regions (34.34% from Flanders; 65.66% from Wallonia; 19.21% unvaccinated persons).

Figure 10 presents a graphic overview of five well-being indicators (i.e., vitality, life satisfaction, sleep quality, depressive complaints, symptoms of anxiety) that have been monitored among Flemish participants since the beginning of the crisis. As can be noticed, there has been a steady increase in well-being since the measures were relaxed before the summer, with this increase leveling off in September-October and well-being even slightly decreasing. However, since the beginning of November, a tentative increase in wellbeing can be noticed again. After

⁵ Author : An Vandeputte, Kenniscentrum Eetexpert.be vzw

controlling for various sociodemographic covariates, a systematic effect of age, gender, and co-morbidity were observed, with younger individuals, females, and individuals with co-morbidity being more vulnerable for poorer well-being.

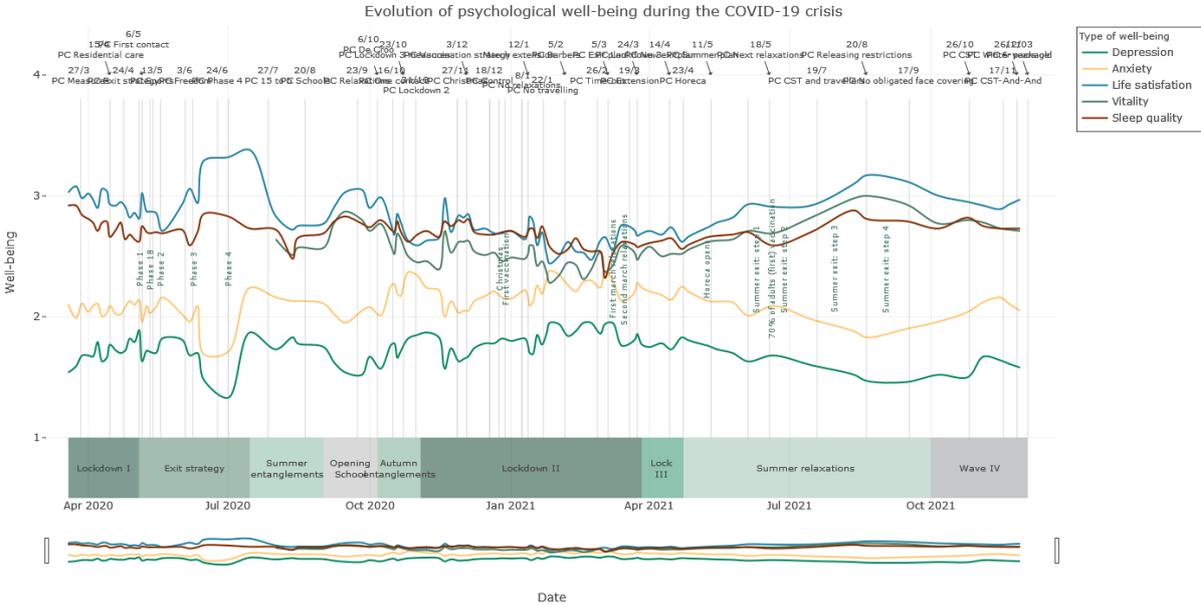
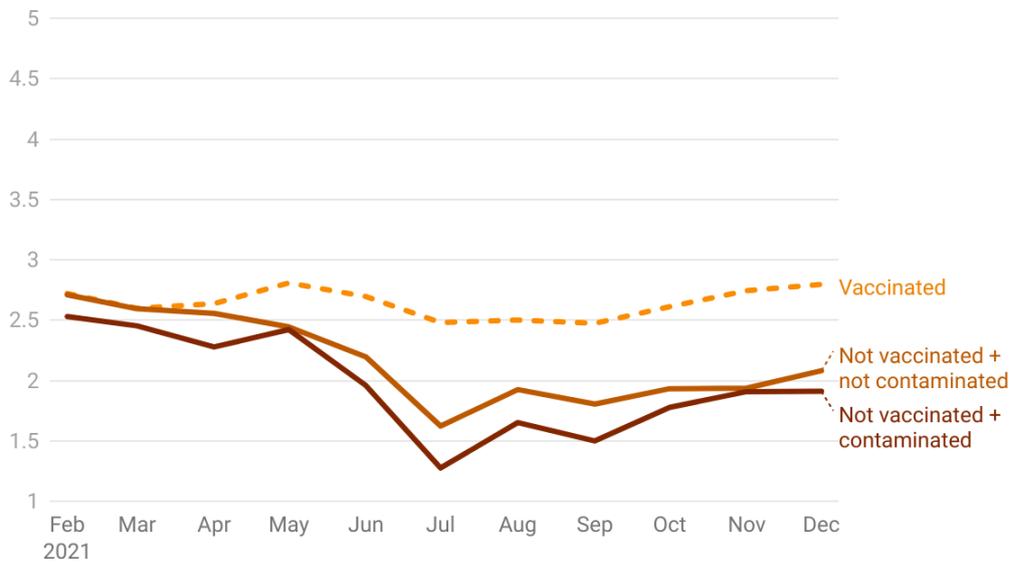


Figure 10: Evolution of psychological well-being during the COVID-19 crisis among Flemish participants

Although vaccination status yielded no systematic relation with well-being, it yielded a clear, yet differential effect on different critical resources of well-being, a finding observed mixed samples of French- and Dutch-speaking participants. As can be noticed in Figures 11 and 12, unvaccinated persons report less insecurity to be infected (figure 11), yet they experience also lower autonomy (figure 12) and relatedness need satisfaction compared to vaccinated persons. Said differently, vaccinated persons are enjoying more the freedom that is afforded to them, which likely explains their felt connection with others; yet, they also stay vigilant and concerned to be infected as they perceive higher risks.

Concerns regarding own health

The Motivationbarometer

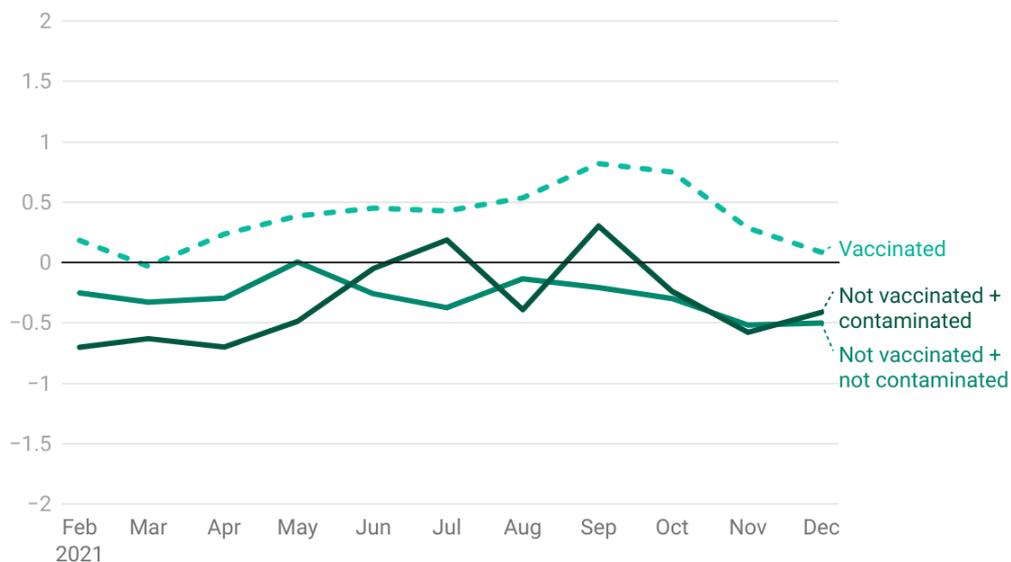


Averages are weighted by age, gender, education and region
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Figure 11: Evolution in concerns regarding own health among (un)vaccinated persons

Autonomy

The Motivationbarometer



Averages are weighted by age, gender, education and region
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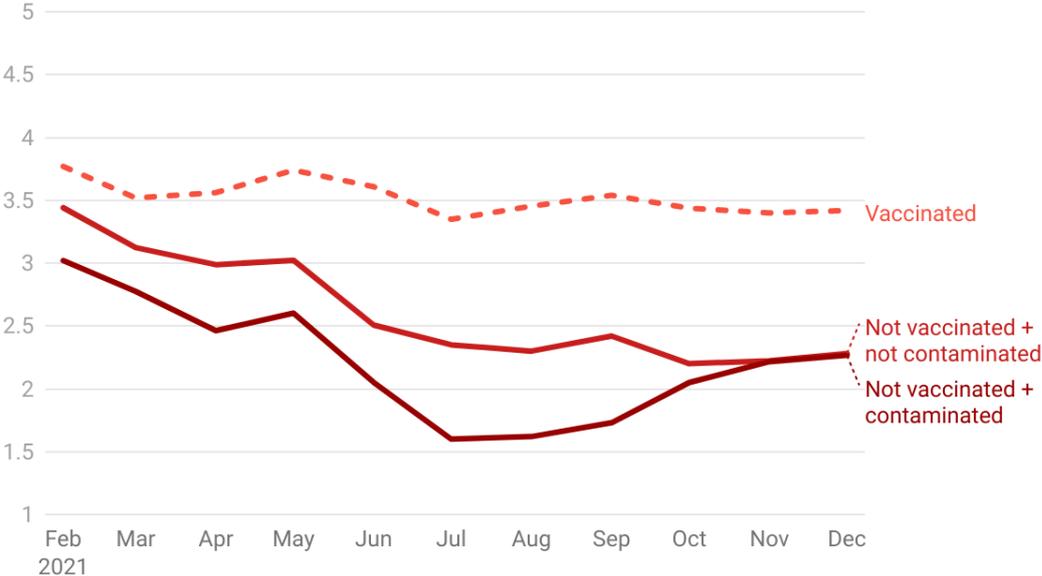
Figure 12: Evolution in autonomy among (un)vaccinated persons

Paralleling these differences in perceived risks and concerns, vaccinated persons stay more motivated to adhere to the measures nowadays. The motivational gap which has been observed between vaccinated and unvaccinated persons is still present today, with

unvaccinated persons being less autonomously motivated to stick to the measures and also reporting being less adherent (figures 13 and 14), an effect that was observed for the three assessed sanitary measures (i.e., keeping distance; disinfecting hands; face covering).

Voluntary motivation to adhere the measures

The Motivationbarometer

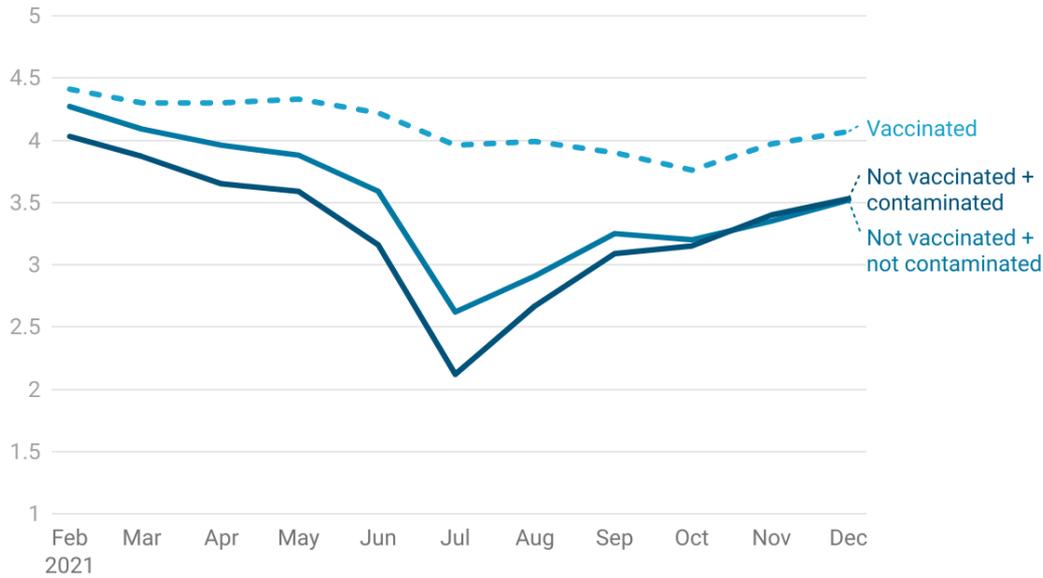


Averages are weighted by age, gender, education and region
Created with Datawrapper

Figure 13: Evolution in autonomous motivation among (un)vaccinated persons

Adherence to the measures

The Motivationbarometer



Averages are weighted by age, gender, education and region

Created with Datawrapper

Figure 14: Evolution in adherence to the measures among (un)vaccinated persons

3.4. Great Corona Study

The Great Corona Study^{6,7} (GCS) has been monitoring the Belgian population since 17th March 2020, interspaced one, two or four weeks apart up till September 2021; with one additional wave completed in December 2021. This web-based survey, which has a citizen science anonymous voluntary design is administered in four languages (NL, FR, DE, EN) on PC, tablet and smartphone and has been taken over 3 million times to date in 44 waves. The survey was predictive of the incidence of detected infections in Belgium⁸.

The GCS monitors the mental health of the Belgian population as measured by the General Health Questionnaire (12 item scale; GHQ-12). In the period since the end of September the GHQ-12 has taken a turn for the worse, especially in students and adults under 45. (figure 15). The GCS also showed that age (like in the Motivation Barometer) has an important impact on the evolution of mental wellbeing. At the extremes they found students consistently at the worst end, and retired persons at the best end of the scale.

⁶ www.corona-studie.be

⁷ This study has also been communicated on this blog: <https://blog.uantwerpen.be/corona/mentaal-welzijn/>. See also other results on <https://corona-studie.shinyapps.io/corona-studie/>

⁸ Neyens et al, 2020

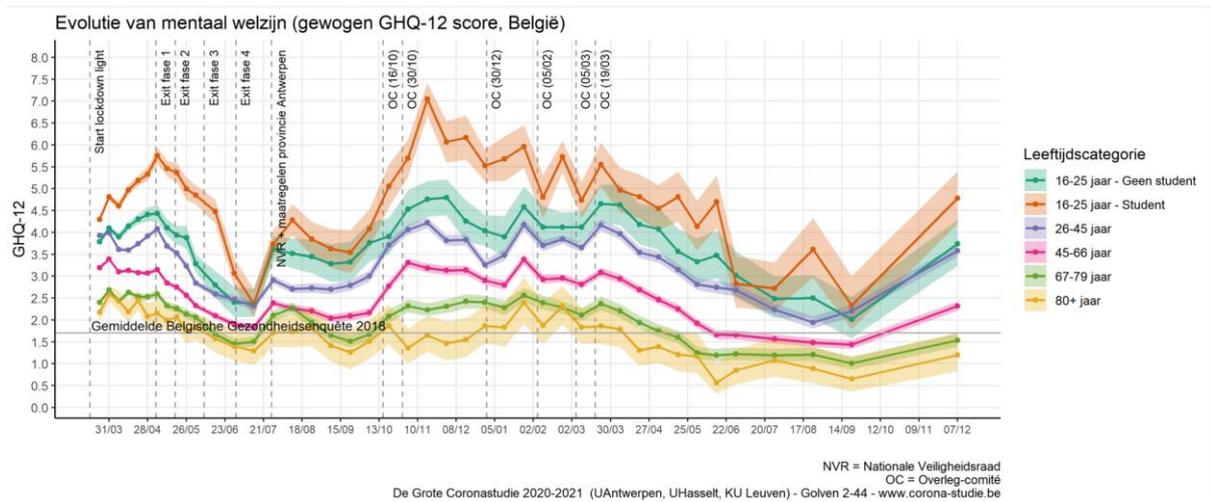


Figure 15: Evolution of GHQ-12 as monitored by the Great Corona Study

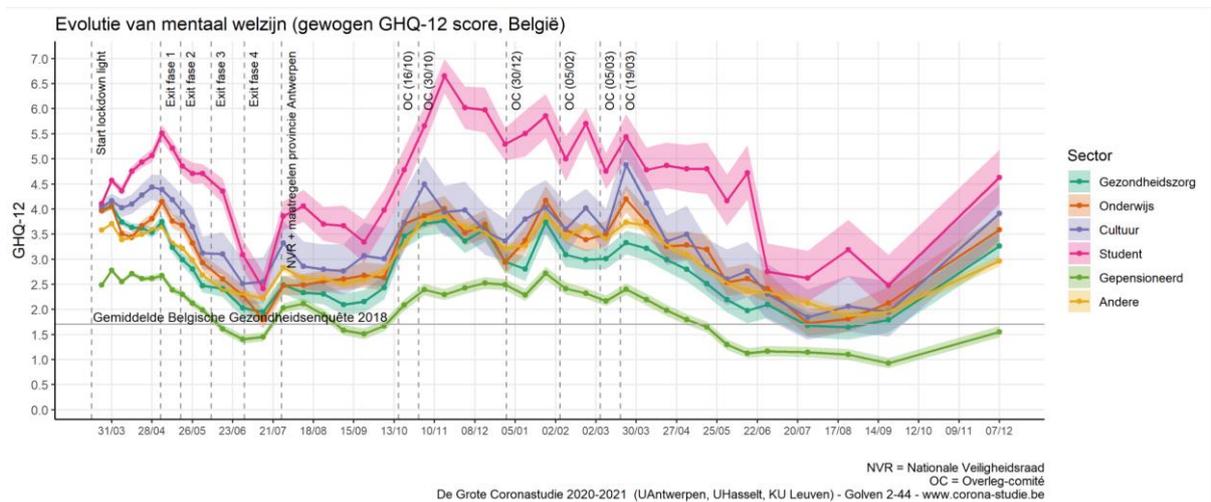


Figure 16: Evolution of GHQ-12 (GSC) - differences per sector

This is also depicted in figure 16, by sector of employment, where apart from the students, people working in the culture & event sector, as well as education and health care are badly affected by the sequence of events that took place between the penultimate GCS wave in late (21st) September and the latest one, Wave 44, in early (7th) December 2021 (n = 18001). The general evolution by gender is similar, but given that proportionately more women are active in the most affected sectors, the gender gap in GHQ-12 has substantially widened again.

3.5. Mental health of the working population

To study the impact of corona on the wellbeing of the Belgian working population, Group IDEWE, the largest Belgian external service for protection and well-being at work, used data of the numerous risks analysis surveys regarding psychosocial well-being that they perform for their customers. These risk assessments focus on the well-being indicators satisfaction, intention to stay and burnout risk.

The figure below shows the percentage of employees with a high score on these indicators per month in 2020 and 2021⁹. For satisfaction and intention to stay it holds that the higher the percentages are, the better the results; for burnout risk, the reverse is true (figure 17). The data of the months April, May, July and August (2020) and July and August (2021) were excluded due to few data.

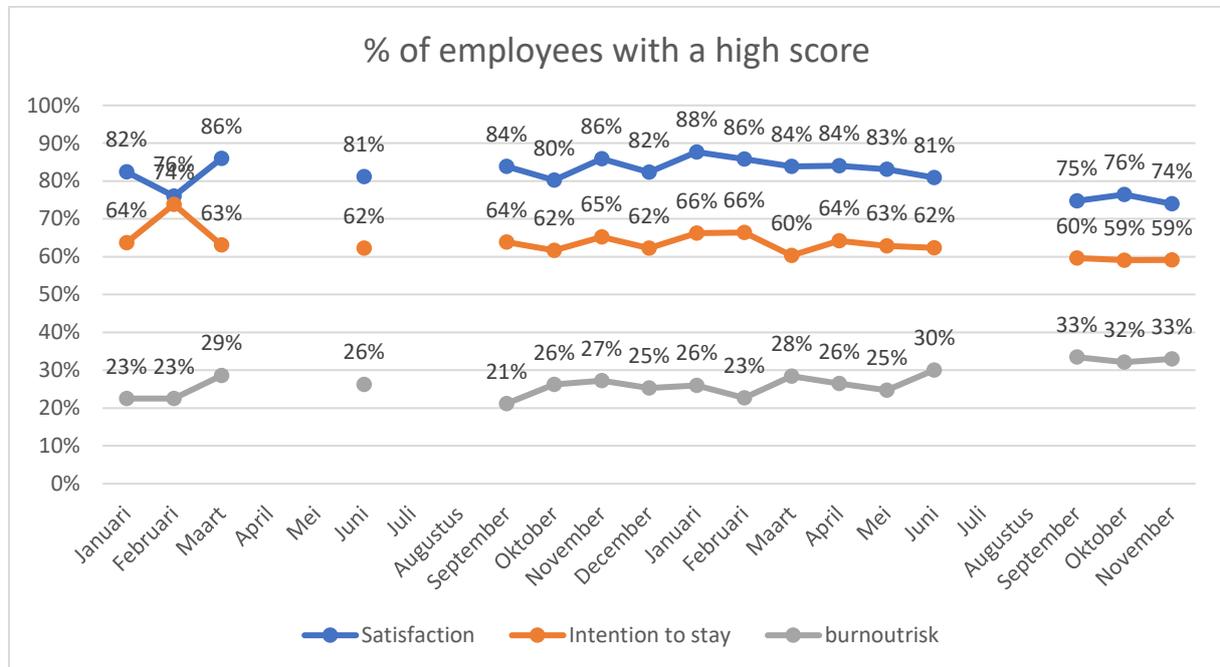


Figure 17 : percentage of employees with a high score for indicators of wellbeing

The results suggest a small impact of COVID-19 on the different indicators of well-being in workers. There seems to be a small increase in burnout risk, while intention to stay and satisfaction seem to decrease.

3.6. Psycholeptic and psychoanalytic medication use

In this short summary¹⁰, we evaluate to what extent the COVID-19 pandemic influenced medication use for mental health by comparing 2021 and 2020 to previous years. To this end, we make use of psycholeptic and psychoanalytic medication use (N05 and N06) up to October 2021 from the FarmaFlux database.¹¹

3.6.1. General evolution

Taking all medication use together (psycholeptics and psychoanalytics), Figure 18 indicates that in comparison to 2019, the average defined daily doses (DDD) per patient in 2020

⁹ Authors: Schouteden M, Vandenbroeck S, Godderis L.

¹⁰ Authors: Lode Godderis, Jonas Steel, Hamelinck Wouter, Lies Grypdonck, Vansnick Luc, Francis Arickx, Mickael Daubie, Koen Straetmans

¹¹ Note that the number of patients is a number by province and month, meaning a patient can appear in multiple provinces and months, and that data on the number of unique patients is absent. Only the data from January – October is used when comparing differences between 2020-2019 and 2021-2020, to make these differences comparable. In other words: when comparing the change from 2020-2021 with the change from 2019-2020, we focus on the months Jan-Oct.

increased for all age categories and genders, with the exception of young males (age 0-15). Compared to 2020, the average defined daily doses (DDD) per patient in 2021 increased even further, with large effects for the younger age groups. The relative effect in younger age groups is higher, though the low absolute numbers in those age groups have to be taken into account to interpret the numbers correctly. In both years, the differences generally diminished as age increased; i.e. younger patients' medication use grew more strongly compared to older patients. The impact of gender differed by age group in both 2020 and 2021.

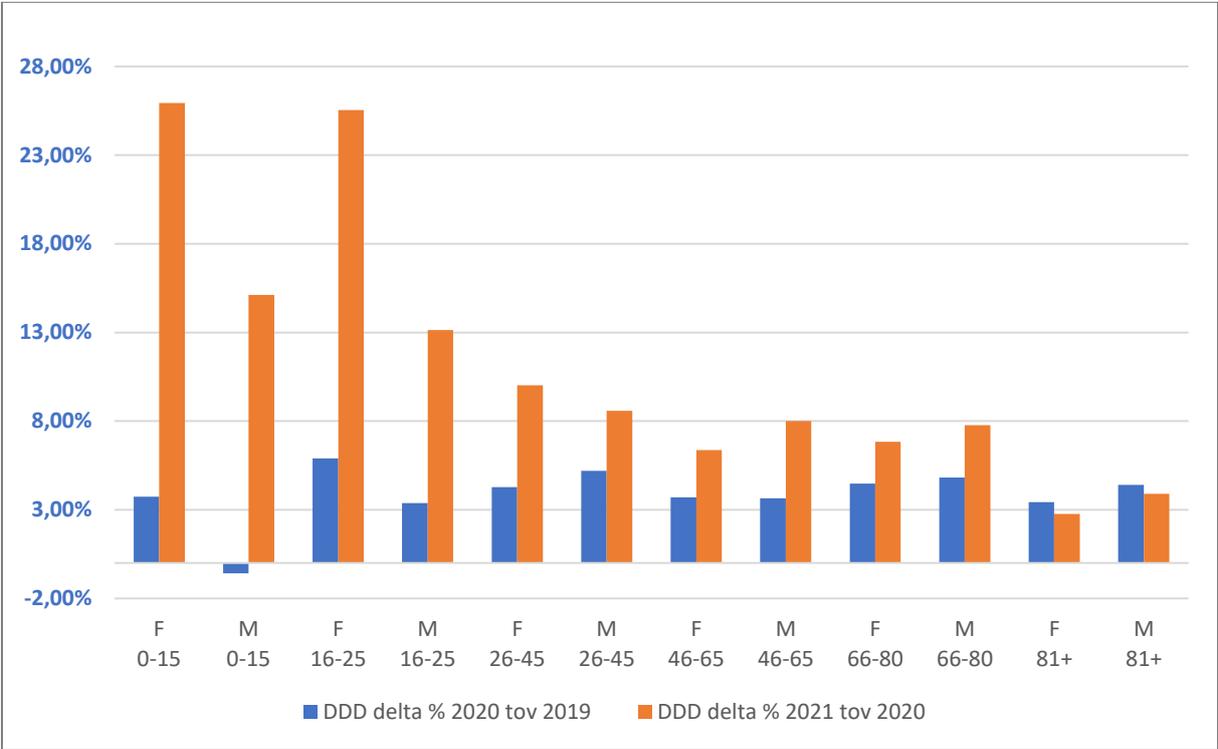


Figure 18: Psycholeptics and psychoanaleptics by age group and gender, % difference 2020-2019 versus 2021-2020 - DDD/patient/year

While the average DDD use, and the use *per patient* increased, Figure 19 indicates that the number of unique patients (PAT) using psycholeptics or psychoanaleptics grew less strongly, stayed constant, or dropped.¹² Hence, less patients consumed more medication in 2020 compared to 2019.

¹² Patients were calculated based on place of delivery (pharmacy) ...

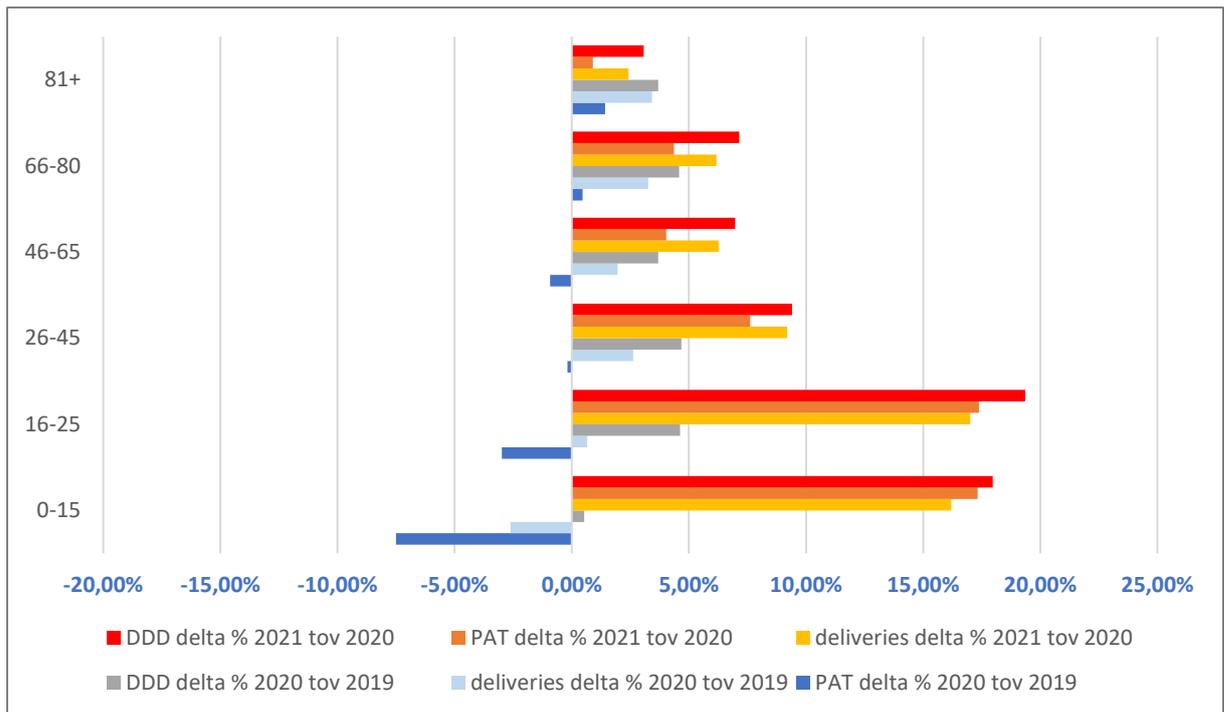


Figure 19: Psycholeptics and psychoanaleptics DDD, deliveries & patients by age group: % difference in 2021-2020 (brightly colored) versus % difference in 2020-2019 (blue/gray) [jan-oct]

In Figure 20, it is shown that a higher medication use in January and February 2020 (before COVID-19) plays a role in these observations, but March 2020, we also saw a large rush on medication: 32.90% more defined daily doses, 28.60% more deliveries, and 19.16% more patients. The rest of the year we noticed a decrease in comparison to 2019, especially in May 2020, followed by a second (but smaller) increase towards December 2020.

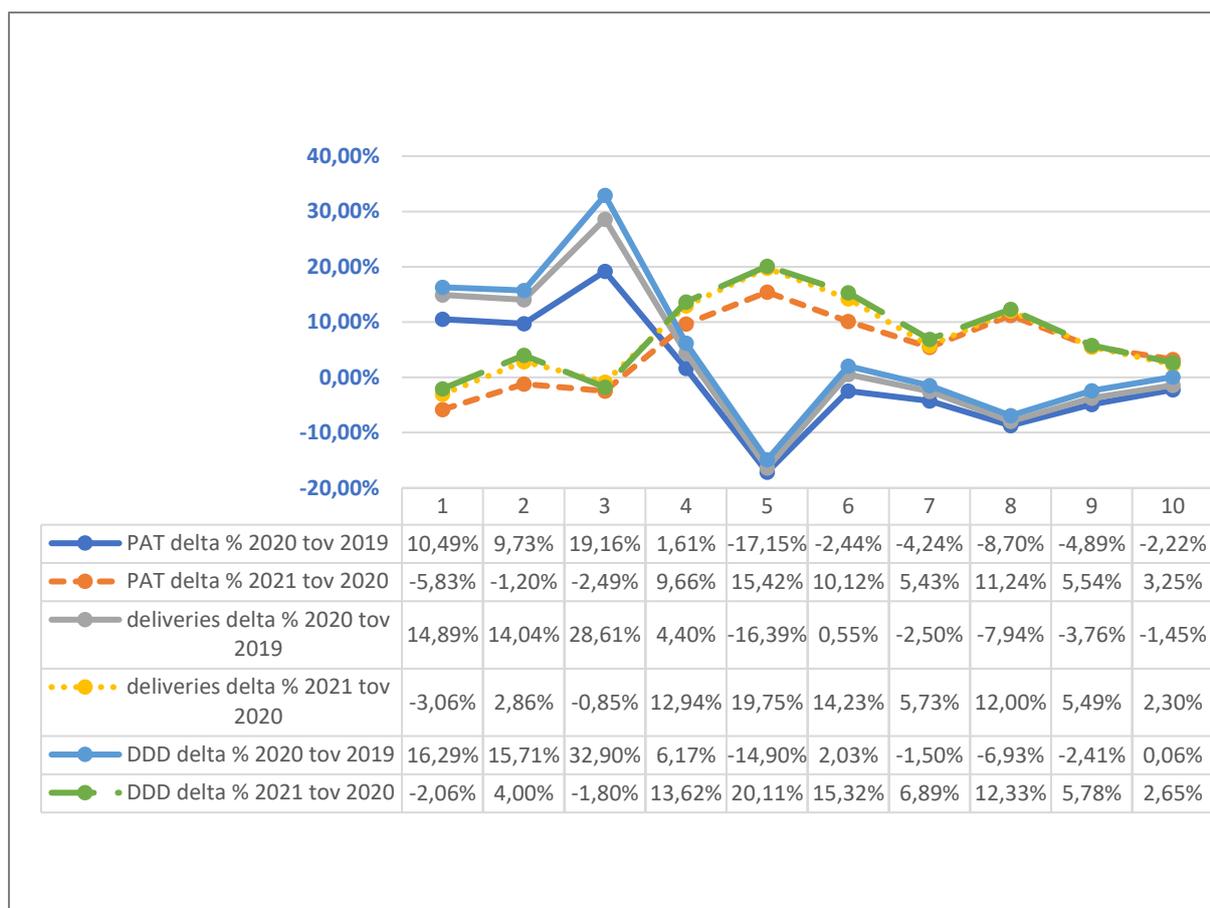


Figure 20: Psycholeptics and psychoanalectics DDD, deliveries & patients by month, % difference 2020 - 2019 versus % difference 2021 - 2020 [jan-oct]

Several explanations can be put forward for these results, but it must be emphasized that these are hypotheses: as there is no direct link between medication use and patients (as would be the case in a longitudinal dataset in contrast to this cross-sectional database), only averages can be compared over time, and strong causal inferences cannot be made. It should also be noted that data from previous years (before 2019) was not available, making it difficult to discern the impact of COVID-19 in 2020 from general time trends (e.g. a general increase in the use of medication over the years).

First, on the demand side, the rise of DDD, deliveries and patients in March 2020 could be consistent with herd behaviour/*hoarding* at the start of the COVID-19 pandemic. This is confirmed by a lower consumption in May 2020, as the (hoarded) supplies had not yet been depleted. Second, the higher medication use per patient could be explained by a higher medication use for *existing patients*, for example because they had more complaints because of the anti-COVID measures (cfr early results of the Great Corona study), or because of reduced psychiatric healthcare use (cfr our other report on psychiatric healthcare use during COVID). Third, *new patients* could have also played a role in the increase in DDD, as COVID and the measures taken to contain it might have given rise to specific disease profiles demanding more medication, for instance through the mental impact on COVID patients, or increased mental complaints due to the social restrictions, financial problems, ... the COVID restrictions might have caused. COVID-19 might have also had an impact on the *help-seeking behaviour* of patients, as financial reasons, COVID-restrictions, postponement of non-urgent medical care, fear of contracting COVID-19, ... might have led them to postpone seeking medical care (cfr our other report on psychiatric healthcare use during COVID), which may have affected their medication use. Finally, the *supply side* could have played a role:

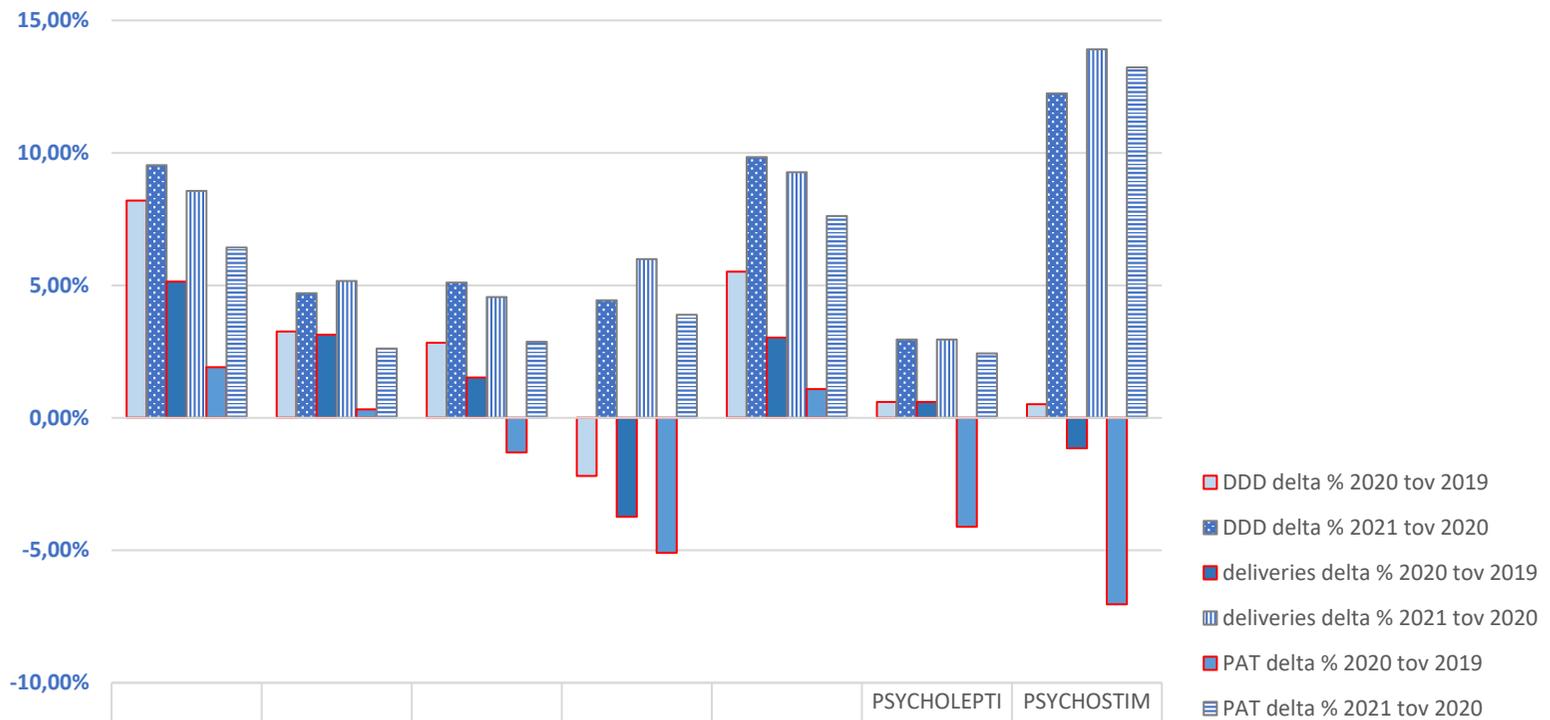
physicians might have increased their prescription behaviour because of the uncertainty surrounding the possibility of physical contacts, or to compensate for the drop in healthcare contacts with patients.

3.6.2. Evolution by category

Total evolution by category In Figure 21, the use of psycholeptic and psychoanaleptic medication is split up by category. The overall use of antipsychotics (N05A), anxiolytics (N05B), hypnotics and sedatives (N05C), and antidepressants (N06A) show similar patterns to those described in the previous section: in 2020 the defined daily doses (DDD) and deliveries of these categories increased, while the number of patients (PAT) grew less strongly, stayed constant, or dropped. Figure 21 also shows that the overall use of “psychostimulants, agents used for ADHD and nootropics” (N06B), and psycholeptics and psychoanaleptics in combination (N06C), remained relatively stable in 2020, but the number of patients (PAT) dropped. The use of anti-dementia drugs (N06D) and its number of using patients all dropped in 2020. In 2021, a similar observation can be made: in comparison to 2020, the defined daily doses (DDD) and deliveries rose faster than the number of patients (PAT) for all categories except N06B.

Evolution by province It is also interesting to observe the differences in daily defined doses (DDD) between provinces, although it should be kept in mind that their population differs (e.g. by age and gender) and the figures are simple aggregates that do not take this into account.

Of the Walloon provinces, Liège is affected the most in both 2020 (compared to 2019) and in 2021 (compared to 2020). The comparison among Flemish provinces points out that Limburg and East-Flanders have known the largest increases in 2021 compared to 2020 in most categories. In 2021 (compared to 2020), the peaks for daily defined doses of anti-dementia drugs are in Limburg (+3.14%) and East-Flanders (+3.20%), for antidepressants in Limburg (+8.68%) and East-Flanders (8.68%), for antipsychotics in Flemish-Brabant (+9.20%), anxiolytics in Limburg (+1.23%) and East-Flanders (+1.68%), hypnotics and sedatives in Limburg (+4.47%) and East-Flanders (+3.66%), psycholeptics and psychoanaleptics in combination in Limburg (+6.39%) and East-Flanders (+2.28%), and “psychostimulants, agents for ADHD and nootropics” in Limburg (+17.08%) and East-Flanders (+14.30%).



	ANTIPSYCHOTICS N05 PSYCHOLEPTICS	ANXIOLYTICS N05 PSYCHOLEPTICS	HYPNOTICS AND SEDATIVES N05 PSYCHOLEPTICS	ANTI-DEMENTIA DRUGS N06 PSYCHOANALEPTICS	ANTIDEPRESSANTS N06 PSYCHOANALEPTICS	PSYCHOLEPTICS AND PSYCHOANALEPTICS IN COMBINATION N06 PSYCHOANALEPTICS	PSYCHOSTIMULANTS, AGENTS USED FOR ADHD AND NOOTROPICS N06 PSYCHOANALEPTICS
DDD delta % 2020 tov 2019	8,20%	3,26%	2,83%	-2,19%	5,52%	0,60%	0,52%
DDD delta % 2021 tov 2020	9,54%	4,71%	5,11%	4,44%	9,85%	2,96%	12,25%
deliveries delta % 2020 tov 2019	5,14%	3,14%	1,52%	-3,74%	3,02%	0,60%	-1,15%
deliveries delta % 2021 tov 2020	8,56%	5,16%	4,56%	5,99%	9,27%	2,96%	13,91%
PAT delta % 2020 tov 2019	1,92%	0,32%	-1,31%	-5,09%	1,08%	-4,11%	-7,04%
PAT delta % 2021 tov 2020	6,43%	2,62%	2,87%	3,89%	7,62%	2,44%	13,23%

Figure 21: psycholeptic and psychoanaesthetic medication use by category, % difference 2020 - 2019 versus % difference 2021 - 2020 [Jan - Oct]

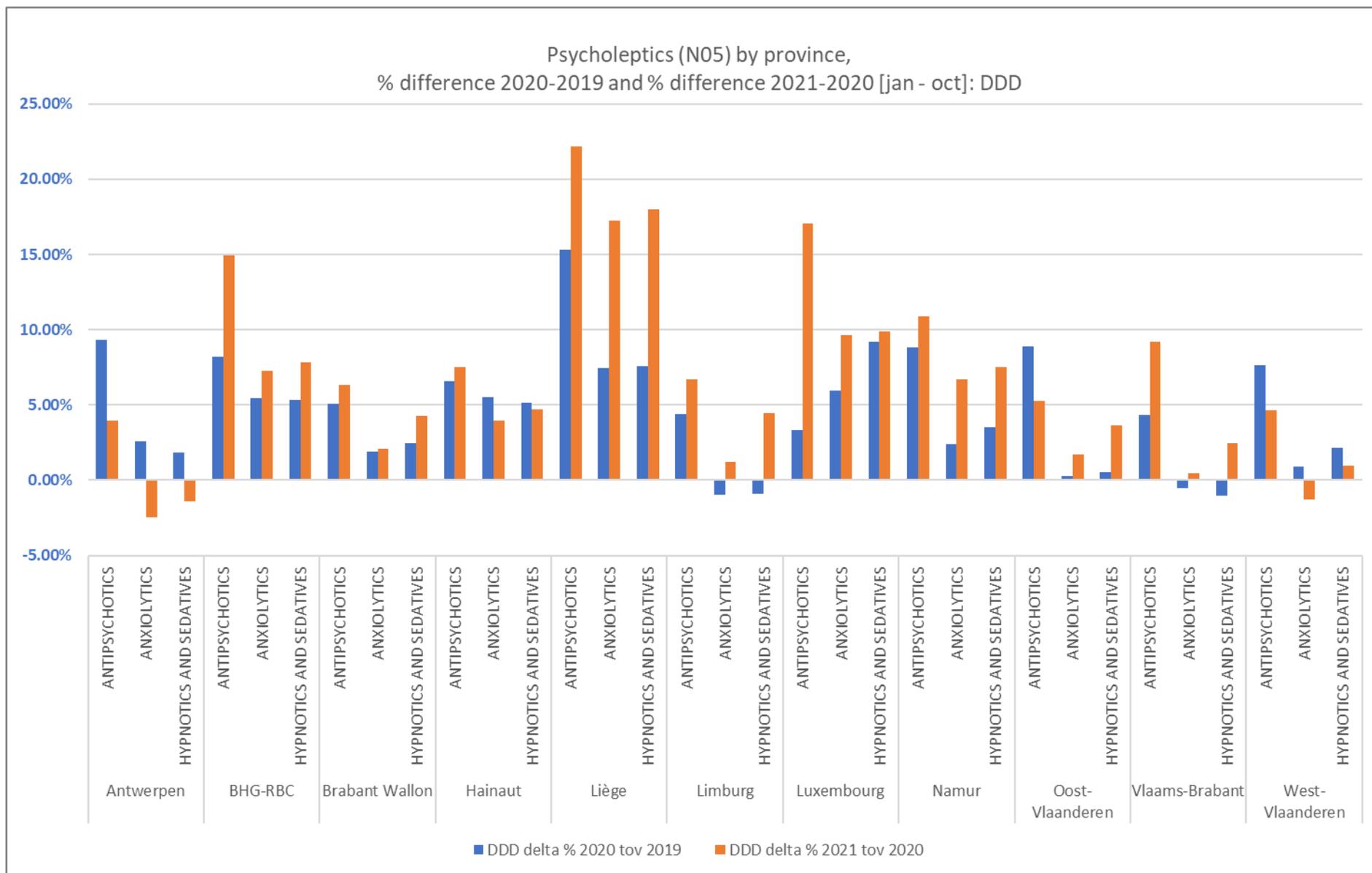


Figure 22

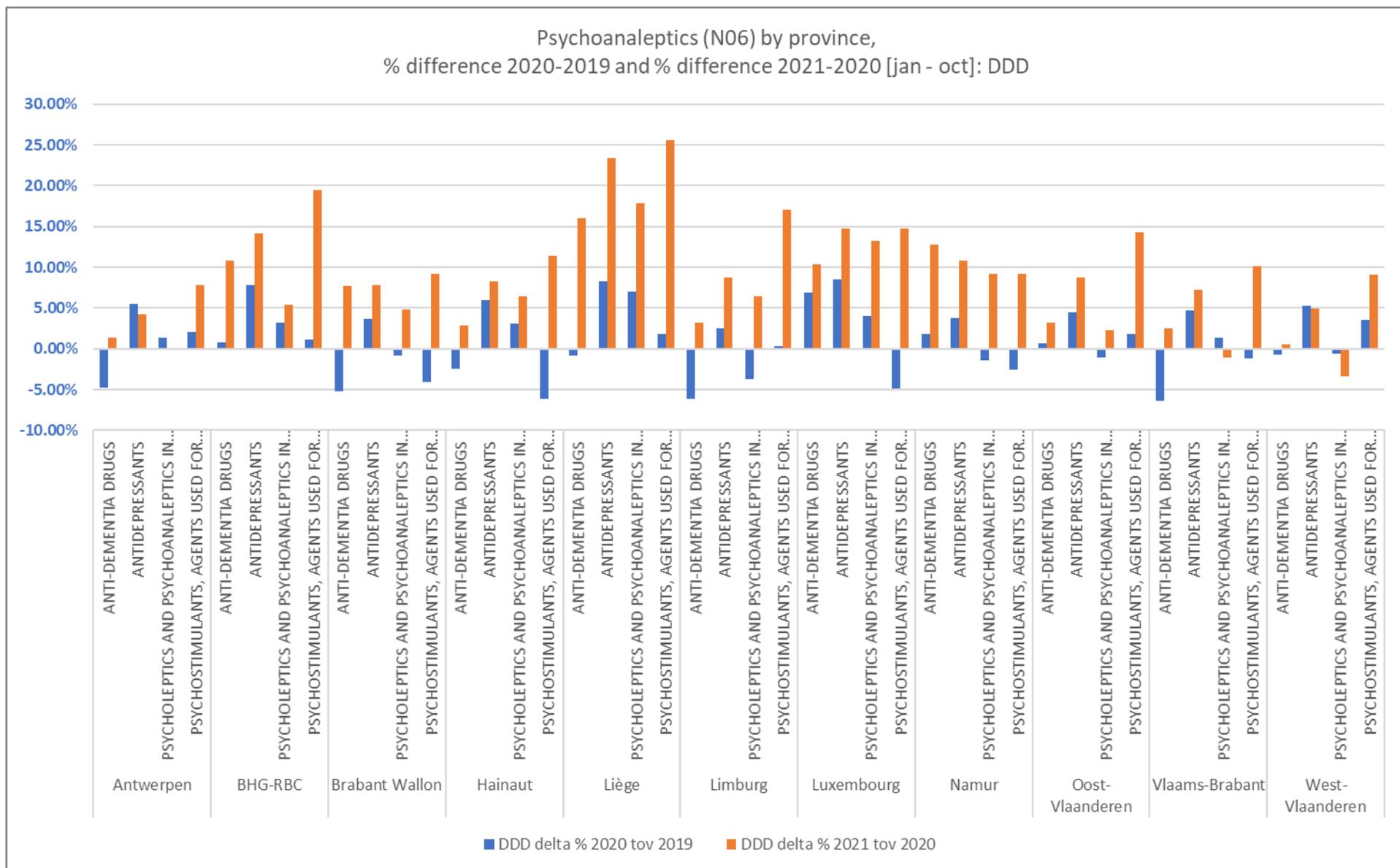


Figure 23

3.6.2.1. N05A antipsychotics

The use of antipsychotics (DDD) in 2020 increased by 8.55% in comparison to 2019. In Jan-Oct 2021, it increased by 9.54% in comparison to Jan-Oct in 2020. This increase is higher when compared to the increase in the same period of the year before: between Jan-Oct 2020 it increased by 8.2% in comparison to Jan-Oct 2019. Especially young females show a sharp increase in 2020 and 2021, as can be seen on the graph below, although this remains a limited group in absolute numbers. In general, the increase in the use of antipsychotics was stronger for females in lower age groups, but this relation reverses from the 46-65 age group onwards. Younger groups have a higher increased use of antipsychotics than older age groups.

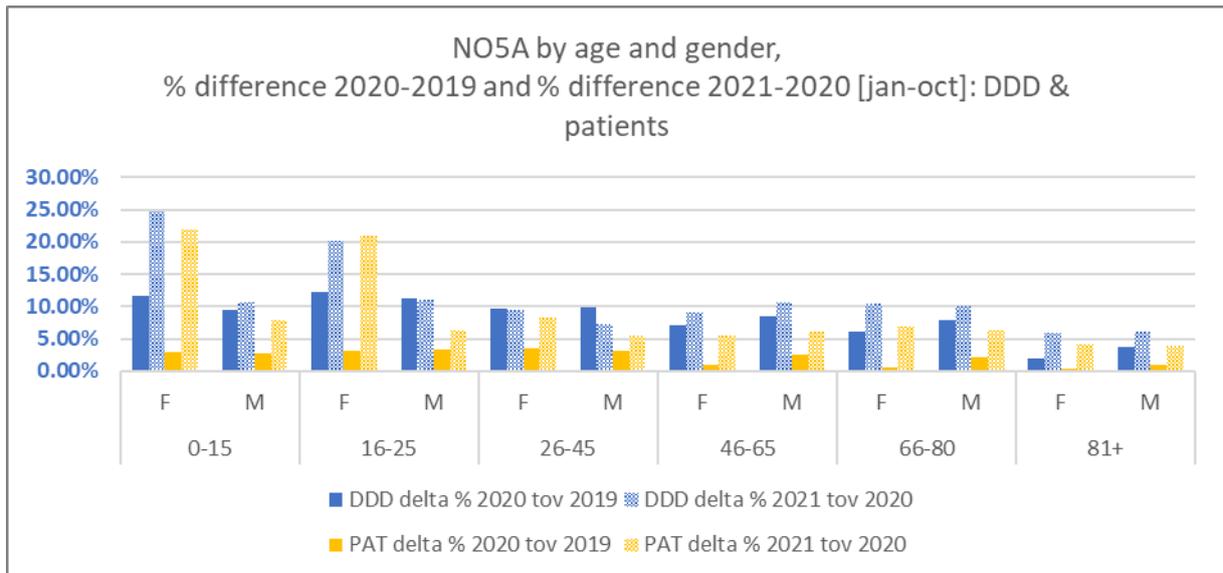


Figure 24

3.6.2.2. N05B anxiolytics

The use of anxiolytics (DDD) in 2020 increased by 3.81% in comparison to 2019. In Jan-Oct 2021, it increased by 4.71% in comparison to Jan-Oct in 2020. This increase is higher when compared to the increase in the same period of the year before: between Jan-Oct 2020 it increased by 3.26% in comparison to Jan-Oct 2019. Roughly similar patterns (as for N05A) can be observed regarding age and gender.

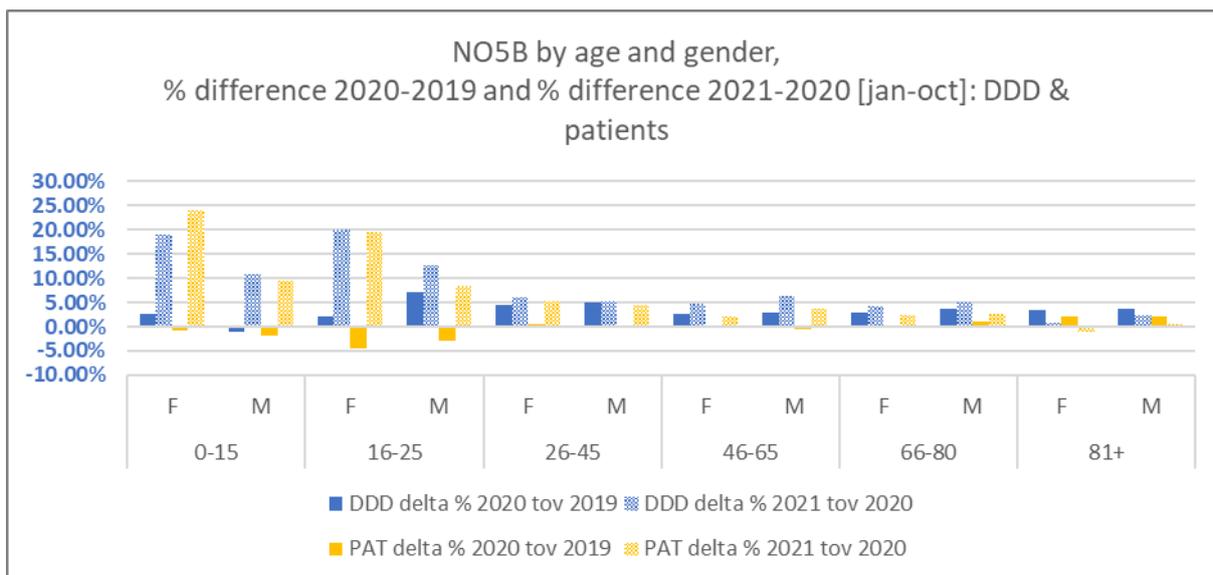


Figure 25

3.6.2.3. N05C hypnotics and sedatives

The use of hypnotics and sedatives (DDD) in 2020 increased by 3.33% in comparison to 2019. In Jan-Oct 2021, it increased by 5.11% in comparison to Jan-Oct in 2020. This increase is higher when compared to the increase in the same period of the year before: between Jan-Oct 2020 it increased by 2.83% in comparison to Jan-Oct 2019. The increases are generally higher for younger age groups. Regarding gender, females have higher increases than males in younger age groups, but lower increases than males in older age groups.

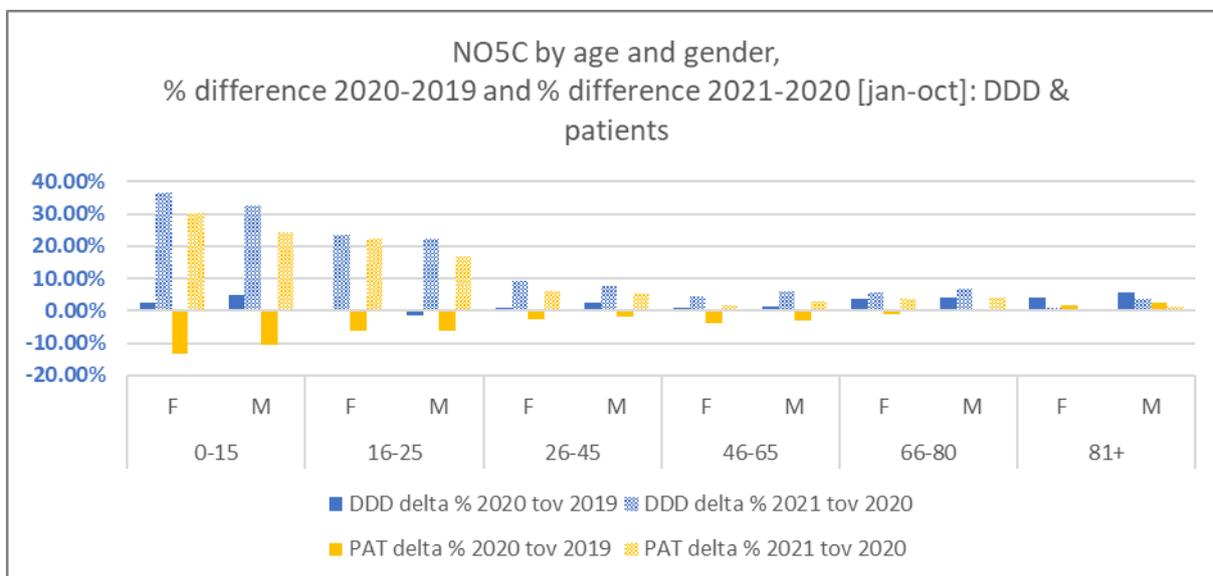


Figure 26

3.6.2.4. N06A antidepressants

The use of antidepressants (N06A) on annual basis (DDD) increased by 5.56% from 2019 to 2020. In Jan-Oct 2021, it increased by 9.85% in comparison to Jan-Oct in 2020. This increase

is higher when compared to the increase in the same period of the year before: between Jan-Oct 2020 it increased by 5.52% in comparison to Jan-Oct 2019. Females experienced a higher increase in the younger age groups.

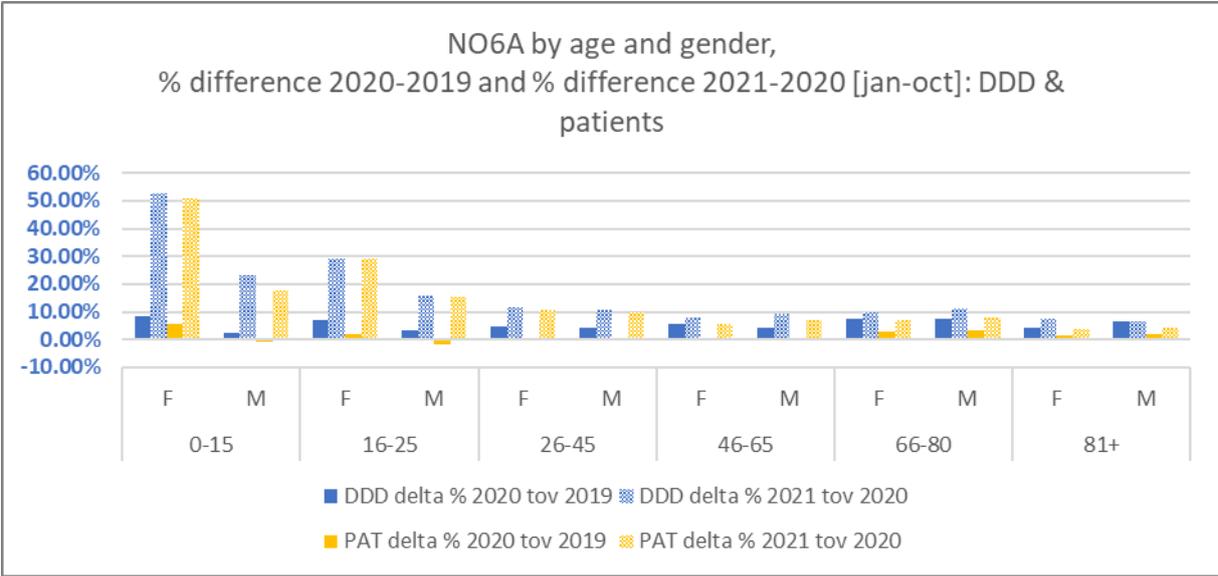


Figure 27

3.6.2.5. N06B psychostimulants, agents used for ADHD and nootropics

The use of psychostimulants, agents used for ADHD and nootropics (N06B) on annual basis (DDD) increased by 0.44% from 2019 to 2020. In Jan-Oct 2021, it increased by 12.25% in comparison to Jan-Oct in 2020. This increase is a lot higher when compared to the increase in the same period of the year before: between Jan-Oct 2020 it increased by 0.52% in comparison to Jan-Oct 2019.

Note that the younger age groups (0-15 and 16-25) demonstrated a lower number of defined daily doses (DDD), deliveries, and patients for N06B (psychostimulants, agents used for ADHD and nootropics) between April and June 2020, which could be caused by the closing of the schools in this period. Also noteworthy is a relatively high increase in 2020 for the age group of 26-45. In 2021, sharper increases are evident in almost all age groups.

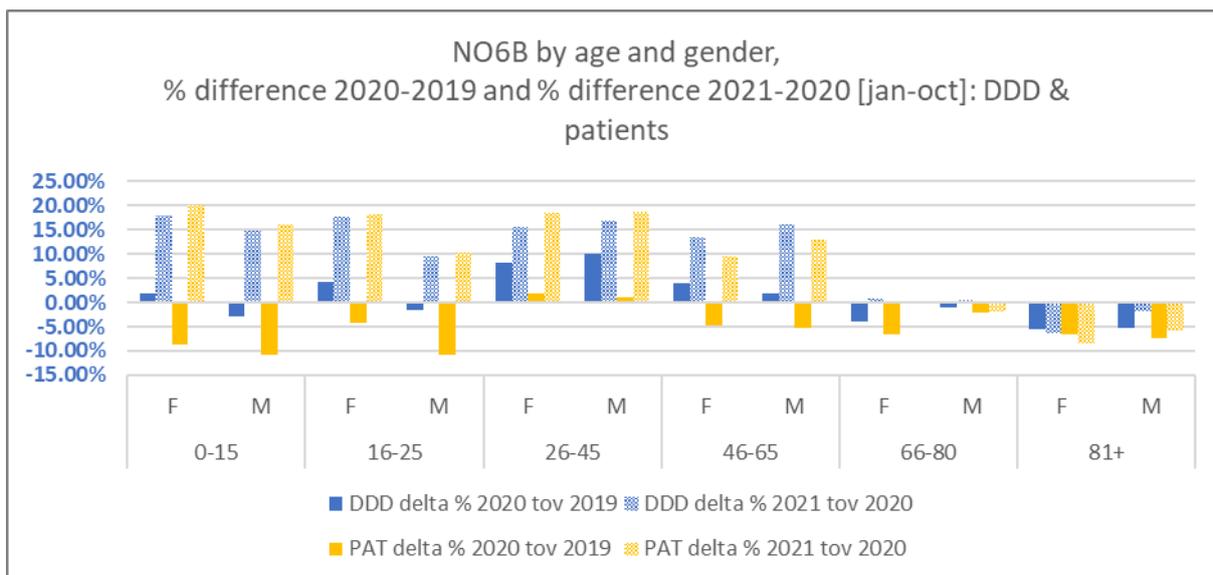


Figure 28

3.6.2.6. N06C psycholeptics and psychoanaleptics in combination

For completeness, we also wish the note that the use of psycholeptics and psychoanaleptics in combination (mainly containing one medicine: DEANXIT, often prescribed as a sedative) increased by 0.72% from 2019 to 2020. In Jan-Oct 2021, it increased by 2.96% in comparison to Jan-Oct in 2020. This increase is higher when compared to the increase in the same period of the year before: between Jan-Oct 2020 it increased by 0.60% in comparison to Jan-Oct 2019. Care should however be taken in its interpretation, because of low absolute numbers.

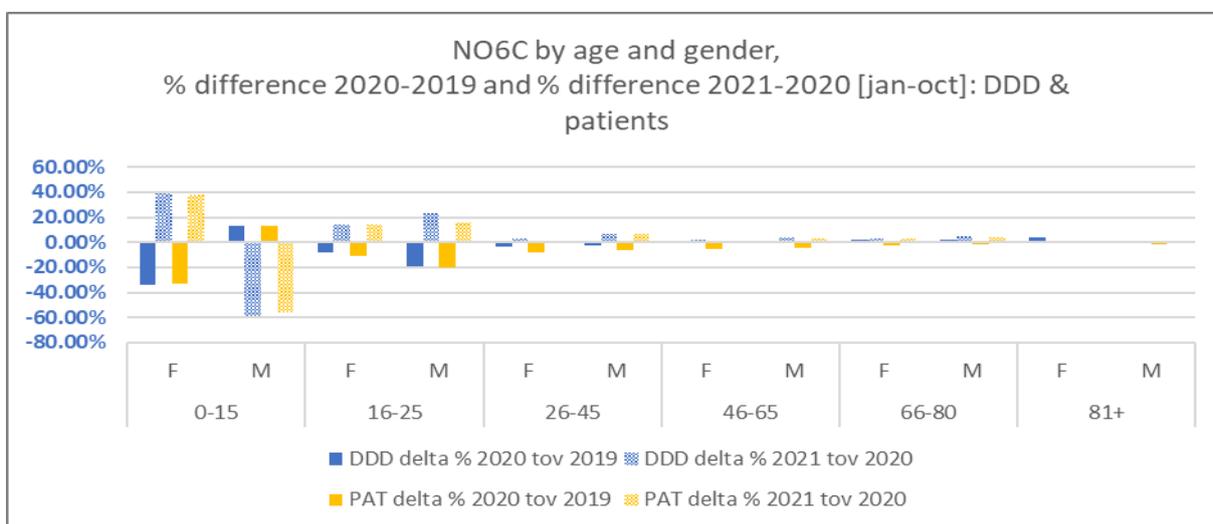


Figure 29

3.6.2.7. N06D anti-dementia drugs

The use of anti-dementia drugs (N06D) on annual basis (DDD) decreased by -2.15% from 2019 to 2020. In Jan-Oct 2021, it increased by 4.44% in comparison to Jan-Oct in 2020. This increase is higher when compared to the change in the same period of the year before:

between Jan-Oct 2020 it decreased by -2.19% in comparison to Jan-Oct 2019. Whereas the decrease in 2020 is a continuation of a diminishing use in previous years, the increase in 2021 does not fall within this same trend. The increase in younger age groups needs to be interpreted with care. Hence, it concerns probably low numbers as there is no indication for this medication in young people.

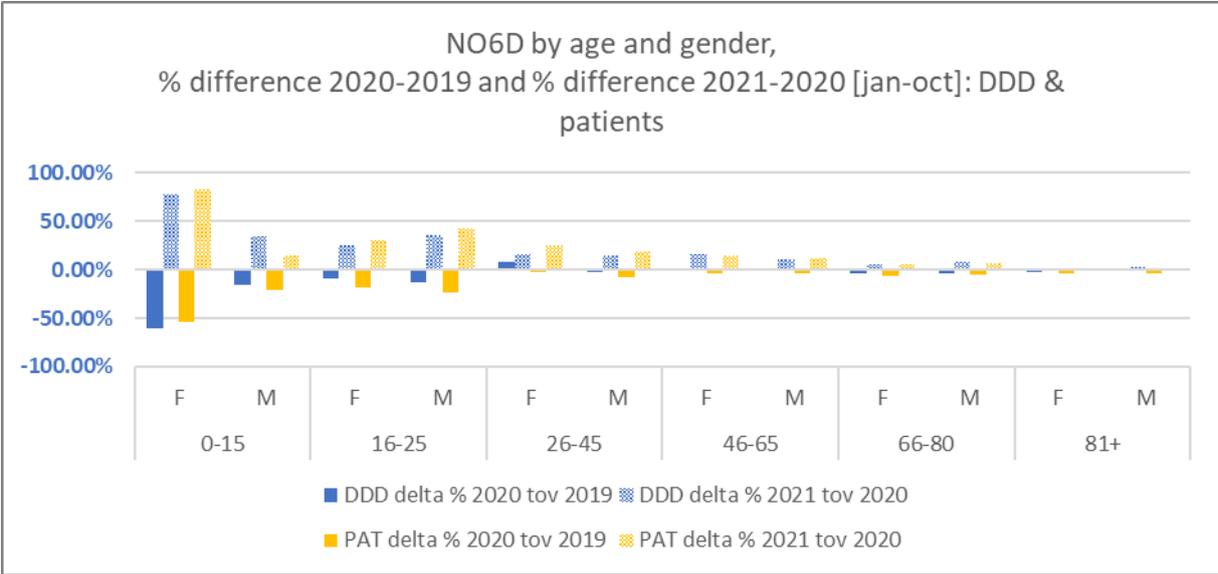


Figure 30

A multitude of factors play a role in these trends: from delaying care due to contact restrictions and lockdowns, to herd behaviour and hoarding, or increased mental health complaints due to COVID-19 and the measures taken to prevent it. While the data does not always allow us to discern between these causes, it is certain COVID-19 has affected the consumption of psycholeptic and psychoanaleptic medication.

3.7. Mental health expenditures

The global COVID-19 pandemic and the measures taken to contain it have evidently harmed the physical health of Belgian citizens, but their mental health has also been affected. In this short summary, we evaluate to what extent this influenced healthcare use for mental health by comparing 2020 and 2021 to previous years. To this effect, we make use of healthcare use data up to July 2021 from the National Institute for Sickness and Disability Insurance (INAMI/RIZIV) ¹³.

Looking at the booked healthcare payments for psychiatrists and child psychiatrists in the figures below, it is observable how the total healthcare expenditures for psychiatrists and child psychiatrists fell below previous years from April to July 2020 (first wave), in October 2020 and

¹³ Authors: Godderis L, Boets I, Steel J. Source data: National Institute for Sickness and Disability Insurance (INAMI/RIZIV). In the context of the COVID-19 crisis, there were two types of measures:
a) Measures without budgetary impact: e.g. classic benefits are replaced by remote benefits, including psychological and psychiatric care;
b) Measures under separate heading 89 are measures with a budgetary impact. For mental health this relates to the extension for children and 65+ year olds of the reimbursement of first-line psychological care in 2020 (the expenditure for this is quite limited). From 2021 onwards, however, this extension is structurally included within the medical care objective.

January 2021 (second and third wave). This was also the case for consultations, visits and advice at doctors' offices. The peaks in expenditures can be explained by quarterly billing in psychiatric hospitals. For the services from 01/07/2020 onwards, The INAMI/RIZIV has switched to monthly billing.

In total, in 2019 the booked payments for psychiatrists and child psychiatrists were €304,375,400, while 2020 €297,486,0 was booked; a reduction and possible under-consumption of -2,3%. This is paired with 10,993,139 booked cases in 2019, and 10,616,831 booked cases in 2020: a reduction of -3.4%.

Looking in more detail, from March 2020 onwards there is a lower expenditure on therapies, psychotherapies, and paediatric psychiatric consultations in comparison with previous years. If distance consultations (which started in April 2020) are factored in, the gap stays apparent between March and June 2020. However, since March 2021 the expenditures rise above levels of previous years when taking into account the distance consultations (Figure 30).

Psychiatrist and child psychiatrists booked expenditures (000 EUR), 2019-2021
(consultations, (psycho-)therapies, paediatric psychiatry, admissions in psychiatric hospitals, revalidation camps, & distance consultations)

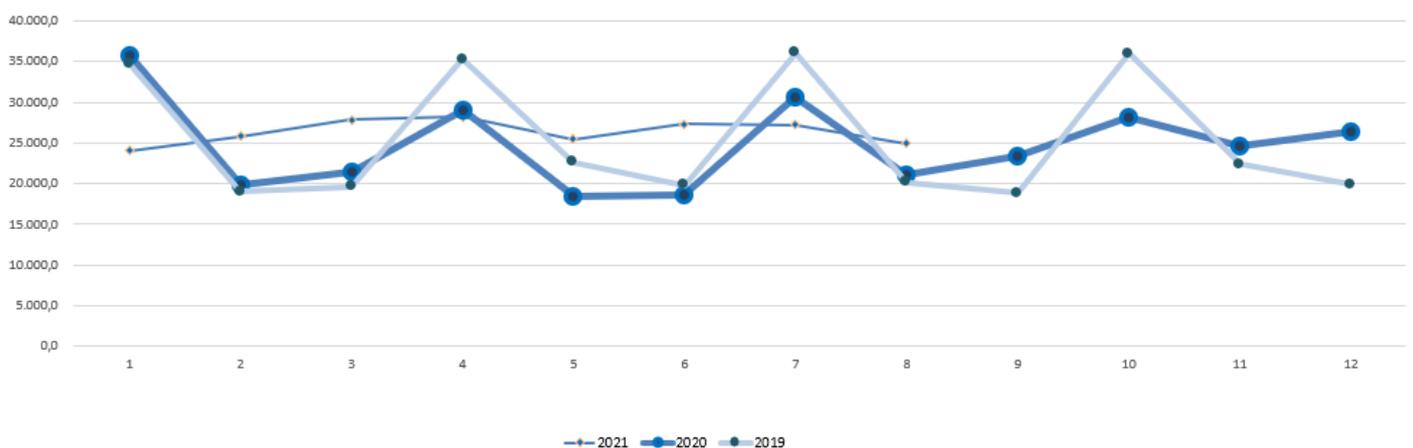
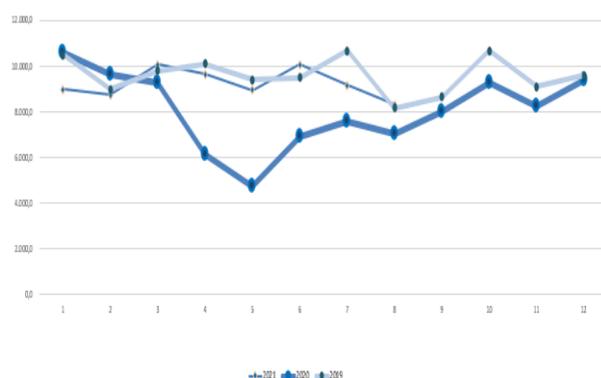


Figure 31: psychiatrist and child psychiatrist booked expenditures

Booked expenditures (000 EUR), 2019-2021
(consultations, (psycho-)therapies, paediatric psychiatry)
WITHOUT distance consultations



Booked expenditures (000 EUR), 2019-2021
(consultations, (psycho-)therapies, paediatric psychiatry)
WITH distance consultation

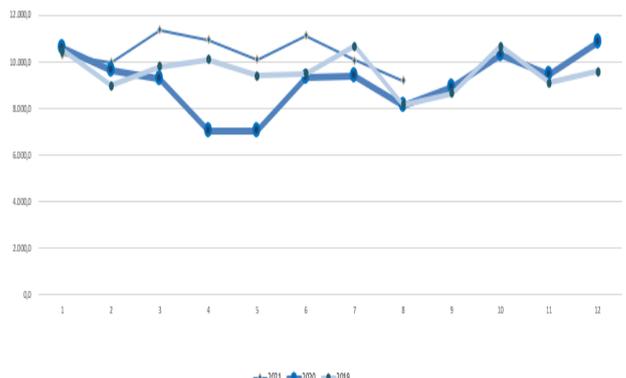


Figure 32: booked expenditures without and with distance consultations

Admissions in psychiatry dropped slightly below the values of previous years from April to July 2020, in October 2020, in January 2021. In February and March 2021, the admissions were higher than previous years, lower in April 2021, and again higher in May and June 2021 (Figure 20). This can be explained by the change to monthly billing instead of quarterly billing. The expenditures on revalidation camps for children and adults in 2020 were lower overall, since many camps were cancelled (Figure 32). This drop can still be noticed in 2021.

A multitude of factors play a role in these trends: from delaying care due to contact restrictions and lockdowns, to increased mental health complaints due to COVID-19 and the measures taken to prevent it. While the data does not allow us to discern between these causes, it is certain COVID-19 has had an impact on Belgian citizens' expenditures for healthcare contacts with psychiatrists and child-psychiatrists.

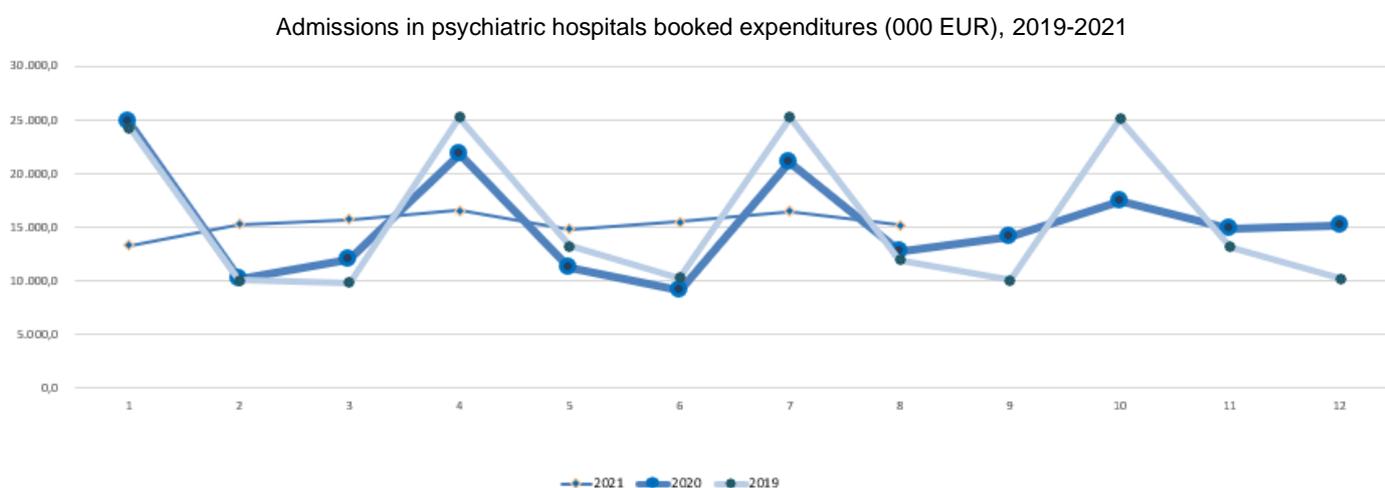


Figure 33: Admissions in psychiatric hospitals booked expenditures

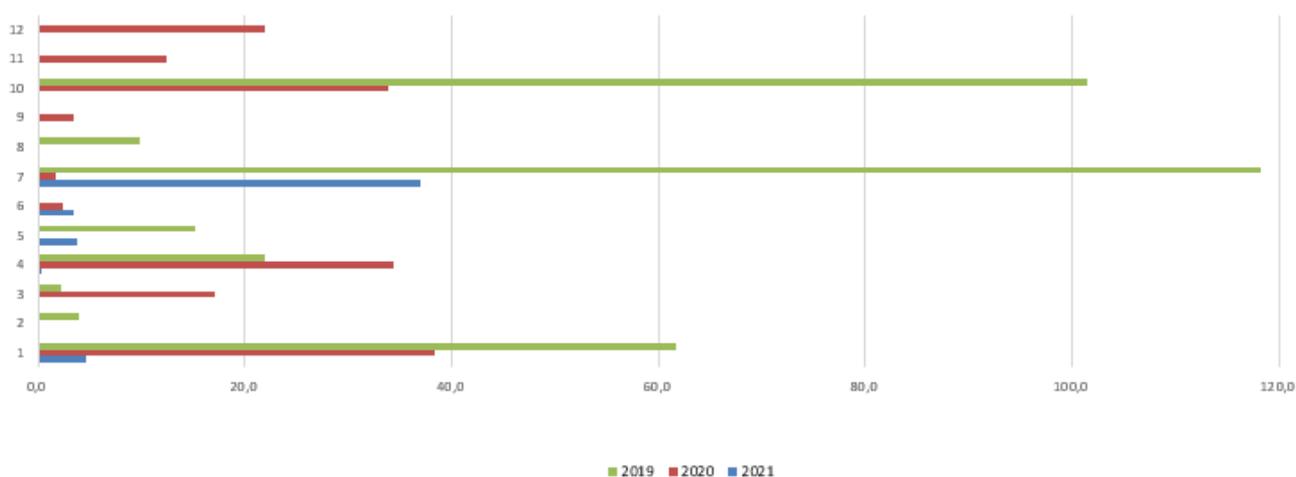


Figure 34: Revalidation camps booked expenditures in 000 EUR (2019-2020)

3.8. Sickness absence

Concern is rising about increasing sick leave in the healthcare sector. In response, we analyzed actual data about short-term sick leave (sickness less than one month), medium-term sick leave (sickness between 1 month and 1 year), long-term sick leave (more than 1

year) in data provided by ACERTA derived from a set of 260,000 employees employed by more than 40,000 employers in the private sector, which includes both SMEs and large enterprises, and on a dataset of 28,000 employees from the healthcare sector.

Across all sectors, 3.4% of workable hours in 2020 were not performed due to illness less than one month. For the first half of 2021 this number decreased to 2.9%. In general, short-term sick leave fell by 3.7% in 2020 (vs 2019) and continued to decrease in 2021 (vs 2020) with 8.5%, most likely due to telework and more limited physical contact decreasing common infections, which are one of the most reported reasons for short sick leave.

In contrast, medium-term sick leave (sickness between 1 month and 1 year) increased slightly in 2020 compared to 2019 with 1.3%. In 2021 the medium-term sick leave clearly decreases in all sectors. Remarkably, if we zoom in specifically on short-term sick leave in the health care sector, it was 9.8% higher in 2020 than in 2019, but decreased again in 2021 with 15.8% compared to 2020.

Taking all forms of absences due to illness (short, medium, and long) together, in 2020 and 2021 healthcare faced respectively 36.2% and 35.6% more absence compared to the other sectors in relation to the year before. The difference with the other professional sectors is higher in the case of long-term illnesses - absences of a year or more - at +46.5%, respectively +49.6%. Short-term sick leave - less than one month, with guaranteed pay - in the Belgian healthcare sector was 24.6% and 14.6% higher in respectively 2020 and 2021 than short-term sick leave for all sectors combined. Medium-term sickness absence - between one month and one year, with guaranteed pay - was 30.6% (2020 vs 2019) and 34.0% (2021 vs 2020) higher in the care sector compared to the average across all sectors.

We further compared the evolution in 2021 (data until November) in relation to the previous year (thus 2020) in different sectors for short-term sickness absence. There it can be noted that since May 2021 the numbers of short-term sickness absence are higher than last year across all sectors.



Figure 35: Short-term sickness absence across all sectors (2021 versus 2020)

A similar trend can be seen specifically for the health care sector, with less short-term sickness absence for the months July and August 2021. Since September 2021, there is again a noticeable peak, in comparison to last year (Figure 23).

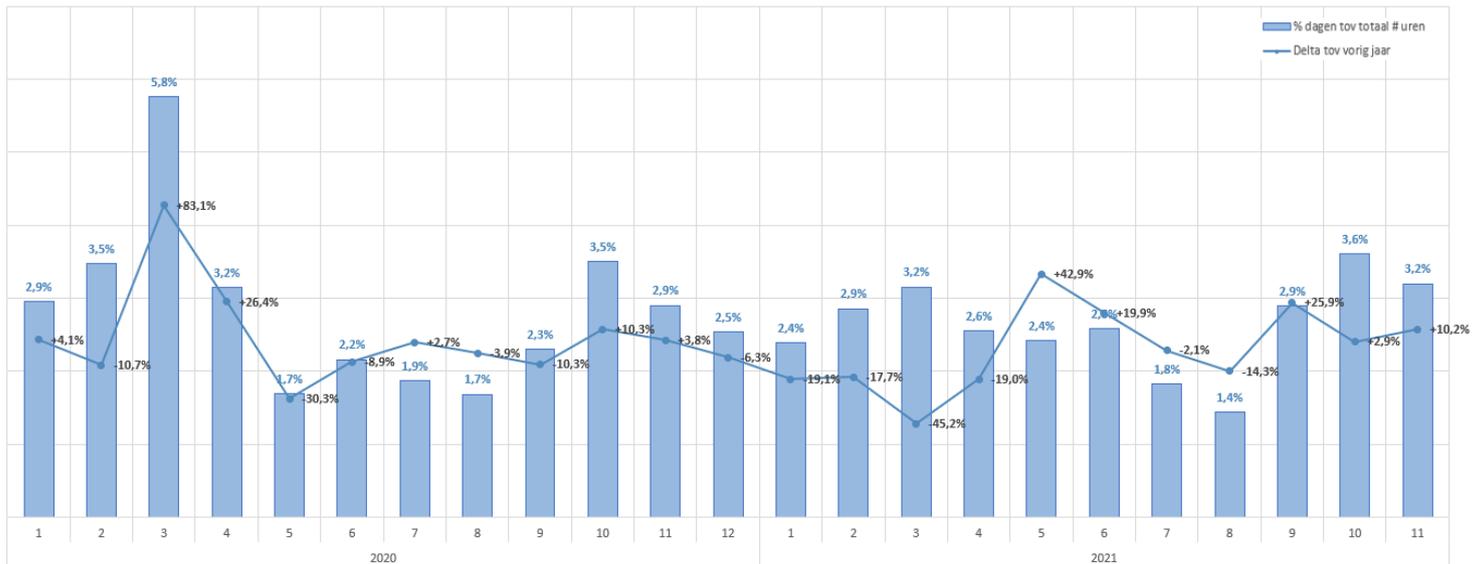


Figure 36: Short-term sickness absence in health care sector (2021 versus 2020)

Consequently, the alarming signals about short sick leave in the healthcare sector are being supported by the numbers, but this peak can be noticed across all sectors.

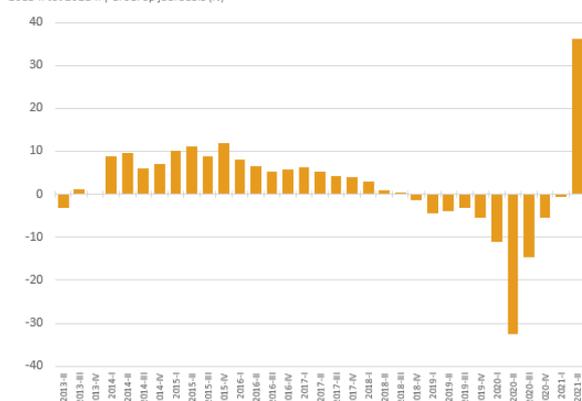
3.9. Temporary unemployment

According to 'Steunpunt Werk'¹⁴ the COVID-19-pandemic has had a clear impact on the Flemish labour market. For quite some time now, they have been monitoring the trend indicators of the Flemish labour market in the field of the economic situation, activity and unemployment, employment and sectors, and vacancies and shortage.

The Federgon index (Figure 24) is an indicator growth of temporary employment (*uitzendarbeid*) on a yearly basis, based on worked hours. There was a drop in growth due to the COVID-19-crisis since March 2020. The recovery in the number of hours of temporary employment that started in May 2020 has known a somewhat unsteady course over the past six months. In the first quarter of 2021 there was a temporary capping, with even a slight drop compared to the fourth quarter of 2020 (-3,0%). However, April and May 2021 saw a new momentum, with the Federgon index rising by +2.1% and +1.6% respectively on a monthly basis. However, in June 2021 this growth came stagnated again, with even a slight decrease compared to May 2021 (-0.7%). While temporary employment is clearly in a better situation than last year (+18.1%), the pre-crisis level is far from being reached. The Federgon index remains below the level of February 2020 and June 2019.

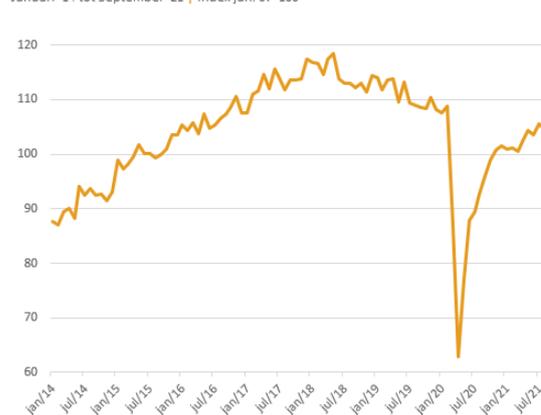
¹⁴ www.steunpuntwerk.be

Evolutie aantal uren uitzendarbeid | VLAAMS GEWEST
2013-II tot 2021-II | Groei op jaarbasis (%)



Bron: Federgon (bewerking Steunpunt Werk)

Federgon-index | BELGIË
Januari '14 tot september '21 | Index jan.'07=100



Bron: Federgon (bewerking Steunpunt Werk)

Figure 37: Evolution of hours worked in temporary employment in Flanders + Federgon-index Belgium

In the second quarter of 2021, there is an increase in the trend level of the unemployment rate both in Flanders (4%) and in Belgium (6,3%) (Figure 25). The change (in comparison to the second quarter of 2020) is most pronounced amongst 15- to 24-year-olds (+4,9ppt), persons who were born outside EU-28 (2,1ppt) and those with a short education (2,2ppt).

Trendniveau werkloosheidsgraad (%) | 15- tot 64-jarigen
2019-II tot 2021-II | Vlaams Gewest, België, EU-27 (2020)

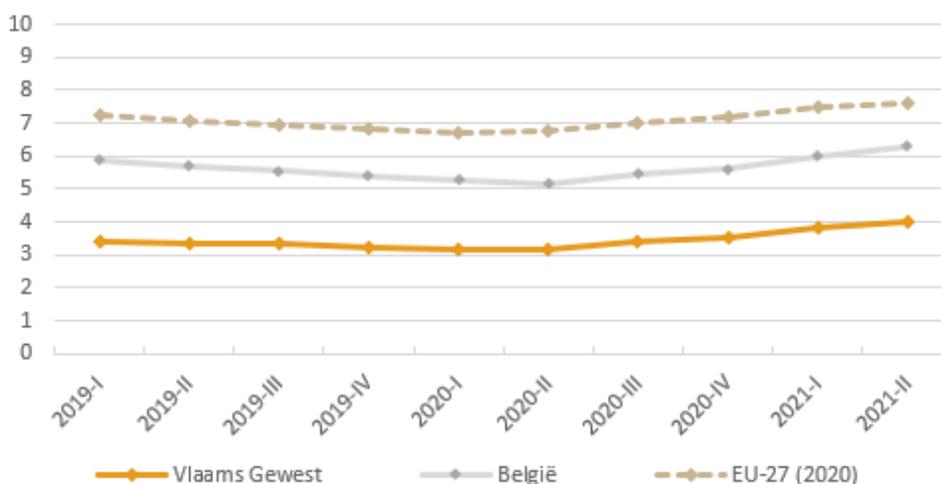


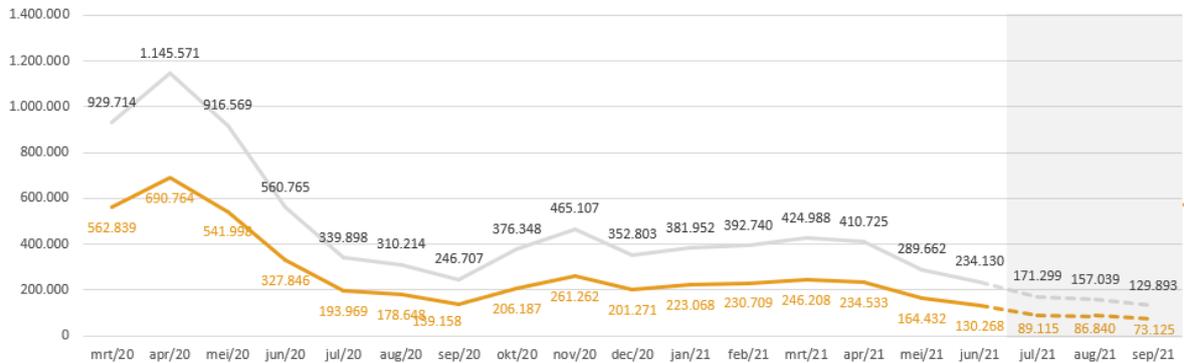
Figure 38: trendlevel unemployment rates

Due to the COVID-19 crisis, it was decided to simplify the procedure of temporary unemployment. This procedure is provisionally extended until the end of September 2021. After the number of temporarily unemployed in the Flemish Region stabilized around 230.000 for several months, a sharp fall can be seen in May and June 2021. In June 2021, the RVA counts 130.000 temporarily unemployed in Flanders as a result of COVID-19, the numbers for Belgium also show a clear decline (from 410.000 in April to 234.000 in June 2021) (Figure 26). The provisional numbers for the months July, August and September 2021 show a further decline. Nevertheless, in June 2021 the number of temporarily unemployed is still well above

the level before the start of the corona crisis. This number is almost three times as high as in June 2019. Most of temporarily unemployment is based in the industrial and administrative sector (Figure 27).

Evolutie tijdelijke werkloosheid ingevolge COVID-19 | Referentiemaanden (met uitbetaling voor 10 oktober)

De gegevens per referentiemaand zijn niet definitief en zullen geactualiseerd worden bij elke nieuwe beschikbare indieningsmaand. Doorgaans zijn de cijfers na 3 maanden definitief te noemen.



Bron: RVA (bewerking Steunpunt Werk)

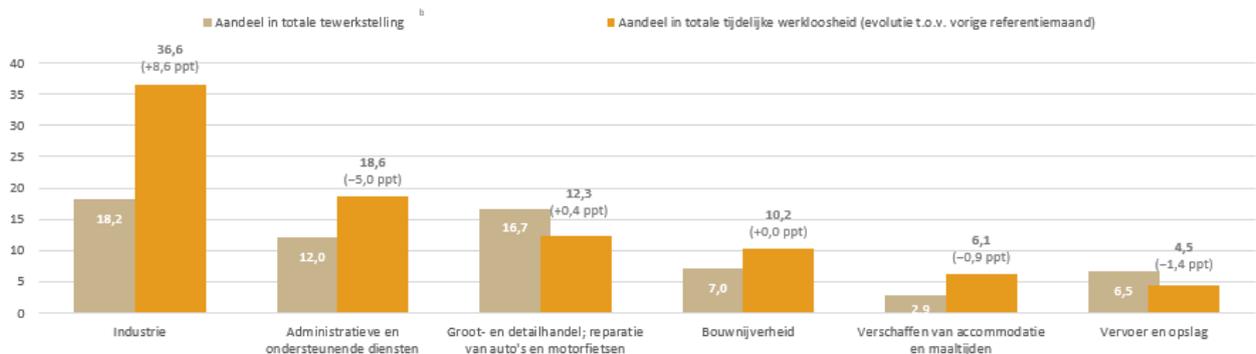
— Vlaams Gewest — België

Voorlopige cijfers

Figure 39: temporary unemployment due to COVID-19, reference months

Tijdelijke werkloosheid ingevolge COVID-19 per sector | Vlaams Gewest

Referentiemaand september 2021 (met uitbetaling voor 10 oktober)



Noten: a. Enkel de zes sectoren met het grootste aandeel in de tijdelijke werkloosheid ingevolge het coronavirus worden weergegeven

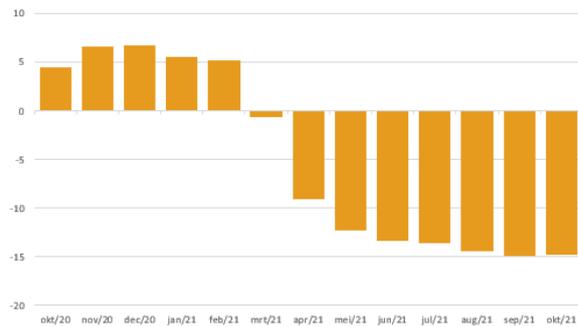
b. De cijfers hebben betrekking op alle tewerkstelling in het tweede kwartaal van 2020 en zijn exclusief de tewerkgestelden in de sector 'Openbaar bestuur en defensie; verplichte sociale verzekering'

Bron: RVA, RSZ (bewerking Steunpunt Werk)

Figure 40: temporary unemployment due to COVID-19 per sector

Since June 2021, Steunpunt Werk does not longer report on unemployed jobseekers (nwwz). VDAB has been using another classification for jobseekers. Since the first quarter of 2021, Steunpunt Werk reports on jobseekers that are unemployed (wzw). Since the outbreak of the COVID-19-crisis, there has been a continuous positive annual growth of 'wzw'. After a steep rise of this number in April – June 2020, this annual growth systematically declined. Only the second lockdown at the end of 2020 caused a temporary reversal of this trend. From March 2021 onwards, the number of wzw knows only a small decrease. Compared to last year, there are more than 30.000 less wzw, which is a decrease of -14,8% (Figure 28).

Evolutie aantal wzw | VLAAMS GEWEST
Oktober '20 tot oktober '21 | Groei op jaarbasis (%)



Trendindex aantal wzw | VLAAMS GEWEST
Januari '08 tot oktober '21 | Index feb.'20=100

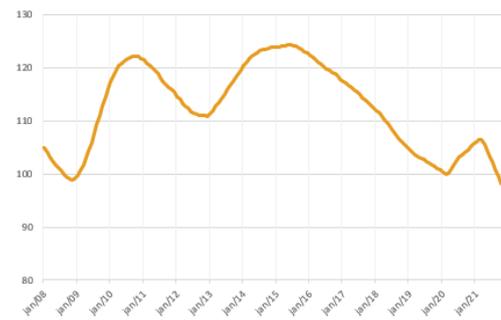
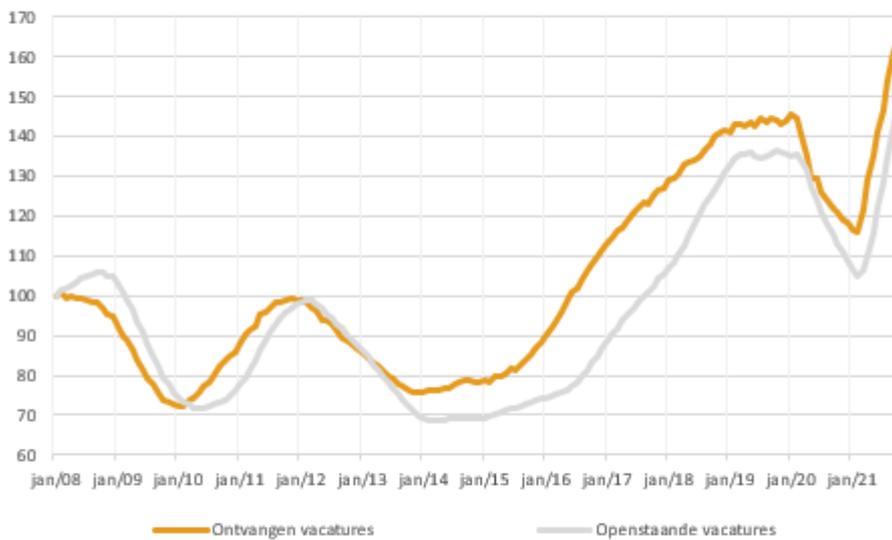


Figure 41: evolution unemployed job seekers

The number of vacancies received in September 2021 is on an all-time high, with 37.984 vacancies (Figure 29). This is 58,8% more compared to last year. Year-on-year growth so far is strongest for vacancies requiring experience (+50.0%), high-skilled (53.1%) jobs and permanent contracts (49.9%). This vacancy growth continues in almost all of the ten largest sectors: the strongest growth is found in services (95.5%) and public administration (73.1%). Despite the increased number of wzw, we note an increasing tightness on the Flemish labor market, influenced by the increasing number of vacancies.

Trendindex aantal VDAB-vacatures | VLAAMS GEWEST

Januari '08 tot oktober '21 | Index jan.'08=100



Trendindex = index van het trendniveau, d.i. het voortschrijdend gemiddelde van de voorbije twaalf maanden

Bron: VDAB (bewerking Steunpunt Werk)

Figure 42: evolution received and open vacancies

4. Authors and contributors

Prepared by: Lode Godderis, Isabelle Boets, Maarten Vansteenkiste, Philippe Beutels, Isabelle Aujoulat, Céline Nieuwenhuys, Dimitri Van der Linden, Jonas Steel

The following experts were involved (in alphabetic order) or provided data. For more details, additions and also if you dispose of data or publications you can contact: prof. dr. Lode Godderis (lode.godderis@kuleuven.be).

AUJOULAT Isabelle	UCLouvain, Institute of Health & Society
BEIRENS Stijn	Opgroeien
BEUTELS Philippe	University of Antwerp
BLAVIER Adélaïde	ULiege
BRUFFAERTS Ronny	UZ Leuven
BOELEN Gijs	Acerta
BOETS Isabelle	KU Leuven, Group IDEWE
BRUYNEEL Luk	KU Leuven, Onafhankelijke Ziekenfondsen
DAUBIE Mickael	RIZIV/INAMI
DEMAREST Stefaan	Sciensano
DEREYMAEKER Kirsten	Opgroeien
DE SMET RUBEN	Labour economics en Steunpunt Werk -KU Leuven
DOGGEN Kris	Sciensano
GERMEYS Inez	KU Leuven
GODDERIS Lode	KU Leuven and Group IDEWE
GRYPDONCK Lies	RIZIV/INAMI
HAEDENS Nele	Opgroeien
HAMELINCK Wouter	Association of Pharmacists Belgium
MAES Sophie	Centre hospitalier le Domaine-ULB à Braine-l'Alleud
NIEUWENHUYS Céline	Fédération des services sociaux
POTS Jennifer	Federatie van Tele-Onthaaldiensten Vlaanderen & Brussel
SMITH Pierre	UCLouvain
STEEL Jonas	KU Leuven
STRAETMANS Koen	Association of Pharmacists Belgium
VAN DEN CRUYCE Nele	VUB
VAN DER LINDEN Dimitri	UC Louvain
VAN HOOFF Elke	VUB
VANSNICK Luc	Association of Pharmacists Belgium
VANSTEENKISTE Maarten	UGENT
VANSTEENKISTE Sarah	Labour economics en Steunpunt Werk- KU Leuven
VERBOOMEN Kathelijne	Acerta

The following administrations and/or ministerial cabinets were heard:

Sciensano
RIZIV-INAMI
Farmaflux
Opgroeien