KCE REPORT 265Cs

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

SUMMARY

ORGANIZATIONAL AND FINANCING MODEL FOR PSYCHOLOGICAL CARE

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HEALTH SERVICES RESEARCH

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OVERVIEW

ORGANIZATIONAL AND FINANCING MODEL FOR PSYCHOLOGICAL CARE

LAURENCE KOHN, CAROLINE OBYN, JEF ADRIAENSSENS, WENDY CHRISTIAENS, XAVIER VAN CAUTER, MARIJKE EYSSEN

FOREWORD

Most of us have heard of Bhutan; a tiny country somewhere north of India, with Buddhist temples that cling to the flanks of the Himalayas. But that is also about where our knowledge ends. It is one of the poorest countries in the world. But did you know that Bhutan is also the very first country that has explicitly made increasing the Gross National Happiness (GNH) an active policy based on four pillars and nine indicators? The four pillars are sustainable and just socioeconomic development, good governance, protection of the environment, and preservation and promotion of the culture. And the first two items in the list of nine indicators are psychological wellbeing and health.

Without wanting to idealise their example, we, with our feverish pursuit of growth in our gross national product, may well have something to learn from this little Asian kingdom. Never before was our purchasing power so high, but at the same time a substantial portion of the population is contending with one form or another of psychological malaise, and the suicide figures remain alarmingly high.

We are, it is true, not yet at the point of striving for happiness as an explicit policy objective and systematically monitoring it, but over the years the realisation has grown among the various authorities in the country that mental health care should be much more comprehensive than treatment of formally diagnosed psychiatric disorders. And that that care should also be timely, and thus easily available. Here we are referring to that professional helping hand that for many people might be sufficient to recover their energy and resilience in the unrelenting rat race, and that for others opens a faster means of access to adequate therapy.

Fortunately there were quite a few building blocks at hand with which we could set to work. There was quite a bit of inspiration to be picked up from experiences in other countries and domestic pilot projects. We have also listened to those active in the field. And we have merged all these aspects into a series of ambitious proposals.

Will this be a boost for our GNH?

Christian LÉONARD
Deputy General Manager

Raf MERTENS
General Manager

KEY MESSAGES

- Results from scientific research demonstrate that the number of Belgians that report a certain degree of psychological suffering is increasing. These problems are mainly mild and moderate (anxiety and depression), and are not necessary specific psychiatric illnesses. They can be solved by providing timely support. People from disadvantaged social classes and the unemployed have more psychological problems in general.
- If these problems are not dealth with in due time, they can evolve in the course of time and become more difficult to treat. They can be a big burden, not only to the suffering person concerned, but also to society, due to absenteeism and loss of productivity.
- Despite the reforms in the mental health care sector, the present supply of care does not fit these psychological problems and needs, due to the complexity of the sector and problems of financial inaccessibility.
- For this study, the legal context and the present situation in Belgium were analyzed and compared with 5 European countries. The proposed model was developed in consultation with the stakeholders and the final propositions were checked with them. However, we were unable to find sufficient reliable data to make an estimation of the budget for that model.
- The model consists of two levels: a first, general level which is largely accessible and provides care for mild and moderate psychological problems, without prior restriction, and a second level with a more restricted access that provides more specialized care for those for whom the first level of care is not sufficient.
- The first level, inspired amongst others by the first-line psychological projects in Flanders (Eerstelijns Psychologische Functie (ELPF)) is directly accessible, regardless of the diagnosis or the severity of the symptoms, but the number of sessions is limited. Through this level, a large part of the psychological complaints can already be resolved. In addition, (potentially) severe situations can be recognized and referred to the appropriate care settings within the existing specialized structures.
- The first level is accessible through two channels: on the one hand through clinical psychologists who have followed a specific training in first-line psychology and who work within the local multidisciplinary network. On the other hand, patients can consult their general practitioner for a long consultation. Similar to the first-line psychologists, the number of sessions will also be limited.
- First-line psychologists will be financed through a combination of a practice allowance, a fixed lump sum per patient, a fee-for-service + a small patient out-of-pocket payment.
- The second level (specialized care) is accessible after referral by the first level by means of a system of gatekeeping or through a psychiatrist. The access is based on a “functional assessment”, as part of the (future) electronic shared patient record, which contains input from the first-line psychologist and the general practitioner and, if necessary, from other professionals. Conditions on diagnosis or on the type of therapy will not be stipulated.
- The access to specialized care is limited to legally recognized caregivers. They should meet specific requirements on ongoing training, should be a member of the local multidisciplinary network and should

practise within or in close collaboration with the existing subsidized structures (*Centres for Mental Health (CMH)* , Centre for Ambulatory Rehabilitation (CAR)). For private practitioners a contract of collaboration with with these structures should be mandatory.

- The number of sessions is limited, but prolongation of treatment should remain possible. In that case the specialized caregiver has to complete the functional assessment and provide a care plan, which has to be approved by an advisory psychologist/psychiatrist of a payment body.
- The specialized treatments would be financed by the NIHDI (INAMI-RIZIV) based upon a nomenclature. The present funding of the 'CMH's' by the regions remains unchanged and can be used for networking and maintenance and activity costs. The out-of-pocket payment for the patient for a consultation should be limited to the equivalent of the reimbursements for consultations in psychiatry. A pay-for-quality component, based on indicators, should be considered in the future.

- Direct access to a private practise of a clinical psychologist remains possible, but in that case treatment will not be reimbursed.
- A number of prerequisites should be fulfilled, in order to:
  - obtain a culture of collaboration and networking between all stakeholders at every level;
  - have sufficient professionals with an adequate level of scholing;
  - provide access to ICT tools, to share information and to register patientdata in a multidisciplinary way;
  - measure quality.

  As these conditions cannot be fulfilled on short notice, the different parts of the system should be implemented in phases and a transitional arrangement should be foreseen.

OVERVIEW

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1. WHY THIS STUDY?

1.1. Psychological suffering, an important problem

The World Health Organisation (WHO) defines **mental health** as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." It nevertheless appears that a steadily increasing portion of the population no longer has, or has less of, these elementary needs met. The results of the national health survey repeatedly published by the Scientific Institute of Public Health[1] demonstrate that more and more Belgians report a certain degree of psychological suffering. In 2013 one third of the population (older than 15) expressed that they had psychological problems, such as feeling stressed or tense, or being unhappy or depressed. Ten percent of the population appear to have trouble with anxiety disorders, 15% show signs of depression, and 30% have sleep problems. These figures have risen sharply since the 2008 survey.

In addition, 16% of the respondents declare that they have taken psychotropic medication (tranquilisers or antidepressants) in the two weeks preceding the interview. Alcohol use is regarded as problematic in 10% of the respondents.

People from disadvantaged social classes and the unemployed have more psychological problems in general. Moreover, according to professionals in the social sector, the decline in mental health due to decreasing vitality[2] is moreover one of the most important consequences of long-term poverty.

Finally, our country is the regrettable record holder in the number of suicides, with an annual mortality rate of 17.4 per 100,000 inhabitants (standardised average for age and gender) versus 10.6 in the European Union (2012 figures)[3].

Our qualitative investigation reports a number of additional characteristics of the malaise of the population. According to many of those in the field, anxiety and depressive disorders are the most common, moderate problems. They are "hard times" or "life problems" that can be solved by ad hoc support, and **not pathologies to be "medicalised" and labelled.**

Moreover these problems are often **multifactorial.** For example, depression can be related to marriage problems, and an alcohol problem can be the consequence of an untreated posttraumatic stress disorder. Often **definite socio-economical factors** also play a role (financial worries, work loss, retirement, social exclusion). Some complaints are **not always recognised/acknowledged** by the patients themselves as psychological suffering (somatisation). One also must be aware that these disorders burden not only those affected, but also **those around them**.

1.2. A substantial social impact

In the labour market this malaise is translated into a rising number of people with a diagnosis of burnout, emotional suffering that is connected with work, in which those involved can also be in a depressive state. In 2012 the Belgian figures[4] showed a prevalence of 0.8% of Belgian employees (19,000 persons/year) who were contending with an established clinical burnout, while 20% of that same population were in the "danger zone".

The toll in mental suffering is difficult not only for the individual, but also for society, especially with regard to **absenteeism and loss of productivity.** The overall cost of psychological disorders in Belgium was estimated at 4% of the GDP in 2001.[5] According to the figures of the RIZIV [*Social Security Administration*] (2013)[6] one third to one half of new requests for disability benefits can be attributed to mental disorders. This is an increase by 58% in the number of invalids due to mental disorders in 10 years' time.

1.3. Psychological care must be enhanced

In 2001 an **in-depth reform of mental healthcare** was carried out to better align the levels of authority with each other. The emphasis is put on care that "is preferably provided in a way that best approximates the living environment" and that focuses on working in networks and care continuity. This reform, often called "Article 107", led among other things to the establishment of ambulatory teams that care for and follow up on people with acute or chronic psychiatric problems at home. The initiative aims to guide and follow up on people with relatively severe problems in particular.

For **mild and moderate forms of psychological suffering**, thus the majority of the problems, the existing approach today is far from adequate. The sector forms a completely unclear structure for the target group, with waiting times (especially in existing subsidised structures) that discourage even the most motivated, and with few financially feasible solutions.

In fact **psychotropic medications** (antidepressants and tranquilisers) **are one of the only easily accessible therapeutic options for people with anxiety and depressive disorders**. Use is higher **in those with the lowest**

educational level (33% are users) **and in the elderly** (35% of those over 75 are users). The use of **antidepressants** is significantly higher than the European average (71.0 doses per day per 1000 inhabitants versus 64.6 for the European average).[7]

Recent sources show that for depressive complaints **a psychotherapeutic approach is at least as efficient and even more lasting than a pharmacological approach,** and that the combination of these therapies delivers the best results[8]. But because psychotherapy is not reimbursed, this treatment is not accessible to the majority of the population. A paradox that the KCE, like many others involved, has recently cited in its report[9] on the approach for depression.

At the time of its appointment in October 2014, the new government announced that "the first line [of mental health care] will be reinforced" and that "possible financing and reimbursement of mental healthcare, e.g. in the context of specific care trajectories and care processes (will) be investigated."

1.4. Toward a new model for the organisation and financing of psychological care

The present report, which has been written at the request of the RIZIV, the FPS Public Health and the Flemish Association of Clinical Psychologists (Vlaamse Vereniging van Klinisch Psychologen, VVKP), must be seen in this context. On the basis of an analysis of the organizational models of mental healthcare in a number of other countries, and an analysis of the Belgian situation, we propose **an organizational and financing model for the professional care of and approach to mild and moderate psychological problems in the Belgian healthcare system**. It fulfils the requirements with regard to quality, accessibility, sustainability and efficiency of the Tallinn Charter.

We stress here once again that this study examines an organisation that **runs in parallel with the approach for severe and long-term mental disorders** in the existing specific institutions and networks. This latter approach is therefore not discussed here. We are however convinced that the approach to nonspecific psychological suffering also plays an important role in **early detection** of more severe disorders and their referral to the already existing structures and initiatives.

NB 1: The professions of **clinical psychologist** and **clinical orthopedagogist** are being revised at this time within the framework of Royal Decree no. 78, but the modifications will probably not yet be definitively established by the end of this report. We will therefore use these two terms in the knowledge that these professions are/will be defined elsewhere. Because there are many fewer orthopedagogists than psychologists, we will only mention the latter in case of specific remarks, to simplify the text. When other and specific measures are applicable to orthopedagogists, we will mention this explicitly.

NB 2: **psychologists who are active in a hospital environment** are not taken into account for this study.

Methodology

After an analysis of the **legal framework** and the **current situation in Belgium** we made an **international comparison** of a selection of five European countries with systems for mental healthcare that appeared interesting to us. These are the Netherlands, Germany, the United Kingdom, Switzerland and Denmark.

To describe the system of each country, including Belgium, we collected information via websites and the grey literature, according to a method that has been validated by the Belgian stakeholders. Every description has been validated by an expert from the country concerned. We then compared the various countries. You can find the full international comparison in Chapter 5 of the scientific report.

The notable features of our international comparison formed the guideline in our **discussions with the Belgian stakeholders** in four meetings (two in Dutch and two in French) in the course of March 2015 (participant list in Chapter 6 of the scientific report and Table 14 for their distribution).

All discussions were recorded, transcribed and **independently analysed by two investigators from the KCE**, according to an earlier deductive method inspired by the **framework analysis** and on the basis of the **soft systems** methodology that is more directed toward the development of plans of action.

We also had early access to the results of the evaluation of the Flemish pilot projects "Eerste Lijns Psychologische functie [*First-line Psychological Function*]"[10] from 2011 to 2015.

After an online survey in December 2015 a **third stakeholders' meeting,** where our proposed recommendations were presented to everyone, took place in January 2016.

Despite all these sources we did not find adequate economic and epidemiological data to make a valid economic estimate of the costs for our action plans in this report. We do propose a methodology and a list of data that are needed for such a cost estimate (see Chapter 9 of the scientific report).

This report is a Health Services Report. It contains no exhaustive literature investigation of the efficacy of the various forms of psychological treatment. nor an epidemiological analysis of the Belgian figures.

2. WHAT IS THE CURRENT SITUATION IN BELGIUM?

2.1. Current organisation of the psychological care offer[a]

In our country today there are many structures and people who provide psychological care. Traditionally the care offer is distributed over three levels:

2.1.1. A first level with direct access:

- The **general practitioner** (GP) plays an important role here, because he is the most important gateway to the healthcare system and he is often the first who is consulted when help is needed, in all age groups. This can involve psychological problems, recurrent somatic complaints, questions on the end of life, addiction, etc. The general practitioner is also the first to hear complaints of a psychosomatic nature.
  The **wijkgezondheidscentra** (Flanders) and the **maisons médicales** (Wallonia-Brussels) [*community health centres*] are group practices where general practitioners work in a multidisciplinary framework with psychologists, psychotherapists, social workers, etc.
- Anyone with a request for help also has free access to the **private practices** of**:**
  - (neuro)psychiatrists,
  - psychologists
  - psychotherapists.

At present only consultations with (neuro)psychiatrists are reimbursed by the mandatory health insurance. The health insurance funds provide partial reimbursement via their supplemental insurance, but variance is big and very limited for the other caregivers.

Other structures, especially in the **psychosocial field**:

- in Flanders the **Centra voor Algemeen Welzijnswerk** (CAW) [*Centres for General Welfare*] give help and advice in personal, social, legal, administrative, financial or material problems. In 2011, 23% of these consultations related to "psychological problems" and 26% to "relationship problems".
- in the French-speaking part of the country, the **Centres de Planning Familial** *[Family Planning Centres]* offer help with sexual and emotional issues, so that they also often treat psychosocial problems (marriage problems, problems of adolescence, parent-child relationship problems, etc.).
- the **Centra voor Leerlingenbegeleiding (CLB) [*Student Support Centres*]/Centres Psycho Médico-Sociaux (PMS) *[Psychological-Medical-Social Centres]*** help young people with difficulties who have been referred by the school or by direct request of parents.

First-line Psychological Function (ELPF) pilot projects of the Flemish government

Between 2011 and 2015 the Flemish government supported seven pilot projects to test out a first-line psychological function (ELPF) within the existing structures. These projects offer easily accessible general care for simple psychological problems that can be treated with **short interventions**. We analyse these projects in detail in item 4.

[a] When 'care' is involved, a request (or an equivalent) is also involved. But many mental health problems do not even reach the stage of an explicitly formulated complaint/question. Many structures in the social field not specifically intended for mental health care accommodate (some of) these persons.

2.1.2. A second level of specialised ambulatory care:

- (**neuro)psychiatrists** provide specialised care, but are directly accessible (cf. previous item: first level with direct access)
- the **Centra voor Geestelijke Gezondheidszorg (CGG)** and the **Services de Santé Mentale (SSM)** ***[Centres for Mental Health, CMH]***, financed by the regional governments, provide specialised **ambulatory** care in **multidisciplinary** structures and fall under the care networks that have been set up by the recent mental healthcare reforms. Consultations with psychiatrists, psychologists and psychotherapists (usually employees) are offered there at a moderate cost.

The **CMH** work in multidisciplinary teams with a psychiatrist (director), psychologists, social workers (basic team) and reception and secretarial personnel. Depending on the project, the team can also include physicians (general practitioners or specialists), nurses, orthopedagogists, psychology assistants, educators, speech therapists, occupational therapists, sociologists, criminologists, etc.

These centres are often overburdened and the waiting lists can be long. Therefore some centres have entered into **collaboration agreements with independent psychologists** under various terms.

An important distinction is that in Flanders these centres are in principle only accessible after referral (25% do get direct access), while in the French-speaking part of the country these are directly accessible.

2.1.3. A third, more hospital-orientated level:

The **hospitals** (psychiatric hospitals or psychiatric services in general hospitals) and structures of the type psychiatric nursing homes, initiatives for sheltered living, etc., are a third care level for patients who need a more intensive approach. These structures work as much as possible in a network, often with structures from the second level.

In the framework of the so-called **"Article 107"** projects, hospital care has more and more been shifted to the living environment of the patient (mobile teams). Yet these initiatives are often still anchored in a hospital structure and are directed primarily toward patients with a pronounced psychiatric care need.

In addition there are also the specific RIZIV agreements for patients in specific care situations (chronic fatigue, rehabilitation, palliative care, etc.) for which the patient pays a moderate contribution.

The role of orthopedagogists

Orthopedagogists were recognised by the law of 4 April 2014. They are practitioners with a specialised university educational level (master) who act autonomously within a scientific framework to prevent, detect and diagnose educational, behavioural, developmental or learning problems, and to treat or guide these persons. Their clientele thus consists of **people with specific needs** (people with a mental, sensory, or physical handicap, relational or developmental disorders, or learning problems).

The training of orthopedagogists differs between the north and the south of the country. In the French community it corresponds to that of clinical psychologists, while in the Flemish community separate training exists. Work is now being done to streamline this.

In Flanders orthopedagogists work in the teams of Centres for Mental Health (CMH), Student Support Centres (CLB), Centres for General Welfare (CAW), and at Kind & Gezin *[Child and Family support]*. They are also employed in paediatric hospitals, (child) psychiatry, etc., in ambulatory rehabilitation centres, drug rehabilitation centres, centres for developmental problems, etc. They also sometimes work in independent private practices.

2.2. The most important identified problems

According to our research and our discussions with professionals in the field, **access to care appears to be far from optimal for people who have mild and moderate mental health problems**:

2.2.1. The first contact is difficult

- There is **no real organized reception for first contact and the existing gateways are difficult to find.**
- A number of these gateways, sometimes called "psy", are perceived by some as stigmatising; the word is still a **taboo**. There are many people who hesitate a long time before they seek psychological help (some sources report an average delay of 10 years[11]). This can cause "chronic" situations to develop that are more difficult to treat.
- A gateway that is often perceived by the patient as less stigmatising is the general practitioner, but it emerged from our meetings withstakeholders that the GP is not always the most effective (well trained) professional in the field of psychological care. It was reported that general practitioners:
  - have not acquired adequate skills for the diagnosis of and approach to psychosocial problems during their basic training (unless they have followed special training);
  - often do not have adequate time to listen in depth to patients who are contending with pronounced "psy" problems (even in the form of somatic complaints);
  - sometimes only prescribe psychotropic medications because they have no other concrete solution. This is connected with the often-cited phenomenon of over-medicalising certain social problems and life difficulties that can be approached in a better way.
  - do not all have a personal affinity with psychological problems.

Moreover, when they want to refer their patient to a psychologist, they are also confronted with the **complexity of the sector and the waiting times.** And if they effectively engage in multidisciplinary collaboration for a patient, their contribution is not appreciated.

Our research also shows that some people do not want their general practitioner to be involved in their psychological problems, often because the GP's relationship and proximity with the other members of the family.

- There are interesting initiatives for **specific target groups** (children, adolescents, the elderly, the socially excluded, immigrants, etc.) but they are not adequately visible/accessible within the existing organisation of mental health care.

2.2.2. The offer is not transparent enough and offers inadequate guarantees

In addition to the lack of visibility of the gateways, the offer is complex. Many **professionals are involved and** there is a multitude of structures with different names that depend on various subsidising authorities, and that are directed toward overlapping target groups.

In the private sector it is sometimes difficult to discern the qualifications and nature of the various therapists (psychiatrists, psychologists and various more or less scientifically trained "coaches" and "therapists"). The title "**psychotherapist**" is, at the time we write this text, not protected or reserved, and the patient has no guarantee whatsoever that the practitioner delivers qualitatively good work. Changes can be expected soon in this area. Today there is, aside from the conditions for recognition of professional statuses, no structural measure whatsoever for evaluating and monitoring **quality of care**.

In Flanders two projects on **quality indicators** have been launched:

- the *VIP²-GGZ project*, which brings together caregivers and university researchers from all sectors of mental healthcare and patient representatives to develop bottom up a series of indicators. The first four indicators can now be validated, but the project is not yet far enough advanced to integrate them into the current care organisation;
- the LUCAS project (KU Leuven), which has already published several reports on indicators for mental healthcare.

2.2.3. High costs for the patient

In the **private sector** (often the only one that is readily accessible) the costs are high:

- private consultations with a **psychologist** cost between € 20 and € 70[12] per session and are not reimbursed by health insurance;
- private consultations with a **psychiatrist** (+/- € 45 per session, of which € 12 is out of pocket for the patient, or € 3 for anyone who benefits from

increased assistance) are reimbursed, but there are too few psychiatrists who provide psychotherapy to cover the demand.
- the **health insurance funds** (partially) reimburse for certain services via their supplementary insurance, but these interventions, which are not subject to objective criteria whatsoever, are very diverse and limited.

2.2.4. Long waiting lists

For subsidised structures like the Centres for Mental Health (CMH) the waiting lists are long. Since 2010 the average waiting time in Flanders for a first contact has been approximately 40 days; 21% of patients must wait one to two months. For children and adolescents this waiting time is on average 53 days (2014). The average waiting time between the first contact and the next session is on average 46 days for adults and 54 days for children/adolescents (2014)[13]. There are no figures for the French speaking part of Belgium.
The same problem with waiting lists is known (however without clear data collection) for private consultations with psychiatrists and to a lesser degree with psychologists.

2.2.5. Care continuity is not guaranteed

Because the mental healthcare reform is primarily based on the concept of **networks**, it would be expected that care continuity is a priority. But some of those in the field regret that the situation is still far from optimal. Two weak points have been cited:
- many professionals work in a “bubble” without attention to the local network and without being a part of it.
- a patient who is discharged after psychiatric hospitalisation must often make it alone, with only a list of practitioners to choose from to contact himself. Nonetheless, the patient is in a highly vulnerable stadium and closer follow-up is absolutely desirable at that time.

3. ACCESS TO PSYCHOLOGICAL CARE IN OTHER COUNTRIES

Our **international comparison** includes five European countries with mental healthcare systems that seemed interesting to us. This includes the Netherlands, Germany, the United Kingdom, Switzerland and Denmark.
We selected the **Netherlands** and **Germany** because in these two neighbouring countries ambulatory psychotherapy is reimbursed by the (statutory or mandatory) health insurance. In two other neighbouring countries, France and Luxembourg, psychotherapy is not reimbursed; this is why we did not retain them. Because psychotherapy is also culturally influenced, we selected **Switzerland** and the **United Kingdom**. Finally, we also added **Denmark**, because it is known for its alternative approach in reimbursement for psychotherapy.
From this analysis it appeared that the gateways to psychological care differ greatly among the countries, but that **no country grants direct access to specialised psychological care.** Usually **this type of care is prescribed by first-line professionals** who can be freely consulted by patients**.** These first-line professionals have **special support** to treat current and moderate psychological problems, however organised and financed in very different ways.

3.1. Direct access to psychological care

In the **United Kingdom and in the Netherlands** the **general practitioners** are the most important access point. They are the central figures in the healthcare system and by extension in psychological care, but they do receive support in this:

- In the **United Kingdom** general practices work directly with other mental health professionals: a psychologist (bachelor or master level), psychotherapist, 'primary care worker', and graduate in mental health.
- In the **Netherlands** there are three types for collaboration are available for general practitioners, to support them in approaching mental health problems:
  - support of a "*practice assistant in mental healthcare"*: a psychologist or assistant in mental health (nurse, social assistant with special training);
  - they can use *e-mental health* programs (see below);
  - they can ask advice from a psychiatrist, psychologist or psychotherapist.

The **British NHS** recently made a number of specialists in mental healthcare directly accessible. The intent was to no longer require an obligatory first consultation bya general practitioner for certain parts of the population to get access to mental health care, in particular ethnic minorities with specific pathologies (posttraumatic, social phobias). However, the NHS still recommends consulting a general practitioner first if possible.

In **Switzerland** patients consult the **psychiatrist** directly, but **psychologists** also work in this office. The psychiatrist delegates part of his work to (a) psychologist(s), but only the fees of the psychiatrist are reimbursed (hierarchic model).

In **Germany** various health professionals work together in **multidisciplinary first-line group practices.** The services of every caregiver are reimbursed (non-hierarchic model). In **Denmark** there is no direct access (see below).

3.2. Access conditions for specialised psychological care

We investigated how financial support of specialised psychological care is organised in the different countries.

3.2.1. Gatekeeping

In the Netherlands, the United Kingdom and Denmark, access is given **through prescription by a physician**; in Germany the first consultation can take place directly, but a prescription from the general practitioner is required after the first session. Some countries make a distinction between specialised care by psychiatrists or by psychologists; in Denmark a prescription is only needed for psychologists, while it is required in the Netherlands for both psychologists and psychiatrists.

3.2.2. Indications

Various countries limit reimbursement to **specific diagnoses**: in the Netherlands, Germany and Switzerland this selection takes place exclusively on the basis of a list of diagnoses from the DSM IV/V or the ICD-10.

In the United Kingdom there is no restrictive list of indications, but access to care is based on **good practice guidelines** are developed by NICE for the most common psychological disorders, .

Denmark chose a completely different approach; access to specialised psychological care is obtained on the basis of a list that links diagnoses to the underlying causes (being a victim of a rape, a break-in, etc.)

3.2.3. Therapeutic methods

Some countries reimburse only certain therapeutic approaches. In the United Kingdom and the Netherlands the condition for reimbursement is that treatment of the indication is evidence-based.

for example, the Dutch system reimburses preventive approaches for depression, problematic alcohol use or panic disorders, because the efficacy of this type of prevention has been demonstrated. On the other hand, prevention of anxiety disorders is not reimbursed, because the efficacy has not yet been adequately demonstrated. Therapies such as psychoanalysis,

neurofeedback and transcranial magnetic stimulation are also not reimbursed.
In the United Kingdom the aforementioned NICE guidelines initially recommended only cognitive behavioural therapy (CBT) for treatment of depression and anxiety disorders. To fulfil this requirement, the NHS had to give thousands of professionals training in this type of therapy (Improving Access to Psychological Therapies - IAPT Programme*)*. Subsequently, NICE also allowed other forms of treatment and the IAPT programme was expanded with other training sessions. For example, a number of less intensive interventions are offered as an alternative to the face-to-face standard consultation sessions of CBT, so that the number of contact hours of the practitioner with the patient is limited.
Germany, Denmark and Switzerland have a less restrictive approach. In Germany reimbursement takes place on the basis of therapeutic orientations; three of these are recognised: analytic psychotherapy, psychodynamic psychotherapy and behavioural therapy. Denmark and Switzerland give complete therapeutic freedom as long as the psychologist is accredited. But because only 10 or 12 sessions are reimbursed, long-term therapies like psychoanalysis are disadvantaged.

3.2.4. Number of sessions

The maximum number of sessions that is reimbursed is limited in most countries.
This limitation takes place in various ways:

- **a fixed number from the beginning,** regardless of treatment, as in Denmark (12 sessions) or Switzerland (10 sessions)
- variable limit **depending on the type of treatment**, as in Germany (a maximum of 80 hours for behavioural therapy, 100 hours for a psychodynamic approach or 300 hours for therapy of the analytic type, divided over a maximum of three sessions per week)
- variable limit **depending on a classification of the patients,** as in the Netherlands, where the intensity of the treatment varies as a function of four types of need: short (5 hours), moderate, intensive and chronic (30 hours)
- variable **depending on the treatment/indication combination** as in the English system.

The length of the sessions is usually limited (usually 45 to 60 min for an individual session). In addition the number of hours of sessions can in some cases be extended on medical advice.
The interested reader will find the full international comparison in Chapter 5 of the scientific report.

4. PILOT PROJECTS FOR THE FIRST-LINE PSYCHOLOGICAL FUNCTION IN FLANDERS

In December 2011 the Flemish government launched seven pilot projects in "Eerstelijns Psychologische Functie (ELPF)" [First-line Psychological Function].

4.1. Objectives

The most important aim was to study the efficacy of a first-line approach to non-complex psychological problems and to examine the cost-benefit ratio. In addition the projects aimed to fit and relieve the existing needs in our society (with the focus on vulnerable population groups). There was also a desire to test different options to examine which approaches provide maximum interdisciplinary and transmural collaboration.

The primary operational objectives were:

- to provide short-term general psychological care for non-complex psychological problems with a low-threshold approach;
- to initiate close partnerships with others in the mental healthcare field according to the stepped care model, and to develop a local care network;
- to improve early detection and intervention for psychological or psychiatric problems.

4.2. Organizational aspects

The anticipated duration of the projects was three years (and was extended). Each project employed one FTE clinical psychologist, usually spread over two psychologists (10 in Brussels); all caregivers had to have at least five years of experience.

Each project received a fixed lumpsum financing (€ 65,000/year) for the compensation of the FTE clinical psychologist, operational costs, and communication with the general practitioner. The contribution of the patients was € 4 to 9 per consultation (free of charge for prisoners, asylum seekers and illegal residents).

Each project could determine its own access modalities and establish its own intervention procedures, but had to initiate a structured collaboration with at least one Samenwerkingsinitiatief Eerstelijnsgezondheidszorg (SEL) [*First-line Healthcare Collaboration Initiative*], the local general practitioners' association(s) and a CMH. This integration was perceived as very positively because it facilitated collaboration with and referral of patients to other caregivers.

The patients had to be referred by their general practitioner. In one project other care agencies could also refer (CAW, advising physician for a health insurance fund, OCMW [*Public Welfare Centre]*).

4.3. Major results

The most common reasons for a consultation were adaptation problems (47%), mood swings (34%), relational problems (31%) and anxiety disorders (27%). Almost 41% of the patients had already had these problems for several years, and 34% for several months; 7.5% of the disorders were considered mild, 47% moderate, 39.5% severe and 6% very severe. There were few crisis interventions. These were however not seen as part of the assignment (except in one project where a consultation day was reserved for this weekly).

The projects had to focus on short-term treatments; 88% of the people (67%-100%) followed one to five sessions and 8% (0%- 22%) followed six to ten. The average number of sessions was 3.1 (1.5-3.9). The waiting times before consultation varied widely, from two days to two months.

Subsequently, 56% of the patients were referred on: 17% to a CMH, 10% to a psychiatrist, 7% to a CAW and the remaining 31% to various other care providers.

Satisfaction with this project was high; the first-line psychologists were highly satisfied with the work performed (score higher than 8/10 for most evaluated items); the other partner clinicians were very pleased with the ELPF function and the collaboration (average scores > 9/10) and the patients too were very positive (average 8.9/10).

The detailed report on the ELPF projects was published in November 2015.[10]

5. APPROACHES TO THE ORGANISATION OF PSYCHOLOGICAL CARE

5.1. A psychological care system with two levels

None of the countries we studied gives direct access to specialised psychological care in the healthcare system. This care has to be prescribed by first-line physicians (general practitioners, psychiatrists, multidisciplinary practices). In these countries they receive support from caregivers who are qualified to handle the broad range of issues of patients with psychological suffering. Thus there is **direct access** to a **first form of treatment for current psychological problems**.

This is similar to the first-line psychological projects in Flanders, the results of which had not yet been published at the time our first consultation discussions took place (March-April 2015). Most participants however already knew them well and were very positive about them.

From all these aspects it emerged that a directly accessible first-line psychological function is probably the most suitable solution

- to give patients the opportunity to have direct access to psychological care without having to consecutively consult various parties;
- to support the professionals in the first line, especially general practitioners,
- to function as a gatekeeper to more specialised psychological care (which most Belgian professionals in the field find necessary to limit costs)
- to limit the waiting lists for more specialised care and quickly and efficiently intervene with people in difficulties.

Our proposal is therefore to introduce a system with two levels in Belgium:

A. A first line of general, easily accessible psychological care

- without prescription
- without criteria for diagnosis, type of user or severity
- but limited to a small number of sessions.

This highly accessible first line can in theory solve a large share of the cases of psychological suffering and consequently **limit the demand for more specialised and/or long-term treatment.** The creation of a first line also provides the opportunity to refer (potentially) more severe cases to appropriate care within the existing specialised structures and initiatives (second and third line).

B. A level of more specialised care for problems that cannot be solved by the first line and are not taken into account in the existing psychiatric care structures.

This specialised care would be accessible **after referral from the first line via a gatekeeping** mechanism **or via a psychiatrist**.

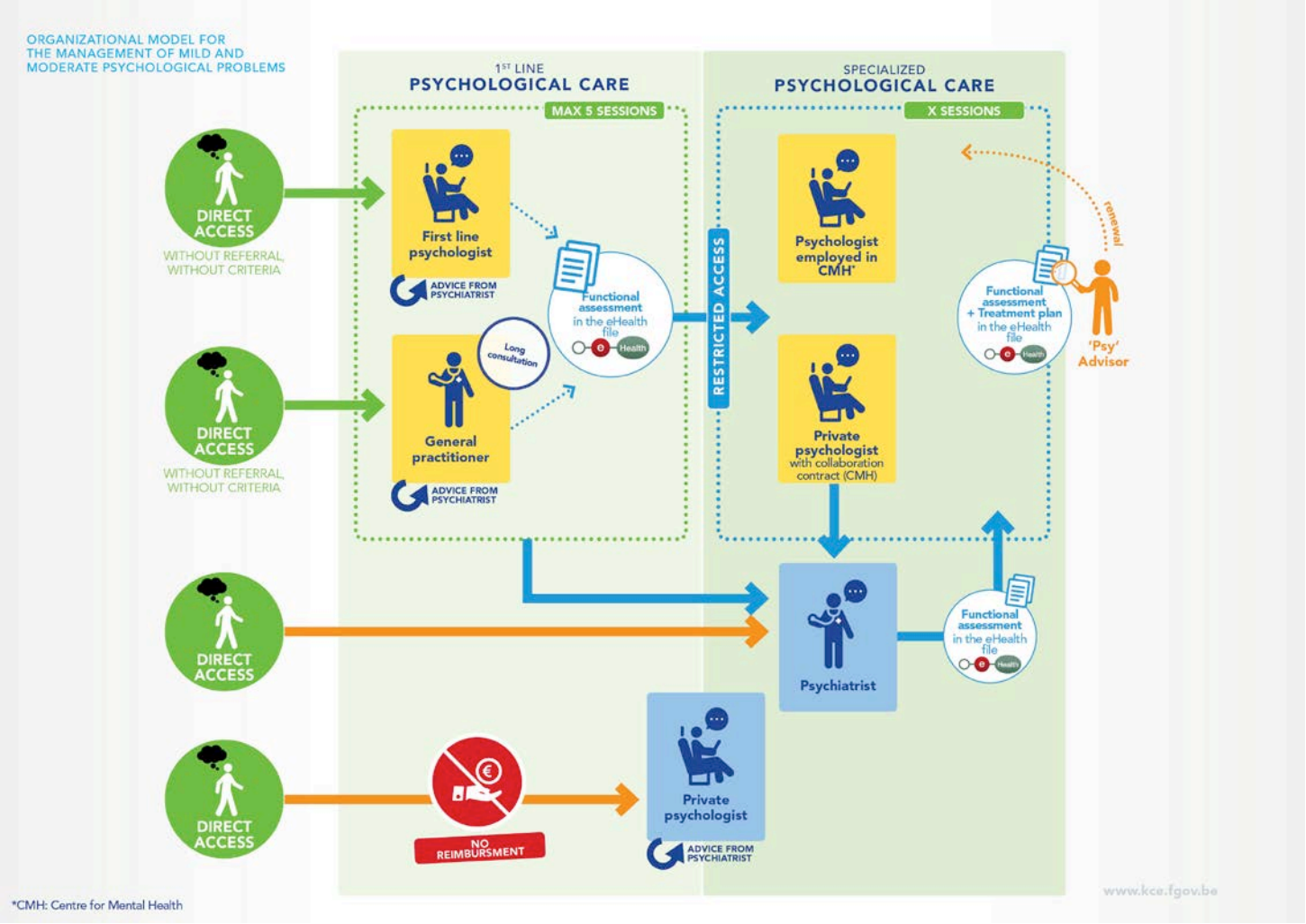
The **system of private practices** of directly accessible psychological care can remain as it functions now, but would not be reimbursed.

To make such a system workable, **a number of financial stimuli and organizational structures** must be provided at the level of the healthcare system to:

- setup a culture of collaboration and practice in networks for all those involved, at all levels;
- have sufficient professionals available with an appropriate level of training;
- make (IT) tools available for information transfer and data entry;
- introduce a system for quality control.

Because the terms for application cannot be implemented in the short term, transitional methods and a phased introduction of the various parts of the system must be provided.

Figure 1 — Organizational model for the approach to mild to moderate mental health problems*



** In specialized psychological care, the word psychologist can be replaced by any professional who is authorised by law to give psychotherapy*

5.2. Parties involved: each level has its characteristics

5.2.1. First line: parties with complementary competences

In most of the countries studied, the general practitioner (GP) is the gateway for patients with psychological difficulties and care needs. Those in the field however wonder whether the GP is in fact the best placed to fulfil that role. The role can also be taken on by clinical psychologists. Because of the sensitivity of the subject, we clarify the arguments below.

A. The general practitioner

The general practitioner is undeniably considered the **key figure in healthcare** and the caregiver who knows the patient, his environment and his life circumstances best. He usually has a **stable and long-term relationship** with his patients and is well placed to have an **overall view of the context** in which difficulties can arise (family crises, work-related problems, financial difficulties, etc.) and to assess the degree of support by the environment

Moreover the general practitioner in Belgium has a **very high degree of trust** of his patients. He manages the **Globaal Medisch Dossier (GMD)/ Dossier médical global (DMG) *[Global Medical File*]** and is therefore the ideal person to coordinate an approach within a care network. He also usually signs the **medical sick-leave certificates**.

He is also **easily and quickly (geographically and financially) accessible**.

When he works in a **multidisciplinary structure** of a community health centre he often also has immediate access to a psychologist with whom he collaborates.

Finally, for many people it is easier to go to a general practitioner than to a "psy" (in the broad sense), because this is less **stigmatising.**

BUT

Those in the field also report that exclusive **limitation** of access to mental healthcare to the general practitioner can cause problems.

There are in fact many people who do not consider their life difficulties to be **medical**. They would like access to a mental health professional but **prefer not to talk about their problems with their general practitioner,** just because he is too close to the rest of the family and relatives.

In addition, general practitioners are often **overburdened** and they cannot always devote much time to every patient. Discussion of a psychological problem requires **time and mental availability.** General practitioners also do not necessarily have the **personal sensitivity,** because they have not received **adequate training** in this matter.

Moreover, **vulnerable populations often do not** have their own general practitioner; for them a mandatory referral via a general practitioner can be an obstacle.

We thus had to find **an adequately flexible formula** in which general practitioners can be involved, but in which they are not the sole. Moreover, adequate financing must be provided to give them the opportunity to devote sufficient time to the patient and his psychological problems and easily give them access to the expertise of other caregivers.

B. The clinical psychologist

The clinical psychologist is scientifically and specifically trained to understand, diagnose and treat the (dys)functioning of the human mind. He can thus **play a central role in first-line psychological care.** In addition he practises a **profession that has been recognised as autonomous** by the law of 4 April 2014 and he thus is entitled to make a diagnosis and prescribe or provide (additional) care without having to make a referral to a physician for this. In this context we refer to the recent definition of 'clinical psychology' of the Superior Health Council[14]:

"the autonomous development and application of theories and methods of scientific psychology in the promotion of health, in the psychological screening, diagnosis and assessment of health problems, and in the prevention, the management and the treatment of these problems in people."

In addition, clinical psychologists have a good **total overview of the various existing (psycho)therapeutic options;** they master a number of these themselves and can apply them immediately in the first line. A number of these options (short therapies, counselling, a small number of intensive interventions) can solve a large share of the problems in a few sessions, without the need for a longer therapy.

BUT

Those in the field also report that reserving the first-line function **exclusively** to psychologists has a number of disadvantages.

Psychologists do **not** have **the same overview of the health situation of the patient** as the general practitioner, because they do not have competences on the somatic side of the problems, and because they do not have access to the medical history of the patient. These somatic aspects

often can nevertheless form an important part of the psychological issue. This implies a potential risk of "**psychologising"** problems that can be solved by medical treatment (e.g. a poorly functioning thyroid that leads to depression).
As already stated, for a part of the population it remains difficult to call on a mental health professional due to the **persistent taboos about "mental illness".** For this part of the population it feels less stigmatising to first approach a general practitioner or consult a community health centre; it is therefore important to keep this option open.

In addition, the report on the ELPF pilot projects states that the first-line function is very demanding and requires **specific skills** and solid **clinical experience**. According to some of those in the field the basic training in clinical psychology is insufficiently broad for offering first-line care. They request organisation of **specific additional training** for clinical psychologists who want to take on this function. They believe **similar ongoing training** should be offered to active psychologists who want to add this competence to their current practice. As a consquence, this training should be a condition for **being authorised to provide first-line psychological care** and should grant access to **specific financing** (see below).
Mutatis mutandis, **the role of clinical orthopedagogists** in a first-line function should be identical to that of clinical psychologists, according to the same modalities and under the same conditions, but only for their specific target public.

C. (Bachelor) assistants in psychology
In the Netherlands and the United Kingdom psychology assistants (bachelor level) may carry out specific tasks in the general practitioner's practice under their supervision.
In Belgium a recognised diploma of "Bachelor in Applied Psychology" (previously "Assistant in psychology" or "graduate assistant in psychology") exists. Holders of this diploma often use the title "psychological consultant". This title is not yet officially protected at present. Bachelors can work in the first line on an independent basis (as a therapist, coach, etc.), as an employee in an organizational structure (CAW, CLB, OCMW) or in a general practitioner's practice. They can also be active in CMHs and (centra voor ambulante revalidatie (CAR) [centers for ambulatory rehabilitation] .

Due to the high level of expertise needed for the first-line psychological care, reluctance was expressed during our contacts with the work field to entrust these responsibilities to bachelors. But due to the expected rise in demands for care in case of setup of a first line of psychological care, it would be realistic that they could take on part of care, on condition that they work **under the supervision of a qualified clinical psychologist** (**master level) trained in first-line psychology**.
D. And the psychiatrist?
As a specialist physician the psychiatrist does in fact not belong in the first line, although in practice he can be directly consulted in our country. His undeniable added value is his in-depth knowledge of mental pathologies and drug therapies. It would be an advantage to have the opportunity to make this expertise available **ad hoc** to the first line of care by means of an advisory role, without the requirement of a mandatory consultation
An **"advisory consultation"** with a psychiatrist can indeed be a great help for first-line professionals with a patient with a complex problem. This consultation should be a high priority. The psychiatrist should be required to send an advisory report to the professional who sent him.
NB: This advisory psychiatric consultation should not be confused with the psychiatric advice that is sometimes requested for work disability.

E. In brief: first-line psychological care should be provided by clinical psychologists, preferably in collaboration with general practitioners when desired.
The patients would thus be able to choose whom they consult, depending on their preference. The general practitioner can in that case charge for a limited number of long-term consultations. The first-line psychologist and general practitioner should be able to request ad hoc advice from a psychiatrist.
In addition to the specific skills that are required to provide first-line psychological care, **the authorised caregivers should fulfil certain requirements with regard to ongoing training and participation in peer review groups with colleagues.** The content of this ongoing training and of the peer reviews should be defined on the basis of consultation with professional groups. This task can be entrusted to the committees provided in the law on the mental healthcare professions of 4 April 2014.
These requirements can be the same for professionals in an organizational structure and for independents.
Bachelors can carry out certain supporting tasks under supervision of a clinical psychologist.

5.2.2. Specialised care: authorised and accredited professionals

The second line of care, called “specialised psychological care”, will consist exclusively of interventions by **authorised and accredited professionals** who have followed **specific training** in certain recognised care techniques (including psychotherapy) or from **orthopedagogists** for certain patients with specific needs.
The **qualification of caregiver of specialised psychological care** exists in fact in all countries (but according to very diverse modalities with regard to authorised profiles and qualification levels).
These caregivers of specialised psychological care should **fulfil specific requirements with regard to ongoing training and participation in peer review groups with colleagues. They should also be a member** of a local multidisciplinary network (see below: consultation). These conditions should be included in an accreditation process.
The **status** of these professionals is not decisive: **independent practitioners** as well as those who **are active in an organizational structure** (CMH) are eligible. This offer thus extends that of the CMH, to strengthen the function.
The various professionals are therefore financed on the federal (RIZIV) or regional level, which can be an additional difficulty.

5.3. Care offer: stepped care and therapeutic freedom, but limited number of sessions

5.3.1. Stepped Care

Stepped care is a care model in which patients **receive the least intensive treatment that suits the nature and severity of their complaints.** If this turns out to be inadequate, the next intensity/specialisation level can be considered ("stepping up").[15]

In our model, patients first have a whole range of interventions offered (in rising intensity) in the first line, before more specialised and/or longer-term care is considered. The latter takes place on the basis of a 'functional assessment (bilan)' that summarises the first-line treatment.

For a severe or urgent problem, direct referral to the psychiatrist or hospital emergency service is of course possible. The same holds in reverse: if the problem does not to belong to the area of (first-line) psychological care, the patient will be referred to other forms of less intensive care ("stepping down"). In this matter, one might not forget the role of self-help groups and informal care givers.

5.3.2. Types of intervention

The **patient profiles** of the ELPF projects correspond to the profiles as described by professionals in the field, namely predominantly "life difficulties", adaptation problems with many facets, often in a familial or social context, that do not necessarily immediately demand a complex approach. Our proposal to apply an approach based on that of the ELPF projects thus seems logical:

- Intake and listening to all complaints
- Drawing up a functional assessment, or possibly making a diagnosis (see below)
- Counselling
- Helping in self-solving of the problems
- A short treatment of moderate problems (uncomplicated trauma, grief, etc.)
- Early detection of (potentially) severe problems and redirection to a psychiatrist
- Referral to longer-term specialised psychological care if needed.

5.3.3. No restrictive lists of indications

Our international analysis showed that the classifications of the DSM IV/V (*Diagnostic and Statistical Manual of Mental Disorder, 4th/5th edition*, published by the *American Psychiatric Association*) or the ICD-10 *(International Classification of Diseases and Related Health Problems, 10th revision, produced by the WHO)* are often used to determine the indications that can be reimbursed.

Proponents argue that a problem can be described very precisely with the classifications, facilitating communication between caregivers on the evaluation and the therapeutic approach. Critics on the other hand have the opinion that these classifications produce stigmatisation and that they hinder a holistic vision of a multifactorial problem. They also point out the risk that the diagnoses might lead to "self-fulfilling prophecy" or that people with atypical, repeated complaints that do not fit any category will be excluded from reimbursement.

These arguments **against the use of restrictive lists of indications** are in accordance with the comments of Belgian field experts. For them, a significant share of the psychic problems they deal with do not origin from characteristic mental pathologies, but are rather a combination of psychic, social and economic problems. Therefore they believe that requiring professionals to make a diagnosis of the DSM or ICD-10 type for this type of patients would result in "social medicalisation" or improper "psychiatrisation". They argue that experienced professionals can judge perfectly whether a patient needs access to specialised care without a formal need to have a diagnosis. The decision should be driven by the **needs of the patient** rather than by criteria on a checklist.

If criteria are in fact indispensable, they would rather base them on guidelines or protocols than on classification tools like the DSM or ICD.

The patient representatives who participated in the discussions also commented that if professionals are required to apply pre-defined diagnoses ("compartmentalized"), they might perhaps "adjust" the symptoms to the characteristics of certain diagnoses.

The position of the KCE is that we do not now have sufficient evidence to recommend an approach determined by precise diagnoses.

5.3.4. No limitation on the type of treatment

In all of the countries we studied, the mandatory health insurance covers individual and group, partner or family sessions. In the Netherlands and the United Kingdom, however, only evidence-based treatments are eligible.
Belgian professionals are convinced of the importance of **evidence-based practice in psychology**, but are not proponents of reimbursement that is limited to evidence-based treatments. His **therapeutic freedom** allows the caregiver to combine aspects of different treatment options, based on his own expertise, to better adapt his care to the specific characteristics of each individual patient. The success of a therapy is also related to the **quality of the relationship** between the therapist and his patient, which cannot be limited to care protocols.
According to the professionals in the field, their future authorisation according to the new legislative measures and the fact that their mandatory training will be a sufficient guarantee of the soundness and suitability of the treatments. Guidelines can be of added value, because it helps professionals to stay aware of the most recent recommendations with regard to evidence-based treatments, but should not become a straitjacket.
The position of the KCE is that we do not now have sufficient evidence to recommend the restrictive list of treatments as now legally stipulated.

5.3.5. Not exclusively face-to-face consultations

The professionals emphasise that for first-line and specialised care **face-to-face consultations are not the only possible approach**:

- Group sessions are cost-efficient for certain patient types (psycho-educational sessions are in fact included in the 'Article 107' projects).
- Certain alternatives to face-to-face discussions, such as telephone or online contacts (see box below), can be very useful for people with mobility problems (cancer patients, the elderly, voluntary caregivers, etc.).
- In the specific case of orthopedagogists, observations at school or at home and guidance of parents and teachers are alternatives to direct contact with children.
- The use of telemedicine must be re-thought in a broader context than that of mental health.

"Alternative" options
Recently the British programme Improving Access to Psychological Therapies (IAPT) has begun to offer interventions such as guided or non-guided **self-help programmes** in the form of books or via computer (***e-mental health***) and larger-scale interventions like **group sessions**.
According to the Swedish Council on Health Technology Assessment (SBU), **cognitive behavioural therapies via the internet with the support of a therapist** should be considered part of the broad offer of useful methods. These options work outstandingly for adults who suffer from a social phobia or mild to moderate clinical depression, on condition that they are motivated to use that method.
In addition, there is the positive recommendation of the Zorginstituut Nederland *[Dutch National Health Care Institute*] (formerly the CVZ) on the programme 'Beating the Blues' (an online Cognitive Behavioural Therapy programme). According to the literature the efficacy of this programme is sufficiently plausible for persons who suffer from mild to moderate depression, but not for anxiety disorders. The programme is thus included in the package that is covered by the Dutch mandatory health insurance for depression.

5.3.6. Limitation of the number of reimbursed sessions

An important characteristic of **first-line psychological care** is **short duration.** We therefore propose to limit this approach to a number of sessions to be determined. Belgian participants in the field agreed that a large share of patients in the first line can be helped with a minimum of sessions (In the ELPF projects, 88% of the patients got 5 or less sessions, with an average of 3,1).

For **specialised care,** the treatment volume is limited in all the countries studied to a number of sessions and/or hours. It appeared from our contacts with the Belgian stakeholders that they perceived **such a limitation to be a reasonable measure here.** The foreign examples however show an enormous variation (from 5 to 300 hours – see Chapter 5 in the scientific report).

In Belgium today, psychotherapy by psychiatrists is reimbursed by health insurance, without limitation of the number of sessions. The same holds for specialised care in CMHs, which is financed by the regional authorities, with a limited contribution from the patient.

The number of sessions with psychologists within specific conventions with the RIZIV is however limited; e.g., a maximum of 17 sessions for chronic fatigue or eight sessions spread over two years for support in smoking cessation.

The number of reimbursements via the supplemental insurance of the health insurance funds for consultations with a psychologist or psychotherapist is also limited, over an entire lifetime or a year, and the number differs substantially from one organisation to another.

In our model the first series of sessions of (reimbursed) specialised care would be limited to a number yet to be determined, with an option for **renewal.**

The advantage of this system is that it keeps costs under control to a certain extent, and encourages the caregiver/patient to take a moment for joint 'reflection' and drawing up a balance sheet of the road that has been covered together. This reflection is then translated into a new **functional assessment and a care plan** that are then presented to a third party (e.g. an "advising psychologist" or "advising psychiatrist" connected with a paying organisation (see below).

For a limited (to be composed) list of **pathologies that require a very long-term approach,** an automatic extension has to be organized. People who are institutionalised long-term and people with a mental handicap may not be forgotten within this framework.

The advising 'psy'

The function of "advisory psychologist" or "advisory psychiatrist" can be compared with that of the "advisory physician", and is thus in particular connected with the medical administrations of the insurance companies. He or she (hereinafter 'he') could act either autonomously or within a multidisciplinary team and under the supervision of an advising physician (to be determined).

The "advisory psy" would not intervene in the first line or for the reimbursement of the first series of sessions of specialised care. He only makes a decision on a request for **extension** of these sessions. He bases on the functional assessment and the care plan drawn up by the specialised caregiver. Thus for a simple extension, the "advisory psy" does not need necessarily to meet the patient. Some of those in the field suggested that the "advisory psy" could also strengthen the advisory task of the medical administrations of the health insurance funds and could be involved in evaluation of cases of work disability and disability due to psychological disorders.

The role of this "advisory psy" thus stays limited to tasks of the insurance institutions, and so involves no supervision of the caregiver**.**

5.4. Access: free in first line, under conditions for specialised care

5.4.1. First line: multiple gateways

Those in the field in Belgium speak out clearly for **direct and very low-threshold access** to first-line psychological care. This means that patients get immediate access **without a prescription.** On that point this model thus differs from the ELPF projects, where patients can only get access after referral by the general practitioner.

It is even proposed that **these gateways should be further expanded:** the OCMWs, the emergency services of hospitals, occupational physicians, the school sector (CLB, school doctors), the CAW, rest homes, advising physicians of the health insurance funds, associations that work with disadvantaged population groups, etc., should all be encouraged to refer people in whom they establish or suspect psychological suffering to first-line psychological care.

This first line must also be **well-distributed geographically**, and **clear information must be disseminated** among the general public and all those in the medical-social field on this new possibility. A certain number of first-line services should also be provided that can receive people with specific needs, such as people with a double diagnosis (mentally handicapped and psychological problems).

NB: due to the numerous comments on the ambiguous definition of the first and second line, in the north and the south of the country, it seems useful to us **to use a name that does not refer to a "line"** or a "level", but is clearly recognisable to the public, for example "psy contact point", "first psy reception", etc. In this report we will however continue to use "first line" to remain consistent with the foreign examples and the ELPF pilot projects.

5.4.2. Specialised care: multidisciplinary gatekeeping

Because the first-line of care must be financially accessible for as many patients as possible, **there must necessarily be a regulation mechanism (gatekeeping) at the pivotal point between the first line and specialised psychological care**.

According to those in the field in Belgium, **doctors, clinical psychologists and orthopedagogists should play the role of gatekeeper** to reimbursed specialised psychological care. Most of those in the field agreed that requiring **multidisciplinary consultation** at this decisive point in the process of psychological care would be useful, especially to "avoid solo-solo circuits".

In this **multidisciplinary consultation,** the first-line psychologist (who gave the indication for specialised care) and a general practitioner should **at least should** be involved, preferably the established general practitioner of the patient, as he has an overall picture of the patient's health status and manages his Global Medical File (GMD). If this is not possible, any other doctor (gynaecologist, paediatrician, geriatric specialist, psychiatrist, etc.) can refer the patient to more specialised and/or longer-term psychological care. Other professionals can also be involved in the multidisciplinary consultation, such as a (child) psychiatrist, social worker, psychiatric nurse, etc., in specific cases. A *systematic* evaluation by a psychiatrist is however not found to be necessary**.**

Specialised treatment would thus depend on a functional assessment (bilan) drawn up after consultation between the first-line psychologist and a general practitioner, with other professionals if desired. This assessment should contain all the information useful to be able to examine whether a specialised approach is needed, including the treatments already followed and a proposal for therapeutic orientation if needed.

The functional assessment must be included in the online shared patient record (eHealth) of the patient. The exact content and the modalities for this functional assessment should be defined on the basis of consultation with professional groups. This task can be entrusted to the committees provided in the law on the mental healthcare professions of 4 April 2014. In a certain sense an **online shared patient record** can thus be a condition for access to reimbursed psychological care. Such an assessment can not only be requested for the decision to refer the patient

to specialised (non-psychiatric) care, but also for the **request for extension** (in the case of limitation of the number of sessions, see below) or for **finalisation of the treatment** (depending on the quality control).

Consultation between general practitioner and clinical psychologist
For some it may be new, but for others the consultation between general practitioners and clinical psychologists will be the affirmation of a sound practice that already exists. By bringing together the **complementary competences** of these two professionals, the problem of each patient can be evaluated in all its aspects and complexity. This consultation should in fact be encouraged as of the first contact with the patient, **and not only in the framework of the functional assessment**.
Because everything related to mental health is so sensitive, this information exchange need not necessarily be highly detailed and extensive. Respect for **professional confidentiality** is after all inherently related to the **relationship of trust** that is essential for an efficient psychological intervention. To prevent 'medical shopping' and combination of various treatments, one professional, as a coordinator of care, should be aware of the interventions provided by other caregivers. The general practitioner is the most obvious person to centralise this information in the Global Medical File, even though he does not give the patient psychological care personally.
The use of a **online medical shared patient record** – with specific access rights – should be the rule. All caregivers authorised by law (who have a therapeutic relation with the patient), including clinical psychologists and remedial educationalists, should receive access, as foreseen in eHealth planning In that way the information can easily circulate without additional work. It also benefits the patient, who will not have to be "questioned" by all those involved. For most, **transfer of the SumEHR** (when completely operational) will be adequate and efficient.

5.5. Active integration into the existing network

All work field experts highlight the importance of encouraging the various professionals not only to work together around the patient, but also to **actively integrate into existing networks and structures**, particularly within the framework and spirit of the reform called "Article 107." In the evaluation of pilot projects ELPF, this active integration into the local network is explicitly mentioned as one of the essential components of the 1st line psychological care function.
It is therefore essential to establish **concrete modalities** to objectify this insertion into local care networks. These arrangements should be defined on the basis of consultation with professional groups. Again, this task could be entrusted to the committees provided committees provided in the law on the mental healthcare professions of 4 April 2014
1st line of psychological care is normally not confronted with **severe mental problems**, nor by **crisis intervention**, but their frontline role inevitably exposes them to promptly receive such patients. The 1st line psychological care function could therefore, in that sense, contribute to the **early detection** function provided by the reform 107.
Regarding patients already treated for **chronic mental illnesses**, synergies could be established based on the needs and local organizations so as to **enhance the continuity of care**. For example, 1st responders could intervene from time to time during transient worsening due to difficult life events, together with the long-term monitoring teams. The example given in the ELPF report regarding motivational encounters conducted by the 1st line function to encourage a chronic patient to resume his treatment is a nice example of such complementarity.

5.6. Location: very flexible accommodation

None of the stakeholders wanted the creation of new structures, in order to not increase the current complexity of the landscape. Whether 1st line or specialized care, the actors are convinced that we have to strengthen the capacity of existing structures.

5.6.1. Regarding the first line of care:

Those in the field propose that the first line can be integrated into a medical house or a medical group practice, a CLB, a CAW, an OCMW and a CMH. "Housing" in existing structures would also promote multidisciplinary consultation.

Our country also has a long tradition of **independent practices.** Many **clinical psychologists work** as **independents,** alone or in a group (e.g. consultation centres). They are approached by a large – often described as more affluent – public. It is thus important to **keep these essential caregivers**. In addition to their usual specialised care provision, those who wish to do so can fulfil a first-line function, under the conditions already cited with regard to education/ongoing training and working in consultation with the existing structures and networks.

This great flexibility in the location of first-line care guarantees a broad geographical distribution.

5.6.2. Regarding specialised (ambulatory) care:

We propose to develop no new structures. This means that specialised care provision should remain where it is now,[b].

CMHs must be encouraged to open **satellite practices** (possibly through agreements with private practices – see below) for a better-distributed care offer. To expand the offer geographically and therapeutically, the private centres, if they wish, can also be recognised and financed under the same conditions as the CMH.

Nothing prevents a first-line psychologist from continuing to treat patients in specialised care if the patients' access conditions to this care (functional assessment) are met and if the professional is authorised for these two competence types.

NB: Patients may **never** be **obligated** to go to the first-line psychologist. In addition the activities of private practices that want to stay outside the system may not change, but then they are not eligible for government financing. **Direct access to a psychiatrist** would in fact have to evolve toward integration into the gatekeeping system, the modalities for this should be discussed with the representatives of the disciplines involved.

5.7. Quality of care

In many countries, quality of care is guaranteed by **training and recognition of the professionals**. For those in the field, an official qualification recognised by law should be the first – and absolute – condition for entitlement to reimbursement. They also propose to set up a **register of caregivers** who are entitled to reimbursement.

The stakeholders also made other proposals for improving quality, such as **inclusion of caregivers in a network, the exchange of traceable information** within this network, or **supervision** and **ongoing training with an accreditation system**.

A connection can also be established between quality and financing, as in **England,** where a system of **pay-for-quality** (IAPT programme) is being developed. In January 2014 the **Netherlands** chose for **registration and benchmarking, with publication of the results** (*Routine Outcome Monitoring* (ROM)). In this type of monitoring the situation of the patient at the beginning and at the end of treatment is compared, so that patients, patient organisations, insurers and caregivers can examine the impact of that treatment.

The professionals with whom we spoke fear a proliferation of registrations and monitoring, although they are convinced that we should evolve toward a culture of evaluation of the results. They are very hesitant about benchmarking, which according to them encourages selection of patients. They do admit that by comparing results, outliers can be traced and called to account.

In Flanders several projects are running to develop quality indicators.

[b] The services of hospital psychologists are not included in this study.

5.8. Mixed financing

The financing of our two-level care model should fulfil a number of conditions:

- the expenditures should remain feasible. This implies that control mechanisms are needed. We chose to manage expenditures by limiting the number of reimbursed sessions;
- financially accessible for everyone, with special attention to vulnerable groups;
- no unique gateway imposed on the patient;
- do not allow reimbursement to depend on a specific diagnosis or type of treatment;
- encourage interdisciplinarity, networking and exchange of information;
- provide the possibility of adding a “pay for quality” aspect in the future;
- and *last but not least*, take account of the distribution of responsibilities as provided in the state reforms.

5.8.1. Financing possibilities for the professionals involved

There are various possibilities for financing (see table). For the professionals consulted, only fee for service or a fixed sum per capita is acceptable.

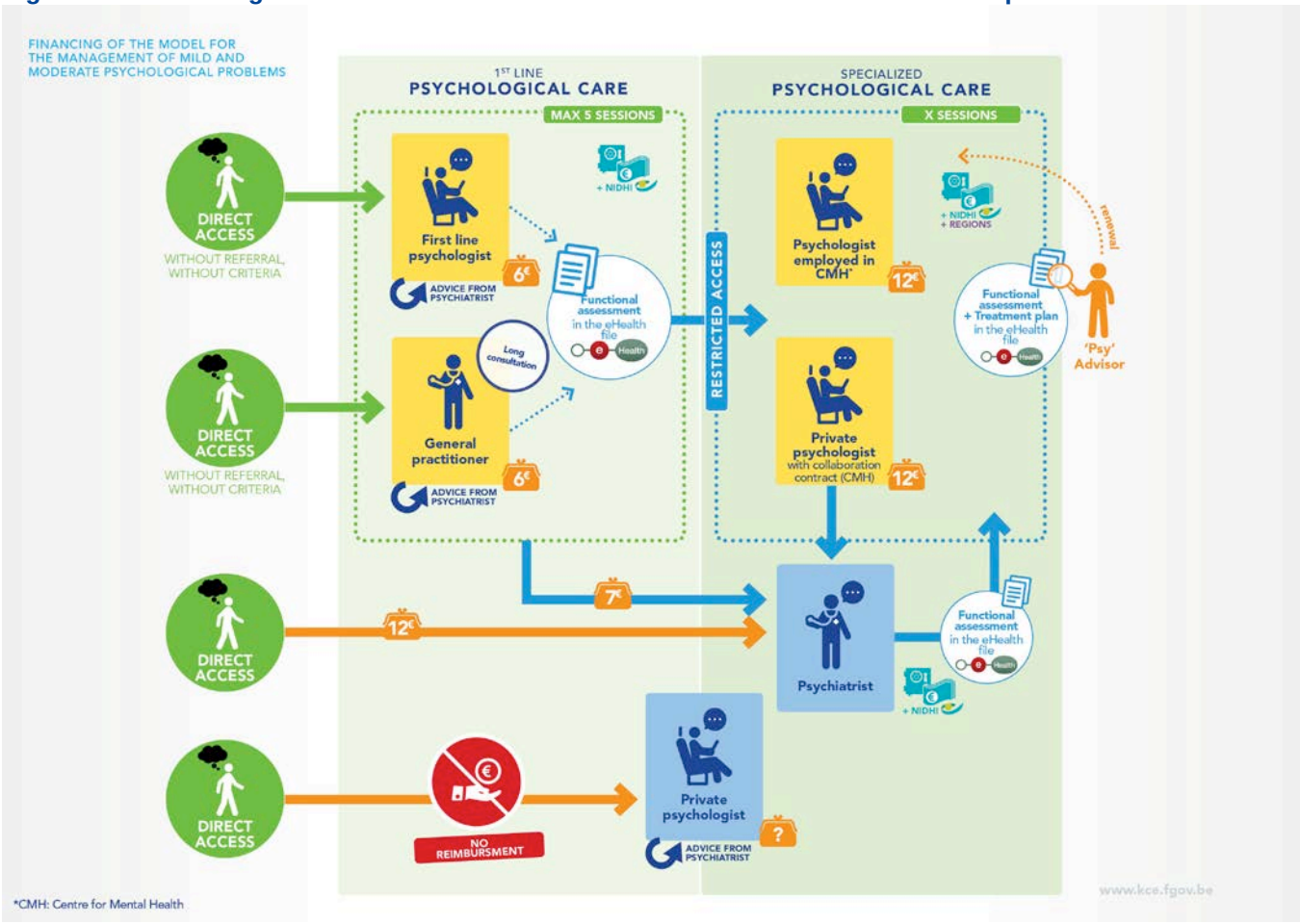
If the capacity of existing structures such as the CMHs is to be expanded, the **heterogeneity of the existing system** must also be taken into account**.** These centres are now in fact financed on a fixed-sum basis by the regional governments. General practitioners, psychiatrists and certain psychotherapeutic procedures in the framework of specific conventions (chronic fatigue, rehabilitation, palliative care, etc.) are however financed by federal health insurance.

Due to the current state reform and the lack of new financial transfers between the federal government and regional governments, a new solution thus had to be found.

Table 1 — General description of the various financing systems of Belgian health care

	FINANCING PER SERVICE	FIXED LUMP SUM PER CAPITA	PAY/FIXED REMUNERATION/ ENVELOPE SYSTEM	PROSPECTIVE FINANCING
What is it?				
Description	Established compensation after each procedure that the care provider performs.	A fixed amount paid to a care provider per insured person in his sphere of influence, for a certain period;	An established (annual) budget, adjusted or not to the number of patients/services provided	An established amount for a specific problem, regardless of duration and cost price of the treatment.
Place in the Belgian context	Compatible with current Belgian model of independent participants.	Applied in Belgium in most community health centres. Difficult to implement for psychologists in solo practices	Used in Belgium for financing CMH, in RIZIV conventions, and more generally in subsidised structures	To be compared with the DRG (diagnosis-related groups) financing for hospitals
Efficiency and risks				
Efficiency: avoids unnecessarily long or superfluous therapies		• Adjustment of consultations on the basis of specific patient need & deterrence of unnecessary procedures.		• Promotes keeping treatment costs low and encourages short treatment periods.
Encourages striving for patient satisfaction		• Encourages long-term relation with the patient.		
Productivity (reduction of waiting lists)	• Promotes increase in the workload	• Encourages taking on more patients in the practice.		• Encourages short treatment periods.
Encourages prevention and patient education		•		
Risk of under-treatment		•	•	
Risk of supplier-induced demand	•			
Risk of patient selection	• Intake of patients with high treatment intensity.	• Intake of patients with low treatment intensity.	• Intake of patients with low treatment intensity.	
Administrative aspects				
Automatic registration of activity data	•			•
Tariff security for the patient	•			•
Income security for the care provider	•		•	
Manageability of state expenditures		•	•	•
Administrative overhead	• More burdensome administration	• Less burdensome administration	• Less burdensome administration	• More burdensome administration

Figure 2 — Financing for the treatment model of mild and moderate mental health problems*/**



** In the specialised care sector the word psychologist can be replaced by any professional who is authorised by law to give psychotherapy.*
*** The amounts in the model are only indicative; they should be the subject of a political decision*

5.8.2. Proposals of the KCE for a mixed model

We recommend **mixed financing systems** for first-line and specialised care, partly fee-for-service and partly a fixed lump-sum. For specialised care the fixed-lump-sum will originate from the amounts that are now paid by the regional authorities.

For first-line psychologists:

- A **"practice allowance"** to compensate for extra-therapeutic activities such as peer reviews, administration and integration into a local interdisciplinary network. This compensation can be adapted to the size of the practice (minimal activity is needed, higher compensation for practices with several professionals, etc., to be determined).
- A **fixed lump sum per patient** for preparing/managing the data in the online shared patient record. This amount is paid only once per patient and per care period.
- A **fee-for-service** (third-party payer, supplements not allowed) for a limited number (e.g. five) of sessions.
- **Patient out-of-pocket payment,** paid by the patient for each consultation, that should be limited to € 6/session (and to € 1.5/session for Preferential Reimbursement), similar to reimbursements for consultations with the general practitioner.

The total amount for a patient within one care period is not allowed to be more than the current compensation for five sessions with a clinical psychologist.
In addition there must be an interval (e.g. of 6 months) between two reimbursed periods of first-line psychological care for the same patient.

As a reminder,

- the general practitioner should be allowed to invoice **long consultations** (a limited number per patient and per year); the modalities for these consultations must however be consistent with the treatment modalities of patients with chronic health problems.
- A new nomenclature code should be allotted to psychiatrists for a **single advisory consultation.** This remuneration must be higher than for a standard consultation, because a single consultation requires proportionally more work.

For specialised psychological care:

- The amounts that the **regional governments** now spend on the CMH remain unchanged, but would only serve to pay the maintenance (and expansion) costs of the care services (general and logistical costs, administrative personnel, communication costs, prevention, management of the patient records) and for the tasks related to the network. Consequently the capacity of this structure can be expanded and the waiting times can thus be reduced.
- Therapeutic procedures by recognised professionals are financed by the RIZIV on the basis of a **nomenclature,** but with a maximum (extendable) number of sessions per patient, still to be determined.
- **The out-of-pocket payment for** the patient at each consultation should be limited to € 12/session (and to € 3/session for Preferential Reimbursement), the equivalent of the reimbursements for consultations in psychiatry.
- A pay-for-quality aspect, based on indicators, should be possible in the future.

Clinical psychologists and orthopedagogists should **have the choice between an employee or independent status**. In the latter case they must **sign a cooperation agreement with a CMH** (or a Centre for Ambulatory Rehabilitation for orthopedagogists) and must be paid via these structures. They may also be active outside the structures of this CMH, which can ensure better geographical distribution of the specialised care offer. To expand the offer, recognition and financing of private centres that intend to can be considered, but under the same conditions as the CMH, provided they offer adequate guarantees with regard to quality, peer review, etc. (still to be determined).

Extension
The decision to extend treatment beyond the maximum established number would be made by an **"advising psy"** on the basis of an update of the functional assessment and a care plan.

Regulation by agreement
We propose introducing a system of 'regulation by agreement' for clinical psychologists and clinical remedial educationalists, as for other healthcare professionals, to limit supplements (which are not allowed for the first-line psychological function).

Access to the psychiatrist
Direct access to the psychiatrist remains possible, but access via a first-line caregiver should be financially encouraged (soft echeloning); patients who are referred to a psychiatrist by their general practitioner or a first-line psychologist should be able to benefit from a lower patient out-of-pocket fee –for their first consultation - than those who consult directly. This should be based on the current reimbursement model of a specialist via referral by the general practitioner in the framework of the GMD.

5.8.3. Out-of-pocket payment of the patient

For the out-of-pocket payment (OOP) of the patient our international comparison shows very diverse practices that depend on the healthcare system in the various countries analysed.
In Belgium the current situation is as follows:

- for a psychiatrist: OOP of € 12 for regular beneficiaries – € 3 for beneficiaries with Preferential Reimbursement
- in the framework of RIZIV rehabilitation agreements: OOP of € 1.73/session for regular beneficiaries – free of charge for beneficiaries with Preferential Reimbursement
- in the centres for mental healthcare (CMH): moderate contribution (€10-11) to free of charge
- Regarding an Art. 107 activity: OOP of € 20 for a consultation in the hospital – free of charge outside the hospital
- in the first-line pilot projects in Flanders: OOP of € 9 per session (€ 4 for beneficiaries with Preferential Reimbursement – free of charge for prisoners, asylum seekers and illegal residents).

Those in the field agree unanimously that the amounts to be paid may not form an obstacle to treatment, but that the financial contribution is a general principle of every therapy, which contributes to the motivation of patients. Moreover it prevents stigmatisation. This point was in fact confirmed by the patient representatives at the meeting.
Free care can thus be considered, but must remain an exception. For highly vulnerable and more fragile population groups, special conditions should be created so that they have access to first-line care and specialised care without being penalised for not having a general practitioner or online shared patient record.

RECOMMENDATIONS[c]

PART A: FIRST-LINE PSYCHOLOGICAL CARE:

To the ministers responsible for healthcare issues:

- **Organise an interministerial consultation for developing a first-line psychological function that is accessible to everyone, without prescription and without criteria with regard to diagnosis, nature of the beneficiary or severity, and according to the model described in the current report.**
- **As soon as the model has been developed, draw up a communication plan on the first-line psychological care offer, intended for the general public and everyone who can refer patients to first-line psychological care. It would also be best to find a clear designation for this new care offer.**

To the universities:

- **Give the Faculties of Psychology (and Orthopedagogy) the task of providing a course program that is specifically focused on first-line psychology/orthopedagogy, in the framework of the basic course and/or additional training.**
- **Give Faculties of Medicine the task to enforce the approach of psychosocial problems in their curricula (basic training) or continued training for GPs.**

To the professional associations:

- **Provide ongoing training for first-line psychologists and orthopedagogists, in collaboration with the universities.**

To the federal minister of Public Health and the FPS Public Health:

- **Expand the assignment of the committees as provided in the law on mental healthcare professions of 4 April 2014 with:**
  - **Specification of the criteria and the modalities for recognition of first-line clinical psychologists and orthopedagogists;**
  - **Specification of the accreditation conditions for first-line clinical psychologists and clinical orthopedagogists (ongoing training, peer review, practice, extension);**
  - **Specification of the criteria that demonstrate integration into a multidisciplinary network.**

To the RIZIV:

- **Establish the financing modalities for first-line psychological care:**
  For first-line psychologists/remedial educationalists:

- **Provide mixed financing: 'practice allowance'; fixed lump sum per online shared patient record opened or complemented; fee-for-service per session (third-party payer, supplements not allowed); patient out-of-pocket payment.**
  The number of sessions financed annually must be limited.
- **Examine the possibility of including a 'pay for quality' aspect in the financing, based on indicators, in the future.**

For general practitioners:

- **Provide financing that allows devotion of adequate time to the patients concerned. The call for financing modalities like the long consultation and, as needed, consultation between different professionals, must be consistent with the modalities for dealing with chronically ill patients.**

For psychiatrists:

- **Provide a nomenclature code for an single consultation (advisory consultation) requested by a first-line psychologist/ orthopedagogist or a physician. It should be mandatory to draw up a report for this consultation, and the patient should be referred back to the prescriber. This consultation can take place only once annually per patient**

[c] The KCE is solely responsible for the recommendations.

PART B: SPECIALISED AMBULATORY PSYCHOLOGICAL CARE (OUTSIDE PSYCHIATRY):

To the ministers responsible for healthcare issues:

- **Organise an interministerial consultation on the organisation and financing of ambulatory psychological care.**

To the competent ministers and the RIZIV:

- **Restrict financing/reimbursement of specialised psychological and remedial educational care to professionals in mental healthcare who collaborate with a recognised multidisciplinary structure (Centre for Mental Health (CMH), Centre for Ambulatory Rehabilitation (CAR), etc.):**
  - **The allocation of financing for the existing CMH and CAR must be adjusted.**
  - **For independent practitioners, collaboration modalities with the existing multidisciplinary structures, from which they will receive part of their compensation, must be provided.**
  - **It should be ensured that these structures are geographically well-distributed (possibly with satellite offices)**
  - **To expand the offer, recognition and financing of private centres that intend to can also be considered, provided they offer guarantees on quality, peer review, etc. (to be determined).**
  - **At present there are inadequate arguments for allowing reimbursement to depend on criteria with regard to the diagnosis or the type of therapeutic approach.**

To the RIZIV:

- **Make the access to financed, ambulatory, specialised psychological care (outside psychiatry) dependent on drawing up a multidisciplinary functional assessment. This assessment should be drawn up by at least a general practitioner and a first-line psychologist or orthopedagogist. It should contain all the information (medical, psychological, social, ongoing treatment, medical history, etc.) to be able to judge whether specialised treatment is necessary. The functional assessment must be documented in the online shared patient record**
- **Limit reimbursement to a specific number (to be determined) of sessions, with the possibility of extension(s) with the agreement of an "advising psychologist/psychiatrist" (see below). An exception can be made for a limited list (to be determined) of disorders that require very long-term treatment.**

To the RIZIV and the health insurance funds:

- **Introduce and define the position of "advising psychologist/psychiatrist", who will examine the need for extension of the number of specialised, reimbursed care sessions on the basis of the functional assessment and the care plan drawn up by the caregiver. The "advising psychologist/psychiatrist" could also strengthen the advisory role of the medical administrations of the health insurance funds and could be involved in evaluation of cases of work incapacity and invalidity due to psychological disorders.**

To the federal minister of Public Health and the FPS Public Health:

- **Expand the task of the Committees provided in the law on the mental healthcare professions of 4 April 2014 with determination of the content of and criteria for the multidisciplinary assessment and care plan, as well as specification of the restrictive list of disorders that are eligible for an exception to the system for renewal of treatment for specialised psychological care.**

PART C: PREREQUISITES

To the managers of eHealth

- **Grant first-line psychologists/remedial educationalists and specialists access (read and write permissions) to future online shared patient record.**

To the FPS Public Health

- **Develop (and follow up) a registry of all clinical psychologists and orthopedagogists as well as other healthcare practitioners who are entitled to give psychotherapy;**
- **Determine which data must be registered and organise this collection with a focus on evaluation of care quality.**

To the RIZIV

- **Examine the possibilities of a reduced patient fee for patients who have been referred to a psychiatrist by a first-line psychologist, similar to referral by a GP to a specialist in case of a GMD/DMG**

To the health insurance funds

- **Limit reimbursement via supplementary insurance to the services of caregivers who are legally authorised.**
- **Communicate information on the new model to the general public, caregivers and psychosocial care providers. This information must be specifically adapted to each target group.**

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COLOFON

Title:	Organisational and financing model for psychological care - Overview
Authors:	Laurence Kohn (KCE), Caroline Obyn (KCE), Jef Adriaenssens (KCE), Wendy Christiaens (KCE), Xavier Van Cauter (SPF Santé Publique – FOD Volksgezondheid), Marijke Eyssen (KCE)
Overview redaction	Karin Rondia (KCE)
Project coordinator:	Marijke Eyssen (KCE)
Reviewers:	Raf Mertens (KCE), Maria- Isabel Farfan-Portet (KCE), Stephan Devriese (KCE), Gudrun Briat (KCE)
External experts:	Claus Haugaard Jacobsen (Psykologklinikken i Vejgaard, Denmark), Anne Dezetter (Université de Sherbrooke, Canada), Glenys Parry (University of Sheffield, United Kingdom), Peter Schulthess (Institute for Integrative Gestalt Therapy Switzerland), Petra Warschburger (Universität Potsdam, Germany), Liselotte Visser (Zorginstituut Nederland)
Stakeholders:	Hervé Andrien (Psytoyens), Areski Boumendil (Domus Medica), Anita Cautaers (SOM Federatie van Sociale Ondernemingen), An Chantrain (Vlaamse Vereniging van Orthopedagogen), Sofie Crommen (Vlaamse Vereniging voor Kinder-en Jeugdpsychiatrie), Jan De Clercq (Federatie van Diensten voor Geestelijke Gezondheidszorg), Jan De Lepeleire (Katholieke Universiteit Leuven), Jacques De Waegenaere (Ligue Wallonne de Santé Mentale), Tom Declercq (Domus Medica), Muriel Deguerry (Commission Communautaire Commune – Gemeenschappellijke Gemeenschapscommissie), Luc Dekeyser (Vlaamse Gemeenschapscommissie), Matthias Dekeyser (Belgische Vereniging voor Relatie-, Gezins- en Systeemtherapie), Gaston Demaret (Association Francophone de Psychothérapie Centrée sur la personne ou expérientielle), Koen Deraedt (RIZIV — INAMI), François Dupont (Fédération des Institutions Hospitalières), Valérie Fabri (Mutualités socialistes – Socialistische mutualiteit), Daisy Flossy (Vlaamse Gemeenschapscommissie), Olivier Fourez (INAMI — RIZIV), Isabelle Fransolet (Association Belge des Psychologues – Belgische Federatie van Psychologen), Valérie Gailly (Service Public de Wallonie), Sylvie Gérard (Conseil Supérieur de la Santé - Hoge Gezondheidsraad), Marie-Claire Haelewyck (Association en Orthopédagogie), Steven Hermans (Christelijke Mutualiteit – Mutualité Chrétienne), Stéphan Hoyoux (Santhea), Gorik Kaesemans (Zorgnet Vlaanderen-Icuro), Paul Kestemont (Association Belge de Psychothérapie – Belgische Vereniging voor Psychotherapie), Charles Kornreich (Société Royale de Médecine Mentale de Belgique), Miguel Lardennois (SPF Santé Publique - FOD Volksgezondheid), Gilbert Lemmens (Vlaamse Vereniging voor Psychoanalytische Therapie - Association des Psychologues Praticiens Psychanalytiques), Thierry Lottin (Union Professionnelle des Psychologues Cliniciens Francophones)), Koen Lowet (Belgische Federatie van Psychologen - Association Belge des Psychologues), Xavier Maes (Vlaamse Koepel van Psychotherapie Verenigingen), Ghislain Magerotte (Université de Mons), Olivier Mariage (Fédération des

	Associations Sociales et de Santé), Danielle Massant (Vlaams Agentschap Zorg en Gezondheid), Laurent Mont (Service Public de Wallonie), Ilse Noens (Katholieke Universiteit Leuven, Vlaamse Vereniging van Orthopedagogen), Tineke Oosterlinck (Vlaams Agentschap Zorg en Gezondheid), Muriel Quinet (SPF Santé Publique - FOD Volksgezondheid), Ellen Renders (Test-Aankoop), Anja Schillebeeks (Vlaamse Vereniging voor Cliëntgerichte en Experiëntiële Psychotherapie en Counseling), Christiaan Schotte (Vrije Universiteit Brussel), Roland Sinnaeve (Vlaamse Vereniging van Klinisch Psychologen), Rik Thys (Socialistische Mutualiteit - Mutualités Socialistes), Xavier Van Cauter (SPF Santé Publique – FOD Volksgezondheid), Nady Van Broeck (Katholieke Universiteit Leuven), Lieve Van Den Bossche (SOM Federatie van Sociale Ondernemingen), Maarten Van Den Bossche (Vlaamse Vereniging voor Psychiatrie), Greet Van Humbeeck (Vlaams Agentschap Zorg & Gezondheid), Benoît Van Tichelen (Centre de Référence en Santé Mentale), Peter Vanden Bilcke (Vlaamse Vereniging voor Gedragstherapie), Jan Vandenbergen (Christelijke Mutualiteit - Mutualité Chrétienne), Ronny Vandermeeren (Vlaamse Vereniging voor Psychoanalytische Therapie), Patrick Vanneste (SPF Santé Publique – FOD Volksgezondheid), Vanessa Vanrillaer (Mutualités Libres - Onafhankelijke Ziekenfondsen), Philippe Vrancken (Belgische Vereniging voor Psychotherapie – Association Belge de Psychothérapie), Carmen Weber (Psytoyens), Michel Ylief (Association pour l'étude, la modification et la thérapie du comportement)
External validators:	Piet Bracke (Universiteit Gent), Xavier Briffault (Centre National de la Recherche Scientifique, France), François Wyngaerden (Université Catholique de Louvain)
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