KCE REPORT 265

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

MODEL FOR THE ORGANIZATION AND REIMBURSEMENT OF PSYCHOLOGICAL AND ORTHOPEDAGOGICAL CARE IN BELGIUM

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HEALTH SERVICES RESEARCH

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Acknowledgements:	Maria- Isabel Farfan-Portet (KCE), Sophie Gerkens (KCE), Kirsten Holdt (KCE), Yasmin Labeni Pedersen (Dansk Psycholog Forening) The Mutualité Chrétienne — Christelijke Mutualiteit for their data
Other reported interests:	All of the experts, consulted for this report, were selected because of their involvement in the domain of Mental Health Care. This might imply that each of them, to a certain extent, has a conflict of interest.
Layout:	Filip Coppens (Smals), Joyce Grijseels (KCE)

Disclaimer:

- **The stakeholders were consulted about a (preliminary) version of the scientific report. Their comments were discussed during meetings. They did not co-author the scientific report and did not necessarily agree with its content.**
- **Subsequently, a (final) version was submitted to the validators. The validation of the report results from a consensus or a voting process between the validators. The validators did not co-author the scientific report and did not necessarily all three agree with its content.**
- **Finally, this report has been approved by a majority of votes by the Executive Board.**
- **Only the KCE is responsible for errors or omissions that could persist. The policy recommendations are also under the full responsibility of the KCE.**

Publication date:	14 april 2016
Domain:	Health Services Research (HSR)

MeSH: Psychology, Clinical; Psychology, Educational; Organization and Administration; Delivery of Health Care; Healthcare Financing; Belgium

NLM Classification: WM105

Language: English

Format: Adobe® PDF™ (A4)

Legal depot: D/2016/10.273/34

ISSN: 2466-6459

How to refer to this document? Kohn L., Obyn C., Adriaenssens J., Christiaens, W., Van Cauter X., Eyssen M. Model for the organization and reimbursement of psychological and orthopedagogical care in Belgium. Health Services Research (HSR) Brussels: Belgian Health Care Knowledge Centre (KCE). 2016. KCE Reports 265. D/2016/10.273/34.

This document is available on the website of the Belgian Health Care Knowledge Centre.

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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
APA	American Psychological Association
APSIH	Association des Psychologues de la santé et d'Institutions Hospitalières
B	Belgium
BJZ	Bureau Jeugdzorg
CanMEDS	Canadian Medical Education Directives for Specialists
CAW	Centrum Algemeen Welzijnswerk
CGG	Centra voor Geestelijke Gezondheidszorg (=SSM)
CH	Switzerland
CHC	Community Health Centers (= FMM – WGC)
CLB	Centrum voor Leerlingenbegeleiding (=PMS)
CM	Christelijke Mutualiteit (=MC)
CPAS	Centre Public d'Action Sociale (=OCMW)
CSS	Conseil Supérieur de la Santé (=HGR)
DE	Deutschland
DK	Denmark
DMG	Dossier Médical Global (=GMD)
ECTS	European Credits Transfer System
EFPA	European Federation of Psychologists' Associations
ELPF	Eerste Lijn Psychologie Functie (=FLPF)
EuroPSy	European certificate in Psychology
FBP-BFP	Fédération Belge des Psychologues – Belgische Federatie van Psychologen
FEPRAFO	Fédération des pratiques médicales de première ligne au forfait – Federatie van eerstelijnspraktijken met forfaitaire financiering
FLPF	First Line Psychologie Function (=ELPF)

FMM	Fédération des Maisons Médicales (=VWGC)
FOD	Federale Overheidsdienst
GMD	Globaal Medische Dossier (=DMG)
GP	General Practitioners
HGR	Hoge Gezondheidsraad (=CSS)
IATP	Improving Access to Psychological Therapies
INAMI	Institut National d'Assurance Maladie Invalidité (=RIZIV)
KCE	Centre fédéral d'expertise des soins de santé – Federaal Kenniscentrum
MC	Mutualité Chrétienne (=CM)
NCSPP	National Council of Schools and Programs of Professional Psychology
NHS	National Health System
NICE	National Institute for Health and Care Excellence
NL	The Netherlands
OCMW	Openbaar Centrum voor Maatschappelijk Welzijn (=CPAS)
OOP	Out-Of-Pocket
PMS	(Centre) Psycho-Médico-Social
QALY	Quality-Adjusted Life Year
RIZIV	Rijksinstituut voor Ziekte- en Invaliditeitsverzekering (= INAMI)
SHC	Superior Health Council
SHI	Statutory Health Insurance
SPF	Service Public Fédéral
SSM	Service de Santé Mentale (=CGG)
TARMED	Tarif médical
UK	United Kingdom

VWGC	Vereniging van Wijkgezondheidscentra (=FMM)
VPP	Vlaams Patiëntenplatform
WGC	Wijkgezondheidscentrum
WHO	World Health Organization

1 INTRODUCTION

DISCLAIMER :

This report is a 'Health Service Research' study. It starts from the assumption that:

- There is sufficient evidence in the scientific literature that a number of specific psychological treatments are effective
- The current psychological care offer in Belgium is not meeting the needs of the population in terms of accessibility
- An essential safeguard of quality of care has to be provided by adequate professional education programs and corresponding legal recognition of the right to practice

This study is not a Health Technology Assessment, hence we did not include an exhaustive analysis or literature review on the above-mentioned assumptions.

The mental health status of the population can be assessed by means of several indicators: from assessment of state of mood and prevalence of mental illness, to suicidal rate, figures of medication use or healthcare use…

The 2013 National Health Survey (NHS)[1] highlighted the worrying state of the mood of Belgian citizens: 33% persons reported having depressive feelings and negative thoughts, 10% of the population experiencing anxiety symptoms, 15% showed signs of a depressive disorder, and 30% reported sleep disturbances.

The prevalence of mental illness (as an entity, including severe problems) in Belgium, is among the highest in Europe.[2]

Fourteen percent of the population above 15 had already thought about suicide and 4.5% had already committed a suicidal act. Moreover, the suicidal ideation/suicide rate in Belgium in 2013 is higher than in 2008. The unstandardized Belgian suicide rate is among the highest in Europe (Belgium 14.2/100.000; The Netherlands 8.2/100.000; France 12.3/100.000; Germany 9.2/100.000)[3]. And the standardized suicide rate (with correction for age and gender) is even higher: Belgium 17.4/100.000 with a European mean (EU-14) of 10.6.

In terms of medication use, although the prescription of antidepressants is increasing everywhere in Europe, the Belgian figures (2013) (71 daily doses / 1000 inhabitant) still remain significantly higher than the average of other European countries (64.6).[4]

Studies also reported worrying occupation-related mental health outcomes among the Belgian population. Research by Hansez et al (2010) revealed a prevalence of clinically diagnosed burnout of 0.8 % of Belgian employees (19.000 persons/year), which might be an underestimation as self-report measures show a burnout prevalence of 30-40%. This might be explained by the fact that only a small part of people with self-reported complaints effectively consults a health care professional[5]

Today, reimbursement for treatment of mental health problems in Belgium includes approaches, such as anti-depressive agents and mental health care centres ('Centra voor Geestelijke Gezondheid' (CGG) - 'Services de Santé Mentale' (SSM)), but other alternatives such as psychotherapy, have been historically excluded from the health care basket. In 2014, an unprecedented shift in mental health policy took place. The federal government announced to finance and reimburse psychotherapy in specific contexts and with certain limitations: it should be accompanied by a reduction in the use of psychotropic drugs and a financially supported collaboration between actors in the field[6].

A first, albeit preparatory, step towards reimbursement was taken with the law of April 4th 2014, amending the Royal Decree n° 78 (November 1967) on the exercise of the health professions. This revision of the law recognises clinical psychology and clinical orthopedagogy as healthcare professions, protects the title of psychotherapist and regulates the execution of psychotherapy. Besides, the October 2014 Government Agreement stipulates that a potential budget could be allocated for its reimbursement[7].

Furthermore, Flanders started experimenting with a first line psychology function and the results of the evaluation of 7 pilots in the autumn 2015 provided new evidence to nurture the discussion on how to build new policies for mental health care in Belgium[8].

In recent years, a myriad of studies on the effectiveness of psychotherapy were published (whether or not in combination with pharmacotherapy). These clinical trials show positive therapy effects for a broad range of mental

problems.[9] Other sources argue that the efficacy of psychotherapy does not only depend on the type of therapy provided (medical model), but - due to the nature and sensitivity of mental problems - also on the presence of other factors such as a strong therapeutic relationship, professional skills and experience, hope and attention (contextual model).[10, 11]

As the law still leaves many options open to concretise the government's plans for reimbursement, a study on the different possibilities was highly recommended.

This report is the logical continuation of these measures. It was asked by the National Health Disease Insurance (INAMI – RIZIV), the Federal Authorities in charge of Public health (SPF – FOD) Health and the Belgian Federation of Psychologists (FBP – BFP).

Based on an analysis of the organizational models of mental health care in selected countries, and an analysis of the Belgian situation, we propose ways to organize a professional reception and taking charge of psychic distress in the Belgian health care system.

During the project, we kept in mind that this system should be qualitative, accessible, efficient, sustainable and equitable, according to the Tallin Charter (2008)[12] and to the performance objectives of the Belgian health care system{Vrijens, 2015 #193}

2 OBJECTIVES AND METHODS

This report aims to address a number of questions of the new Minister of Health as well as RIZIV – INAMI regarding the possible future introduction of psychotherapy in the reimbursement package of RIZIV – INAMI:

- for which indications/patients
- which treatments
- under which conditions
- at what tariff level

As was previously mentioned, a new organizational framework for psychotherapy is on its way. This report provides a critical discussion of the elements that need to be taken into account in order to continue to build this framework in Belgium. We assume that there is sufficient evidence in the scientific literature that a number of specific psychological treatments is effective; that the current psychological care offer in Belgium is not meeting the needs of the population in terms of accessibility and that an essential safeguard of quality of care has to be provided by adequate professional education programs and corresponding legal recognition of the right to practice.

In order to identify possible models and criteria to build a new organizational and financing model for Belgium in an 'health service research' process, it was decided that, in this study, the KCE should start from an international perspective and examine the organization and reimbursement of these professions abroad, in order to draw lessons for Belgium and to test feasibility in the Belgian context.

Methodological considerations lead us to focus on organizational aspects and not to preform cost-effectiveness analysis for psychotherapy. Even if we would focus on a single indication of mental health problems, we would encounter insuperable methodological difficulties, given that RCTs report clinical outcomes using a variation of scales which are consequently pooled in systematic reviews by standardised mean difference rates and odds ratios. These ratios cannot be translated into a pooled score on a single generic or disease-specific quality-of-life scale. This implies that no cost per QALY can be calculated, at least not in a methodologically correct way. Furthermore, due to the absence or weakness of robust data for several

aspects of psychological health care demands and health care consumption in Belgium, it was decided not to perform a cost-benefit analysis.

So, although identifying those indications for which there is evidence of effectiveness (and cost-effectiveness) was an explicit question from the RIZIV-INAMI, we unfortunately cannot provide a solid answer this question. However, we conducted a separate search to define the elements necessary to perform a calculation of the cost of psychological health care in Belgium. Nevertheless, the reader can find a list of potential variables related to mental health care consumption that can be used in future estimations. In addition we will suggest a theoretical model for the financing of the model we will finally propose. (chapter 9)

Final methodological approach

Specific methodology to each section is presented in the related chapter.

Firstly, we describe the Belgian context including the current legal framework (chapter 3), the position of clinical psychologists, clinical orthopedagogists and psychotherapists in the mental health care system and the existing initiatives (chapter 4).

Secondly, in order to identify criteria for building a qualitative, accessible, efficient, sustainable and equitable system (i.e. the criteria for a performant health system[4]), we select 5 countries to analyse several characteristics of their mental health care system. The description and analysis are validated by local experts (chapter 5).

Thirdly, we submit our results to the critical view of the field (chapter 6), i.e. representatives of professional associations involved in mental health care (GP, psychologists, orthopedagogists, psychotherapist, psychiatrists), representatives of patients, of healthcare institutions active in mental health, of health insurance and of administration, presenting them the main criteria identified, as a hypothesis for a new model. We will call them the 'stakeholders' in this report. This steps will help us to select criteria to be included in the model.

Fourthly, based on the former steps, we will build a preliminary model (chapter 7). This will be assessed on the acceptability by a larger group of stakeholders through an online survey (chapter 8). The objective of the survey is to identify the criteria that are not acceptable for the field and the arguments raised in order to prepare a final meeting with all the participants.

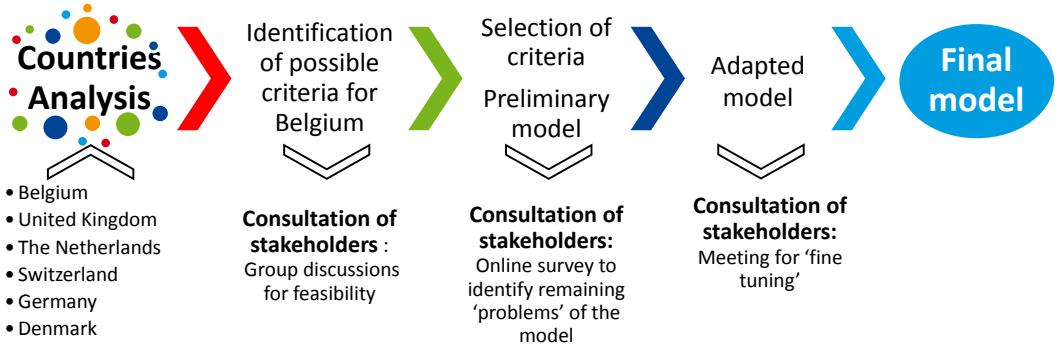
The final meeting aims to fine-tune our model.

The discussion on the financing of the model is presented in chapter 9.

The general design of the study is presented in the figure below

In summary, we will build a model, in a progressive and iterative way, based on our critical analysis of foreign examples and a 'test' with the field in order to make it acceptable and feasible.

Figure 1 – General design of the study



3 THE LEGISLATIVE BELGIAN CONTEXT

Author: Xavier Van Cauter

3.1 Law of 4 April 2014 governing mental health professions and amending Royal Decree no. 78 of 10 November 1967 on the practice of health professions

3.1.1 *Legal framework on mental health*

Until the law of 4 April 2014, the framework surrounding mental health care included:

1. With regard to medical specialities, doctors specialising in psychiatry were the only recognised speciality active in the field of mental health.

   In this context, the Ministerial Decree of 3 January 2002[a] sets out the accreditation criteria for doctors specialising in psychiatry, particularly in adult psychiatry and the accreditation criteria for doctors specialising in psychiatry, particularly in child and adolescent psychiatry.

   Furthermore, there are still a certain number of doctors specialising in neuropsychiatry who have retained this title since they acquired it before the Ministerial Decree of 29 July 1987[b] repealing this speciality, came into force.
2. Two ministerial decrees, both published on 24 April 2013, created a particular professional qualification of nurse with a special expertise in mental health care and psychiatry[c] and a particular professional title of nursing professional specialised in mental Health care and psychiatry specialised in Mental Health Care and Psychiatry[d] respectively.
3. It should also be noted that the title of "Expert Psychiatrist" was created under the framework of the legislation on internment[e]. Under the implementation of this provision, the Federal Public Service Public Health and the Superior Council of Doctors are currently considering the feasibility study and potential opportunity to create a level 3 title of "Doctor specialising in Legal Psychiatry".
4. Finally, it should be emphasised that the title "Psychologist" is subject to professional title protection at the level of economic affairs, in accordance with the Law of 8 November 1993 protecting the title of psychologist. This protection covers anyone holding a psychologist qualification, including those working in the context of mental health.

During the discussions on establishing a professional ethics code under the framework of this economic-type protection, it was agreed that, once they were recognised as healthcare professionals, psychologists active in the context of mental health would not be subject to this framework but to a framework, in particular ethical, appropriate to the specific nature of their practice.

3.1.2 *Reason for the Law of 4 April 2014*

During the 2010-2014 parliamentary term, there was a strong feeling for a need to establish a new framework for mental health:

The 4th National Health Survey[1] highlighted the worrying state of mental health of the Belgian population. A quarter of the Belgians felt that they were plagued by depressive feelings and negative thoughts, 9% of the citizens went through a depressive period, 8% had somatic complaints, 6% suffered from anxiety symptoms and 21% (one out five) reported sleep disturbances. Almost 14% of Belgians considered themselves as having serious mental difficulties.

Of course, this psychological state is not unique to the Belgian population. In a report on global health, the World Health organization (WHO) stated that

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a Ministerial Decree of 3 January 2002 defining the accreditation criteria for doctors specializing in psychiatry, particularly in adult psychiatry and for doctors specializing in psychiatry, particularly in child and adolescent psychiatry.

b Ministerial Decree of 29 July 1987 defining the special accreditation criteria for specialist doctors, clinical supervisors and placement services for the specialties of neurology and psychiatry.

c Ministerial Decree of 24 April 2013 defining the accreditation criteria authorizing nursing professionals to claim the particular professional qualification of nurse with a special expertise in mental health and psychiatry.

d Ministerial Decree of 24 April 2013 defining the accreditation criteria authorizing nursing professionals to use the particular professional title of Nursing Professional specialized in Mental Health Care and Psychiatry.

e Article 5 § 2 of the Law of 21 April 2007 on the internment of persons affected by mental disorders.

clinical depression is expected to be ranked second in the global burden of disease by 2020 if its impact is measured as a cause of death, handicap, inability to work and consumption of medical resources.

Moreover, every year in Belgium, in excess of 2,000 people commit suicide and more than 20,000 attempt to do so. With a suicide rate of nearly 19 per 100,000 inhabitants in 2013, Belgium, alongside Finland, France and Denmark, was considerably above the global average, estimated at 14.5 per 100,000 inhabitants.

Similarly, the volume of psychotropics prescribed in Belgium was a concern for the parliamentarians. Figures from the Belgian National Institute for Sickness and Invalidity Insurance (INAMI) show that in 2012, almost 283 million antidepressants were consumed in our country. Their use saw a 45% increase from 2004 to 2012[13].

During the 2006-2008 period, Belgium consumed, per capita, 15% more sleeping pills and tranquillizers than France, approximately 3 times more than Great Britain, the Netherlands and Germany and 5 times more than Norway. These figures place our country top in Europe for this period.

Furthermore, the number of children and adolescents who have been prescribed amphetamine class drugs for attention deficit hyperactivity disorder (ADHD) increased by 74% between 2004 and 2007.

Given these figures, it became clear to the parliamentarians that the promotion of good mental health and the prevention of mental illnesses is one of the key challenges facing our healthcare system.

As a consequence, the Legislator examined the health care services offered in our country and the care given to patients in the field of mental health.

It became clear that the organization of this sector was unsatisfactory and appeared totally incomprehensible to patients.

It was therefore highlighted that while more and more Belgians are explicitly expressing a need for psychological support, those requesting it admitted that they do not know who and where to ask.

Patients are unaware of the specific roles of the various stakeholders (general practitioner, psychiatrist, psychologists, psychotherapist, etc.). Besides, there are many who, although they refuse to consult their general practitioner or a psychiatrist (because of fear for an almost automatic prescription for a drug treatment or in an attempt to protect their privacy lead by taboo on or fear of stigma because of psychiatric disease), hesitate to turn to other professionals (psychologists, psychotherapist) for fear of ending up in the hands of a charlatan.[14]

Indeed, as the title of "psychotherapist" is not protected or reserved, the patient had no guarantee as to the quality of the "therapist" that they consulted. This exposed them to potential abuses including a significant risk of attempts to be influenced by sectarian movements.

Furthermore, the lack of official recognition for these practitioners as professionals working in the health field might hinder the multidisciplinary care of patients as recommended by the WHO. This organization explicitly calls for a biopsychosocial approach to psychological and psychiatric problems, in order to better identify and understand the consequences of individual and social factors on disease and health over the long-term.

Furthermore, although their position in mental health care was unregulated, these professionals, and particularly psychologists were de facto included in the personnel standards of various care services, institutions and care programmes (e.g. oncology or psychiatric services). This situation made them vulnerable as they did not benefit from any protection. From a strictly legal perspective, these practices may be considered as the illegal practice of medicine.

Finally, clinical psychology and psychotherapy could be interesting alternatives to drug treatments. These professionals offer treatments and counselling, techniques that could, in some cases and for certain patients, prove to be very effective.

The Minister for Public Health also prioritised the ability to offer the best mental health care to those who need it.

In this regard, his concern was twofold:

- To provide the patient sufficient guarantee about the quality of care on offer, particularly in terms of requirements regarding training, professional ethics and observing patient rights. This field of activity, which concerns people in psychic distress is also highly conducive to the development of deviant practices with sectarian tendencies.
- Within the framework of health, to recognise competent mental health practitioners. Indeed, at that moment, although psychologists and orthopedagogists, along with psychotherapists were already working within the framework of health, they were not recognised.

The Minister of Public Health's objective was therefore to outline a legal framework within which psychologists and orthopedagogists, together with psychotherapists could be included, and which would enable them, through interaction with other professionals, including the general practitioner and the doctor specialising in psychiatry, to work as a network around the patient requiring mental health care.

3.1.3 *The development of the law*

In order to lead to the Law of 4 April 2014 governing mental health professions and amending Royal Decree no. 78 of 10 November 1967 on the practice of health professions, a somewhat specific legislative technique was used.

Parliament had already been actively working on this issue for several years and during the parliamentary term in question, several proposals had been submitted.

Rather than submit an additional proposal or amendments on behalf of the Government, the Minister for Public Health wanted to be part of this discussion process that was already underway. Consequently, working with the parliamentarians involved and in consultation with the professionals concerned, the Minister for Public Health tried to find a consensus between the existing proposals, while respecting the healthcare framework as it was conceived. This consensus was cast in a series of amendments by the parliamentary majority made to the initial proposal submitted by Mrs Muylle[f]. The proposal was then amended by the Senate on the technical issues before been definitively adopted in the House.

- The Law, thus adopted, presents the following guidelines:
- Firstly, the Law integrates clinical psychologists and orthopedagogists into the framework established by Decree no. 78 which relates to health professionals.
  The integration of orthopedagogists raised questions during the debates in the House given the diverse nature of the training between the French Community and the Flemish Community. Dutch-speaking education treats this as a separate discipline while in terms of French-speakers, it is covered jointly with clinical psychology.
- Secondly, the Law created an accreditation framework for the practice of psychotherapy. According to the Law, psychotherapy is not recognised as a profession in itself, but as a practice which is accessible to a certain number of practitioners (health professionals or not) through certain conditions, including specific psychotherapy training. In practical terms, psychotherapy is therefore a practice reserved for professionals trained for this purpose and as such they alone can use this title.
  This framework aims to offer better clarity for the patient seeking mental health care, to give these service providers protection and obligations comparable to other healthcare providers and above all to protect the patient by defining the skills needed to practice these professions.
- Finally, the Law establishes an advisory council specific to each of the new disciplines recognised, together with a Superior Mental Health Council, the aim of which is to consider the cross-cutting challenges related to mental health by bringing together the various stakeholders involved in the field of mental health (psychiatrists, clinical psychologists, psychotherapists, general practitioners, social workers, educational representatives, etc.).

3.1.4 *Analysis of the key provisions of the Law of 4 April 2014*

3.1.4.1 *Regarding clinical psychology and orthopedagogy*

The Law complements Royal Decree no. 78 with a new chapter 1 sexies on the practice of clinical psychology and orthopedagogy[g].

Clinical psychology

Independently of the Law of 8 March 1993 which governs the **use of the title of psychologist**, the Law of 4 April 2014 governing mental health professions and amending Royal Decree no. 78 of 10 November 1967 on the practice of health professions aims to integrate clinical psychologists into the Royal Decree no. 78 of 10 November 1967 on the practice of health

[f] Parliamentary bill 53K1598 of 16/06/2011 amending Royal Decree no. 78 of 10 November 1967 on the practice of health professions, with a view to regulating the practice of clinical psychology and special needs education.

[g] Article 12 of the Law of 4 April 2014 governing mental health professions and amending Royal Decree no. 78 of 10 November 1967 on the practice of health professions

professions. This recognition sanctions this profession as duly trained professionals fit to work on the psychological well-being of patients.

In order to practice clinical psychology, the professional in question must possess the ad hoc accreditation, the conditions for obtaining, maintaining and withdrawal of which are determined by the King on the advice of the Federal Council of Clinical Psychology[h].

This accreditation can only be granted to a person who holds a university degree in the field of clinical psychology recognising at least 5 years of study or 300 ECTS credits including a placement in the field of clinical psychology. Assimilation measures are planned for professionals who can prove minimum professional experience.

The Law defines the **practice of clinical psychology** as the usual performance of independent actions seeking to or presented as seeking to prevent, review, screen or establish a psychodiagnosis, for an individual and within a scientifically-backed reference framework for clinical psychology, for real or imagined, psychological or psychosomatic suffering and the care or support of that person. This definition is the result of a long consultation between clinical psychologists and doctors.

In terms of the legal provision, the clinical psychologist profession cannot be integrated into a medical profession or a paramedical profession; it is a healthcare profession in its own right.

Orthopedagogy

The Law also incorporates orthopedagogists into the health professions recognised under Royal Decree no. 78 and no one can practice this discipline unless they are validly accredited to do so[i]. As an exemption to this restriction, an individual holding a clinical psychology accreditation and who is trained in special needs education during his/her clinical psychology course may practice orthopedagogy.

This provision aims to resolve the disparity between special needs education training in the French Community where university training in special needs education is integrated into psychology courses and therefore covered by the same degree and the Flemish Community where this training is awarded a separate degree. It is therefore appropriate to allow French-speaking orthopedagogists to practice in the same way as their Dutch-speaking counterparts.

The **accreditation in orthopedagogy** can only be granted to someone who holds a university degree in the field of special needs education recognising at least 5 years studying in full-time education or 300 ECTS credits, including a placement in the field of special needs education.

The Law defines the **practice of orthopedagogy** as the usual performance, within a scientific reference framework for special needs education, of independent actions that aim to prevent, review and screen educational, behavioural, development or learning problems in people and the care or support of such people.

The Federal Council of Clinical Psychology and Orthopedagogy

Both professions sit are represented in the Federal Council created for this purpose[j]. The Law establishes a Federal Council of Clinical Psychology and Orthopedagogy, composed of an equal number of clinical psychologists and orthopedagogists who assume an academic duty for the subject and by practitioners put forward by representative professional organizations from the sector. Alongside the clinical psychologists and orthopedagogists, two psychiatrists are represented in the Council. The multidisciplinary nature of the Council, as desired by the Legislator, should strengthen the links between these two complementary professions.

This Council is responsible for providing opinions on all matters relating to the practice of clinical psychology and orthopedagogy, and this on the request of the Minister for Public Health or at the Council's own initiative. The Council can also give opinions to the Community Governments, at their request, on any matter relating to their training. This is a very useful link between this Federal body and the Communities, as since the 6th State reform, the Communities have been responsible for organising training programs and accreditation of professionals.

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h Article 21 *quatervicies*, § 2, of Royal Decree no. 78 of 10 November 1967 on the practice of health professions.

i Article 21 *quinquiesvicies*, § 1, of Royal Decree no. 78.

j Article 21 *quinquiesvicies*, § 1, of Royal Decree no. 78.

Thus, since the 6th State reform, the Communities are responsible for the processing of individual dossiers by the accreditation commission for clinical psychology and orthopedagogy and its organization.

Common provisions

The Law makes a series of provisions that are common to health professionals, applicable to clinical psychologists and orthopedagogists[k].

Thus, notably, clinical psychologists and orthopedagogists:

- are subject to the obligation of continuity of care as is imposed on all healthcare professionals;
- enjoy the freedom of establishing a psycho-diagnosis;
- enjoy the freedom of therapeutic choice;
- enjoy the protection of their title;
- are subject to monitoring by medical commissions.

Furthermore, the Law of 4 April 2014 incorporates an article 11 bis into Royal Decree no. 78, applicable to all health professionals, stipulating that it is the responsibility of every care provider to send the patient to another competent provider when the health problem encountered exceeds its field of competency.

3.1.4.2 *Regarding psychotherapy*

The practice of psychotherapy

Chapter 3 of the Law of 4 April 2014 governing mental health professions and amending Royal Decree no. 78 of 10 November 1967 on the practice of health professions is autonomous legislation that creates the legal framework governing the practice of psychotherapy.

Article 34 of the Law establishes the principle of the obligation of accreditation in order to be able to practice psychotherapy and use the title of psychotherapist.

However, psychotherapy is not a health profession in itself, but rather a discipline bringing together a number of techniques that may be used by a broad range of practitioners (health professionals or not) as long as they are specifically trained and accredited to this effect.

The Law defines the **practice of psychotherapy** as the usual performance of independent acts seeking to or presented as seeking to eliminate or ease the psychological difficulties, conflicts or disorders of an individual, the performance of psychotherapeutic interventions based on a psychotherapeutic reference framework, considered as a system in its own right, for this individual or a group of individuals, including this individual.

The Legislator recognises, a priori, four reference frameworks (psychoanalytic and psychodynamic psychotherapies, behavioural and cognitive psychotherapies, systemic and family psychotherapies and humanistic, person-centred and experiential psychotherapies). These four domains were defined by the Superior Council of Hygiene[l]. Other reference frameworks may be recognised on the advice of the Federal Council of Psychotherapy.

It should be highlighted that while "psychoanalytic psychotherapies" are recognised, psychoanalysis, per se, is not recognised as a reference framework.

The Law stipulates[m] that, in order to be **accredited to practice psychotherapy**, the practitioner concerned must:

- hold at least a first degree awarded by a higher education institution in the field of health professions, psychology, learning or social sciences that recognises a at least 3 years of study or 180 ECTS credits;
- be trained, by a university institution or college, in the basic concepts of psychology;
- have studied a specific psychotherapy course which accounts for at least 70 ECTS credits over four years of training.

In order to be able to **begin a specific psychotherapy course**, the applicant psychotherapist must first hold at least a first degree awarded by a higher education institution in the field of health professions, psychology, learning or social sciences, and be trained in the basic concepts of psychotherapies, as referred to in § 1, 2.

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k Article 2 to 11 and 17 to 33 of the Law of 4 April 2014 governing mental health professions and amending Royal Decree no. 78 of 10 November 1967 on the practice of health professions

l Opinion of the Superior Council of Hygiene no. 7855 of 13 July 2005

m Art. 38, § 1, of the Law of 4 April 2014

The King must still determine, on the advice of the Federal Council of Psychotherapy, the number of hours of specific psychotherapy training, but this should comprise of at least 500 hours of theory training and a placement of at least 1,600 hours of supervised clinical practice in one of the recognised psychotherapies.

The Legislator started with the idea that, while the specific training may be accessible from different qualifications, psychotherapists should nevertheless, in order to guarantee patient safety, have sufficient knowledge, particularly in the field of psychology. This knowledge will be assessed and dispensed by the colleges and universities.

With regard to clinical psychologists and doctors specialising in psychiatry, their training will give them direct access to the specific psychotherapy training.

Under the Law, only universities, colleges, institutes or associations approved for this purpose by the King on the advice of the Federal Council of Psychotherapy will be able to dispense specific training in one of the recognised branches of psychotherapy.

What remains to be done

The Law is only a framework which establishes, in particular, the structure for the practice of psychotherapy, but a large number of elements still need to be set out in the regulatory acts for the implementation of the Law.

The Federal Council of Psychotherapy

To do so, in particular and as is traditional in the field of health professions, the Law establishes an advisory council comprised of professionals and responsible for advising the Minister for Public Health regarding each of these implementing measures. Furthermore, the Federal Council of Psychotherapy is responsible for giving the Minister for Health and the Communities opinions on all matters relating to the practice of psychotherapy.

The Council is made up of psychotherapist members from the professional world and academia, equally distributed between recognised psychotherapeutic trends, along with two doctors specialising in psychiatry.

Provisions for non-healthcare professionals

Section 3 of Chapter 3 of the Law sets out the rights and duties of the psychotherapist, which are similar to those of health professionals. It is also expressly provided that the King can make the provisions of Royal Decree no. 78 applicable to psychotherapists who are not health professionals.

Registry

The Law provides that the psychotherapist is subject to registration in the database of health professionals (Registry) and the approval of his title. This registration will enable, for example, mutual societies to identify accredited professionals and send their affiliates to these professionals, clearly identified by the public authorities.

Other provisions

Psychotherapy must not exclude the use of traditional medicine and, based on this, the Law makes the psychotherapist responsible for **referring the patient** to an appropriate and competent health professional, when the necessary care exceeds their competencies.

Similarly, the Law structures the relationships between the different practitioners who work around the patient and stipulates that the psychotherapist who is not a doctor must, with the patient's consent, inform the general practitioner about the patient and the change in his health condition, whilst however respecting patient-psychotherapist confidentiality.

The Legislator has provided for the establishment of a **specific professional ethics code for psychotherapists**.

The Legislator also makes the legislation on **patient rights**[n] applicable to psychotherapists. This aims to promote the relationship between patient and professional practitioner, especially in terms of information and consent and is designed to guarantee care quality.

Quite conventionally, the Law provides for a series of penal sanctions applicable to those who contravene the legal provisions. In fact, it appears that this type of sanction is highly impractical. Perhaps, within this framework, the Legislator could focus on administrative fines, which are much more practical to enforce.

[n] Law of 22 August 2002 on patient rights

Also quite conventionally, the Legislator has provided **transitional provisions** that enable those who can prove a psychotherapy practice on the date of the Law's publication, to develop their training and experience with a view to being authorised to use the title. As long as such a recognition procedure has not been set up, those able to prove sufficient training and experience in the subject on the Law's publication date can continue to practice.

3.1.5 *Mental Health Council*

Finally, the Legislator has established a Mental Health Council, comprised of members from the Federal Council of Clinical Psychology and Orthopedagogy and the Federal Council of Psychotherapy, with the task of providing the Minister for Public Health, on the Minister's request or at the Council's own initiative, opinions on the cross-cutting issues relating to clinical psychology, orthopedagogy and psychotherapy and the relationship between these disciplines and other health professionals. This Council must reflect the diversity of the professions and the necessary multi-disciplinary nature of the practices in the field of mental health.

The Law is set to come into force by 1 September 2016 at the latest, with the freedom for the King to set an earlier date.

3.2 Recent evolutions (January 2016)

Currently the Minister of Public Health prepares further refinements of the law of 4 April 2014. The aim of the Minister is the finalisation and activation of the new version of the law at the latest on September 1, 2016.[o] Transition measures will be defined.

Some main proposals for adaptation are:

- to integrate psychotherapists in the framework established by the coordinated law of 10 May 2015 on the practice of health professions, by defining the different types of psychotherapy (cognitive behaviour therapy, systemic and family therapy…) as treatment modalities. Clinical psychologists, orthopedagogists and psychiatrists enjoy the freedom of therapeutic choice, and they can use the treatment modality of their choice in their therapeutic relationship with their patient/client. Chapter 3 of the law of 4 April 2014 on psychotherapy will be cancelled.
- to define how auxiliary disciplines in mental health care (e.g. bachelors in psychology, orthopedagogy,…) can be integrated in the system.
- to update the competencies of the orthopedagogists as described in the law of 4 April 2014, and to allow them not only the freedom of therapeutic choice but also the right to make diagnoses.
- to replace the Federal Council of Clinical Psychology and Orthopedagogy, the Federal Council of Psychotherapy and the Mental Health Council, all created in the law of 4 April 2014, by one Federal Council for mental health professionals. This Federal Council will have three seats (each with a Dutch and a French representative): one seat for psychiatrists, one for clinical psychologists, and one for orthopedagogists. The French speaking representative for the orthopedagogists can be a psychologist with orthopsychological orientation.

This report is up to date until January 10th 2016. On this date, these proposals were still under discussion, and not yet turned into law.

[o] Belgische Kamer van Volksvertegenwoordigers/ Chambre des Représentants de Belgique; 18 dec. 2015 - DOC 54 1535/001. 2015-2016. Chambre 3e session de la 54e législature. Kamer 3e zitting van de 54e zittingsperiode.

4 CURRENT SITUATION OF MENTAL HEALTHCARE IN BELGIUM

Mental healthcare in Belgium is provided through many different organizational structures.

- The centres for mental healthcare ('centra voor geestelijke gezondheid' (CGG)[15] - 'Services de santé mentale' (SSM)[16]) constitute a second line of care, providing care on ambulatory basis and in a multidisciplinary setting. Patients receive partial reimbursement for psychological and psychotherapeutic consultations at these centres, however, there are long waiting lists. In the Walloon region the SSMs are situated at both the first and the second line (see further).
- Hospitals (psychiatric departments in general hospitals and psychiatric hospitals) constitute a third line of care for patients requiring hospitalisation. However, in some of these institutions, ambulatory consultations are provided by psychiatrists or psychologists (single consultations or sessions with/for follow-up).
- Other structures in secondary care are psychiatric nursing homes, initiatives for sheltered accommodation, rehabilitation centres, psychiatric home care, etc.
- Patients also have free access to the private practices of (neuro) psychiatrists, psychologists and psychotherapists, practicing in solo or in group. However the latter two providers are currently not reimbursed.

In addition, other structures not directly dedicated to mental health welcome patients with psychological difficulties:

- In ambulatory care, the GP has an important role in primary care, providing the patient an entry point into the healthcare system.
- Community Health Centers (CHC / Maisons Médicales / Wijkgezondheidscentra) are (in most of the cases multidisciplinary) group practices where GPs collaborate with psychologists, psychotherapists, social workers, etc. Depending on the information we retrieved from the Belgian organization FEPRAFO (Fédération des pratiques médicales de première ligne au forfait – Federatie van eerstelijnspraktijken met forfaitaire financiering) there are 155 community health centers in Belgium from which 140 gather in several professional organizations : 'Fédération des Maisons Médicales' (FMM) represents 95 CHCs in the Walloon and Brussels region; 'Vereniging van Wijkgezondheidscentra' (VMGC) represents 23 CHCs in Flanders and Brussels; 'Vereniging van Wijkgezondheidscentra' (VMGC) represents 11 CHCs but four of these are also part of FMM; ''Fédération des Pratiques Médicales de Première Ligne au Forfait' represents 12 effective members and 3 associate members. Figures from other sources show slightly different figures[17, 18].
- The Centra voor Algemeen Welzijnswerk (CAW)[19] – Centres de Planning Familial[20] offer support and advice citizens in case of personal (mental), sexual, social, relational, legal, administrative, financial or material problems in a multidisciplinary approach. Eleven CAWs with 69 access points (5 in Brussels) are located in Flanders and 107 centres (29 in the Brussels region) are located in Wallonia.
- The CLB (Centra voor Leerlingenbegeleiding) / centres Psycho-Médico-Sociaux (PMS) offer advice and support at school to pupils or their parents.

Many clinical psychologists and clinical orthopedagogists, and to lesser extent psychotherapists, are active within all these structures. In most of the cases, when they work in a structure, it is on salaried basis and in a multidisciplinary setting.

For more details on the general framework for mental health care in Belgium, we refer the reader to the following KCE reports:

- report 144 (2010)[21] on the organization of mental healthcare for adults
- report 170 (2011)[22] and 175 (2012)[23] on mental healthcare for children and adolescents.

Note however that these reports are not entirely up to date as the 6th State reform of 2011 made provision for a transfer of a number of competences to the Communities and Regions (see further).

4.1 Some concerns about mental health care in Belgium

The report on availability and adequacy of professional mental health care in Belgium from the Koning Boudewijn Stichting/King Baudoin Foundation (KBS/FRB, September 2015)[24], based on focus group discussions between health professionals and other stakeholders, revealed the existence of a significant treatment gap for psychological problems in Belgium. A first striking finding is that people do often not get access to mental health care at all. For example, about 30% of persons with a depression get professional help, compared to 95% of persons with diabetes. Secondly, the severity and urgency of accompanying social problems (e.g. homelessness, immigration related problems, poverty) also hampers (the search for) treatment of psychological support. And finally, people do not always get a treatment for the entirety of their psychological problem as comorbidities or underlying problems (e.g. alcoholism) are often not taken into account. The report shows a broad range of provoking institutional factors, in terms of issues regarding specialisation of care versus a generalist/holistic approach, lack of continuity of care, and barriers to transmural collaboration. Also cultural factors, such as stigma, social labelling, bad previous experiences with mental health care and differences in expectations regarding treatment, are found to inhibit adequate psychological care. Finally, social factors such as unemployment issues, social vulnerability and the cumulative vicious effect of a combination of poverty, mental behavioural disorders and economic problems were reported to impede mental health care. The study of the KBS/FRB emphasizes a strong need to reorganize access to mental health care in Belgium, in terms of early detection and prevention (especially for vulnerable groups), promotion of multidisciplinary approaches and interdisciplinary recognition, smooth circulation between the lines of mental health care, investment in easily accessible 'reception'-initiatives, shift from institutionalized care to first line care, and setup (or facilitation) of comprehensive care in collaborative networks. Finally the report also pleads for education and training of health professionals for the specific needs for first line mental health care.

4.2 The position of clinical psychologists, clinical orthopedagogists and psychotherapists in the Belgian mental health care system

4.2.1 *'Centra voor geestelijke gezondheid' (CGG) – 'Services de santé mentale' (SSM)*

The foundation of CGGs – SSMs in Belgium dates back to mid-seventies of the last century. The Belgian Federal State Reform of 1980 assigned the programming, the control and the funding of CGG – SSM to the community governments.

4.2.1.1 *Role and mission*

The centers for service of mental health care in Belgium (CGG – SSM) play an important role in the delivery of psycho-medical-social care (reception, diagnosis, psychological/psychiatric treatment, psycho-social guidance and follow up) in an outpatient structure with a multidisciplinary approach and in collaboration with services and organizations in mental health.[25]

The mission of a CGG – SSM implies initial care (reception), analysis of the situation, diagnosis, and therapeutic work (psychiatric, psychotherapeutic or psychosocial treatment). The main aim is maintaining or reintegrating citizens in the society. Besides, CGGs – SSMs also have to be involved in organization, development and collaboration of information campaigns, local research projects, training programs and prevention activities, focused on professionals as well as citizens, to promote early detection of psychological problems. A fundamental characteristic for this kind of organizations is a multidisciplinary approach (psychiatrists, psychologists, orthopedagogists, social workers, speech therapists …) in order to provide psychiatric, psychological, social and administrative support for care seekers or eventual referral to other health care services. Some of the CGGs – SSMs have developed a more specific focus on certain populations (e.g. addiction, sexual delinquents, suicide prevention, traumatic stress, forensic treatment programs …).

4.2.1.2 *Place in the healthcare system*

The CGGs (Flanders) were situated by decree in the second line of health care[26]. The SSMs (Walloon region) were defined to cover the first line as well as the second line of mental health care[16].

4.2.1.2.1 Flanders

The Flemish decree of May 18, 1999 reorganized the Flemish CGG landscape, resulting in significant upscaling, a decrease in the number of the CGG-centers in Flanders and a more structured and transparent governance.[27] In 2015, 20 CGG's are spread over the Flanders region. In 2014, 1019 FTE were employed in CGGs (mean: 51 FTE per center); 61% of them were involved in face-to-face contacts with care seekers, group therapy or follow-up of clients. 58.0% of professionals who had direct contact with clients were psychologists, 10.3% were psychiatrists, 25.6% were social workers (mix of bachelors and masters) and 6.1% had another function. Five percent of the staff contingent worked on prevention (e.g. drugs, alcohol, and suicide) and 9% was involved in project work. On average, 79% of staff was paid from fixed envelope funding, 2% were self-employed (most of them were psychiatrists) and the others were paid by alternative project funding or patient contributions. For the financing of the Flemish CGGs, almost 78% of funding is provided by the Flemish Government (envelope system), 2% of the available financial resources comes from patient contributions, and the rest is covered by third parties and the federal social security (nomenclature – 3.5%) (see also chapter 4.4.3). The calculation of the envelope financing is based on historical staff figures. In recent years alternative funding and project funding on ad hoc basis is provided by the Flemish Government.[28, 29]

The Flemish Government maintains a stricter view of the lines of (mental) health care than the Walloon Government. Officially, as CGG are situated in the second line of care, Flemish care seekers can enter CGGs only after referral by GPs, hospitals, centers for educational guidance or youth protection bodies. However, it is tolerated that up to 25% of new patients start on their own initiative, without referral. The distinction between the first, second and third line of mental health care in Flanders is however not always strict and clear, because of a myriad of (local) initiatives to relieve the rising demands for care and to organize (regional) continuity of care. The Flemish figures for CGGs from 2014 show a self-reference rate for elderly of 16% and 21 % for youngsters. 'Overlaps' between first line initiatives and CGGs on the one hand and CGGs and psychiatric hospitals on the other hand are perceived by health care professionals as strengthening the network, as complementary and as a good example of stepped care.[27]

4.2.1.2.2 Wallonia

The Walloon decree of April 3, 2009, that was integrated in 2011 in the 'Code Wallon de l'Action Sociale et de la Santé'[30], defined a new legal framework for the accreditation of SSMs to support and strengthen the anchoring in networks, to reorganize mental health workers in teams and to improve the visibility and clarity in the mental health field for care providers and patients. SSMs are situated in the first line as well as in the second line of health care and promote a broad scope and a generalist approach of mental health care (reception, support, therapy, prevention,…). This implies that SSMs are open access mental health facilities. In 2015, 65 SSMs were approved in Wallonia, representing 90 localizations of activity (including satellites). Almost 900 people are active (employed and self-employed) in these organizations. The SSM teams assure four mandatory activity areas: (1) psychiatric function, (2) psychological function, (3) social function and (4) secretarial work and reception. However, other functions can be involved in the SSM ('fonctions complémentaires'), depending on specific projects, target groups or activity areas: specialists in somatic medicine with additional training in adult or child psychiatry; bachelors and masters in speech therapy, physiotherapy, criminology, mental health nursing, occupational therapy, psychology and post-graduates in paramedical disciplines, psychomotricity and remedial teaching.[30] The number of staff in SSMs funded by the Walloon government in 2015 is 461 FTE, of whom 39.5 FTE (8.5%) are psychiatrists and 156.5 FTE (34%) are psychologists[p]. Figures for the number of not-subsidized staff were not available at the time of the report.

[p] Data from Service Public de Wallonie (26.10.2015)

4.2.1.2.3 Brussels region

For the Brussels Region 'CGG Brussel vzw' covers the organization of CGGs, consisting of 6 regional activity groups, geographically spread over the region[31]. The centers focus on specialized tailored care, comparable with the Flemish situation. The collaboration between SSMs in the Brussels Region is coordinated by the 'Ligue Bruxelloise Francophone pour la Santé Mentale' (LBFSM)[32]. This organization is recognized and funded by the Commission Communautaire Française de la Région de Bruxelles-Capitale as coordinator for the ambulatory facilities in the Brussels region. The LBFSM consists of 70 member organizations, including 22 SSMs and 5 'SSMs bruxellois bi-communautaires'[33]. The 22 SSMs have united in the 'Fédération des Services de Santé Mentale Bruxellois francophones' (F.S.S.M.B) which is part of the LBFSM[34]. The tasks and structure of SSMs in the Brussels region are comparable with the SSMs in the Walloon region.

4.2.2 *Various new initiatives*

In response to the growing demand for more accessible and better developed community-based primary mental healthcare services, several initiatives have been taken to explore different ways to enlarge the current treatment possibilities for the patient. The initiatives are organized at different levels.[35] In this section we zoom in on three initiatives of particular interest when considering the role of psychologists and psychotherapists in an ambulatory setting:

- The projects including psychologist consultations within the framework of art. 107 of the Hospital Act
- The pilot projects on the first line psychology function initiated by the Flemish government
- The projects undertaken by centres for mental healthcare employing independent psychologists.

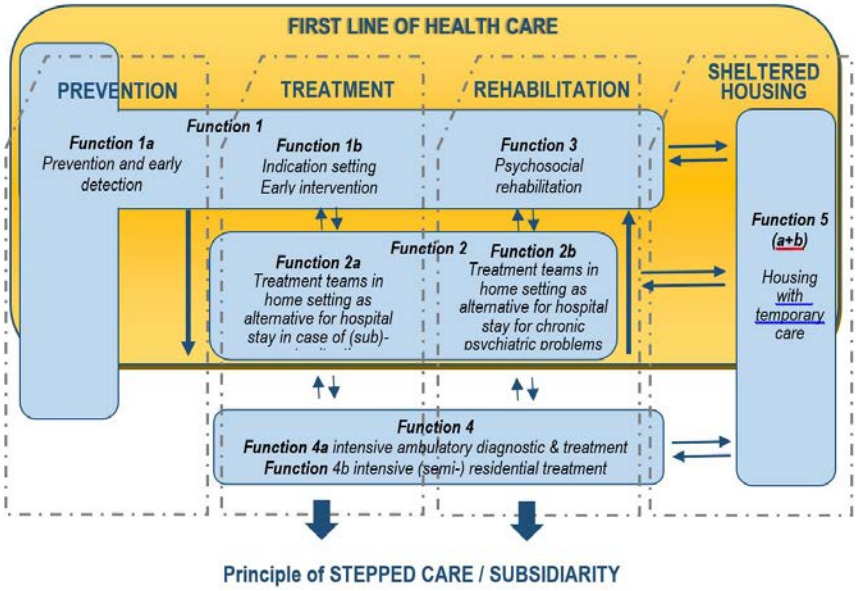
4.2.2.1 *Projects initiated under the regulation of Article 107 of the Hospital Act*[36]

Under the regulation of Article 107, hospitals have developed a broad spectrum of initiatives to provide partly reimbursed psychotherapy from psychologists and psychotherapists on ambulatory basis. In 2002 (and amended in 2004), the Belgian government published a joint declaration on the future policy in mental healthcare concerning networks and care trajectories[37]. The aim of the Article 107 regulation is to decrease the number of hospitalised persons and to keep the persons as long as possible in their home environment where they keep their own social contacts. Article 107 provides psychiatric hospitals and psychiatric wards of general hospitals a financial technique which allows them to flexibly reallocate a part of the Budget of Financial Means to the means and manpower required for new initiatives.

The initiatives must accomplish at least one of the five functions:

- Promotion, prevention, early detection and early intervention
- Treatment teams (mobile teams) at the patient's home environment
- Psycho-social rehabilitation
- Intensify residential specialised care
- Variety of specific housing forms ("woonvormen") for persons with a stable chronic problem

Figure 2 – Model of project art. 107



Based on UPC KULeuven, 2010[38]

Nineteen projects were initialised across Belgium: 2 in Brussels, 6 in the Wallonia and 11 in Flanders. Some of the outpatient psychologist consultations were organized at the hospital, others outside the hospital (e.g. home visits). The majority of the projects opted for a phased approach of the five functions. Most of the projects focused on function 2 (home treatment as alternative for in-hospital treatment for chronic, sub-acute or acute mental health problems. Some projects focused on function 1 (prevention and early detection) and function 3 (psychosocial rehabilitation). Functions 4 and 5 are planned in certain projects but these are at present not (completely) realized. Collaborators perceive the projects as a way to learn from each other (collaboration) and perceive the collaboration as an added value in terms of quality and continuity of care, but they also perceive intercultural or organizational obstacles, feelings of competition and imbalances in communication as a hindrance.[39]

4.2.2.2 *Pilot projects on the first line psychology function initiated by the Flemish government*[40]

In December 2011[41], 7 pilot projects on first line psychology function (FLPF / eerste lijn psychologische functie ELPF) were initiated and financed by the Flemish government, in order to test the effectiveness of FLPF, the cost effectiveness, the fit with the current needs in society (including the care for vulnerable groups) and the ideal setting for the FLPF to maximize interdisciplinary and transmural collaboration.

The main aims of the projects were:

1. to deliver easily accessible, short-term generalist care for non-complex psychological care,
2. to develop close collaboration with other health professionals (starting from the model of stepped care) and building a network,
3. to improve early detection and early intervention in case of psychological problems.

The first line psychology function had to be embedded in existing health care structures, such as GP practices or CAW. The duration of the pilot projects was 3 years.

Description of the projects:

- In each of the projects, 1 to 2 psychologists were employed, constituting a full time equivalent, with the exception of the project in Brussels which employed 10 psychologists (cumulative equivalent to a full time employment).
- Only clinical psychologists with minimum 5 years of experience were eligible to be part of the pilot projects.
- The focus of the projects had to be on adult care seekers.
- Every project was free in the definition and the setup of its gatekeeping and referral criteria.
- Every project had freedom of choice for the type of therapy delivered
- The patient's OOP was set at 9€/session and 0€/session for vulnerable groups

Evaluation of the projects:

In November 2015, Coppens, Neyens, & Van Audenhove published an evaluation of the FLPF[40].

In most of the projects, patients needed referral from the GP to have access to the psychologist. A minority of projects employed a broader access strategy and also accepted referrals by other health care entities (e.g. CAW, staff from health insurance, OCMW, staff from welfare centres). The projects were embedded in a myriad of existing health care structures, such as community care services, GP practices, welfare centres, group practices, CAW, entry functions for mental health care. This embedding was perceived as very positive by most of the stakeholders and was found to facilitate collaboration and referral.

The projects were financed with a fixed lump sum of 195 000€/3 years (65 000€ per year)[42] covering:

- the remuneration of the psychologists (who were salaried employees),
- the operational costs,
- communication with the GP and networking.

Patients had to pay 9€ per consultation, and vulnerable groups and specific types of patients (e.g. people in detention, asylum seekers and illegal immigrants) were treated free of charge. However in a number of cases,

especially in case of longer treatments (more sessions) the patient's OOP was 4€/session.

The project treated on average 155 patient per year (median: 150) in on average 444.1 sessions (median: 384)[40].

The pilot projects focused on **short term treatments**. 950 on 1085 (on average 88%) of care seekers (range between FLPF projects 67% - 100%) received one to five therapy sessions and 10.3% (range 0% - 22%) received six to ten sessions. Only a very small group (1.7%) received more than 10 sessions. The overall mean number of sessions was 3.1 (range 1.5 – 3.9).

The most common **reasons for consultation** of the FLPF were adaptation problems (47%), mood swings (34%), relational problems (31%) and anxiety (27%). Almost 41% of the consulting patients suffered from mental problems already for several years, while 34% stated to suffer for several months. Based on the scores of the Brief Symptom Inventory (BSI)[43, 44], as assessed by the FL-psychologist at the intake of the patient, seven and a half percent of the population suffered from mild mental health problems, 47% were found to have moderate problems, 39.5% of the complaints were considered severe and 6 % of the population had very severe mental health problems. Crisis intervention was not provided very frequently by most of the ELPF (except one that reserved one day a week for this kind of consultation). Pilot projects stated that this kind of intervention is not part of their core activity.

A significant difference in **delay to consultation** was found between the centres, ranging from 2 days to 2 months.

The pilot projects reported to **consult with other health professionals**, to discuss specific patient related therapeutic problems, in about 74% of the cases (range 42% - 100%), more specific with the GP (59.5%), another first line psychologist (17.5%) and a CGG (14%). About 56% of the patients were referred from FLPF to other health professionals for treatment or follow up: Of these, 16.7% were referred to a CGG, 10.1% to the psychiatrist, 7% to a CAW, about 1-2% each to OCMW, GP, Psychiatric department in hospital, CLB and psychiatric (home) care and a significant part was referred to 'other' facilities.

Patient satisfaction with FLPF over the 3-year pilot-period ranged from 8.5 to 9.2/10 (Mean 8.9, SD 1.1). Drop-out of patients on referral to FLPF ranged from 0 – 22% and during first line psychological care from 1 to 19%.

The authors draw in addition a series of more qualitative conclusions about the FLPF pilot projects:

- Organization of mental health care is not structured clear enough for care seekers as well as health care professionals;
- Networking is important for the FLPF to build strong collaboration, promote continuity of care and facilitate intervision;
- Crisis interventions are no a core activity of FLPF. However the first line psychologist needs to recognize these situations and must be able organize urgent care if necessary. However, short treatments in exacerbation of chronic mental health problems can be sufficient in some patients.
- Psycho-education in group needs to be promoted for FLPF as it will shorten the waiting list. However the organization of these events is time consuming.
- It is necessary to define a 'standard task profile' for the FLPF, however one has to keep in mind to leave enough room for flexibility to fit the first line function with regional needs
- The first focus of FLPF has to be on assessment and detection of mental health problems. Secondly FLPF has to focus on short generalist treatments. Third focus has to be on provision of information, advice and tips and on referral.
- The client core group for FLPF should include chronic and mild to moderate mental health complaints, preferably in vulnerable or disadvantaged groups and immigrants. There should not be a refusal based on age of the care seeker.
- The profile of the FLPF should include: experience with a broad range of psychological problems from all groups in primary care; an empathic communicative and open minded attitude; being specialist in fast detection of mental health problems; being experienced in short interventions and group sessions; having a good overview of regional care opportunities; being flexible, efficient and independent but still remain a team player.
- There is a need for a specific training in specific topics for the FLPF function.

- The FLPF must be easily accessible for care seekers, with regard to location, risk of stigma, waiting list, close collaboration with GPs, low pricing, treatment tailored to culture or ethnic differences and consultation time planning.
- Number of FLPF should be calculated carefully to avoid long waiting lists. Reimbursement of FLPF is necessary for the success of this function, however not for free but with a patient's OOP of 4 – 9 €/session.

4.2.2.3 *Independent psychologists at centres for mental healthcare*

A number of centres for mental healthcare, such as CGG – SSM, have started contracting with independent psychologists to provide consultations in private practice at the locations of the centre. By doing so, they aim to increase the capacity of care provision, to reduce waiting lists, and to improve access to care, including after-hours consultations. Patients are provided three referral options:

- Referral to the psychologist working within the centre. The patient only pays a specific co-payment and tariffs are set by the Community (e.g. for CGG 11€/session)[45]. Patients opting for this choice may face long waiting lists.
- Referral to private practices of psychologists or psychotherapists outside the centre. The patient pays a tariff that is freely set by the provider. In some cases the patient can get partial intervention via the complementary insurance of his or her sickness fund.
- Referral to the private practice of psychologist at the centre. The patient pays a tariff that is set in agreement with the centre and can be income-related or fixed. In some cases, the patient can get partial intervention via his or her sickness fund. The financial arrangements between the psychologist and the centre can take various forms, but it is an essential part of the agreement that the psychologist pays the centre for overhead costs including the use of the building, heating, utilities and administration.[46]

4.2.3 *The 6th State Reform*

In Belgium, responsibilities for health policy are shared between the federal level and the federated entities (regions and communities). A special law on the 6th institutional reform, concerning the repartition of competences between federal and federated authorities, has been published (Law of the 6th of January 2014. It sets out the major guidelines and strengthens the role and responsibilities of the federated entities (regions and communities).

The federal level is responsible for the regulation and financing of compulsory health insurance; legislation covering different professional qualifications; etc.

At the level of federated entities (regions and communities), governments are responsible for 'personal' matters, including the homogenisation of mental health care.

To facilitate cooperation between the federal level and governments of regions and communities, inter-ministerial conferences are regularly organized.

4.3 Mental healthcare practitioners: regulation, education and work setting

We mainly focus here on the mental health care practitioners concerned by the law of 4th April 2014, i.e. clinical psychologists, psychotherapists and clinical orthopedagogists. The role of physician practitioners active in mental health care is only briefly described here.

4.3.1 *Physicians*

GPs and psychiatrists can practice mental health care such as psychotherapy under their therapeutic freedom. They may or may not have followed specialised training in psychotherapy.

A number of problems have been observed by the Superior Health Council (Hoge Gezondheidsraad (HGR) – Conseil Supérieur de la Santé (CSS)) on the role of GPs in first line mental health care[47]:

- GPs often exclusively prescribe drug treatment. They rarely refer patients to psychologists, psychotherapists or psychiatrists.
- The collaboration between GPs and 'psy'-professions is considered difficult. It is often unclear to GPs what support they can get from a

psychiatrist. When a patient is hospitalised in a psychiatric service, there is relatively limited information exchange between the hospital and the GP.

- The education of GPs is insufficient to provide mental health care.
- There is no possibility to bill a longer consultation, to evaluate or diagnose the mental status, nor for multidisciplinary contacts with a psy-professional

4.3.2 *Clinical psychologists*

On the basis of the definition of other health care professions, a review of the scientific literature and of the definitions advanced by permissible and professional organizations in different countries, a definition of a clinical / healthcare psychologist in Belgium is proposed by the Superior Health Council: "Clinical / health care psychology is the autonomous application and development of theories and methods of scientific psychology in the promotion of health, in the psychological screening, diagnosis and assessment of health problems, and in both the prevention, management and treatment of these problems in people"[48].

Approval

Since 1993 the title of psychologist is protected. In 2014, the law of 4th April provides that, from 2016, the practice of clinical psychology will be authorised under approval of the Minister in charge of Public Health. The requirements will be defined by the federal council of clinical psychology and orthopedagogy (see also chapter 3).

Education

According to the law of 4th April 2014, clinical psychologists have to obtain a university degree in clinical psychology, involving at least 5 years of study (full time) or 300 ECTS, including a traineeship in clinical psychology.

Work setting

- First line:
  Clinical psychologists work are in private practice, in multidisciplinary centres such as 'wijkgezondheidscentra'–'maisons médicales', or in first line institutions such as 'Centra voor Algemeen Welzijnswerk' (CAW) – 'centres de planning familial' or CLB (Centra voor Leerlingenbegeleiding)/centres Psycho-Médico-Sociaux (PMS).
- Second line:
  Psychologists are working in ambulatory mental health community centres (SSM – CGG) that offer specialised mental healthcare services.

In hospital setting, there are norms for psychologists that determine the minimum number of FTEs that need to be employed. These norms are typically set per bed. In hospitals (be it general or psychiatric), psychologists are mainly at work in psychiatric services:

  - A-services (neuropsychiatry – observation and treatment)
  - K-services (neuropsychiatry for children – observation and treatment)
  - T-services (neuropsychiatry for adults – treatment)
  - Tg-services (neuropsychiatry for geriatric patients) – only at psychiatric hospitals
  - Tf-services (function family nursing) – only at psychiatric hospitals
  - IB-services (intensive treatment for severe patients) – only at psychiatric hospitals
  - Urgency psychiatric services
- or in the following specialised services:
  - Sp-Neur (specialised service for neurologic patients)
  - Sp-Pall (specialised service for palliative care, including mobile team intra-hospital palliative care)
  - Sp-PsyG (specialised service for psychogeriatric care)

Psychologists are also engaged in other hospital services such as oncology, cardiology, nephrology, pulmonology, gynaecology, paediatrics etc.[35]

Besides the hospital and the mental health community centres, there are psychologists working in others settings (e.g. psychiatric nursing homes, rehabilitation centres, etc.- see above), even at home as it is the case in palliative care with the support at home team, intervening at the patient's residence place (house, rest and care houses, psychiatric care houses, in sheltered accommodation, etc.).

Employment status

Many psychologists are self-employed, often in combination with employment in the above-mentioned organizations.

Competences

The Superior Health Council has published an advice on the profile of competencies for the healthcare/clinician psychologist in Belgium[48]. The function of hospital psychologist was defined by the APSIH (Association des Psychologues de la santé et d'Institutions Hospitalières).[49]

Authorised acts

The law of 4th April 2014 defines the practice of clinical psychology as autonomous usual acts, in a scientific reference framework, in prevention, examination, screening, psycho-diagnosis of, real or supposed, psychic or psychosomatic sufferings and the treatment and support of the person.

Further precision or definition of authorised acts could be done in the future on the advice of the federal council to be installed.

4.3.3 *Psychotherapists*

Approval

Regulation of the practice of psychotherapy is foreseen by the law of 4th April 2014. To be allowed to practice psychotherapy, practitioners will have to be habilitated by the federal council of psychotherapy. Before the new law is implemented, anyone can legally call him or herself "psychotherapist" (see also chapter 3).

Education

According to the law of 4th April 2014, candidates for a recognised practice of psychotherapy need to have a bachelor diploma in a health profession, psychology, educational sciences or social sciences, of at least 3 years or 180 ECTS. In addition, they have to be trained in basic notions of psychology in a university or 'high school' ('hogeschool' – 'haute école') and must have followed a course in psychotherapy of at least 70 ECTS during 4 years, i.e. 500 hours of theory and 1 600 hours of practice in one of the psychotherapeutic orientations recognised by the law (psychoanalytic or psychodynamic; cognitive-behavioural; systemic and family psychotherapy; humanist person-centred and experiential).

Postgraduate courses in psychotherapy are offered to psychologists, physicians, psychiatrists or child psychiatrists. They are offered at universities as well as at high schools. The postgraduate programs offered by universities meet the standards set by the European Federation of Psychologists' Associations (EFPA).[35]

Awaiting the implementation of the law, many training programmes are offered for psychotherapy professionals by private institutions or professional associations of psychotherapists[35] without any regulation on their content.

Work setting

Psychotherapists are working in private practice or are engaged in health care settings (first or second line), such as CAW, CLB – PMS, OCMW – CPAS or CGG – SSM.

Employment status

Psychotherapists are self-employed, often in combination with employment in the above-mentioned organizations.

Competences

Today, because there is no recognised title of psychotherapist, no up-to-date competences' referential is available for Belgium.

Authorised acts

The law of 4th April 2014 defines the practice of psychotherapy as autonomous usual acts aiming to supress or alleviate difficulties, conflicts or psychic troubles of a person. These acts are based on a psychotherapeutic reference framework and are addressed to the person or to a group to which the person belongs.

The acts are not defined as such by the law but the psychotherapeutic reference frameworks recognized by law are:

- psychoanalytic or psychodynamic;
- cognitive-behavioural;
- systemic and family psychotherapy;

- humanist person-centred and experiential)

This list could be later extended on advice of the federal council of psychotherapy (still to be implemented).

4.3.4 *Clinical orthopedagogists*

Approval

Today clinical orthopedagogists are not recognised as a profession as such. In 2014, the law of 4th April foresaw that, from 2016 onwards, the practice of clinical pedagogics will be authorised under approval of the Minister in charge of Public health. The requirements will be defined by the federal council of clinical psychology and orthopedagogy (see also chapter 3).

Education

Clinical orthopedagogists have to obtain a university degree involving at least a 5 years study (full time) or 300 ECTS. The training in orthopedagogy starts with an academic bachelor in pedagogical sciences. From de third year onwards, students can opt for orthopedagogy. They finally graduate as orthopedagogists within the master of pedagogical sciences.

There is also a professional bachelor in orthopedagogy. In Flanders this program has a model track of 3 years of study (180 ECTS) at a university college (short university-type higher education). Graduated bachelors in orthopedagogy often work as educator-counselor in different settings. In Wallonia, a professional bachelor degree as specialist in orthopedagogy (baccalauréat) can be obtained by all graduates of short university-type higher education in a psycho-pedagogical, paramedical and social orientation. The program has a model track of 1 year (60 ECTS). Graduates often work in institution for learning disabilities/developmental problems or for disabled persons. However, these bachelors in orthopedagogy cannot act as a clinical orthopedagogist.

Work setting

- First line:
  Clinical orthopedagogists are working in first line private practices, also at CAW's, services and offices of Kind & Gezin and in institutions for special needs education.
- Second line:
  In second line, clinical orthopedagogists are sometimes working in mental health community centres (CGG – SSM). They are also engaged in hospital services such as paediatrics, child and youth psychiatry, etc. But often, they work in ambulatory rehabilitation centres, centres for developmental problems or addictions.[50]

Employment status

A number of orthopedagogists works (partly) as self-employed health care professional in private or group practices.

Competences

Official competences for the profession of clinical orthopedagogist are available at the website of International society of professional organizations of educationist (http://www.paedagogos.org).

The following profession specific competences are described:

- Professional competences: Scientific knowledge and skills regarding evaluation and diagnostics, treatment and therapy, education, promotion, guidance, counselling, research, and planning.
- Social competences: skills in collaboration and counselling within the social system and discipline specific, as well as interdisciplinary situations.
- Reflexive competences: due to their autonomy orthopedagogists are responsible for their professional acts. By consequence, they should be able to reflect adequately in function of evaluation, intervention and supervision.

Authorised acts

The law of 4th April 2014 defines the practice of clinical orthopedagogy as autonomous usual acts, in a scientific reference framework, in prevention, examination, screening of educational, behavioural, developmental or learning troubles of a person, as well as the treatment or the support.

For the moment there is no more precision or definition of authorised acts. This could be done in the future on advice the federal council to be implemented (see also chapter 3).

4.4 Current financing of ambulatory psychological and psychotherapy interventions

In this section, we briefly give an overview of how psychological and psychotherapy interventions are financed to date in their main ambulatory settings, i.e. private practices of physicians – mainly psychiatrists – and psychologists, on the one hand, and at centres for mental health care, on the other hand.

A brief description of the financing of psychological and psychotherapy interventions provided in other settings, such as the rehabilitation centres, psychiatric departments in general hospitals and psychiatric hospitals can be found in appendix. Financing of mental healthcare interventions in settings such as psychiatric nursing homes, initiatives for sheltered accommodation ('beschut wonen' – 'habitation protégée') and other are not detailed in this report.

4.4.1 *Financing of psychological and psychotherapeutic interventions delivered by physicians in ambulatory setting*

Mental health care delivered by doctors ((neuro-)psychiatrists or other specialists and GPs) is financed on fee-for-service basis. The largest part of the fee is reimbursed by the national statutory insurance, the remainder is paid by the patient.[35]

For (neuro-)psychiatrists (and in some cases a neurologist or other specialist) different RIZIV – INAMI fees exist, the main ones being for:

- consultations,
- psychotherapeutic treatment of minimum 45 minutes,
- psychotherapeutic treatment of children and adolescents of minimum 60 minutes,
- family sessions of psychotherapeutic treatment of minimum 60 minutes
- group sessions of psychotherapeutic treatment for maximum 8 patients, minimum 90 minutes
- detailed and individual psychiatric evaluation of a patient; editing a report; evaluation prescribed by a GP or medical specialist
- consultation with evaluation and writing of report for the coordination of care ("liaison function report")
- fee for a consultation in an emergency service
- fee for a multidisciplinary team consultation in a child psychiatry hospitalisation unit (K), for a minor, under the supervision of an accredited medical specialist in psychiatry, with report. This fee may be charged once a week. To this multidisciplinary consultation should participate, besides the medical specialist in psychiatry, the psychologist and the nurse or educators which hold the daily supervision, at least one social nurse, manual therapist, physiotherapist, speech therapist or teacher.[22]
- consultation between psychiatrist and psychologist or orthopedagogist on ambulatory treatment of minors.
- neuropsychological examination in case of dementia. The technical execution of the examination can be performed by a neuropsychologist who collaborates as qualified helper. In this case, the psychiatrist, neurologist or geriatrist bills the code and pays the neuropsychologist.

As stated above, for GPs no specific RIZIV – INAMI codes exist for longer consultations for psychotherapeutic support, which in practice hampers the delivery of this type of support.

4.4.2 *Financing for psychological and psychotherapeutic interventions delivered by psychologists or psychotherapists in ambulatory settings*

RIZIV – INAMI reimbursement

Only in a limited number of settings, interventions by psychologists are reimbursed by RIZIV – INAMI.

- For the treatment of patients with chronic fatigue syndrome, the following conditions apply:
  - The patient is referred by a recognised multidisciplinary centre for the diagnoses of the chronic fatigue syndrome
  - Only cognitive behavioural therapists can perform cognitive behaviour treatment ambulatory sessions. They need to have a university degree in psychology (master or licence) and have to be trained in cognitive behavioural therapy during 3 years (i.e. 180 ECTS) in a Belgian university. They also have to sign a contract with the compulsory health insurance.
  - Per patient, a maximum of 17 sessions are reimbursed. One session lasts 50 minutes.
  - Note that at the beginning of 2015, only Flemish therapists signed a contract, as there are only recognized for chronic fatigue syndrome centres in Flanders.
- Within ambulatory or residential centres for rehabilitation ('centres de rééducation fonctionnelle' – 'revalidatiecentra'), psychologists are financed through a convention with RIZIV – INAMI. The centres for rehabilitation offer multidisciplinary support for several diseases. They encompass coordinated multidisciplinary activities aimed at enhancing the activities and participation of persons with function restrictions, taking into account relevant external and personal factors.[51] Depending on the type of disease or restriction, the patient attached to the centre can benefit from psychological support.
- In some cases, psychiatrists or other specialists can bill for interventions performed by psychologists/psychotherapist to whom they commission a task. An example is the code for a neuropsychological examination in case of dementia (see also above). A psychologist/psychotherapist can execute the task, but it is the psychiatrist, neurologist or geriatrist who bills to RIZIV – INAMI. The neuropsychologist in that case is paid by the specialist.
- Another example is the reimbursement by RIZIV – INAMI for consultations with a tabacologistq: 30 euros for the first session of smoking cessation consultation, and 20 euros per session for 8 follow up sessions in smoking cessation over two years. In smoking cessation services associated with major hospitals, the maximum remaining unpaid by the patient is usually 5€ maximum 10€ per session, but it is often completely free.

Complementary reimbursement for psychological or psychotherapeutic interventions

As reimbursement by RIZIV – INAMI is quasi inexistent, many sickness funds reimburse psychotherapy to selected patient groups and up to certain amounts as part of their complementary insurance package. At most sickness funds the members are obliged to take this complementary insurance (only at the neutral sickness fund this is optional), therefore many persons have access to this reimbursement.

A report of the Flemish Patient Platform (Vlaams patiëntenplatform – VPP) of July 2014 provides a publicly available overview of reimbursement policies of sickness funds in Flanders.[52] Information was reviewed by the sickness funds in June-July 2014. The overview analysed the reimbursement policies along the following 4 axes:

- Who is entitled to reimbursement of psychotherapy?
- Which psychotherapeutic treatments are eligible for reimbursement?
- The reimbursement level and the conditions for reimbursement
- Which providers are entitled?

q Professional in smoking cessation suppot - Not necessarily a psychologist

VPP concludes that, in general, a large diversity in reimbursement policies can be observed. Most frequently reimbursement is limited to children and adolescents. Only a few sickness funds provide reimbursement for adults.

Most sickness funds do not restrict reimbursement in terms of indications. A number of sickness funds, however, do detail a restricted list of indications or comorbidities, such as cancer or chronic somatic diseases.

There is a large diversity in number of sessions reimbursed. At some sickness funds, a number of sessions are reimbursed yearly, at other sickness funds a series of sessions is only reimbursed a single time, or lifetime limited.

Different criteria are imposed to psychologists or psychotherapists. Some sickness funds work with a list of registered practitioners, other leave the patient free to choose their therapist if he/she responds to the criteria defined by the sickness fund.

4.4.3 *Financing for psychological and psychotherapeutic interventions delivered in centres for mental health care (CGG – SSM)*

Financing of the mental health care centres (see section 4.2.1) is based on subsidies granted by the federal entities, i.e. Regions (the biggest part), the Communities, and by the Federal Government.[53] In Flanders, the main part (78%) of the subsidies are based on historical personnel data. On top of the general subsidies, several extra subsidies (4%) have been granted to a number of centres on rather ad hoc basis to fund task extensions and specific projects. 2% of financing comes from client contributions and 4% from RIZIV – INAMI. The remainder financing comes mainly from federal and local governments.[29]

4.5 Cost of psychologists and psychotherapists in Belgium

Considering that reimbursement tariffs abroad are of limited use to the Belgian context, this section brings together a number of data on the current market cost of psychologists and psychotherapists in Belgium:

- current market tariffs of psychotherapists
- cost of psychologists in hospitals (based on the KCE manual for cost-based pricing of hospital interventions, which in turn is based on data collection by IF-IC (Instituut Functieclassificatie - Institut de Classification de Fonctions)
- cost of psychologists in centres for mental health care.

4.5.1 *Current tariffs for a psychotherapist consultation*

Based on CM data

We focus on data provided by the Christian Mutualities (CM) in Flanders (2006-2014) as this dataset constitutes the largest dataset available for Belgium. Most other sickness funds have varying reimbursement policies across their local offices.

Table 1 shows the descriptive statistics for the tariffs of a consultation by Flemish psychotherapists who signed an agreement with the CM. The median tariff for a general consultation (usually taking 45 minutes) in this sample is 45 euros. The data are based on 1630 registration numbers of psychotherapists. A single psychotherapist can have more than one registration number if he or she works in different practices. The registered psychotherapists meet the following conditions in terms of education:

- Degree in human sciences at high school or university, and
- Degree in a complementary and scientifically based psychotherapy course:
  - Of minimum 3 years (180 ECTS)
  - Organized by an educational institute recognised by the government
  - Giving access to membership of an umbrella organization for psychotherapists in Belgium, bringing together psychotherapists from more than one educational institute
  - Within one of the following orientations: psychodynamic, experiential, behavioural or system psychotherapy; or integrative psychotherapy.

Seventy eight percent of the registered psychotherapists has a master degree, 22% has a bachelor degree. 37% of the registered psychotherapists followed psychotherapy training at university, 60% at an educational institute other than university. The remainder 3% consists for the largest part of persons still in traineeship of the psychotherapy training and a very small

part has not followed psychotherapy training but has been accepted through an exception procedure.

In total 0.77% of the CM members up to 25 years benefitted from this complementary reimbursement scheme in the year 2014.

More detailed data on patient volumes, reimbursement expenditures and registered psychotherapists are available at the 'CM Landsbond'.

Table 1 – Tariffs of a psychotherapy consultation applied by Flemish psychotherapists who are registered at CM (n = 1 630)

	Min	Percentile 25	Mean	Median	Percentile 75	Max
Tariff of a consultation (€)	20	40	44	45	50	70

Source: based on data from CM Landsbond (2015)[54]

Based on estimates of the professional associations

In a recent publication on private health expenditures in Belgium[55], the tariffs for self-employed registered clinical psychologists were estimated by the professional associations at € 50 per session.

4.5.2 *Cost of a psychologist in hospital setting*

A psychologist at work in a hospital setting cost per hour 44€ ,based on a dataset retrieved by IF-IC (Instituut Functieclassificatie - Institut de Classification de Fonctions). The data retrieved by IF-IC are gross wage data from 2010 and the KCE transformed these data into total cost data, including attractiveness and end-of-year boni, employers' social contributions and other personnel related costs such as social subscriptions, statutory insurance against work-related accidents, occupational medicine costs and extra-legal insurance). The total cost was consequently calculated per hour, taking into account the effectively productive working hours per FTE, adjusting for holidays, on-the-job education and training time, sickness, accident and other leaves when paid by the employer. The IF-IC dataset is based on a sample of 15 Belgian hospitals with in total 14 658 FTE and 20 351 employees. The data collected are based on the functions of the employees, not on their education. More detail on the data can be found in KCE report 178 (2012)[56].

4.5.3 *Cost of a psychologist in centres for mental healthcare*

Table 2 shows the gross wage cost, holiday pay and end of year boni for psychologists in Flemish mental healthcare centres. Note that these data are not directly comparable to the data from the KCE manual in the section above, as they do not include other personnel related costs such as employers' social contributions etc.

Table 2 – Annual gross wage cost, holiday pay and end of year boni for psychologists in mental healthcare centres (€)

Function: Psychologist	Annual gross wage §	Holiday pay §	End of year bonus #	Attractiveness bonus #
Seniority 0 yrs	36 015,97	2 761,22	1 234,02	629,47
Seniority 23 yrs	55 755,72	4 274,6	1 727,51	629,47

§ Loonbarema's Paritair Comité 331 - Centra voor Geestelijke Gezondheidszorg; van toepassing vanaf 01/01/2013 tot overschrijding spilindex 122.01. Source: based on www.vso.be and personal communication

5 INTERNATIONAL COMPARISON

5.1 Introduction

5.1.1 *Objective*

The international comparison aimed at identifying possible options and criteria for building the organizational and financial model for Belgium.

5.1.2 *Methods*

Country selection

The countries selected for this analysis are the Netherlands, Germany, England, Switzerland and Denmark. Where applicable we also added the information on Belgium. Amongst Belgium's neighbouring countries, we selected the Netherlands and Germany as these are countries where outpatient psychotherapy treatment is covered by statutory or compulsory health insurance. France and Luxembourg were not included as outpatient psychotherapy is not part of their publicly funded health insurance basket. Given the fact that psychotherapy practice has developed differently in Francophone and Anglo-Saxon countries, we added England and Switzerland. Finally Denmark was added because of its different approach to the reimbursement of psychotherapy.

Data collection

Firstly, we developed a template to collect data in each of the selected countries. The template was developed based on general elements describing healthcare professions. Afterwards, we briefly tested it in order to add sections that emerge from a first approach of our material. The template was consequently reviewed and, finally it was submitted to key experts for final approbation.

The description of each of the countries is based on a grey literature search and a selection of peer-reviewed articles. Two KCE researchers collected data. Because of language reasons, information on Denmark has been completed by a Danish speaking contact from the professional association of psychologists. Each country section and our final analysis have been validated by an expert of the country.

5.1.3 *Structure of the chapter*

This chapter starts with a cross-country analysis that brings together the variety of approaches observed in the selected set of countries. For each of the themes, we discussed the different ways to give form to a reimbursement policy for outpatient psychotherapy services. A description is given of the options taken in the examined set of countries. This description is consequently nourished by discussion elements from both grey and scientific literature on the advantages, disadvantages and implications of the policy options.

The cross-country analysis is based on the country sections (available in appendix) which present the information in more detail for each of the countries. The cross-country analysis and country sections follow a similar structure:

- We first briefly describe the mental health care professions, their education, their role, typical work settings and regulation. Given that in 2014 a new law has been adopted in Belgium regulating mental health care professions, and that many decisions have been taken with this law, we do not go into much detail on this topic.
- We then look at the organization of the outpatient mental health care within the larger mental health care context and the referral system giving patients access to specialised mental healthcare.
- We consequently focus on the indications and the psychotherapy treatment types covered by the national statutory insurance, as well as the duration and intensity of the covered treatments. We focus on coverage by statutory health insurance rather than on private health insurance, as the latter may vary widely from one insurance to another within a country. E.g. we describe the NHS in England, not the private sector. For Germany, we look at the GKV ("Gesetzliche Krankenversicherung").
- We further describe the payment methods for each of the covered treatments and involved professionals and discuss what incentives they create. In this part we focus on tariff structure and building blocks of the tariff calculation, rather than on monetary values, i.e. the actual level of payments for professionals. Monetary values are to be interpreted within the context of a country's specific healthcare system (employment status of the healthcare professionals (independent

workers or salaried employees), education and role of the professionals, etcetera) and context at large (cost of living, taxes, etc.) and therefore considered of limited relevance to the Belgian situation.

- Throughout the different sections, we also look at measures taken to support quality. Depending on the dimension considered, different tools can be used to support quality:
  - Quality of health care professionals can be ensured by regulating the profession and thereby the education, accreditation, continuous training, on-going supervision etc.
  - Quality of health care provision, i.e. the treatments delivered, can be supported by the enforcement of guidelines.
  - Quality of health care coordination can be ensured through appointing a single responsible person for treatment coordination.
  - In a separate section on 'quality measurement' we will focus on national or regional initiatives taken to register outcome (patient recovery) and other data, aimed at improving quality of the mental health care system in a country.
  - In the preparation of this study we also searched for data on global expenditures by national statutory insurance to cover outpatient mental health care. However, these data were not available for all countries. Moreover, since global expenditures depend heavily on the covered package (indications, treatment intensity), payment levels and access to services (referral scheme, waiting lists, etc.), it is not possible to directly extrapolate them to the Belgian context to support budget impact calculations. Therefore these data were not included in the report.

5.2 The mental health care practitioners

5.2.1 *Regulated professions and functions in the mental health care system*

Table 3 provides an overview of the different professions active in mental health care in the analysed set of countries. The table focuses on professions that play a role in the publicly funded health care systems for each of the countries. Medical doctors (GPs and psychiatrists) have not been added to the table as these play a role in mental health in all of the countries – although their role may vary from country to country.

For some of the listed professions (those with a ®), the title and/or practice is regulated by law. For other professions this is not the case, they are '**functions'** rather than '**regulated professions'**.

Note that in many instances, there may be overlap between different professions and between functions and professions. In the Netherlands, e.g. a professional can have both the title of clinical psychologist and psychotherapist. In Belgium, e.g. the first-line psychologist as tested in pilot projects, is also eligible for obtaining the title of clinical psychologist.

Table 3 – Overview of mental healthcare professions and functions (other than medical doctors) in the analysed set of countries (independent of whether their services are eligible for reimbursement or not)

Belgium	The Netherlands	UK (England)	Germany	Denmark	Switzerland
• Clinical psychologist ® • Psychotherapist ® • First line psychologist (i.e. in pilot projects)	• Healthcare psychologist ® • Clinical psychologist ® • Clinical neuropsychologist ® • Psychotherapist ® • Mental health nurse specialist ® • GP's mental healthcare practice assistant	• Clinical psychologist ® • Counselling psychologist ® • Health psychologist ® • Forensic psychologist ® • Primary care graduate mental health worker • Primary care counsellor • Psychological wellbeing practitioner (IAPT§ programme) • High intensity therapist (IAPT§ programme) • Assistant clinical psychologist • Psychotherapist • Counsellor	• Psychologist (title ®; practice not regulated) • Psychological psychotherapist ® • Child and youth psychotherapist ® • Alternative practitioners for psychotherapy ('Heilpraktiker') ®	• Psychologist ® • Child psychologist ® • Adult psychology ® • Work and organizational psychology ®	• Psychologist ® • "federal approved psychotherapist"® (independent and delegated)
• Clinical orthopedagogist ®	• Clinical orthopedagogist	• Orthopedagogic subjects are found in 'Special education', for what concerns children with special needs in education, and 'Developmental Psychology' or 'Orthopsychiatry', for the child rearing related subjects[57, 58]. • The 'Child and Adolescent Mental Health Services' belong to the domain of mental healthcare. There has not been an attempt to develop general orthopedagogics[58]. • Learning disabilities nurses Learning disabilities nurses, child psychotherapists and clinical psychologists specialising in children with mental health problems or learning disabilities are employed by NHS	• Orthopedagogics translate in 'Sondernpädagogik', 'Heilpädagogik' or 'Pädagogik der Behinderten', all related to 'Special education' (Schoorl et al., 1995). • Klinische Heilpädagogik (Master only available at University of Freiburg)	• Masters (or bachelors) educations are organized in Denmark. Nevertheless, they do not have a focus on mental illnesses and people who are trained in these methods are not considered mental health professionals.	• Master in Heilpädagogik/Sonderpädagogik and Bachelor in Klinische Heilpädagogik organized in Switserland. Nevertheless, as in Denmark they do not have a focus on mental illnesses, rather on field of special education.

§ *IAPT: Improving access to Psychological Therapies*

Psychological interventions and psychotherapy practiced by a medical doctor are regulated by law in all of the countries analysed.[59] On top of the regulation on medical doctors, all countries analysed also have legal regulations on the title and/or practice of at least some of the mental health care professions. The Netherlands, Germany and Switzerland have regulation on both psychologists and psychotherapists. England and Denmark only have regulation on psychologists, not on psychotherapists. When there is a recognition of the practice of psychotherapy, practitioners who are not satisfying the legal conditions are breaking the law.

Regulation of professions supports quality of care

A uniform legal definition of the professional activities is an important tool to support quality control of training programs and delivered services, on the one hand, and to facilitate coordination of care, on the other hand.[59]

Regulation of the profession however appears not a 'condition sine qua non' to involve professionals in the health care system. It can be observed in some countries that, on top of the regulated professions, also non-regulated professions play an important role in the delivery of mental healthcare, be it mostly in multidisciplinary settings:

- In the Netherlands, for instance, two functions are integrated within the health care system, although they are not part of the law on health care professionals: the GP's mental health care practice assistant and the clinical orthopedagogist.
- In England, only the professions of practitioner psychologists (includes clinical, counselling, health and forensic psychologists) are regulated by law. In fact, many of the practitioners listed in Table 1 for England are subject to regulation and accreditation either indirectly as they are member of another regulated profession (medical doctors, nurses, psychologists, social workers) or as they are part of a national training initiatives like the IAPT programme. Nevertheless, for many other practitioners, there is no mandatory registration nor accreditation. They have the possibility to join voluntary registers of professional bodies, but there is no law guaranteeing this.

Regulation of orthopedagogy as distinct profession is rare

To our knowledge the profession of orthopedagogist is only regulated in Belgium as a distinct profession. In the Netherlands, orthopedagogists can register at the NIP (Dutch Institute for Psychologists), but neither their title nor practice is regulated by law as such. In Germany, persons with a master's (some federal states accept also bachelor's) degrees in education ('Diplompädagogen') or social education ("Sonderpädagogen) can apply for the regulated title of psychotherapists for children and young people. In Switzerland exists the profession of "Heilpädagoge" or "klinischer Heipädagoge" on the level of a bachelor or master degree.

In Belgium, the Netherlands and Germany, there is a master's degree in education with a specialisation in clinical orthopedagogy (in Germany: *Klinische Heilpädagogik*, only at University of Freiburg). There is no distinct profession of orthopedagogist in England, where their function is undertaken by a range of specialist practitioners including paediatricians, child psychiatrists, clinical child psychologists and child psychotherapists.

5.2.2 *Work settings*

Table 4 gives an overview of typical work settings for clinical psychologists, clinical orthopedagogists, psychotherapists and other mental health care professionals, for each of the countries. A distinction is made between the professions or functions active in **GP setting** and those at work elsewhere, i.e. in specialised settings. **Specialised care settings** are here defined as settings providing care outside the GP practice, dedicated to mental health care. They mainly consist of one or a combination of the following:

- Specialised mental health professionals working in private practice and on ambulatory basis, who are self-employed and treat persons who may or may not be referred by another health care professional. A private practice can be either a solo or group practice and either a mono- or multidisciplinary practice.

- Community mental health care services, providing a comprehensive range of mental health services on ambulatory basis (E.g. 'CGGCSM' in Belgium; Mental Health Teams in the UK; 'Instelling voor Ambulante Geestelijke Gezondheidszorg' in the Netherlands, etc.) In England, mental health NHS Trusts also provide specialist psychological therapy services in secondary care, distinct from community teams.

Table 4 only shows the work settings where the interventions of the concerned professional are covered by statutory insurance.

- Private practices for psychologists and psychotherapists exist in all countries (regardless of whether the profession is regulated or not). However their practice is not in all cases reimbursed. In the UK, for instance, psychologists and psychotherapists can work in private practices, but they only have the possibility to do so outside the NHS, although the NHS may purchase some services from the private and not-for-profit sector. When they want to deliver covered services as part of the NHS, they need to join either a GP practice or a multidisciplinary community mental health team. In Belgium, psychologists, psychotherapists and orthopedagogists may collaborate with a psychiatrist in a group practice, however, their interventions are not reimbursed, in contrast to the interventions of the psychiatrist.
- Hospitals, providing inpatient services.

Table 4 – Work settings according to the type of mental health practitioner (except for physicians)

	Clinical psychologist	Psychotherapist	Orthopedagogist	Other
GP practice	• B[r] • UK	• B[s] • UK		• NL: e.g. GP's mental healthcare practice assistant • UK: e.g. Primary care graduate mental health worker, IAPT worker
Psychiatrist practice	• B[t] • NL	• B[u] • DE • CH	• B[v] • NL	
Private practice (other than GP or psychiatrist practice)	• B • NL • CH • DK • UK	• B • NL • DE • DK • UK	• B[w] • NL • DE	
Community mental healthcare services	• B • NL • UK • DK • CH	• B • UK • DE • CH	• B • NL • DE	
Hospitals	• All countries	• B • NL • UK • DE • CH	• B • NL • DE	

B: Belgium - UK: United Kingdom (NHS England) – DE: Germany – NL: The Netherlands – DK – Denmark – CH: Switzerland

r in 'wijkgezondheidscentra'-'maisons médicales' and Flemish pilot projects

s http://websites.mijndokter.be/demeiklok/rob-loosveldt-psychotherapie-jongeren-en-volwassenen/

t http://www.anthe.be/medewerkers_robben.html

u http://www.sibling.be/OverOns.html

v http://groepspraktijkequisano.be/nl/ms/ms/psychologiepsychotherapie-schilde-2970/ms-1000012665-p-5/

w http://www.de-kiezel.be/

The following observations can be made based on Table 4:

- In some countries (the Netherlands, England), GP practices are, always or sometimes, strengthened by a mental health care professional (psychologist, psychotherapists or other). This is also the case for the 'wijkgezondheidscentra'-'maisons médicales' in Belgium and the pilot projects in Flanders on the first-line psychology function (FLPF).
- In some countries, psychiatrist practices are strengthened by a mental health care professional. Mainly two systems exist.
  - A hierarchical system (as in Switzerland) where only the psychiatrist is allowed to bill statutory insurance fees, however, (s)he can delegate work to employed psychotherapists
  - A non-hierarchical system (as in Germany) where multiple professionals collaborate in a multidisciplinary group practice, with each of the professionals eligible for coverage.
- Community mental health care services and hospitals generally employ a variety of practitioners.

5.2.3 *Education of the mental health practitioners*

In this section we zoom in on the education required to perform psychotherapy and psychological interventions or to collaborate with a GP or psychiatrist as a mental health care professional. As in all countries examined the practice of psychiatry is restricted to specialised physicians, we do not elaborate on the education for psychiatry.

5.2.3.1 *Access to the practice of psychotherapy (profession or function)*

Education level and training required to be authorised to practice psychotherapy differ from country to country and from one main degree to another.

Table 5 presents the training required to practice psychotherapy for the countries where this profession is regulated, regardless of whether the practice is reimbursed or not. (Reimbursement will be discussed later.)

Table 5 – Training required per main degree to be authorised to practice psychotherapy in countries where psychotherapy is regulated

Main degree	Belgium *	The Netherlands	Germany	Switzerland
Physicians	GP and psychiatry education (No extra training required)	GP and psychiatry education (No extra training required)	Psychiatry, psychosomatic specialist and any other specialist education $ + psychotherapy training	Psychiatry education + psychotherapy training
Psychologists	Master in psychology + psychotherapy training	Master in psychology + psychotherapy training	Master in psychology + psychotherapy training	Master in psychology + post-graduate in psychotherapy
Other	Bachelor in mental healthcare, psychology, pedagogics or social sciences + psychotherapy training	Master in pedagogics or mental healthcare + psychotherapy training	Master in education or social science # + psychotherapy training	N.A.

** According to the law of 4th April 2014 (not yet implemented)*
$ A specialist other than psychiatrist and psychosomatic specialist, who followed psychotherapy training, gets the title of "Fachgebundene ärztliche Psychotherapeuten"
 # Master in education or social science only gives access to 'child and youth psychotherapy'

Table 6 – Training 'required' to practice psychotherapy in countries where psychotherapy is not regulated

UK (England)	Denmark
NHS education requirements: • GP or psychiatry education with post-qualification training in psychotherapy. • Professional Doctorate in clinical psychology + training in psychotherapy • Professional Doctorate or equivalent in Counselling Psychology • Psychotherapist or counsellor training to standard recognised by accrediting body (UKCP, BACP or other register) • Social worker, mental health nurse, other mental health professional education + training in psychotherapy	No education requirements

Psychotherapy: an interdisciplinary treatment with variation in educational levels

In all analysed countries (see Table 5) where psychotherapy is regulated, the practice of psychotherapy is open to more than one profession:

- In Switzerland, the profession of psychotherapy and the training for it, is only accessible to physicians and psychologists.
- In Belgium, the Netherlands and Germany, other entry points exist besides the ones for physicians and psychologists, e.g. for masters in orthopedagogy.

Note that in the Netherlands and in England, and in the treatment of mild problems only, psychotherapy is also provided by mental health workers working in GP setting, although they do not necessarily fulfil the legal requirements for the title of psychotherapist.

Only in few countries physicians require psychotherapy training

In all countries where psychotherapy is regulated, psychologists require extra training to practice psychotherapy. This is not always the case however for physicians. Germany and Switzerland are the only countries where physicians (GPs and/or psychiatrists) also require extra training to practice psychotherapy. In all of the countries, however, GPs do not generally provide psychotherapy treatment because of time restrictions. It is furthermore often criticised, whether the general training, especially for GPs, is sufficient to guarantee - or to optimally support - the quality of their psycho-therapeutic interventions.

NHS England provides the broadest access to the practice of psychotherapy

When there is no regulation on the title, everybody is allowed to provide psychotherapy. However psychotherapists employed by the NHS England usually also need to meet certain requirements in terms of background and education: social workers, mental health nurses and any other mental health professional are eligible for employment at NHS but usually must have followed additional training in psychotherapy (see Table 6). A variation in educational level favours a broad inflow for psychotherapists, especially in primary care.

5.2.3.2 *Access to the title of psychologist in the mental healthcare sector*

In Table 7 we compare the education required to access the title of psychologist in the mental health care sector. Mainly two regulation approaches can be observed:

- In Belgium, Germany and Switzerland, a master degree in psychology is sufficient to access the regulated title of (clinical) psychologist. This

implies that there is no regulated title (and accordingly regulated education path) for a specialised psychologist in these countries.

- In Denmark, regulation exists for both a generalist psychologist (for which a master degree is sufficient) and a specialist psychologist (for which a master degree must be followed by extra training). In the Netherlands, regulation only exists for the specialist psychologist titles which require extra training after a master degree. A generalist psychologist training does not give access to a regulated mental health care profession in the Netherlands.
- In England, regulation exists for seven specialisms within psychology, all subsumed under the protected titles 'Practitioner Psychologist' or 'Registered Psychologist'. In the mental healthcare sector, the most common regulated title is 'clinical psychologist' which requires a Professional Doctorate in Clinical Psychology (DClinPsych). Forensic and health psychologists require a Masters Degree (with the award of the British Psychological Society qualification in the specialism, (or equivalent).

Note that regulation of the title does not necessarily imply regulation of the practice, as is e.g. the case for psychologists in Germany.

Table 7 – Access to the regulated titles of psychologists in the mental healthcare sector in six countries (independent of whether their interventions are reimbursed or not)

Belgium	The Netherlands	UK (England)	Germany	Denmark	Switzerland
• 'Clinical psychologist' ® Master degree of 5 years in psychology • 'Clinical orthopedagogists' ® Master degree in orthopedagogics and additional psychotherapy training	• 'Healthcare psychologist' ® Master degree of 4 years in o psychology, o health sciences, o orthopedagogics + 2 years full-time training • 'Clinical psychologist' ® • 'Clinical neuropsychologist' ® Healthcare psychologist training + 4 years training (consisting of: o +/- 25 course days per year o + 3 days per week supervised practice)	• 'Practitioner *Psychologist'* ® Masters degree + award of British Psychological Society specialist qualification *or* Professional Doctorate in psychology • 'Clinical psychologist' ® Professional Doctorate in clinical psychology (equivalent to three postgraduate years supervised practice and training)	• 'Licensed psychologist'® Master degree in psychology	• 'Psychologist' ® Master degree of 5 years in psychology • Licensed or public authorization 'Psychologist ® Psychologist + 2 years of clinical practice including 160 hrs of supervision (→ public authorisation) +3 years of full-time work (within 8 years) and 240 hrs supervision in the speciality + 40 hrs personal development work	• 'Psychologist' ® Master degree of 5 years in psychology

® Recognized by Law

5.2.3.3 *Access to the professions or functions in mental health working in collaboration with a physician*

Table 8 shows the education required for the mental health care practitioners collaborating with a physician (with a GP for Belgium, the Netherlands and England; with a psychiatrist for Switzerland). In the Flemish pilot projects on first line psychology in Belgium, the professionals allowed to collaborate with a GP are clinical psychologists and clinical orthopedagogists. The Netherlands and England have broader access to the functions collaborating with GPs. In Switzerland, only recognised psychotherapists are allowed to work with a psychiatrist as delegated psychotherapists.

Table 8 – Education of the mental health care practitioners who work in collaboration with a physician (GP or psychiatrist)

Belgium	the Netherlands	UK (England)	Switzerland
Collaboration with a GP			**Collaborating with a psychiatrist**
First line psychologists (E.g. in 'wijkgezondheidscentra'-'maisons médicales' or Flemish pilot projects): • clinical psychologist	***GP's mental healthcare practice assistant:*** • social-psychiatric nurse • nurse with mental healthcare experience • social worker etc. • + specific training	***Primary care graduate mental health workers:*** • nurse • social worker • psychologist • + specific training • High intensity therapists: • registered qualification in nursing, clinical psychology, social work, occupational therapy or a psychological therapy; • graduate primary care mental health worker + High Intensity CBT course (2 days a week at university + 3 days supervised practice over 1 year) ***Psychological wellbeing practitioners (PWP)*** • graduate (not necessarily in psychology) • those who can demonstrate that they can perform academically and people from local communities, with a wide range of life experience. Experience of working with people with mental health problems is essential. + training of 1 day per week academic work and 4 days supervised practice over a 9 month period, totalling 45 days' training	***Psychologist psychotherapist delegated by psychiatrist:*** • Psychologist satisfying the Swiss charter for psychotherapy and/or professional associations (+ cantonal legal provisions)

5.2.4 *Roles of the mental healthcare practitioners*

Although we could elaborate much further on how the work content differs for each of the mental health care professions through the different countries, we focus in this section on the diagnostic function. The diagnostic role is of special interest as it is linked to the access scheme of a country (direct access versus referral), which will be discussed further Germany has the most restrictive policy in terms of diagnosis: only physician psychotherapists and psychotherapists actually are allowed to make the diagnosis, which is consequently sent to the statutory insurance to get reimbursement.

In the countries working along the stepped care principles (i.e. the Netherlands and England, see further), a diagnosis is made at the different layers. In the Netherlands, a first diagnosis must be made at the GP practice in order to decide on whether the person must be referred to mental health care (be it primary, secondary or tertiary) or not. If the person is referred to mental health care, a new diagnosis is consequently made by the responsible treatment professional who is in charge of the coordination of care for a specific patient.

5.3 Patient's access to reimbursed clinical psychology, psychotherapy and clinical orthopedagogy interventions

5.3.1 *Conditions for reimbursement*

Table 10 shows a summary of the conditions for reimbursement of psychotherapy and/or psychological interventions in terms of providers, access (upon referral or direct access) to reimbursed treatment by those providers, patient indications and treatment types. In the subsequent sections, each of these aspects will be looked at in more detail.

Table 9 – Which professions are allowed to make a psycho-diagnosis?

Belgium	The Netherlands	UK (England)	Germany	Denmark	Switzerland
• GP • Psychiatrist • Clinical psychologist	• Primary care GP, mental healthcare practice assistant, mental health nurse, social worker • Primary/secondary/tertiary mental health care: Responsible treatment professional ("hoofdbehandelaar"), who can be: o Psychiatrist o Clinical (neuro)psychologist, o Psychotherapist, o Healthcare psychologist, o Specialist/clinical geriatrist, o Addiction physician o Mental health care nurse specialist o Clinical orthopedagogists	• Primary care: GP, clinical psychologist, practice nurse, primary care graduate mental health care worker, etc. • Specialised mental health care: Any specialised mental health care profession	• Any of the regulated professions allowed to practice psychotherapy: o Physician psychotherapist o Psychotherapist o Child and youth psychotherapist	• GP • Psychiatrist • Psychologist	• GP • Psychiatrist • Clinical psychologist • Psychotherapist

Table 10 – Summary of the conditions for reimbursement for psychotherapy per country

	Belgium	The Netherlands	UK (England)	Germany	Denmark	Switzerland
Health care providers for which treatment is reimbursed (outside GP practice)	• Psychiatrist	• Psychiatrist • Health care psychologist • Clinical psychologist and clinical neuropsychologist • Psychotherapist • Other professionals (such as social workers, nurses, …) may also be involved in ambulatory mental healthcare, however, these are not allowed to contract directly with insurers	• Clinical psychologist • Counselling psychologist • Health psychologist • Forensic psychologist • Primary care graduate mental health worker • Primary care counsellor • Psychological wellbeing practitioner • High intensity therapist • Assistant clinical psychologist • Psychotherapist • Counsellor	• Physician psychotherapist • Psychotherapist • Child and youth psychotherapist	• Psychiatrist • Psychologist	• Psychiatrist • Delegate psychotherapist in medical practice • Delegate psychotherapist in a hospital psychiatry
Access to specialised mental health care (outside GP practice)	• Direct access to psychiatrist	• Referral by • GP • occupational physician	• Depends on service: GP referral not mandatory for all services	• No GP referral required at start • Medical report by GP mandatory after probationary sessions	Referral by GP	Referral by GP / psychiatrist
List of indications	No	Yes	Yes	Yes	No for psychiatrists Yes for psychologists	Yes
List of treatments	No	Yes	Yes	Yes	No	No
Limitation on the number of reimbursed sessions	No	Yes	Yes	Yes	No for psychiatrists (with acceptance of the GP) Yes for psychologists	Yes

* *The job description doesn't include psychotherapy as such*

5.3.2 *Direct access versus referral systems*

In this section we focus on the access to reimbursed services. Indeed, in all countries persons have direct access to non-reimbursed psychological and psychotherapy interventions.

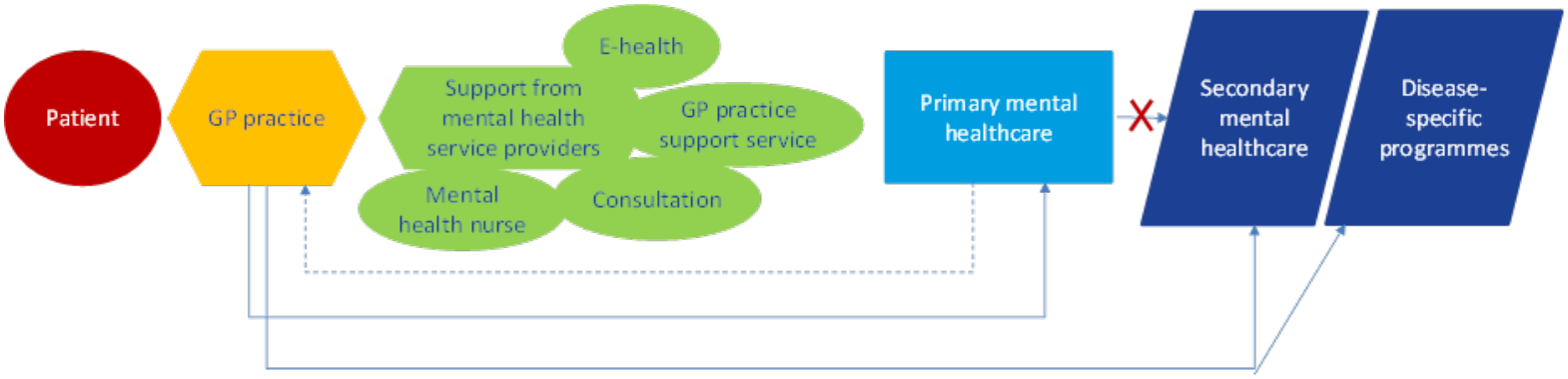
Gatekeeping systems

In several systems, such as the Netherlands, the UK and Denmark, primary care doctors and their practice are the cornerstone of diagnosis, treatment and specialist referral for mental health problems. In these countries, GPs have a strong gatekeeping role in general (see Table 10).

Figure 3 illustrates the central role of the GP practice in the Dutch care model.

It is remarkable however that the NHS England recently opened up access to some specialist mental health care services to self-referrers. As there was a concern that the need for referral impeded access to some members of the community, the pilot sites for the IAPT programme also accepted self-referrals as an experiment to test whether the possibility of self-referral increased access to people with mental health problems who would not otherwise have access to services. One of the two pilot sites successfully implemented this, showing that self-referral gave greater access to services for ethnic minorities, and finding qualitative evidence of greater self-confidence and hope of recovery in the self-referred group[60]. Comparisons of self-referred and GP-referred persons in one of the pilots indicated that the self-referrers had similarly high scores on the diagnostic questionnaires (PHQ-9 and GAD-7) as the GP-referred, but tended (non-significantly) to have had their problem longer. Furthermore, self-referrers appeared to more accurately track the ethnic mix of the community (minorities were underrepresented among GP referrals) and had higher rates of posttraumatic stress disorder (PTSD) and social phobia, two conditions that traditionally tend to be under recognised. These findings led the government to include self-referral in the roll-out of the IAPT programme[61]. Nevertheless, persons are given the advice to, when possible, and unless they have a specific reason not to, to discuss it with their GP first.[62]

Figure 3 – Organization of the new model of care and care pathway in the Netherlands



Source: based on Forti 2014[63] and website "Invoering Generalistische Basis GGZ"

Gatekeeping brings a number of advantages

- In general, the following advantages are pointed out for a gatekeeping system:
- The GP's practice is easily accessible, close to home and a visit to the GP may be less stigmatising than a visit to a mental health care specialist. The barriers to help-seeking and acceptance of treatment in this setting may be considerably lower.
- In most systems, the majority of people report at least one primary care visit per year. This means that the GP maintains a more or less stable and enduring relationship with their patients. On this basis, the GP may develop a deeper understanding of the development of both somatic and mental comorbidities and of the psychosocial context in which a person's distress and illnesses occur (e.g. interpersonal and family crises, occupational problems, and financial difficulties).
- The accumulating knowledge in clinical psychology and psychotherapy has resulted in various treatment options, and many of these can be applied in primary care.[64]

There are also societal advantages linked to a gatekeeping system. Mental health problems are of high prevalence.[64] A selection process before a person is referred to specialist services is a tool to help restrain health care costs, on one hand, and to reduce waiting lists for specialist services, on the other hand. The argument that the filtering role of the GP effectively reduces costs, relies on the assumption that, in a system of self-referral, some patients misdiagnose themselves and search for specialised help too quickly.

GPs are often criticised for lacking specific competences

Compared to primary care providers, specialised workers are at advantage over general practitioners in terms of qualification and training in state of the art therapy.[64] The introduction of the GP's mental health care practice assistant in the Netherlands was not unanimously welcomed by all psychologists, who argued that the specialised processes of diagnostics and assessment of the indication, was left to a cheaper and less-well trained professional.[65]

In some GP-referral systems GPs are supported by other professionals or e-mental health programmes

GPs generally work under time pressure, often leaving *limited time per patient contact. To cope with this, the Netherlands and the UK developed a 'collaborative model', an approach where nurses, social workers and psychologists work together within the primary care setting as facilitators taking over some of the tasks of screening, monitoring, counselling and patient education.*[64]

3 collaborative modalities are offered to Dutch GPs to support them in their tasks for mental health care:

- the assistance of a mental health worker,
- the support of e-mental health programmes (see further), and
- consultation of a psychiatrist, psychologist or psychotherapist.[66]

Guidelines for GPs

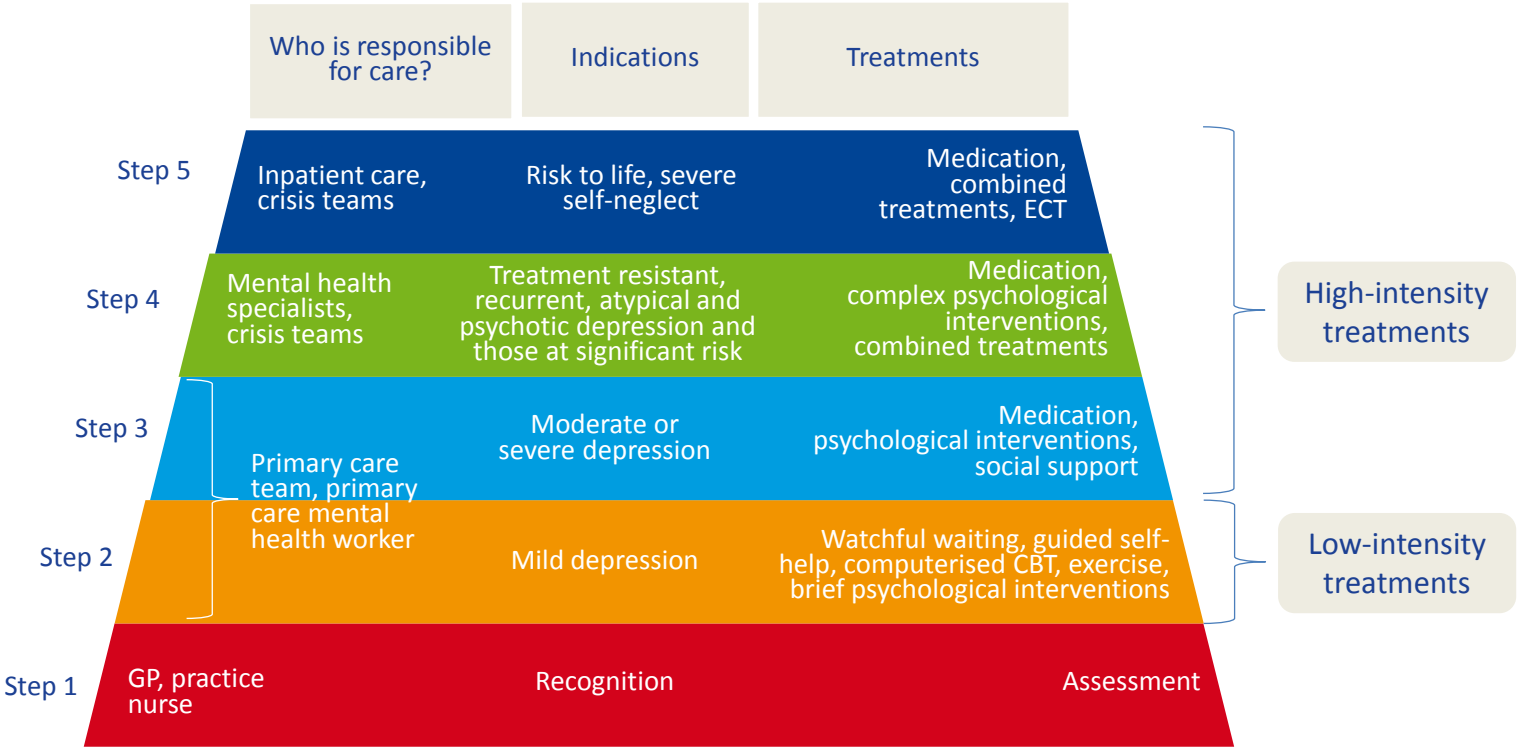
In the Netherlands e.g., the Dutch College of General Practitioners (NHG) and Trimbos Institute (a centre of expertise on mental health and addiction) developed guidelines for the treatment of several mental illnesses, such as anxiety and depression. Furthermore, the network "Kwaliteitsontwikkeling GGz" is currently developing standards of care for specific mental illnesses.

The principles of 'stepped care' and 'matched care'

Referral schemes are available for the Netherlands and the UK. Both systems follow the principles of stepped and matched care.

- **Stepped care** means that persons are in the first instance treated at the lowest appropriate service level, only stepping up to more intensive or specialist services as clinically required, and with the ability to step down to less intensive care as part of a recovery pathway.[67]
- **Figure 4** shows an illustration of the stepped-care principle developed by NICE (National Institute for Health and Care Excellence) for the treatment of persons diagnosed with depression. An essential feature of stepped care is that it is self-correcting as it implies a scheduled review to detect and act on non-improvement for the person with mental problems. Stepped care is found to be efficient, cost effective and reduce the waiting lists (Meeuwissen & Van Weeghel, 2003)[68].
- **Matched care** means that a person with a clear disorder is directly referred to the right care services without a delay taking place in treatment. In this case, the GP will directly refer the person and not start a low-level treatment first.

Figure 4 – Stepped-care model developed by NICE



Source: based on Derbyshire Healthcare NHS Foundation Trust67, 69

Stepped care requires close collaboration between mental healthcare professionals

- Stepped care is increasingly seen as an appropriate model for efficient provision of needs-based mental health care services.[70] Still, a study in the Netherlands that evaluated the implementation of the stepped care principle in primary care, found a number of gaps between routine primary care and optimal care (as formulated in the guidelines) for depression:
  - GPs relied on their clinical judgment and rarely used instruments to assess and monitor the severity of depressive symptoms.
  - Structured, evidence based interventions such as self-management and e-health were rarely offered to patients with depressive symptoms.
  - Specific psychological interventions for relapse prevention or for chronically depressed patients were not available.

The study also put forward a range of influencing factors for the provision of optimal depression care. Close collaboration with other mental health care professionals was considered an important factor for improvement by nearly all GPs.[71]

Self-management essential in all levels of stepped care

Stepped care also increases standards of self-management. Supporting the individual's role in self-management is considered important at all levels of stepped care: the person with problems is an integral part of the team.

5.3.2.1 *Direct access systems*

Other systems, such as in Germany, provide direct access to mental health care specialists but with an intervention of the GP at a later phase. In Germany, persons can go directly to a psychiatrist or psychotherapist. A medical report by the GP, however, is required to have one's treatment approved for reimbursement, after the first probationary psychotherapy sessions have taken place. So, a medical evaluation by a GP appears a mandatory step not only in gatekeeping but also in self-referral systems.

5.3.2.2 *Mixed systems*

In Switzerland patients have direct access to a psychiatrist-psychotherapist but need to be referred by a GP or a psychiatrist to be reimbursed for a treatment by a psychologist-psychotherapist.

5.3.3 *Reimbursed indications for psychological and psychotherapy interventions in ambulatory settings*

Table 11 gives an overview of the indications covered by the statutory insurance for each of the countries analysed.

Table 11 – Indications for psychological and psycho therapeutic interventions covered by health insurance per country in ambulatory setting

The Netherlands	UK (England)	Germany	Denmark	Switzerland
Included DSM IV/V disorders, except for • adjustment disorders such as burn-out • learning behaviours, such as dyslexia (are covered but not as mental health care) • work or relationship related problems **Excluded** • psychosocial help • psychological help related to somatic illness (is covered as specialist somatic care)	**Included** No restrictive list of indications or threshold levels. NICE developed guidelines for • depression • generalised anxiety disorder • panic disorder (with or without agoraphobia) • obsessive-compulsive disorder (OCD) • post-traumatic stress disorder (PTSD) • social anxiety disorder • alcohol-use disorder • depression in adults with a chronic physical health problem • ante and postnatal mental health • borderline personality disorder • anti-social personality disorder • self-injury **Excluded** No exclusion list	**Included** Mental illness appearing in the ICD-10 list **Excluded** No exclusion list	**Included** Restrictive list for treatment by psychologist: • invalidating disease • tried to commit suicide • minor or moderate depression • anxiety including minor or moderate OCD , only persons between 18 and 38 years • victims from: • robbery, violence and rape • traffic accidents and other severe accidents • incest or other sexual assaults before age of 18 • relatives • to someone with a severe mental disease • to persons hit by an invalidating disease • after a death (of beloved one) • women who have had a provoked abortion after 12th gestational week **Excluded** • No exclusion list	**Included** ICD-10 mental disorders and behaviour disorders categories **Excluded** • self-discovery • self-realization • personality development

5.3.3.1 *DSM and ICD classifications are commonly used*

The Netherlands, Germany and Switzerland use a standardised diagnostic list to define the indications eligible for reimbursement: either the DSM IV/V (Diagnostic and Statistical Manual of Mental Disorder, 4th/5th edition)[72] - published by the American Psychiatric Association – or the ICD-10 (International Statistical Classification of Diseases and Related Health Problems, 10th revision) - produced by the WHO[73].

England has no restrictive list, but NICE developed guidelines for a list of common mental healthcare problems. Denmark has a different approach, basing the criteria on not only a medical indication (such as depression), but also on the cause of the mental 'dysfunction' (such as robbery). Furthermore Denmark is the only country limiting the patient's age in a number of indications.

5.3.3.2 *Psychic complaints versus psychic illness*

In its policy orientations, the Dutch CVZ previously distinguished between psychic 'complaints' and psychic 'illness'. Psychic illness was defined on the basis of DSM IV disorders (with some exceptions – see Table 11). Persons with psychic complaints rather than disorders, as for instance complaints related to marital problems or overwork, can go to their GP, but are not indicated for primary or specialised mental health care.[74] As the distinction between complaints and illness however led to opposition from the care professionals, the CVZ has abandoned this distinction. The essence however remains that the GP only refers to mental health care in case of a suspected psychic disorder as listed in DSM-IV/V.

5.3.3.3 *Mental health problems are often multi-layered*

In the Netherlands, a number of indications, such as burn-out and relationship related problems are excluded from the eligible indications as listed in the DSM list. These exclusions have been made as these are legally excluded by the Minister from the insurance package (under "Regeling zorgverzekering", article 2.1, h and i). The exclusions however have been criticised on many aspects. According to some professionals, clearly distinguishing between covered and non-covered problems is often difficult as mental health problems can be complex and multi-layered. For instance, depression may be masquerading as relational problems and alcohol abuse may find its origins in a non-treated post-traumatic stress disorder.[75] Unsurprisingly, data also show that since burn-out has been excluded from coverage, there has been a shift away from the indication of burn-out to other indications that are covered.[76].

5.3.4 *Reimbursed psychotherapeutic treatments*

Table 12 shows the covered types of psychotherapy per country. In every country, individual sessions, group sessions, couple or family sessions are covered by the compulsory health insurance.

Table 12 – Covered types of psychotherapy treatment per country

The Netherlands[66]	UK (England)	Germany	Belgium / Denmark / Switzerland
INCLUDED **Treatments must satisfy the legal criterion of "state of science and practice'. According to the most recent review of CVZ in 2013, these are the following:** **- can be used for multiple indications**: • CBT • Problem solving therapy • Interpersonal therapy • Short term psychodynamic psychotherapy • Motivating talking therapy • Cue-exposure treatment • Behavioural therapeutic relation therapy • Group psychotherapy • Exposure in vivo • Psychological panic management • Cognitive restructuring • System therapy **- use restricted to a single indication:** • Community reinforcement approach: addiction • Hypnotherapy: conversion disorder • Dialectic behaviour therapy: borderline personality disorder • Systems training for emotionally predictability and problem solving: personality disorder • Mentalization based therapy: borderline personality disorder • Mindfulness based cognitive behavioural therapy: recurrent depression	**Main focus at primary care and steps 1-3 of stepped care model is on CBT and low-intensity interventions, such as**: • Individual facilitated self-help • Computerised CBT • Structured physical activity • Group-based peer support (self-help) programmes • Non-directive counselling delivered at home • Self-help groups. **Besides CBT and low-intensity interventions, the following talking therapies are amongst the most frequently provided in the NHS:** • Counselling • Behavioural Activation (which can also be considered as a type of CBT) • Interpersonal Psychotherapy • Behavioural Couples Therapy • Short term psychodynamic therapies (including Psychodynamic Interpersonal Therapy and Dynamic Interpersonal Therapy) • Cognitive Analytic Therapy • Dialectical Behaviour Therapy	**Covered by SHI:** • Analytical psychotherapy (*Analytische Psychotherapie*) • Psychodynamic psychotherapy (Tiefenpsychologisch fundierte Psychotherapie) • Behavioural therapy (*Verhaltenstherapie*)	**All psychotherapy treatment types***

- Relaxation therapy: generalised anxiety disorder
- Eye movement desensitisation and reprocessing: post-traumatic stress syndrome
- E-mental health programs (e.g. 'Beating the Blues' and 'Fear Fighter')

EXCLUDED:

- Neurofeedback
- Psycho-analysis
- Gestalt therapy

**In Denmark, a work group is going to look at quality and evidence but still anything goes*

5.3.4.1 *The Netherlands and UK (England) focus on evidence-based treatments*

In order to define the treatments eligible for reimbursement, the Dutch CVZ performed a series of literature reviews in which it examined the effectiveness of a vast number of interventions for psychic problems. Based on insufficient evidence on their effectiveness, the CVZ judged that psychoanalysis, neurofeedback, deep brain stimulation and transcranial magnetic stimulation should not be part of the insured package. The CVZ furthermore concluded that prevention should be covered for persons with a high risk for depression, problematic alcohol use or panic disorder. Preventive treatment of persons with a high risk on other anxiety disorders however should not be part of the insured package, as there is insufficient evidence on its effectiveness.[74]

Also NICE performs comprehensive literature reviews to provide evidence-based guidance on the treatment of mental health problems. Initially, NICE guidelines on the treatment of depression and anxiety recommended cognitive behavioral therapy (CBT) only. Following these guidelines, the IAPT programme trained thousands of professionals in this type of therapy. More recently, however, NICE guidelines have been slightly revised in line with the evidence and currently include a few other types of talking therapy. Consequently, many IAPT services are now slightly widening their provision of therapies.[77] In practice however, other therapeutic approaches also are available and some 'evidence-based' approaches are being provided by people not adequately trained in their delivery.[78]

A similar evolution took place in Sweden, where the government restricted payment for training of professionals and treatment to cognitive behavioural methods. This restriction came under fire as the government's investment in cognitive behavioural therapy did not appear to live up to expectations and Socialstyrelsen officially decided to end the CBT monopoly.[79] Criticisers of limiting the provision to CBT therapies, furthermore argue that results of treatment may also depend on personal preferences and the match between a person's preference and the received treatment. Research has also shown that effectiveness of psychotherapies varies not only between psychotherapy modalities, but also between psychotherapists[x80-83].

[x] Glenys et al have completed a study that shows the massive variability between therapists' outcomes remains even when case mix is taken into account through sophisticated multi-level modelling. (not published yet but under review) (Glenys, 2015, Personal communication)

5.3.4.2 *Germany, Denmark and Switzerland have a less restrictive approach*

In Denmark, if a person needs psychotherapy according to the GP, there is no restriction on the type of treatment provided by the authorised psychologist. However, as the person can only have 12 sessions reimbursed, long therapies like psychoanalysis are not encouraged. Danish psychiatrists are also free to provide any kind of psychotherapy. The same holds for Belgian psychiatrists who rely on their therapeutic freedom.

5.3.4.3 *Alternatives to 1-to-1 talking therapies are being explored*

In the NHS of England, significant numbers of low intensity interventions are offered as an alternative to the classical 1-to-1 cognitive behavioural therapy talking sessions. Low intensity interventions reduce the amount of time the practitioner is in contact with the treated person. They include guided and unguided self-help programmes, supported in book or workbook format or delivered on the computer (e-mental health), or high-volume approaches such as group sessions.[84]

5.3.4.4 *Internet-delivered psychological treatments*

A review on the efficacy, safety and cost-effectiveness of internet-delivered psychological treatments for mood and anxiety disorders, was commented in the 'KCE has read for you' publication[85] on the systematic literature review performed by the Swedish Council on Health Technology Assessment (SBU).[86] This review concludes that internet-based CBT with therapist support may be considered as part of a wider range of psychological methods for several conditions and mainly for patients who are motivated to seek this form of treatment. Studies show positive results for adults with social phobia or mild to moderate major depression, and who have themselves sought this form of treatment. There is also some evidence of positive results for panic disorder and generalised anxiety disorder. Still, further research is needed as most trials compared the treatment only with waiting lists and have short follow-up periods (< 6 months).[85]

We also refer to the positive advice formulated by the Dutch CVZ on the e-mental health programme 'Beating the Blues'[87]. The CVZ advice concludes that, based on scientific literature, the effectiveness of the programme is sufficiently plausible in persons with mild to moderate depression and that the programme is accepted in the Dutch compulsory health coverage package. The programme however is not accepted in the treatment of anxiety disorders. In England, 'Beating the Blues' was the first computerised CBT programme to be authorised by NICE (2006), but subsequent guidance[88] has relaxed that requirement in the light of later evidence, and now recommends any product that meets their quality standards.

5.3.5 *Intensity of the reimbursed treatments*

Figure 5 shows the number of hour's treatment covered by compulsory health insurance in all countries analysed.

5.3.5.1 *In Germany the number of hours depends on type of psychotherapy*

The number of hours differs for behavioural versus analytic versus psychodynamic treatment. The number of hours can be extended after approval, up to two times and up to 80 hrs, 300 hrs and 100 hrs for behavioural, analytic and psychodynamic psychotherapy respectively. There is a maximum treatment frequency of three sessions per week and the allowed number of sessions is adapted for group sessions.

5.3.5.2 *In the Netherlands the number of hours depends on patient classification*

In the Netherlands, the length of the therapy covered depends on the care package. Four care packages have been defined to finance care providers: short, medium, intensive and chronic care (see Figure 6 for more details on the classification). The number of hours financed varies from five for the short package to thirteen for the chronic package. Note that these are the hours used as basis for the tariff calculations and that they are not imposed as such to the providers. Only in exceptional circumstances, persons are allowed to follow more than one care package within primary mental health care within the same year. If there is a need for more than one trajectory in a year, this rather indicates that there is a need to refer to specialised care, provided by multidisciplinary teams at integrated provider organizations that offer care both in inpatient and outpatient setting, at stand-alone community services or mental hospitals.

5.3.5.3 *NICE provides detailed guidance, not only on number of hours, but also on treatment period*

In England the number of hours covered depends on the indication. NICE provides the following guidance for low-intensity interventions:

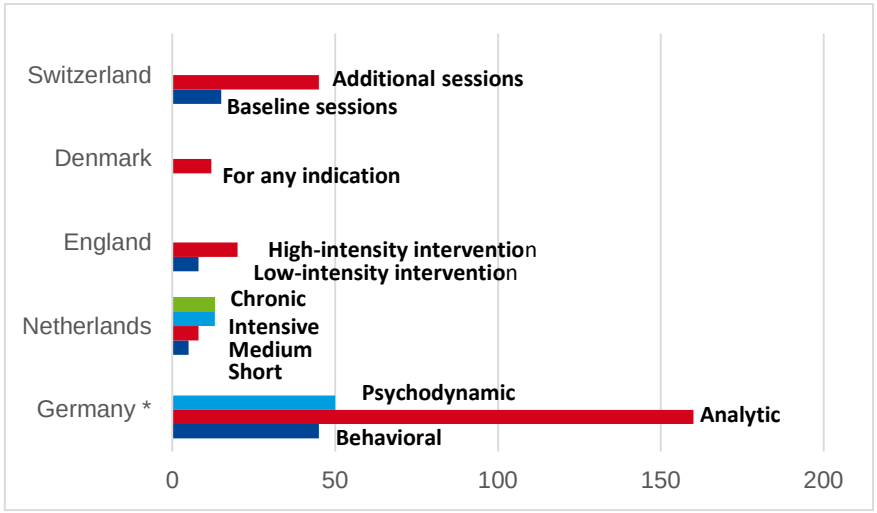
- Individual guided self-help based on the principles of CBT should consist of up to six to eight sessions (face-to-face and via telephone) normally taking place over 9 to 12 weeks, including follow-up.
- Computerised cognitive behavioural therapy (CCBT) should take place over 9 to 12 weeks, including follow-up.
- a structured group physical activity programme consists typically of three sessions per week of moderate duration (45 minutes to 1 hour) over 10 to 14 weeks.
- Group-based CBT should consist of 10 to 12 meetings of eight to ten participants.

For the high-intensity interventions, consisting of individual CBT, the duration of treatment should typically be in the range of 16 to 20 sessions over 3 to 4 months (not automatic: guidance – some patients longer, some drop out before). Providers are also recommended to consider providing two sessions per week for the first 2 to 3 weeks of treatment for people with moderate or severe depression and follow-up sessions typically consisting of three to four sessions over the following 3 to 6 months for all people with depression.

5.3.5.4 *Flat number of hours covered in Denmark and Switzerland*

In Denmark, the number of sessions is limited whatever the indication or the treatment to 12 sessions of 45-60 minutes per indication. Clients suffering from anxiety and/or depression can have another 12 sessions – thus a maximum of 24 (2 x 12) if the GP will refer once more and the client still meet the diagnostic criteria after the first 12 sessions. If both anxiety and depression one can have 2x12x2 =48 sessions, etc. Finally, in Switzerland, the sessions are limited in time, per multiple of 5 minutes. No distinction is made for type of treatment, nor for the indication. The covered duration of the sessions nevertheless depend on the configuration: individual session are reimbursed up to maximum 90 minutes; couple, family or group sessions are reimbursed up to maximum 105 minutes per person. Psychotherapists are required to submit a short report before the 10th session to a medical advisor who decides whether or not an additional 30 sessions are reimbursed. After a total of 40 sessions, a more comprehensive report is required.

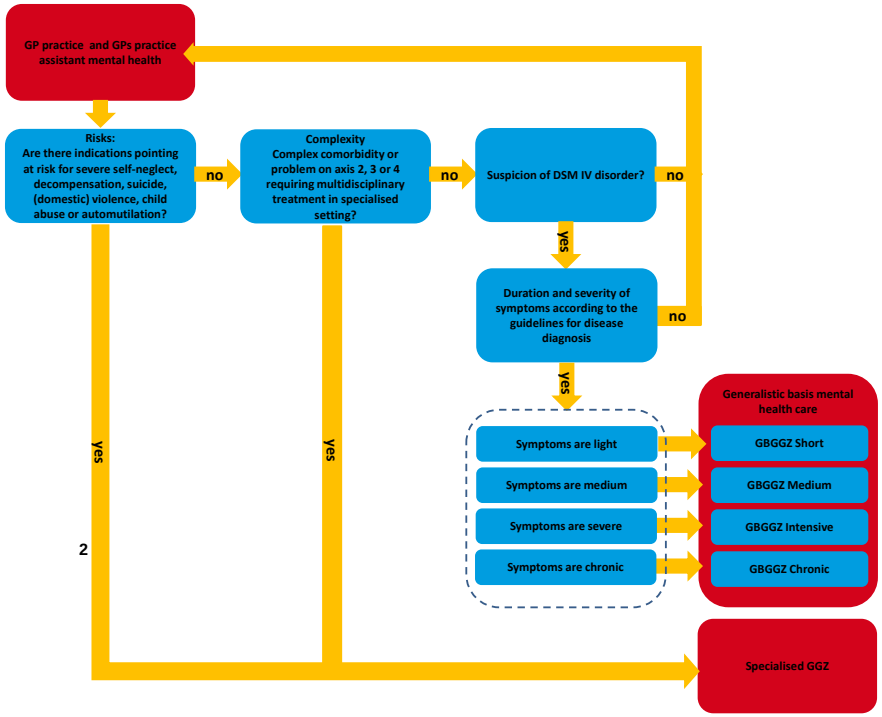
Figure 5 – Maximum number of hours/sessions for 1-to-1 treatments covered by statutory health insurance per country



* *In exceptional cases, up to two extensions are possible in Germany*

Taking this perspective, Germany appears to be the most 'generous' country in the reimbursement of psychotherapy, particularly for analytic treatments. At the opposite, the two countries mostly focusing on CBT (the Netherlands and England) and Denmark cover the least number of hours.

Figure 6 – Dutch referral and reimbursement scheme



Source: modified from Invoering Generalistische Basis GGZ[89]

5.4 Payment for mental health care services

Table 13 gives an overview of how psychological and psychotherapy services are paid for in the analysed countries, distinguishing between services provided in GP setting, other ambulatory settings and hospital settings. Remuneration of the mental health professionals (salaried versus fee-for-service) and their employment status (employee versus self-employed) are also detailed in the table as these two factors intertwine with how services are paid for. In this section we mostly focus on payment for outpatient services.

Table 13 – Payment for psychological and psychotherapy interventions

	The Netherlands	UK (England)	Germany	Switzerland
GP settings	**Payment for the service:** GP's mental health practice assistant: • 75% an increase in the subscription tariff (capitation fee) • 25% fee-for-service: o general consult o consult longer than 20 minutes o home visit o telephonic consult o e-mail consult o group consult • Remuneration of the mental health professional: Salary **Employment status:** o Employee	**Payment for the service:** • Part of GP payment : mainly capitation fee • Remuneration of the mental health professional: Salary Some fee-for-service in general practice **Employment status:** Employee	Not applicable	Not applicable
Other ambulatory settings	**Payment for the service:** Primary mental health treatments: DBC payments for 4 care intensity trajectories: • Short • Medium • Intensive • Chronic	**Payment for the service:** • IAPT programme: • aim to switch to outcome payment **Other services:** • activity-based payment **Remuneration of the professional:** • Salary **Employment status:** • Employee	**Ambulatory psychotherapists' practices:** **Payment for the service:** Capped fee-for-service basis, with a payment ceiling set for each professional and adjusted for his or her • specialisation • number of cases the professional treated • patient age **Remuneration of professional:** • Fee-for-service **Employment status:** • Self-employed	**Ambulatory psychiatry practices:** **Payment for the service:** Fee-for-service (TARMED), with different fees for: • Psychiatrists-psychotherapists services • Delegated psychotherapists services • Psychiatric outpatient and non-medical services in recognised institutions or hospital recognised divisions **Remuneration of the professional:** • Psychiatrist: fee-for-service • Delegated psychotherapist: salary **Employment status:** • Psychiatrist: self-employed • Delegated psychotherapist: employee

	The Netherlands	UK (England)	Germany	Switzerland
Secondary and tertiary mental health (hospitals)	**Payment for services:** • 140 DBCs for treatment • 7 DBCs for accommodation **Remuneration of professional:** • Part salaried (mostly at university hospitals) • Part fee-for-service **Employment status:** • Part employee • Part self-employed	**Payment for services:** • Payment for mental health clusters **Remuneration of professional:** Salaried **Employment status:** Employee	**Payment for services:** • Since recently G-DRG based • However, still a per diem payment **Remuneration of professional:** • Salaried **Employment status:** • Employee	**Payment for services:** • DRG-based payment for inpatient services • Fee-for-service for outpatient services in hospital **Remuneration of professional:** • Salaried + large part of outpatient fees **Employment status:** • Employee

5.4.1 *Payment of mental health services in GP setting*

5.4.1.1 *Mental health services in GP setting in the Netherlands and England are paid by capitation fees*

In the UK (England), health services in GP setting are mainly covered by a weighted capitation fee. GP practices are entitled to a global sum, which is practice based, as it is a payment to the practice rather than to individual GPs. The bulk of this sum is determined by an allocation formula, the Carr-Hill formula, which reflects care needs based on the number of people registered at the practice and the age-sex mix of the patients, as well as factors related to the health status of the population.

In the Netherlands, mental health services provided by the GP's practice assistant are paid for by a combination of a capitation fee and a fee-for-service. Both in England and the Netherlands, mental health care workers at work in GP setting are mostly employees and remunerated on salary basis.

According to KCE report 85[90], mainly 3 systems can be distinguished to pay for primary care:

- Capitation payment: a payment per patient, adjusted for its risk characteristics, paid periodically and independent of the number of contacts and time spent with the patient
- Fee-for-service system: a payment per consultation or intervention
- A fixed payment system: a salary for the health care workers.

Review of the literature led to the following conclusions:

- In case of a capitation fee, there is a risk for quicker transferral to secondary care and increased prescription of drugs.
- A capitation fee system leads to better care quality in terms of coordination, continuity and accessibility.
- Global expenditures are more manageable in a capitation fee system.
- An inappropriate tariff setting may lead to risk selection in a capitation fee system.[90]

Furthermore, KCE report 170[22] pointed to the fact that a fee-for-service system may compromise a multidisciplinary approach. Capitation, on the other hand, may lead to under-provision of services. In order to help narrowing gaps in care provided by multiple providers, integrated financing of care may be desirable, however, only few successful example models exist.

5.4.2 *Payment of mental health care workers in other ambulatory settings*

5.4.2.1 *Germany and Switzerland pay ambulatory consultations on fee-for-service basis*

In Germany, a large part of physician-psychotherapists and other psychotherapists have their own practice. Different codes exist for diagnosis, child and youth therapy sessions, short and long treatment sessions, individual versus small group versus large group sessions, psychometric tests, and etc.

In Switzerland a tariff matrix applies with fees differentiated by provider and provider setting on one hand (psychiatrist, delegated psychotherapist, outpatient services in hospital psychiatry, outpatient services in recognised institution or hospital division), and by intervention on the other hand. Not all interventions can be billed by all providers or in all settings. Fees exist for the following interventions:

- Diagnosis and treatment, individual session
- Individual therapy, 1st session (exclusive for psychiatrists)
- Individual therapy, every next session (exclusive for psychiatrists)
- Couple session
- Family session
- Group session
- Phone consultation
- Service in the absence of the patient
- Psychiatric crisis intervention
- Comment of psychological and psychiatric test by the specialist (exclusive for psychiatrists)

5.4.2.2 *The Netherlands pays outpatient mental healthcare by DRG-like system*

The Netherlands pay outpatient health care providers according to a DBC ("Diagnose-Behandel-Combinatie") classification which classifies patients into four categories according to whether they require a short, medium, intensive or chronic treatment. Health care providers who contract with insurers get paid for the services provided based on the patient mix, regardless of the actual services provided or actual costs incurred. In the past, several countries introduced a DRG-based payment, primarily for hospital services. Governments communicated several reasons for making the shift to this payment system, the main ones being to increase efficiency, to enhance transparency and fairness of payments and to improve quality.

However, as with any other payment system, DRG-based payments can also lead to unintended effects, such as increased patient volume for unnecessary care, cream-skimming and dumping of patients (to select the most profitable patients) and up-coding (categorising the patient as a more severe patient than actually is the case). For further reflections on the intended and unintended consequences of DRG-based payments, we refer to KCE report 207.[91]

5.4.2.3 *The IAPT programme shifts to results-based payment*

Concrete plans exist to shift the payment of the IAPT programme in England from block and cost-volume contracts towards an outcome based payment. Five separate outcome domains were selected for the pilot phase testing the outcome based payment:

- Equity of Access Outcomes (15%)
- Clinical Outcomes (50%)
- Work & Social Adjustment Outcomes (10%)
- Employment Outcomes (10%)
- Patient Satisfaction & Choice Outcomes (15%)

The Equity of Access domain is measured at a service level for all the patients discharged each month and broken down into five measures:

- Was the number of BME (black and minority ethnic) patients discharged at least 80% of the expected number? (Given the local prevalence of depression & anxiety in BME people and the proportion of BME people in the local population)
- Was the number of patients, who are aged 65 or over, discharged at least 80% of the expected number? (Given the local prevalence of depression & anxiety in people aged 65 and over and the proportion of people aged 65 and over in the local population)
- Was the number of people discharged who had referred themselves at least 10% of all the discharges?
- Did at least 80% of the people discharged start their treatment within 28 calendar days of their referral?
- Was the number of people treated for a specific anxiety at least 15% of those treated for all anxieties (including general anxiety)?

The Clinical Outcomes are based on comparison of first and last scores on the clinical scale for measuring symptoms for each patient. Payment takes only place if the amount of improvement exceeds the minimum that would be considered *statistically reliable*. If the change in scores exceeds this amount, the size of the payment will be adapted depending on how far the person has moved towards recovery. Different measures are used depending on disorder (depression: PHQ-9, generalised anxiety disorder: GAD-7, etc.)

The Work and Adjustment Scale Outcomes measure reduced disability and improved wellbeing of persons treated. The scale consists of 5 questions. As with symptom change, change on the scale only triggers a payment if it is sufficiently large to be statistically reliable.

Employment Outcomes measure the number of persons who moved into employment and off of sickness benefits.

Finally, the patient satisfaction & choice outcomes are split between satisfaction (11.25%) and choice (3.75%).

5.4.3 *Payment of mental health workers in secondary and tertiary settings*

5.4.3.1 *Predominantly DRG-based payments for secondary and tertiary care*

In the Netherlands, England and Germany, payment for inpatient mental health care services is based on diagnosis-related groups (DRGs) or DRG-like classifications. In the Netherlands, 140 groups have been defined for mental health care. In England, 21 mental health care clusters have been defined. Germany shifted towards DRG-based payment for mental health care, although the payment remains a per diem payment.

Switzerland also plans to shift to a case-based payment in function of diagnosis and severity (normal and intensive treatment) and in function of the length of treatment. The introduction of this new payment for inpatient mental health services is planned for 2018.

As payment for inpatient mental health services are not the primary focus of the current report, we do not further elaborate on this.

5.5 Quality management

As already stated in the introduction, the topic of quality has been touched upon in several of the previous sections. We found many countries supporting the quality of training and practice of professionals through regulations on the professions. We saw the example of England and Germany, where national practice guidelines are developed and spread. And to give another example, the IAPT programme in England is shifted towards results-based payments, as a way to maximally enhance quality of provided services. Note that the English health policy is however still evolving: The English Department of Health policy unit has commissioned work on mental health related quality of life measurement as a more appropriate outcome, since current clinical outcome measures does not seem to capture what mental health patients report as important to their recovery of quality of life and wellbeing. In this section, we zoom in on yet another aspect of quality management, the measurement of outcomes, for which we take inspiration from the Netherlands

5.5.1.1 *Routine Outcome Monitoring (ROM) in the Netherlands*

The government agreement on mental health care of 2013-2014 stipulates that care providers of the primary mental health care sector would use ROM from January 2014. By measuring start and end status of the individual patients, patients, patient organizations, health insurers and care providers are given a view on the impact of the treatment. ROM data are delivered to the Stichting Benchmark GGZ that compares and publishes the data.[92] A scientific council was installed, which supervises the scientific framework within which the Stichting Benchmark GGZ operates.

The objectives of ROM are multiple. First of all, benchmarking outcomes across institutions should support improvement of care. It brings transparency and may serve ‘pay-for-performance’ in the longer run. As ROM results in observational research data, it is also suited to provide insight into the effectiveness of treatments in clinical practice, for which the efficacy has been demonstrated in RCT’s (efficacy versus effectiveness).

The introduction of the ROM however has been criticised, mainly on the grounds of risk of bias, confounding factors and sensitivity, which would hamper meaningful comparison between institutions[93].

As the health care providers collect data themselves and may fear that they will be penalised for bad results, ROM is considered to hold a substantial risk for bias. This risk has been internationally described as ‘gaming’, i.e. playing with the methodology in order to achieve better results. The risk for bias however might already be attenuated by a number of measures:

- By using standardised instruments, filled out by the patient, overrating of the results is counteracted.
- As the health care providers are incentivised to maximise their response, the risk of selectively including cases or doing the after-measurements, may be limited

Despite these elements, it remains possible for providers not to include cases for which they suppose results will be disappointing. Furthermore, still many other ways are possible to influence the results. It is therefore important to be vigilant for bias, to examine this problem in the start-up period and to be aware of it on the long term when deciding on the financial consequences of the benchmarking.

As patient populations may differ systematically between providers, ROM also deals with an issue of confounding factors. To account for differences in case mix, outcomes per subgroup of patients should be compared. However, it is currently largely unknown in mental health care to what extent treatment outcomes differ in function of patient variables. Further data collection and analysis is required to map which are the most important confounders in real world practice and to point out how valid comparison between institutions on the basis of ROM could be enabled. Being able to differentiate between successful and failed treatments is crucial for the ROM to be useful. However, current measures have been criticised on their sensitivity and further research remains necessary to develop sensitive outcome measures adapted to the broad range of patient categories and covering a wide range of outcome domains. The scientific council however, is aware of this issue, and therefore considers the outcome measures as work-in-progress. Furthermore, it is not policymakers who determine the instruments used. The currently introduced instruments have been determined by the field, in expert groups of professionals installed by GGZ Nederland. Alternative instruments can be added upon proposal of institutions and positive evaluation by the scientific council[93].

6 BELGIAN STAKEHOLDERS' VIEWS ON THE ORGANIZATION AND THE REIMBURSEMENT

6.1 Introduction

In order to explore the Belgian situation regarding the organization and financing of mental health care, we organized four stakeholder meetings with several types of actors in the field. The aim was to translate insights and ideas from the international comparison to the Belgian context and reflect on desirability and feasibility. This step will clarify the selection of the criteria for the Belgian model we are building through this study.

6.2 Methodology

6.2.1 *General design*

This consultation of stakeholders was inspired by soft system methodology (SSM). SSM offers a set of principles which can be adopted and adapted for use in any real situation in which people want to take action to improve it. SSM is not a clear sequence of steps, but a learning cycle, which goes from finding out about a problematical situation to defining/taking action to improve it[94]. The starting point is always a problematical situation, characterised by multiple interacting actors with each their own perception of reality (world view).

6.2.2 *Participants*

We decided to collect the opinions from all types of stakeholders in the field of mental health care, both in the French-speaking and Dutch-speaking part of Belgium. Participants selected were representatives of professional associations (GPs, psychologists, orthopedagogists, psychotherapists, psychiatrists), representatives of patients, of healthcare institutions active in mental health, and health insurance and of administration. We also made sure to have participants who are currently working in or on pilot projects in the context of Art. 107 or the Flemish first-line psychology function.

In order to facilitate participation of everyone in the best conditions, the total group was divided in 4 groups, two in each language. Although we invited the same types of stakeholders to each group, busy agenda's did not allow perfect equivalent groups.

Table 14 – Stakeholders who have participated in the meetings

Stakeholders representative of…	French-speaking		Flemish-speaking	
	Group 1	Group 2	Group 1	Group 2
Psychologists	1	1	1	1
Orthopedagogists	1	1	1	1
Psychotherapists	1	1	1	1
Psychiatrists	1	1	1	1
General practitioners				1
Patients		2		1
Maisons médicales / Wijkgezondheid centra	1			
Mental healthcare centres (CCG – SSM)	1	1		1
INAMI – RIZIV		1	1	
Regional Ministry		1		2
Federal Public Service Public health (SPF – FOD)		1		
Sickness funds	1	1	1	1
Healthcare settings	1	1	1	

6.2.3 *Data collection*

The four meetings were organized at the end of March and the beginning of April 2015 at KCE offices. They each lasted 3 hours.

A few days before the meeting, all participants received background information, i.e. the chapter on the Belgian context (chapter 4) and the chapter on the international comparison (chapter 5). This contributed to get a common body of knowledge.

To structure the stakeholder meetings we formulated a number of statements referring to what we learned from the international comparison. We took a hypothetical position to elicit the discussion during the meetings.

The statements refer to a 'hypothetical world view', SSM terminology for stakeholders' perspective. This means that they express one way of looking and thinking about the real situation. These statements were used as a device to ask questions about the real problematical situation, enabling it to be explored. For example, stakeholders were asked whether they would like the real situation to be more or less like that described in the statements. This made them reflect on the desirability and feasibility of the position taken.

For each of the statements, we introduced different modalities for possible implementation with the main conclusions of the former analysis (Chapter 5). Consequently we asked the stakeholders for their reaction to the statements and the perceived advantages and disadvantages of the different modalities. The statements were deliberately formulated in a general way, i.e. open to different interpretations, to elicit comments and facilitate the discussion during the stakeholder meetings. The statements were the following:

- Towards a stepped care model starting with the GP or other first line structure
- Towards access to secondary care upon referral
- Towards a financing based on standardised diagnostic criteria
- Towards the financing of evidence-based treatments
- Towards the financing of face-to-face consultations and variations such as group and telephone consultations, e-mental health programs
- Towards a financing based on the type of treatment

This questioning structured the discussion about the real-world situation, the purpose of that discussion being to surface different worldviews and seek possible ways of changing the problematical situation for the better. This means: finding an accommodation, "*that is a version of the situation which different people with different worldviews could nevertheless live with*" (Checkland et al[94], 2010,p. 11).

The stakeholder meetings have been recorded, but were not literally transcribed. The analysis was done based on detailed minutes of the meetings. The audio's helped to reconstruct parts of the discussion and fill in the gaps.

6.2.4 *Analysis*

Two researchers analysed the data independently and constructed a framework reflecting the ideas emerging from the discussion. One researcher used an approach inspired by framework analysis, the other one used soft systems methodology. These two approaches were chosen because of their complementarity, framework analysis being more deductive and focussing on summarising the theme's reflected in the data, while soft systems methodology is more process-oriented and focussing on actions to improve the situation. In a next step the two frameworks were compared and integrated. This means that the framework of one researcher was complemented with the ideas appearing exclusively in the framework of the second researcher. There were no clear divergences or disagreements between the two documents. The findings section is the result of the integration of the findings coming from both approaches, as a thematic analysis.

6.3 Findings

In this section we report ideas and arguments brought about by stakeholders. Based on the stakeholders' ideas, we described proposals about the organizational and financial aspects of the mental health care system. The propositions do not reflect a unanimous consensus throughout all aspects, however we have tried to reflect the nuances mentioned by the stakeholders.

6.3.1 *Preliminary considerations*

Before discussing the modalities of the organization and financing of clinical psychology, clinical orthopedagogy and psychotherapy, stakeholders pointed out several concerns.

Stakeholders stressed the importance of the work already done and the lessons learned in the context of Art. 107 and the Flemish first-line psychology pilot projects. The new initiatives taken were perceived as promising but also showed limitations (e.g. organizational difficulties, turn-over of psychologists) and the current report should take into account both the success factors as well as the weaknesses of these projects.

Second, some stakeholders suggested not only to consider mental health problems and mental disorders for reimbursement, but to enlarge the patient group to those in end-of-life situations.

Furthermore, some pointed to the fact that we should be aware of the risks of both over-psychiatrisation and over-psychologisation of problems, such as those related to relational difficulties, personal development, career counselling, grief and bereavement.

Today in Belgium the following observations have to be taken into account:

- Existing already financed structures are not well known, are often only accessible on referral and are overloaded.
- While there is an overmedicalisation of psychological problems (e.g. subscription of psychofarmaca is very high in Belgium), many situations requiring psychological support, or even psychotherapy, are not taken care of (for example, post-hospitalisation).
- General practitioners are not sufficiently trained in mental health.
- General practitioners are overworked – the system should not add additional workload.
- The organization of the access to and reimbursement of physiotherapy or speech therapy are not examples to follow because of their complexity.
- Medical shopping is common practice and no coordination exists.

In addition, stakeholders stressed that access to clinical psychology, orthopedagogy and psychotherapy should to be facilitated. Indeed, while access to mental health care is mainly direct, patients are reluctant to consult. On average people wait ten years to consult for mental health difficulties.[95]

Several barriers have been mentioned:

- **Financial access**: the costs of a consultation and/or a treatment are dissuasive. Particular attention should be paid to vulnerable groups to help them access mental health care. Accessible mental health care is offered in mental health care centres (CGG – SSM) but waiting lists hamper an appropriate treatment within an acceptable timeframe.
- **Stigmatisation**: Often patients do not want to be identified with a mental health problem. Access to this type of care could be easier and less stigmatising through general, multidisciplinary centres or through GP practices.
- **Medicalisation**: Often patients do not see their difficulties as medical problems. In addition, patients do not always want their GP to be informed about their problems. This pleads for a direct access to mental health care professionals, and against the idea of the general practitioner as the sole gatekeeper.
- **Alternative to displacement of the patient**: Even though alternatives for face-to-face consultations also entail certain risks, alternatives such as telephone or online consultations could be facilitating in case of mobility problems. Reservations to these alternatives are for example the risk to (reinforce) isolation of the patient and the fact that the home residence is not always a place suited for care (except in orthopedagogics).
- Finally, the system has to guarantee access and therefore has to be attentive to avoid structural bottlenecks. It must also facilitate the identification of the most serious problems.

6.3.2 *How to organize clinical psychology, clinical orthopedagogics and psychotherapy?*

According to the stakeholders, the discussion about the possible organization of clinical psychology, clinical orthopedagogy and psychotherapy has to fit within the framework of the ongoing reform art. 107 that promotes networks and collaboration. In addition, because the specificities of the Belgian system, foreign models are estimated to be less useful.

The following themes emerge from the discussions during stakeholder meetings.

6.3.2.1 *Define the first and the second line and implement a stepped care approach*

- Today in Belgium, lines of care are not well defined because of direct access to most health care professionals. With the organization of the access to psychology and orthopedagogics, we have the opportunity to sharpen the definition.
- In the discussions, stakeholders agreed on the fact that, in general, first line health care should imply “easy access” (geographically, time wise, and financially), and offer general and non-stigmatising care. It is thus defined as the entrance to the health care system. First line encompasses GP practices, but also other first line structures (social & mental health; schools; OCMW –CPAS; CLB –PMS; CAW/Centres de Planning Familial; …), especially for mental health problems. While the Flemish legislator foresees that CGGs have to be in second line, some stakeholders find that they could also be in the first line.
- Next to or included in this first line general health care access, a **first line psychological function** should be defined: it should consist of an ambulatory general psychologist consultation with or without the possibility of short treatments (10 sessions max). It should be accessible to everyone. It has to be considered as an entry point in the ambulatory mental health care system, even in continued care in case of change of setting (for example post hospitalisation)
- The content of the interventions of the “first line psychological function” should be generalist: anamnesis, early detection, referral, counselling,

help to problem self-resolution, but sometimes also resolution of the problem within a few sessions (non-complicated post trauma, mourning …), not (necessary) psychotherapy. Moreover, merely listening to someone can temporarily alleviate the suffering even if there is need for further help, which then can be delayed.

- The type of the interventions could be diverse: face to face consultations, home visits, observations in school, group trainings, e-health programs, follow up at home etc.
- This function could to be assumed by a clinical psychologist/orthopedagogist with a master diploma but some stakeholders also argued in favour of bachelors. In each case they should have a senior profile because the function is complex and demands many years of experience.
- **Second line** could encompass more specialised and/or long term treatment, including psychotherapy. The system has to take into account (and compared to what is happening today, reduce) the waiting time to access second line.

6.3.2.2 *Open access to reduce barriers and avoid over-medicalisation (independently of the financing)*

According to the stakeholders, it is important not to over-medicalise psychotherapy and psychological/orthopedagogical help. Offering treatments only within medical settings or only upon referral by physicians introduces, according to the stakeholders, a bottleneck and discourages persons with problems to seek help. Many problems in life are just “difficult times” and not necessarily a medical problem or a mental health pathology. Particularly psychologists and psychotherapists point to the fact that some patients fear that their problems will not be kept secret if their GP is the family doctor. On the other hand, some stakeholders raise the point that the Flemish pilot projects are characterised by a large inflow of patients to the first-line psychologist. Therefore, without introducing new bottlenecks, the inflow should be managed and channelled in some way.

In addition, many stakeholders stress the importance that the GP nevertheless takes a central position within primary care. The patient should not necessarily pass by the GP, but the GP should at least be informed early on that his/her patient is in treatment. There should be a strong collaboration between the first line psychological function and the GP.

Finally, access to long treatments should, according to some stakeholders, be conditional to an evaluation by a ‘third’ party, e.g. advisory physician (‘adviserend geneesheer’ – médecin conseil).

Advantages of easy access to first-line psychological care:

- **No bottlenecks**
- **Avoid overmedicalisation**
- **Some patients prefer not to pass by their GP or another first-line structure for privacy reasons**
- **GPs and other non-mental health first-line structures should not get overloaded with patients asking for a referral**

Disadvantages of easy access to reimbursed first-line psychological care:

- **Risk of overpsychologisation, too large inflow of patients (and associated societal cost in case of financial support)**
- **Risk of fragmentation of care, lack of communication towards GP**

Towards a collaborative model between the first-line psychological function, GPs and other first-line structures

6.3.2.3 *A needs assessment instead of a diagnosis to enter the system*

A diagnosis is not necessary to decide on referral (or on the reimbursement of the treatment). According to the stakeholders it seems better to focus instead on patient needs.

Obliging to diagnose has the inconvenience that it tends to over-psychiatrise patients. Tools used in other countries like DSM or ICD are classification tools, not diagnostic tools giving access to protocols of care. It would be better to base diagnosis on guidelines or protocols, but not on standardised lists or checklists.

The assessment should, according to the stakeholders, ideally be done by a multidisciplinary team in first line psychology.

6.3.2.4 *Towards multidisciplinarity*

A multidisciplinary approach has to be encouraged in order to work together around the patient (cf. 'Together we change[96]).

Because we (also) talk about health care, the GP should preferably be included in the multidisciplinary team, next to other practitioners such as a first line clinical psychologist/orthopedagogist, psychiatrists, possibly a paediatrician, physiotherapists, etc. (cf. decree former legislature).

Note that face to face collaboration between professionals is not always necessary, discussion by phone is also valuable.

The multidisciplinary team should:

- Assess the situation / put a diagnosis (but not necessary for referral or reimbursement)
- Plan the treatment (including referral)
- Follow and coordinate care
- Reassess the situation regularly

Increase GPs competences in mental health

GP's have close relationships with their patients and their families. Nevertheless, GP's are not extensively trained in mental health and seem to be inclined to solve problems with the prescription of medication. This is regrettable because the GP could play more roles:

- Regarding the detection and the intake of the patient: The GP is often confronted with mental health problems (especially within vulnerable groups) hence is the right professional to detect problems, to orient the patient towards the right professional or detect a need for psychotherapy. Indeed, if the GP is able to refer patients on his own (to the first line psychological function or to second line professionals), it would improve the access, avoid bottlenecks and fasten the process because cooperation with other professionals would not be systematically needed. In order to increase intake of patients with psychological needs, it is thus necessary to reinforce the GP's competences in mental health care.
- Regarding the coordination of care: because the GP has also a central role (via the Global Medical Record), he/she could also be the ideal actor to coordinate and follow the patient from the beginning and during the treatment.

In order to assign these roles to GP's, it will be necessary to coach them (e.g. by a clinical psychologist) or give them the opportunity to get familiar with mental health care practitioners. This will facilitate them to be attentive to psychological problems and improve their approach of the psychological problems of their patients.

Although reinforcing the GP's competences could increase access to mental health care, stakeholders reminded us that, as was already mentioned, many patients do not want their GP to be informed. The GP should thus by preference be not the only entrance to mental health care or the only potential coordinator.

Encourage networking

Psychologists, orthopedagogists and psychotherapists should ideally be part of one or several networks to ensure intervisions/ peer discussions. Networks could be thematic: children, elderly, poverty, etc.

Coordination and information sharing

Stakeholders stressed the importance of sharing information between the practitioners involved in the treatment of the patient. At least it seems important that practitioners know that other professionals are intervening, and, eventually, which kind of professionals are involved. It is not necessary to share the content of the treatment.

Sharing information with respect for professional secrecy is in the best interest of the relationship with the patient. In this way, the collaboration with a GP has thus to be encouraged but with respect to patients' wishes.

The electronic medical file will be of importance in this case. Nevertheless, although the access to the electronic medical file is foreseen by the law for clinical psychologists and orthopedagogists, it is not yet the case for non-health care professional psychotherapists.

Because patients are sometimes consulting several therapists together or successively, it is important that one person coordinates care. The coordination could be done by the GP or by the multidisciplinary team.

6.3.3 *How to finance clinical psychology, clinical orthopedagogics and psychotherapy in the context of the national health insurance?*

All stakeholders agreed that the system should be kept affordable and that resources should be used in the most adequate way. They all agreed on the necessity of imposing conditions to reimbursement.

6.3.3.1 *What are the priorities for reimbursement?*

Keeping in mind current budgetary restrictions, a stepwise approach for the implementation of the new psy-professions in the health care system was largely agreed upon. Ideas on priorities however diverged and different suggestions were made on what to prioritise:

- Vulnerable groups
  Some stakeholders insisted on the fact that access should be guaranteed for everybody, but if priorities must be defined, priority should be given to vulnerable groups. In their view, if the demand is too high, the existing structures should reorient patients who can afford it to private consultation.
- Primary care
  Some suggest to put the focus on primary care, providing broad access to as many patients as possible. Advocates of broad first-line coverage argue that providing early treatment has preventive effects. They do not expect an undue demand for care, as patients nowadays often wait far too long before starting therapy.
- Patients with most severe pathologies
  Other stakeholders, in contrast, argue that research is not conclusive when it comes to the preventive impact. According to them, there is also research showing that providing treatment to the whole patient group does not reduce the number of patients with severe pathology. Only if the system can adequately take care of the patients with the most severe pathologies, resources should be used to take care of the group of patients with lighter problems, which outnumber the former group.
- Expand capacity of existing structures and give priority to multidisciplinary networks
  Some favour to support the existing structures (mental health centres or multidisciplinary (GP) practices) in first instance to help them extend their services in order to be able to meet the demands and reduce waiting times, to expand access to primary mental health care and to decrease the need for more specialised help. Psychologists/orthopedagogists should preferably belong to multidisciplinary teams or networks, as this facilitates adequate referral of patients, patient-file sharing etc.

6.3.3.2 *Therapeutic orientations to be financed*

The treatment orientations to be financed should be the four ones as stipulated in the new law. Stakeholders see no point in debating on this issue again. Although they support the importance of evidence-based practice in psychology, they are not in favour of limiting reimbursement to evidence-based treatments. The example case of the chronic fatigue syndrome, for which reimbursement is limited to cognitive behavioural therapy, should according to them not be generalised. Looking at the broader patient population, many stakeholders stress the importance of therapeutic freedom where the therapist can combine elements from multiple treatment types to match the specific situation of each patient. If the professionals are accredited according to the new law and follow continuous education, this should be sufficient to guarantee, as much as possible, the quality of the provided treatments. Guidelines on treatments could further support the professionals to stay up-to-date with the latest recommendations on evidence-based treatments.

6.3.3.3 *Intervention types to be financed*

Financing should not be limited to face-to-face consultations

Besides face-to-face consultations, also other types of interventions should be considered for financing. The following reflections emerged:

- Group sessions are cost-effective for some patients and psycho-educative sessions are conform the art. 107.
- Other alternatives to face-to-face sessions could be reimbursed if they are effective, since they can be helpful for certain (less mobile) patient groups (carers, cancer patients, etc.): e.g. phone and computerised treatments (e-mental health). E-learning tools are already discussed

some committees and Domus Medica is since long demanding the implementation of such tools.

- In the specific case of clinical orthopedagogics, interesting alternatives to face–to-face interventions are observations at schools, guidance of teachers and/or parents without direct contact with the child.
- The use of telemedicine has to be reflected upon in a wider context than mental health only.

Financially encourage collaboration between professionals

Multidisciplinary collaboration was highly valued by the stakeholders. To enable the development of multidisciplinary networks time investments in collaboration efforts should be financially rewarded.

6.3.3.4 *Patient contribution: financial support for the most deprived patients*

Stakeholders agreed that out-of-pocket payments should be lower or free for the most disadvantaged groups, as too high out-of-pocket payments may hinder treatment for those who cannot afford it. Yet, stakeholders also point to the fact that patients who have out-of-pocket payments may be more motivated to follow the therapy. This pleads in favour of out-of-pocket payments for the general population. Patients in the meetings confirmed this.

6.3.3.5 *Tariffs setting*

The level of tariffs or financing has not been part of the stakeholder discussions. In case of fee-for-service, a system of “convenant” (‘conventionering’-‘conventionnement’) for the practitioners seems evident.

6.3.3.6 *Number of sessions*

Regarding the number of sessions to reimburse, psy-professionals agree that in the context of first-line care, many patients can already be helped with no more than 5 to 8 sessions. Although the exact number of sessions depends on the patients’ needs. In case of grief, for instance, 3 sessions may be sufficient. For longer treatments, there is no such indicative number.

A point of attention to keep in mind is the specificity of orthopedagogy that takes charge of disabled persons. In the case of an innate disability, the number of sessions required is much higher than for acquired disability.

6.3.3.7 *Financing models*

Different financing models have been discussed in the stakeholder meetings.

Salary or yearly fixed financing

Stakeholders point to the example of how psychologists are currently financed in the mental health care centres (CGG – SSM). According to them, this way of financing does not really stimulate the professionals to increase the number of patients treated, nor to lower the treatment duration, nor to reduce waiting lists. When considering a lump-sum financing, a capitation financing seems to be a better alternative. Fixed financing is also how GPs are currently in part financed through the “praktijkvergoeding”.

Capitation financing

The advantage of capitation financing over fixed financing, is that it stimulates to increase the patient load. However, the example of ‘wijkgezondheidscentra’-‘maisons médicales’ (WGC – MM) also shows disadvantages, as patients e.g. cannot go elsewhere unless with the agreement of the WGC – MM as in this case RIZIV – INAMI does not reimburse the consultation anymore, instead the centre itself needs to reimburse the consultation. Stakeholders remind that GPs are currently also partly financed through capitation payment through the payments for the electronic patient record (GMD – DMG).

Fee-for-service

According to some stakeholders, a fee-for-service system must be avoided as it does not enhance collaboration nor referral of patients to other professionals as each professional would be incentivised to keep the patient for him/herself.

Other stakeholders are in favour of a fee-for-service system - a system where the clinician psychologists or clinician orthopedagogists bills the fee, not the psychiatrist. The currently existing fee for a neuropsychological

examination in case of dementia, which is billed by the psychiatrist, poses problems for psychologists.

Combination of models

Stakeholders agree on the trend towards mixed financing systems, as e.g. in the Flemish first-line psychology pilot projects, where the salary of the psychologist is financed partly by a fixed lump sum and partly by a contribution per consultation by the patient him/herself.

Financing models for first-line psychological care

Two main options for financing treatment in first line arose from the stakeholder meetings. The options are not mutually exclusive and can thus be combined.

1. *Lump sum financing of the 1st line psychologist who is part of a network*
    - The first-line psychologist is part of a multidisciplinary network with a GP practice, a 'wijkgezondheidscentrum'-'maison médicale', or other first-line structures such as CAW/Centres de Planning Familial, OCMW – CPAS, CLB – PMS, BJZ.
      If the patient wants to avoid to pass by his/her GP, he/she can make an appointment directly with the psychologist of the practice.
    - It is the network that is financed with a lump sum on per capita basis increased by a personal contribution of the patient per consultation
    - It implies that the psychologist is a salaried worker

This is a system which auto-regulates itself in a number of ways. The first line psychologist will adapt the number of sessions according to the patient's needs and there is limited risk of supplier-induced demand. No maximum number of sessions per patient needs to be fixed by the National Health Insurance. This financing model, however, is not easy to implement for solo GP-practices, which are still very common in Belgium.

2. *Fee-for-service of the first line psychologist*
    - In combination with a monitoring of and if necessary quota restrictions on the number of professionals with RIZIV – INAMI number to attune the supply to the needs and to control national expenditures. By means of e.g. an exam after graduation (if the number of graduates exceeds the number of free positions), as was the case e.g. for physiotherapists in the years 2005/2006/2007 in Flanders.
    - In combination with a maximum number of reimbursed sessions for first-line treatment.
    - Fee-for-service per consultation and a personal contribution of the patient per consultation.
    - Psychologist can be self-employed.
    - The psychologists / orthopedagogist is also in this option preferably part of a multidisciplinary team or network. A multidisciplinary team however, for some stakeholders, does not only comprise psychologists but also a physician in order not to fragmentise physical and mental healthcare. Other stakeholders find it sufficient that the psychologists works in group practice with other peers in order to foster quality.

Financing models for second-line ambulatory care

When considering expanding the capacity of psychologists outside the centres for mental healthcare, a fee-for-service financing model arises as main option. A number of ways to control expenditures are as following:

- Stakeholders favour an intervention by a third party, e.g. a physician/psychiatrist or an advisory physician, to evaluate the necessity for secondary care. An evaluation by a psychiatrist in all cases, however, does not seem necessary.
- Stakeholders did not consider the way how reimbursement of speech therapy is organized in Belgium to be an example of best practice. Stakeholders find this process too heavy, shuffling patients back and forth between healthcare professionals. (For speech therapy, a specialist physician first prescribes an evaluation. Consequently the speech therapist does the evaluation and communicates the results back to the specialist physician. Finally, the specialist physician decides on a prescription for speech treatment or not. Only upon his/her prescription speech therapy can start. To obtain agreement for reimbursement, the speech therapist furthermore needs to send a request for reimbursement, together with the prescription for the evaluation, the evaluation and the prescription for the treatment to the advisory physician of the sickness fund.)

- Before or at the start of second-line therapy, a diagnosis or at least a 'functional assessment appears recommended, although patients comment that diagnoses tend to change frequently and therefore lose credibility.
- A limitation on the number of consultations, although the number of consultations needed depends heavily on the patient.
- A monitoring and if necessary a limitation of the number of professionals with RIZIV – INAMI number.

Financing models for inpatient interventions

Psychologists working in hospitals are currently financed by a diversity of systems. To a large extent, they are financed by deductions ('afdrachten'-'rétrocessions') from specialists to the hospital, and stakeholders find this situation problematic as it creates tensions between the professional groups. There are systems where psychologists are financed based on their presence at multidisciplinary meetings and this sometimes creates inappropriate use of the system. In many cases there is no financing of a psychologist intervention. A financing on lump sum basis, sufficiently large and fit to the diverse and expanding set of tasks endorsed by psychologists, and not simply based on patient contacts or presence at multidisciplinary meetings, is suggested by stakeholders as a better alternative.

6.3.4 *How to support quality*

Registration could be a way to support quality. However, stakeholders insist to avoid too much registration and, if there is a specific one, outside the data collected by the health insurance, they stress on the necessity to well define the aim of the registration.

Stakeholders mentioned other ways to support quality: registration required in a network, documented or traceable information exchange in the network, compulsory supervision/continued education…

Next to it, it seems important to introduce a culture of assessment of the outcomes. The KULeuven has developed a tool to measure the therapeutic alliance between therapist and patient, to be completed with the patient. This could be an option. The Superior Health Council (CSS – HGR) is evaluating the mental health evaluation tools that will give more avenues for the future.

Stakeholders do not seem to be in favour of a benchmarking based on outcome assessment in order to avoid patient selection. Nevertheless, such analysis could allow the identification of outliers (practitioners).

6.3.5 *Additional issues:*

Not every psychiatrist is trained in psychotherapy. However a nomenclature code exists and is labelled as 'psychotherapy'. Actually it is used to bill 'long consultation'. It was proposed to rename it to avoid confusion.

6.4 Conclusion

The following leverage points were identified during analysis of stakeholders' input and shape the organizational and financial model that emerged from the data:

- Who can refer to secondary care? (GP, first line psychologist, both, …)
- At which points should financial barriers be relaxed, in function of:
  - The care path we want to stimulate
  - The target group with the biggest needs/least means
- Which conditions need to be coupled to financing of mental health care:
  - Conditions for patients
    - Co-payments (differentiated according to income?)
    - Type of care needs (e.g. assessed in terms of dysfunctioning), with exclusion of e.g. coaching and personal development
  - Conditions for professionals
    - Subscription to a multidisciplinary network
    - Accreditation (continuous training)
    - Use of clinical guidelines
    - Recognition of the therapist
    - Type of consultation: e.g. individual or group

Taking into account these variables, the model emerging from the stakeholder meetings is characterised as follows:

- **Organization of primary mental health care**:

  First line structures, multidisciplinary networks in which amongst others psychologists and GP's can register. Multidisciplinary collaboration is

strongly valued by the stakeholders we met. The GP plays a key role within primary care, but he does not play the role of sole gatekeeper. Rather multidisciplinary collaboration networks should be formed including the GP to assure at least information transfer between the professionals involved. This way the GP works in close collaboration with first line psychologists to which he can refer. Other first line players, such as OCMW's (CPAS) and CAW's, should be taken into account too, as they are the point of entrance for a certain group of patients. The most important function of primary mental health care is the evaluation of patients' needs - not necessarily a diagnosis - , referral and follow-up.

- Requirements to realise a broad first line entrance to mental health care are:
  - A shared electronic medical file accessible to the care professionals in the multidisciplinary network
  - Remuneration for collaboration and communication between care professionals
  - First line psychologists should have a senior profile. According to stakeholders, in the Flemish pilot projects they are starters and this resulted in a high turnover. In addition a clear function description is needed for this new position. For example, it should be clear whether the first line psychologist only assesses patients' needs or offers short term therapies/interventions too. Also the follow-up after back referral by second line professionals should be considered.
- In addition, the first line function of mental health care centres (CCG – SSM) could be strengthened.
- **Financing criteria**
  - Recognition of the therapist, in addition to quality assessments at the level of trainings and accreditations. The following arguments were put forward:
    - Good therapists know what kind of therapy/intervention is best suited to solve a certain mental health care problem in a certain context, and are made accountable for this.
    - Lists of diagnoses and/or evidence-based treatments are difficult to work with, because a treatment, even evidence-based, does not work for everybody in all circumstances. The system should allow the therapist to search and try several therapies (therapeutic freedom).
  - Subscription to a multidisciplinary network.
  - Written report embedded in the shared electronic medical file.
- In addition, stakeholders agreed that financing should be limited to mental health problems, hence relational problems, self-development, coaching etc., should be excluded. Also they suggested to keep a certain amount of co-payment to make patients accountable, responsible and motivate them ("signe de sa volonté de s'en sortir").

7 INTERMEDIARY RESULTS: TENTATIVE MODEL BASED ON, FOREIGN EXAMPLES AND STAKEHOLDER INTERVIEWS AND “EERSTE LIJNS PSYCHOLOGISCHE FUNCTIE PROJECTEN”

Based on our analysis of the current mental health care offer in Belgium (chapters 3 and 4), the foreign examples we analysed (chapter 5) and the lessons learned from the Flemish first line psychology function projects (FLPF), we can summarize as follows the requirements that a future system for Belgian psychological care should meet:

For the patient:	For the healthcare system:
• provision of a readable and easily accessible entrance • affordable care • access within a reasonable time • competent professionals • continuity of care	• a clearly structured organization of psychological care • a financially sustainable system • sufficient professionals • measurable and good quality of care • well-organized multidisciplinary structures and integration into the existing network

7.1 A system with two components

None of the countries studied does allow direct access to specialized psychological care covered by the healthcare insurance. Care seekers must be referred by physicians involved in primary care (general practitioners, psychiatrists, multidisciplinary practices). These first line of care physicians receive support from qualified professionals to meet the demands of patients with mental distress. However, care seekers have direct access to a first level of support for common psychological problems. This approach was favoured in the Flemish FLPF projects.

We conclude that direct access to a first line psychological function (FLPF) probably is the most appropriate solution to support the existing professionals in the Belgian first line healthcare system. We also conclude that it is needed to ensure gatekeeping to more specialized psychological care, in order to limit costs and resolve long waiting times in specialised care. This first "triage" of psychological burden and distress in the general population would indeed limit the waiting lists for more specialized care resulting in faster access for people with more severe difficulties.

Our proposal is to create a system in Belgium with two components (levels of access):

1. A function of first line ‘generalist’ psychological care (FLPF), accessible to all, without prescription, regardless of diagnosis, beneficiary or gravity. However, we propose that it should be limited to a small number of sessions.
2. A second line of more specialized care, reserved for those for whom this first line approach is not sufficient. This level will be accessible only on referral.

The current system of private practice of psychological care, with direct access to primary as well as specialized psychological care, can remain as it is today and act as an alternative pathway to psychological care, but we propose not to make it eligible for a reimbursement by authorities.

7.1.1 *First line care accessible to all*

This chapter describes the definition of first line psychological care and its entrance doors, practitioners, their competency profiles and accreditation, location of the function, its internal organizational arrangements, and finally the financing terms.

7.1.1.1 *The content of first line psychological care*

Given the analysis of the results of the Flemish FLPF-projects, regarding its patient profiles, the reason for consultation is often related to "life difficulties". These multifaceted situations do often not require an urgent, complex and ‘specialized’ management. Therefore, it is obvious to suggest, as in FLPF projects, to set up an approach according to the principles of stepped care, with provision of tailored care depending on the gravity of the

complaints and referral to next levels depending on specific criteria. From that viewpoint the core activities of a FLPF can be described as:

- Welcome and listening to all the complaints;
- Establishing of a functional assessment, or if relevant, a diagnosis;
- Counseling;
- support and empowerment in case of self-solvable problems;
- Individual and group psycho-education (sleep problems, stress management, ...);
- Brief intervention for moderate issues (uncomplicated psychotrauma, mourning, ...);
- Early detection and redirection of (potentially) severe problems to a psychiatrist or to next levels of specialized psychological care (matched care);
- Reference to more specialized psychological care if necessary.

The types of intervention in first line psychological care should not necessarily be limited to face to face consultations: group sessions, online programs, consultations by telephone or other remote interfaces, observations in school (for orthopedagogists), home visits (for the elderly and disabled). It would also be advantageous to provide an opportunity to the first line practitioner to get advice and support from a psychiatrist, via a specific nomenclature code, by means of a single advisory consultation with a psychiatrist, after which the patient should be referred back to him/her.

7.1.1.2 *Access to 1st line psychological care*

According to the foreign examples, Belgian stakeholders advocate for a very low threshold for the first line psychological function. This implies that patients should directly get access to psychological care providers in first line without prescription. Nevertheless, on this point, opinions diverge. Also in FLPF projects, patients consult the psychologist after GP's referral.

Multiple entrance doors to first line psychological care should increase accessibility: OCMW – CPAS, emergency care, physicians, the school sector (CLB – PMS), CAW/Centres de Planning Familial, medical advisors, associations working with disadvantaged populations, etc. should all be encouraged to guide potential patients to the first line of psychological care if psychic distress is suspected.

Finally, the FLPF should be geographically well distributed and clear information has to be given to the general public and all medical and social actors.

7.1.1.3 *First line psychological carers*

Several type of healthcare practitioners should intervene according to the foreign examples and the discussion with stakeholders.

The clinical psychologist

The clinical psychologist is trained specifically and scientifically to understand (dys)functioning of the human mind, to diagnose these problems and provide an adequate treatment. It should therefore be a central actor of a FLPF. In addition, clinical psychologist are recognized as an independent profession by the law of April 4, 2014 and therefore have the right to diagnose and prescribe or provide (complementary) care autonomously. In addition, clinical psychologists have a good overview of the existing therapies; they have experience in some of them and could startup these already in first line. Indeed, some of these therapeutic options (brief therapy, counseling, low-intensity interventions) could solve many of the FLPF problems in a few sessions, without using a longer therapy. Nevertheless, stakeholders point out that reserving first line care exclusively to psychologists, may present certain disadvantages:

- Clinical psychologists have a less complete overview of the patient's health status compared to GPs, since they do not have access to the somatic aspects and to patient's medical and medication history, which sometimes represent a major component in the mental problems patients consult with. The potential risk is a "psychologisation" of issues that could benefit from a medical solution (e.g. thyroid dysfunction causing depression).
- For a part of the population, the use of a professional mental health service remains difficult as "mental diseases" are perceived as a taboo. This part of the population is found to feel less stigmatized to consult first with a GP or in a medical house / wijksgezondheidscentrum. Therefore it is important to keep this alternative possibility to get access to mental health care.

In terms of qualification of the providers, being qualified and trained as a clinical psychologist seems to be insufficient to work in a FLPF. Indeed, the report of the Flemish FLPF pilot projects underlines that (1) the first line psychological function is very demanding, (2) it requires specific skills, (2) there is a need to have a broad clinical view and (3) it requires sufficient clinical experience. Stakeholders also reported that the scope of basic training in clinical psychology is not broad enough to adequately ensure first line mental health care. They propose the setup of an specific additional training for clinical psychologists who intend to step in this FLPF. Moreover, given the high demands and the specific requirements, they are also reluctant to entrust first line mental health care to Bachelors in Psychology as is the case in the Netherlands. However, because of the workload that can be expected if such a FLPF should be launched, it would be realistic to allow Bachelors in Psychology to provide certain aspects of care under supervision of a Master in Clinical Psychology who is trained in first line psychological care.

Besides the specific skills to be recognized to work in a FLPF, providers should also comply with certain requirements for continuing education and participation in intervision groups.

The clinical orthopedagogists

The clinical orthopedagogists should intervene in a FLPF on the same terms and conditions as clinical psychologists, but only in relation to their specific audiences.

The GP

Stakeholders recognize that, in most countries, the GP is the sole entry point provided for patients with mental difficulties because of his/her privileged position in healthcare. Moreover, due to his central position in health care he has the best overview of the patient's medical history, background, living conditions and social network. The GP has, in general, a stable and often long-term relationship with his/her patients and is well placed to have a global vision of the context in which difficulties arise (intra-family crises, (un)employment problems, financial difficulties, etc.). In Belgium, the level of trust patients have in their GP is very high. The GP also is the manager of the Global Medical File (DMG – GMD) and is therefore an ideal actor to coordinate a health care network. The GP is also very accessible for the population (geographically and financially). In some cases, when the GP works in a multidisciplinary structure, such as a medical home, he/she can have immediate access to a psychologist (being a team member). For many people, it is less stigmatizing to consult a doctor instead of a mental healthcare practitioner. Nevertheless, stakeholders also argue that limitation of access to mental health care only to GPs might pose some problems (already briefly mentioned above). Indeed, many of the "life difficulties" where patients consult with are not purely medical. Some people want access to a mental health professional but would rather not talk to their GP for exactly the reasons of proximity to family and relatives, as mentioned before. Health care statistics also show that the most vulnerable populations often do not have a 'regular' GP. This implies that for these people, a mandatory entrance to mental health care via a GP could be an obstacle. Furthermore, GPs often state that they are already overloaded and cannot always devote much time to a single patient, what can be especially problematic in case of psychological problems. We therefore advocate to find a flexible formula to allow GPs to be involved in accordance with their wishes but where they should not be the only access point to mental health care.

Finally, if specific skills and competences are required for psychologists to practice first line psychological care, there should be a similar requirement for GPs. Indeed, they are not specifically trained in the management of psychological problems. Moreover, they state not to have sufficient knowledge of the different therapeutic approaches in the practice field of mental health. A possible solution to close these knowledge gap could be to create an additional training for GPs who wish to be more closely involved in FLPF, recognizing them through a specific RIZIV – INAMI skill code. This approach is comparable with the current ECG certification for GPs or the diabetes educator certification for home care nurses. This would allow him/her to conduct long consultations for psychological reasons (but with a limited number of sessions per patient per year) and to prescribe reimbursed specialized psychological care (see below). In the proposed model, this possibility would be reserved for GPs holding this specific competence "psy".

The psychiatrist

As a specialist physician, psychiatrist theoretically do not have a place in the first line of health care. Due to the liberal Belgian health care system however, it is possible for every citizen to consult them directly. Because the psychiatrist is undeniably of added value because of his profound knowledge of both mental pathologies as drug therapies, it might be interesting to put this expertise punctually at the disposal of the first line. However without making it a prerequisite, which would result in an unbearable workload and an untenable cost.

7.1.1.4 *Place of the 1st line psychological care*

Stakeholders did not favor the creation of new structures, in order to avoid introduction of new elements of complexity in the present health care landscape. The FLPF should rather reinforce the capacity of existing structures. For example it could be installed in a medical house / WGC, , a PMS – CLB, but also a family planning center or a CAW, an OCMW – CPAS, or even in a CGG – SSM, etc. This "accommodation" in existing structures would have the advantage to promote a multidisciplinary approach. It has to be stated here that in our research project several actors have emphasized the (informal) role that is often played by clinical psychologists in medical structures, to sensitize doctors to the psychological aspects of diseases they encounter. This is also highlighted in the report of the Flemish FLPF pilot projects.

Belgium also has a long tradition of private practice of medicine. Many clinical psychologists practice as independent professionals, solo or in groups. These providers are well known in the general population. It is therefore important to maintain the role of these actors in the proposed offer of psychological care, allowing them to endorse a specific function in the first line if they meet the training and accreditation requirements. However, we want to stress that in the proposed model, care seekers in the first line of psychological care are never obligated to attend the FLPF for their mental problems and can choose to remain outside the system with a private clinical psychologist. However, the model described here should be the only pathway for first line mental health care that could give access to financial participation of public authorities.

7.1.1.5 *Consultation of the actors and information sharing*

Insertion into the existing network

Stakeholders emphasize the importance of multidisciplinary collaboration between the various professionals working around the patient and advocate for the integration into existing networks and structures, particularly within the framework and spirit of the reform known as "Article 107 ". In the evaluation of pilot projects FLPF, this active insertion in the local network is explicitly mentioned as one of the essential components of the first line psychological care.

Coordinate stakeholders and share information

Coordination around the patient and sharing of information between professionals that are involved are both needed according to stakeholders. Given the sensitive nature of the topics related to mental health, the sharing of information should not necessarily be detailed and extensive. The professional secrecy is a crucial factor in the establishment of necessary trust, needed for an effective psychological intervention. But to avoid medical shopping and accumulated or parallel approaches, it is important that at least one practitioner is aware of which professionals are involved in relation to a certain patient (always subject to the explicit agreement of the latter), and that a single professional coordinates care. The patient's GP is probably the most suitable actor to centralize this information in the Global Medical Record, although it is not essential, according to the stakeholders that he/she personally receives the patient for psychological care.
The use of a centralized electronic medical record (eHealth) - with protected access based on therapeutic relationship - must be the standard.

7.1.2 *A second line of more specialized care for the people who need it, regulated through a gatekeeping*

For issues that cannot be resolved in the first line of mental health care and which are not yet taken in charge by existing psychiatric care facilities, it is necessary to provide access to more specialized (or longer-term) care. This care should be given by professionals (clinical psychologists, psychiatrists, other doctors) who have received specific training in officially recognized mental healthcare techniques (including psychotherapy). Stakeholders emphasized that financial aspects are a major obstacle for a significant part of the population to receive specialized psychological care. They advocated

for a financial intervention of the authorities, although they were sensitive to the budgetary impact that it could represent. They therefore suggest to regulate access to specialized care.

In the countries that we studied, GPs are often the sole gatekeepers to specialised mental health care. Nevertheless, according to the stakeholders we met, physicians as well as clinical psychologists/orthopedagogists are able to take the role of gatekeeper to specialized reimbursed psychological care. Indeed, these professions are considered as autonomous professions by Belgian law and should a priori not be conditioned by other healthcare professionals. However, most of the stakeholders we consulted agreed that a multidisciplinary collaboration is a more obvious approach. Moreover, it is necessary to avoid self-referral trajectories.

The multidisciplinary dialogue should include at least the first line psychologist, who has a clear view on the psychological indication for specialized care) and the GP (preferably the patient's entitled GP), who has a global vision of the patient's health status and who manages the Global Medical Record). However, any other doctor (gynecologist, pediatrician, geriatrician, psychiatrist ...) who wishes to refer the patient to more specialized psychological care and / or longer duration can be involved. However, a systematic assessment by a psychiatrist to get access to specialized psychological care is not deemed necessary (cf. the present procedure for the reimbursement of speech therapy in Belgium, which is perceived too heavy and complicated).

The assessment of the need to specialized care could be based on diagnose. Our international analysis shows that the DSM IV / V classifications (Diagnostic and Statistical Manual of Mental Disorder, 4th / 5th edition, published by the American Psychiatric Association) or ICD-10 (International Classification of Diseases and Related Health Problems, 10th revision, produced by WHO) are often used to delineate the indications eligible for a refund. Nevertheless, the Belgian stakeholders do not support the use of exhaustive lists of indications because they believe many of the psychological problems they face are outside characterized mental illness but rather are related to "life problems" multifactorial, that can be linked to family and social context (particularly in times of crisis like today). Obliging professionals to put DSM diagnoses or codes of ICD-10 on such problems leads to "medicalization of the social problems," or "psychiatrization" (e.g. ADHD diagnoses explosion and bipolar disorder in recent years). They believe it is entirely possible for experienced professionals to decide on the need to give a patient access to specialty care does not present a formal diagnosis. The patient's needs should guide the decision rather than the presence of a series of criteria on a checklist. They prefer, if it is really needed that the criteria were rather based on guidelines or protocols.

Moreover, literature findings suggests that proponents of diagnostic labelling in psychological care advocate that the use of this system results in a proper and accurate description of problems and that it facilitates the communication between health care professionals in terms of assessment and treatment of problems. The opponents however criticize that labelling leads to stigmatisation, that it hampers a holistic view on/approach of the patients' problems and that it might become a 'self-fulfilling prophecy' for certain practitioners. Some argue that patients with complex, unclear, 'mixed' problems might be excluded from reimbursed care because no label can be put on them.[97] An important issue, in relation to the present report, is that mild and moderate psychological problems often consist of a combination of social, psychological, cultural and economic factors, which are difficult to capture in a predefined diagnostic classification system.

The risk identified by stakeholders in using predefined diagnostics is that some providers could 'adapt' observed symptoms to fit to criteria.

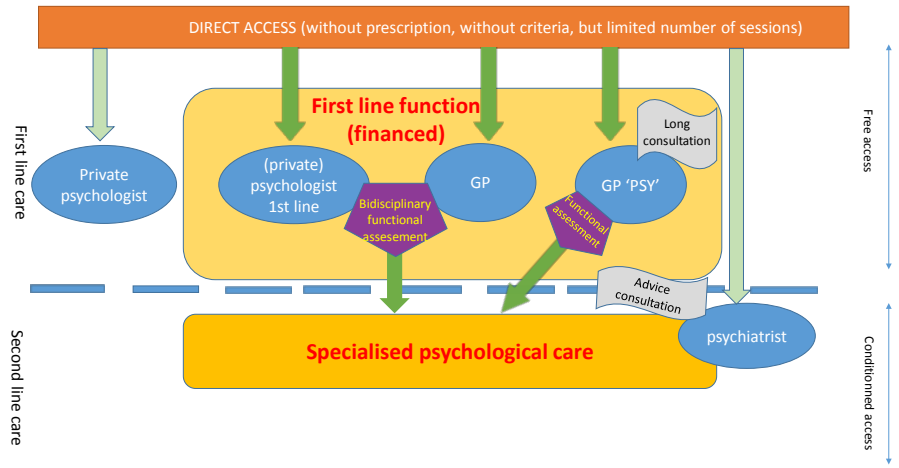
Stakeholders proposed to preferably condition the access to specialized care by establishing a 'functional assessment' realized by the 1st line psychologist in consultation with de GP. This should include:

- a somatic assessment in order to identify the somatic components. This should be realized by a physician;
- the inventory of the medications
- a psychological assessment with a proposal for therapy, realized by a first line psychologist

This assessment should be also used to ask for prolongation of the number of reimbursed sessions or to close the treatment (in order to measure the quality of care). It should be part of the electronic medical record (eHealth) of the patient (with his/her approbation)

Our first proposal of model should thus be schematized as illustrated in the Figure 7.

Figure 7 – Intermediary model for the organization of psychological care



7.2 Reimbursement of the psychology/orthopedagogy care

In all countries we studied, compulsory health insurance also works well for individual sessions as group, couple or family. However the Netherlands and Great Britain, only evidence-based approaches come into consideration. Belgian professionals we met, although convinced of the importance of evidence-based practice in psychology, are not in favour of limiting the reimbursement only to evidence-based treatments. Indeed, the therapeutic freedom of the provider allows it to combine elements from different approaches, based on its own expertise, to adapt better to the specific characteristics of each individual patient. Moreover, the success of therapy results also of the quality of the link established between therapist and patient, which cannot be reduced to care protocols. Also according to stakeholder, their future recognition under the new legislation and the fact that they undergo mandatory continuing education should be a sufficient guarantee of the quality of delivered treatments. The guidelines could be an advantage, allowing them to keep abreast of the latest recommendations for evidence-based treatments, but they should not become too rigid frames.

The reimbursement should not be restricted to vulnerable people. Nevertheless existing protection mechanisms (such as beneficiary of increased intervention) should also be applied for psychological care.

In terms of number of reimbursed sessions, in all countries we studied, the volume of treatment, it is counted as the number of sessions and / or hours is limited. The Belgian stakeholders also believe that such a limitation would be reasonable to apply to us. This limit varies widely in the countries we studied, (ranging from 5-300 hours) and can be applied in several ways:

- fixed regardless of the treatment, such as Denmark (12 sessions) or Switzerland (10 sessions)
- vary depending on the type of treatment, as in Germany (maximum of 80 hours for a behavioral therapy, psychodynamic 100 or 300 an analytical approach to such therapy, divided into 3 sessions per week max)
- vary according to a classification of patients, such as the Netherlands where the intensity of the treatment varies according to four types of needs: short (5: hour), medium, intensive and chronic (30 hours)
- vary depending on the combination treatment / indication as in the English system.

The duration of the sessions is generally limited (typically 45-60 min for a single session). Moreover, in some cases, the number of hours or sessions may be renewed, on medical advice. This modeml could be used for specialised care. For first line care stakeholders we met stated that a large amount of people could already be helped with small number of session. This was confirmed by the FLPF pilot projects (3,9 mean).

The out of pocket part for the patient

In the foreign examples, the OOP depends overall of the type of healthcare system of the country. In Belgium, patient will pay 12€ by the psychiatrist (without supplement), 10-11€ in a mental health service, 9€ in the FLPF etc. Financial aspect could not be a barrier to seek and receive help according to the stakeholders we met but an out of pocket participation makes part of the therapy, participating in the motivation of the patient.

8 TEST OF THE TENTATIVE MODEL TO ORGANIZE ACCES TO PSYCHOLOGICAL (AND ORTHOPEDAGOGIC) CARE IN BELGIUM AMONG STAKEHOLDERS

In order to fit as much as possible with the reality of Belgium, we found necessary to test our tentative model among stakeholders we met. We decided to conduct then a survey among stakeholders to point out remaining potential problems and be aware of the unacceptable proposals.

8.1 Methodology

8.1.1 *Design*

We consulted stakeholders using an online survey as *"a method for structuring a group communication process"*[98]. This was followed by a meeting

We first administrated an online questionnaire with LimeSurvey®. The questionnaire consisted of a list of possible recommendations related to the new model, which was based on the previous steps of the research process (see chapter 7). The survey was launched the 4/12/15, followed by 3 reminders with 1 week interval and was ended on the 6/01/16. The major aim of the survey was the preparation of the final stakeholders meeting.

This final meeting was planned at the end of January 2016 in order to present and discuss the model, which was adapted to the points of disagreements and the comments of the participants. Two hours were scheduled for this discussion.

8.1.2 *Participants*

We invited a group of 60 stakeholders in the field of mental health care that were identified for this project. The group consisted of policy makers, health practitioners' representatives of several disciplines, patients' representatives and health insurers. All of these invitees received the online questionnaire and an invitation to participate in the closing meeting.

8.1.3 *Data collection tools*

8.1.3.1 *Online questionnaire*

The questionnaire was developed in French and Dutch. It was pretested by 6 KCE experts (3 FR and 3 NL), not implied in the study, to test the comprehension and the navigation. An example of the survey is available in the appendices. Participants had to indicate whether they agreed with each proposals, as a whole. For each proposal they did not agree with, they were asked on which precise point they disagreed. The opportunity was also provided to add additional disagreement points related to each proposal.

8.1.3.2 *Final stakeholders meeting*

Prior to the meeting, we sent a document with the results (in French and Dutch) to the participants of the survey. Every proposal of the survey was listed and coloured in function of the percentage of acceptance. Raw data and comments were also reported in the document. This was done for informational purposes only, in order to give an idea of the 'strength of the consensus' (> 85% acceptance, 75-85% acceptance, 50-74% acceptance, <50% acceptance).

The new model, which was adapted based on the results of the survey, was presented during the meeting and commented by the participants. A simultaneous translation French/Dutch was provided in order to facilitate the discussions.

8.2 Results of the survey

Detailed results of the survey are available in the appendices.

8.2.1 *Participants*

From the 60 people invited for the survey, 49 people participated in the survey and 46 questionnaires were completed entirely.

Table 15 – Description of the participants in the online survey (several possible answers)

	n
Representative of	
Psychologists	7
Psychotherapists	8
Orthopedagogists	1
Psychiatrists	4
General Practitioners	1
Public administration (SPF, communities, regions, INAMI –	9
Sickness funds	4
Patient/consumers organization	5
Umbrella organization of (mental) healthcare institutions	5
Research centre / university	6
Healthcare practitioners	**25**
Profession	
Psychologist	15
Psychotherapist	13
Orthopedagogist	6
Psychiatrist	5
General practitioner	1*
Director of a healthcare department	2
Place of practice	
Private practice	13
Ambulatory setting	8
Residential setting (including hospital)	12

** 1 written comment*

Forty two stakeholders participated in the meeting.

Table 16 – Stakeholders who have participated in the final meeting

Stakeholders representative of…	n
Psychologists	4
Psychotherapists	11
Orthopedagogists	4
Psychiatrists	3
General Practitioners	2
Public administration (SPF, communities, regions, INAMI – RIZIV)	9
Sickness funds	3
Patient/consumers organization	1
Umbrella organization of (mental) healthcare institutions	5

All categories of participants that responded to the questionnaire (see table above), were also present at the final meeting.

8.2.2 *Proposals according to their acceptability level*

In general, the model in its whole was judged as acceptable by the respondents. More precisely:

- 3 proposals reached more than 85 % of agreement;
- 5 proposals reached an acceptance rate between 75% and 84%;
- 4 proposals reached 50-74% acceptance;
- 5 proposals were clearly rejected, reaching less than 50% of agreement.

Except for 3 proposals, rejection was due to disagreement with one or two modalities.

8.2.2.1 *The first line psychology*

Our model proposed to develop a **first line psychological function (FLPF),** offering several treatments based on a 'stepped care' approach. Respondents agreed (at least > 75%) on the following missions: welcome and listening of complaints, functional assessment, help with coping, psychoeducation, early detection and referral of severe problems to a psychiatrist, and referral to a specialized healthcare practitioner if necessary. 'Counseling' and 'brief therapy' were less accepted, while 'group sessions' in first line psychology function were rejected by the majority. Respondents suggested also to include coaching for other healthcare practitioner, e.g. GP.

The respondents agreed to develop a care model, **accessible to anyone without medical referral**. (n=41/45). Nevertheless, respondents indicated that the implication of the GP at start is important. They agreed also that this function could be **performed by clinical psychologists and orthopedagogists recognized by Law, trained in first line psychology and experienced** (or after going through specific internship). One respondent added that this training should be mandatory for every clinical psychologist. Others would like the function to be open to other professionals, with a specific training. However, they **reject the idea that GPs, specifically trained for this function** (with the creation of new competence INAMI – RIZIV code) **could be part of the first line psychological function**. Some rejected the idea of an additional training, other mentioned the shortage for GPs in Belgium and that priority should thus be given to medical care.

Our proposal to condition the practice in an FLPF to an **accreditation (renewable every 3 years)** that should include (1) continuing education and training, (2) inscription into an intervision-group, (3) effective participation in this group and (4) effective practice in first line psychological care was also agreed by respondents. Remarks we received concerned the lack of proof regarding the efficacy of the system of accreditation and the risk of administrative workload associated.

A high agreement among stakeholders (>85%) appeared regarding a mandatory **registration** of the 1st line psychology practitioners **in the multidisciplinary local network**.

They also agreed on the necessity of **geographic availability and distribution** by means of integration in existing structures combined with the setup of private FLPF practices.

The **financial accessibility of the FLPF for the patient should also be guaranteed** by means of financial support of the public authorities and by granting access to everyone, without criteria related to diagnosis, beneficiary or severity. Patient's 'out-of-pocket' share should be limited to 9 euros, according to 21 respondents, or min 10 euros according to 16 respondents. Nineteen respondents felt 5 sessions to be sufficient for the FLPF while 22 respondents proposed to go up to 10 sessions.

Our model stated that, in order to support practitioners of the first line of psychological care, an advisory consultation of a psychiatrist should be made available. This proposal generated many comments, mainly because it was not defined precise enough in the document to understand the difference with the current possibilities. We will thus precise this topic in the next development step.

8.2.2.2 *The second line: specialized care*

We proposed to offer a next level of specialized care for those whose psychological problems exceed the treatment possibilities of FLPF, i.e. who need more than a limited first line approach.

Access

In order to define eligibility for reimbursed specialized psychological care we proposed to condition the access through the compilation of a bi-disciplinary (GP – psychologist) functional assessment, which should be included in the electronic health record (EHR) of the patient. This proposal was rejected as such, but it appeared that the main problem concerned the medical aspect of the assessment and that this should be part of the EHR of the patient. Obviously, based on the comments given, the content of the functional assessment was not clear to the respondents at this stage. Many reported not to understand the added value of the medical information. Because the majority rejected the creation of a 'psy GP', they rejected also the idea that the bi-disciplinary assessment could be done by this practitioner alone. We also received comments afterwards, stressing the fact that the functional assessment should not be divided in a psychological part giving by the psychologist and in a medical part (somatic and treatment) coming from the

GP. GP has a global view on the patient and is able to bring more than just 'somatic' aspects and vice versa. (S)He has information on the history of the patient, the social or the familial context and could also participate in the psychological assessment.

Limitation of the sessions

In order to keep the model financially tenable, we proposed to limit the number of reimbursed sessions, however with a possibility for renewal. This was generally accepted by the respondents. One of the comments was that the number of sessions should be defined according to EBM. But the discussion turned also on the financing mechanisms that we did not submitted to the respondents' panel: how to avoid overconsumption if the number of session is fixed? How to manage the different organizational aspects of psychological care (mobile team, CGG – SSM, polyclinics, etc.)?

Our suggestion to provide the opportunity to renew a series of sessions of specialized psychological care by means of consideration and approval by a third part (e.g. an « advisory psychologist working in a sickness fund » was rejected. The problem seems to be related primarily to the status of the "advisory psychologist". A stakeholder emphasized that linkage to a sickness fund, might carry the risk of 'conflict of interest'. He suggested to appoint an 'independent psychologist supervisor'. Others advocated to commission a psychiatrist for this function.

Our proposal to condition the renewal to the compilation of a functional assessment and a 'treatment plan' was also commented. Especially the treatment plan seems to be difficult to accept for a number of respondents, as this is perceived to imply an explicit choice for a specific type of therapy.

On the other hand, the automatic renewal for a list of psychological disorders requiring life-long treatment was accepted, even though if it was suggested that it could also be granted by a psychiatrist instead of defining a limited list.

Practitioners

Similar to the first line of psychological care, we proposed to authorize only practitioners recognized by law to provide specialized care. Reimbursement should only be granted to patients treated by a clinical psychologist working with a CGG –SSM. Remuneration of the practitioner, even if he or she is independent, should be done through the centre. The mandatory (financial) link with a CCG – SSM was rejected by the stakeholders. The following concerns were raised: (1) the CGG –SSM organizations are considered by some as inefficient, (2) the principle of 'independent practice' seems to imply for some that remuneration should directly be given to the practitioner, without intermediary, (3) the risk of increase in administrative workload, and (4) if collaboration has to be encouraged, this should not be mandatory.

We also proposed to guarantee a sound geographical distribution of the offer of specialized psychological care, what was largely supported by the respondents.

Financial aspects

The remuneration of practitioners via the CGG – SSM was rejected but the proposal that financing of the centers must be reinforced was welcomed, even with collaborations with independent practitioners

8.2.2.3 *Information sharing*

We proposed to provide software tools for information sharing in a 'mental health' component of the standardized electronic health records (eHealth). This folder should be accessible to a specialized psychological care provider, who has a therapeutic relation with the patient, and to the GP, who is entitled to be the manager of the Global Medical Record (DMG). The patient's consent should be a condition of reimbursement for therapeutic acts by specialized care. A significant part of the respondents raised ethical concerns, especially regarding the link between reimbursement of the patient and his/her obligation to give access to the data to the GP. The fact that the mental health component should be a separated part of the EHR was experienced as stigmatizing and leading to fragmentation of care.

8.2.2.4 *Limitations*

This survey methodology was chosen to test the acceptability/feasibility of the model in the perception of the stakeholders. Results cannot be considered as representative for the entire work field as we compiled a purposive sample and not a statistical one. However, we aimed to make it as inclusive as possible, in order to collect all points of view with regard to the organization of care for mild and moderate mental health problems.

Although, the results of the survey were solely used to prepare a general discussion on a new model for organizing the care, in a consultative way,

the risk of 'lobbying' remains realistic. However, our approach of treating the responses mainly as 'qualitative' material and the fact that every proposal, made through the building of the model, was formulated by and after an analysis by KCE, reduced the risk of bias significantly.

Although we did not try to achieve statistical representativeness for the debates, we admit that few GPs were present or participated in the several steps of the consultation. In total 4 GPs, as representative of GP-organizations, have really been involved and at least one was present at each consultation. Nevertheless this weak participation of the GPs in the survey has as consequence: their place in the proposed system was mainly assessed by non-GPs.

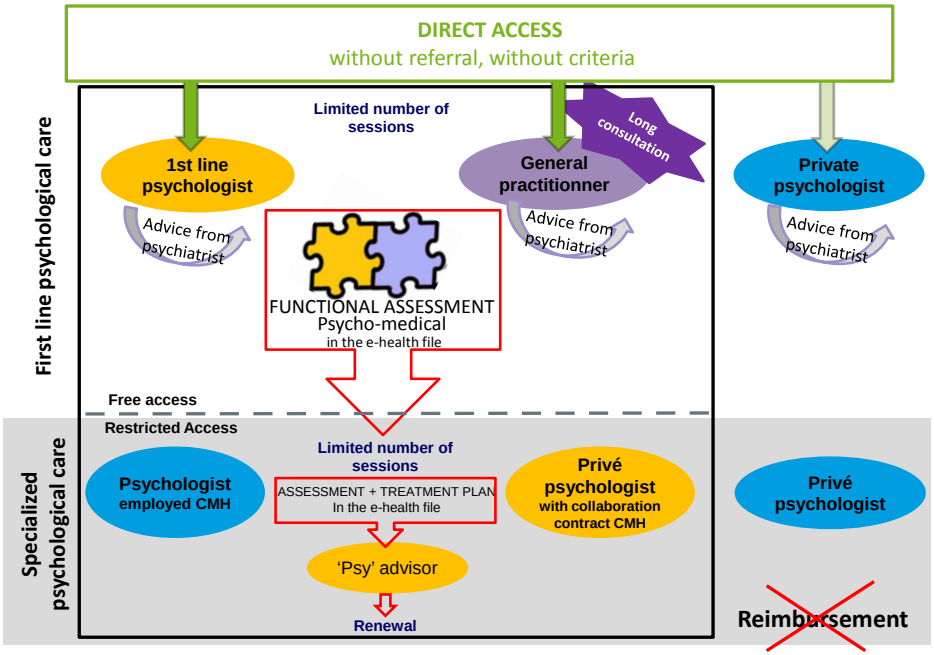
In order to avoid too extensive explanations in a rather long questionnaire, we deliberately choose not to explain the origin of our model in details. This might have been perceived as a lack of clarity by some of the respondents and probably might have led to misinterpretation of certain element of the model. Finally, we mention that some incongruences remained in the wording of the concepts we used in the survey, what might have led to some difficulties in responding.

8.3 Adaptions to the model

The model was refined according to the results of the meeting but still keeps the needs, as identified in the former steps. The following aspects were adapted:

- Suppression of the 'Psy GP'
- Specifying of the concept of 'one time advice from a psychiatrist':
  This is a single consultation of a patient in the first line of psychological care with a psychiatrists, prescribed by a GP or a first line clinical psychologist, to get advice related to the specific problems of the patient, and with the obligation of back referral. The idea is to allow 1st line care professionals to receive an advice from a psychiatrist in case of doubt. The need is to have rapid access to this specialist, to get adequate information and to be sure of back-referral. This implies that time has to be spent by the psychiatrist for reporting and concertation. We propose to value this advice more than a classic consultation, conditioning it to the fact that the psychiatrist needs to 'reserve time' for priority advice in his/her agenda with obligation to give a report to the prescriptor. This type of benefit should only be used ones per patient per year.
- Precision of the functional assessment: we enlarge the notion of the functional assessment to 'any useful information', not only psychological and medical. Moreover, every practitioner could give this information, without restriction to the discipline (GP or psychologist)
- Specification of the concept of 'Psy advisor':
  In order to guard provision of high quality care, to keep the model financially tenable, and to avoid excesses, we decided to install a 'Psy advisor'. To encourage the practitioner to reconsider regularly the necessity to continue his treatment, we proposed to mandate a 'third party' to verify the actual need to prolong/continue the treatment. Because this advisor should have good competences in the assessment and approach of common psychological problems, we propose to entitle this role to a psychologist or a psychiatrist. However, this does not necessarily imply that this person has to be employed in the sickness fund.
- The independent psychologist in the reimbursed system:
  In order to increase the capacity of the MHC (CGG – SSM), to optimize the geographical availability of reimbursed specialized psychological care and to encourage intervision, we propose that independent psychologists can set up a collaboration with a MHC (signed agreement) leaving them the opportunity to work in the MHC or from their private practices. The financial implications, due to the complexity of the financing system in mental healthcare in Belgium, will be further described in chapter 9.

Figure 8 – Model adapted after the survey - to be discussed with stakeholders



8.4 Results of the meeting

During the meeting, the 'new' model as well as the explanation of the modifications was presented to the stakeholders, as a guidance to precise the final model and its modalities. Discussions raised regarding the following issues: The notion of the 'Psy advisor', the collaboration between the GP or the psychiatrist on the one hand, and the psychologist on the other hand, the problem of reserving the financing of specialized psychological care to practitioners working in (or in collaboration with) CGG – SSM, and the issue to give particular attention to people with a handicap or a double diagnosis.

- **The notion of "Psy advisor":**
  The role of the "psy advisor" could be expanded to the evaluation of the legitimacy of temporary work incapacity for patients with mental health problems. Indeed, this role is currently performed by a 'medical advisor' who does not always have the specific competences to appraise the situation. The medical advisor therefore often asks for additional advice of a psychiatrist, which is time consuming for the psychiatrist (who is already overloaded). Moreover, it obliges the patient to see an extra practitioner. In case the 'psy advisor' function is established, it could be useful to alleviate this complex, time consuming process for the patient as well as for the psychiatrist.
- **The collaboration between the psychologists and the GPs:**
  The nature of the collaboration between these first line practitionners, as described in the model, was considered to be 'too light': a smooth and reliable collaboration between the GP and the psychologist was found to be crucial to ensure provision of qualitative. It is however known that, eventhough both parties are enthusiastic, collaboration remains difficult in everyday practice. Stakeholders also regretted that this kind of collaboration was 'imposed' (mandatory) at the end of the 5 consultation sessions in first line. Nevertheless, our 'new' model does certainly not prohibit consultation between practitioners. Moreover, in view of the future recognition of the psychologists as health professionals, and the planned information sharing between practitioners by means of a shared electronic medical record (eHealth), 'peer to peer' discussion should be facilitated and encouraged. The use of good models of collaboration could also be a competence to develop in the training of the first line psychologist, and of the GP.
- **Link between the psychiatrist and the psychologist:**
  Stakeholders regret that the psychiatrist is not present in the model, and particularly the collaboration between the psychiatrist and the psychologists. Indeed, this collaboration already exists and should be part of the model. They also raised the question of the necessity for a psychiatrist to get access to the specialized psychological care by use ofa functional assessment realized by both first line actors in order to refer a patient to specialized psychological care.
- **The need of a signed financial and collaborative contract with a CCG/SSM is mandatory for the psychologists who would like to offer reimbursed specialized psychological care to their patients:**
  The mandatory link with a CGG – SSM, as described in the model, was criticized: stakeholders were concerned that this system will give CGG – SSM the freedom to select psychologists who they accept to

collaborate with. Moreover stakeholders stated that CCG – SSM often have a specific therapeutically orientation of preference which might imply that collaboration with certain psychologists could be hampered (or even be impossible) because of divergent therapeutic approaches. A second issue that was mentioned is the perceived contradiction between the 'independent status' of the private psychologists and the requirement to negotiate and sign a contract and including a financial transfert between the institution and the psychologist. Nevertheless, in the hospital context this system is well established, as physicians (often working as independent practitioner) have negotiated contacts with their institution. In this context, this does not seem to be perceived as a contradiction.

- **Patients with disability:** A stakeholder mentioned the issue of persons with a "double diagnosis", as a combination of intellectual disability and behavioural or psychiatric problems. A recently published report of the Superior Health Council[99] revealed the problems of these persons in finding tailored care in Belgium, and recommended to organize a network of services, adjusted to all types of needs of these persons, throughout the country. These services should be part of the regular mental health care supply as much as possible while on the other hand taking into account the specific difficulties of this population. The stakeholders suggested to provide a set of transparent, geographically distributed access points for these population in the new system. Also, it should be guaranteed that professionals can dispose of the necessary extra time and qualifications for this target group.

8.5 Conclusion of the stakeholders consultation

Modifications of the model after the stakholder consultation:

- **Removal of the 'GP Psy'**
- **Specification of the concept of 'one time advice from a psychiatrist'**
- **Clarification of the functional assesment**
- **Clarification of the 'psy advisor' role**
- **Addition of the psychiatrist and its link with the psychologists (including functional assessment)**
- **Precision of the financing system for independant psychologists for specialzed psychological care**
- **Provision of the option to recognize 'private centres' for specialized care that might be considered for reimbursement**
- **Increase of attention in the recommendations for patients with disability and double diagnosis**

9 FINANCING OF THE PROPOSED MODEL

Depending on the literature on organization of mental health care, the international comparison we made for this report, and the discussions we had with stakeholders (see section 6.3.3.7), several models of financing can be proposed. Every model has proven to have advantages and disadvantages, which have to be taken into account when building a (new) remuneration system[100]. Therefore, some of the most prominent models are described and discussed below. Based on this information, we propose a financing model for Belgium.

9.1 Possible models for financing mental health care

Salary or yearly fixed financing

In this model, health professionals are paid a fixed recurrent amount of money (monthly, quarterly), and pay is not tied to enrolees or services rendered. Practitioners do not have a financial incentive to change their treatment patterns, either in terms of what is done during each visit or the number of visits. They also do not face financial risk, unless their contract includes withholds, bonuses, or retrospective utilization targets or performance goals linked to future salary increases[101]. However, as the salary is fixed, it gives little opportunity to artificially prolonged therapy or overtreatment, which is an argument to keep the system financially tenable. On the other hand, some sources argue that it does not give a financial incentive for increase of capacity, resulting in longer waiting times and a decrease in patient satisfaction[100].

In Belgium, psychologists are currently financed by use of this system in mental health care centres (CCG – SSM). According to stakeholders, this way of financing does not really stimulate the professionals to increase the number of patients treated, nor to lower the treatment duration, nor to reduce waiting lists. When considering a lump-sum financing, a capitation financing seems to be a better alternative. Fixed financing is also how GPs are currently in part financed through the “praktijkvergoeding”.

Capitation financing

In this system, health practitioners are prospectively paid a fixed amount of money to expend on health for the patients registered to them. This implies that a comprehensive range of defined services is guaranteed to every enrolled patient for a fixed price.[100] The delivered therapy or materials can differ substantially between systems, as these depend on the contract between the different parties. Advantages of this system, as stated in literature, are (1) discouragement of carrying out test and treatments of doubtful value, (2) creation of a link between payment and performance, (3) promotion of activities focused on prevention and patient education, and (4) more accurate estimation of future health expenditure. Disadvantages could be (1) health professionals will not be encouraged to increase workload, (2) selective intake of low-risk/low-cost/low-workload patients, (3) restriction of the practitioner’s freedom to determine the patient list size.[100, 101]

The Belgian example of ‘wijkgezondheidscentra’-‘maisons médicales’ (WGC – MM) shows additional disadvantages. For example, patients cannot go elsewhere unless with the agreement of the WGC/MM as RIZIV – INAMI does not reimburse the consultation anymore, instead the centre itself needs to reimburse the consultation. In Belgium, GPs are currently also partly financed through capitation payment through the payments for the electronic patient record (GMD – DMG).

Fee-for-service

In the purest form of this model, health professionals are paid for every service and test that they provide based on the usual and customary charges in the local area (defined by the health insurance system)[101]. Health professionals who work in this system have an incentive to increase the number of services or therapy sessions they provide. The health insurance system will pay these practitioners for procedures that they provide without regard to the total cost for the health care system. There is no incentive to avoid more costly tests and procedures because there is no defined budget that introduces financial risk.[101] Studies estimate that a totally free fee-for-service system might result in a substantial increase of health care cost.[100] The advantage of the system might be that it promotes higher availability of practitioners (including out-of-hours care).

According to some Belgian stakeholders, a fee-for-service system must be avoided to finance psychological care in Belgium because it does not enhance collaboration nor referral of patients to other professionals as each professional would be incentivised to keep the patient for him/herself. Other stakeholders are however in favour of a fee-for-service system, where the clinical psychologist or orthopedagogist bills the fee, not the psychiatrist as

is today for certain interventions conducted by a psychologist (e.g. assessments).

Combination of models

Taking into account that every financing system has its advantages and disadvantages, it might be better to opt for a mixed system, combining one or more of the described models. Elements of the different systems can be used to encourage certain aspects of care, while discouraging dysfunctional or abusive aspects, in attempt to promote a performant and financially tenable health care system[102].

9.2 A financial model for psychological care in Belgium

The organizational model of psychological care, that we propose consist of a first line of psychological care (free and easy accessible, without prescription or diagnostic, with a limited number of sessions, and financially tenable) and a second line of specialised psychological care (only accessible on prescription) (see section 10.2). In fact, there is also a third line of care, including institutional mental health care (e.g. hospitals). However, this line of care is out-of-scope for the present report and will therefore not be discussed in this financial chapter.

For the first and second line of psychological care, we propose a separate financing system, partly due to specific problems we were confronted with. For every line of care, we first describe the criteria we took into account, followed by a description of the current model. Finally we will briefly propose a way to make the place of the psychiatrist for specialized care more coherent in the system.

9.2.1 *Financing model for first-line psychological care*

The financing system for first-line psychological care …

- has to promote interdisciplinary networking and collaboration;
- has to stimulate interdisciplinary information sharing through the management of an electronic patient file;
- should facilitate the opportunity to psychologists and GPs to get 'one-time' advice from a psychiatrist (with back-referral);
- has to guarantee that the patient pays an equal out of pocket (OOP) payment, whatever the point of access to first line psychology he/she chooses, i.e. a first line psychologist or a GP;
- has to promote a tendency towards delivery of a limited number of consultation sessions (e.g. a maximum of 5 sessions) and discourage to keep a patient until the maximum of reimbursed sessions.

Additionally…

- the cost for society for the first line of psychological care has to be kept tenable;
- the patient's OOP payment ('remgeld'/'ticket modérateur') has to be kept affordable;
- special financial efforts have to be made for the reimbursement of vulnerable groups, comparable with reimbursement for other treatments in healthcare;
- the existing reimbursement system has to be simple and standardized;
- the remuneration of the first line psychologist per patient per treatment trajectory should not exceed the price of the maximum permitted number of sessions, based on the consultation fee charged by a clinical psychologist today (e.g. 50€/consultation, c.f. data from the health insurance companies);
- Psychologists and orthopedagogists should be allowed to work salary based (e.g. as an employee in CAW/Centre de Planning Familial, OCMW – CPAS) as well as self-employed in first line psychological care;
- 'Pay for quality' should to be considered for the future.

As a combination of the above mentioned criteria, we propose a mixed system of financing for the '**first line psychologist'**. This mixed funding consists of:

1. A fixed 'practice allowance', as a compensation for extra-therapeutic activities, such as networking, intervision, administration and integration in a local collaborative network. This allowance has to be adapted on the size of the practice (minimum threshold of activity to benefit, which might be more important for practice with several practitioners, to be defined).

2. A fixed lump sum per patient for the input/maintenance of psychological status and care data in the electronic medical health record (e-Health). This sum is only payable once per patient per consultation episode.
3. A 'fee-for-service' for a limited number of consultation sessions (e.g. 5 sessions) (third-party payer, no supplements allowed).
4. The patient's own share per consultation session has to be standardized. We propose a limitation to 1.5€/session for vulnerable groups and 6€/session for the general population. This is equal to the OOP payment for a GP consultation and applies a factor four ratio between the general population and the vulnerable groups (the OOP payment for the general population divided by 4 for vulnerable groups).

Total remuneration of a clinical psychologist: The sum per patient of all of these components over a treatment period should not exceed the actual remuneration of a clinical psychologist consultation today for the maximum allowed number of sessions (for example: limitation to 5 sessions/patient/treatment period x 50€/session = 250€ max.).

In case the first line psychologist works as a **salaried employee,** he has to be remunerated, based on negotiated salary scales, as currently used for other health care professions (e.g. nurses, midwifes, speech therapists).

The **GP** should have the opportunity to organize long consultations (limited to a certain number of sessions per patient) to take care for people with psychological problems.

Nomenclature for an advisory consultation of a **psychiatrist** should be installed. The fee for this consultation should be higher than for a classic one because (1) priority should be given to patients 'referred for advice' and (2) time has to be spent on consultation with the referrer (including report). Reimbursement for this type of advice should be allowed only once per patient and per year.

Clinical psychologists who decide not to be recognized as First line Psychologists, are free to keep on working in their **private practices** but their activities will not be eligible for reimbursement.

9.2.2 *Financing of specialised psychological care*

For the financing system for specialised psychological care the following aspects have been taken into account:

- The model of financing has to reinforce the existing structures of specialised psychological care, resulting in an increase in treatment capacity.
- Many of the existing structures are already overloaded.
- the cost for society for specialised psychological care has to be kept tenable.
- Practitioners in specialised psychological care should work in a collaborative and multidisciplinary context.
- Centres for specialised psychological care (CCG – SSM) are currently financed by the Federal Entities (lump sum funding).
- Therapeutic acts (nomenclature/ fee-for-service) are currently financed by the Federal statutory health insurance (INAMI – RIZIV).
- Psychologists and orthopedagogists should be allowed to work salary based (as an employee) as well as self-employed (paid by the organization as independent health practitioner) in specialised psychological care.
- Although CGGs – SSMs get a lump sum financing from the Federal Entities for their activities, to date a part of their income also comes from 'fee-for-service financing, as psychiatrist can submit nomenclature forms for their therapeutic activities in CGGs – SSMs. This is in fact an example were both sources of funding are already combined.
- The model should install barriers to prevent 'open ended' financing for specialised psychological care.
- Existing reimbursement systems have to be simplified and standardized.
- Special financial efforts have to be made for the reimbursement of vulnerable groups, comparable to other healthcare reimbursements.
- A better geographical distribution of specialised care has to be promoted.
- Pay for quality has to be considered for the future.

As a combination of the above mentioned criteria, we propose a mixed system of financing **specialised psychological care**. This financing consist of:

- A 'lump sum' financing, as paid at present by the Federal Entities, for the activities of CGGs – SSMs. The amount should remain the same as it is today and should be used for extra-therapeutic activities such as logistics, housing, maintenance, administration, keeping up electronic health records, supportive staff, networking and collaboration, mental health promotion, prevention and education.
- A 'fee-for-service' financing for the therapeutic acts, conducted by psychologists, orthopedagogists (and psychiatrists), paid on a nomenclature basis by the statutory health insurance. The price per consultation should be negotiated.
- The patient's OOP payment per consultation session has to be equal to reimbursement of a psychiatrist consultation today, i.e. 12 €/session for the general population and 3€ for vulnerable groups; standardisation of the OOP payment, a factor four ratio between the general population and the vulnerable groups (the OOP payment for the general population divided by 4 for vulnerable groups).
- Duration of treatment (number of sessions) should be limited, with possibility of renewal of the therapy cycle.

Clinical psychologists should have the option to work for CGGs – SSMs as an employee or self-employed. In the latter situation, there has to be a legal contract of structured multidisciplinary collaboration between the parties. In both cases however the CCG – SSM should collect the nomenclature fees of therapy acts and pay the health professionals (salary or contract based remuneration). **Salaried psychologists** should be remunerated, based on negotiated salary scales, as currently used for other health care professions (e.g. nurses, midwifes, speech therapists). **Independent psychologists**, who signed a legal contract of collaboration with a CCG – SSM could agree to work in the location of the CCG – SSM or outside (as a satellite) and should be paid, based on their practice activities. It can however be considered by the Regional Governments to allow independent psychologists to set up additional private group practices in specialised psychological care, independently of the existing CGGs – SSMs. However, we plead these practices to be in line with the existing centres in terms of legal conditions, requirements and financial policy.

In order to keep the costs tenable, we propose the following mechanisms:

- Only recognized 'clinical psychologists' can be eligible for reimbursement.
- As a consequence of gatekeeping, patients will only get access to reimbursed specialised psychological care after referral by a first line psychologist or a medical doctor, including the compilation of a multi-disciplinary functional assessment.
- Number of sessions in the first line as well as in specialized care is limited.
- The opportunity of renewal for specialized care will be assessed by a third party. An advisory psychologist/psychiatrist should be installed to consider and grant this renewals. However, exceptions could be forseen for a limited list of specific (chronic) pathologies.

9.2.3 *The place of the psychiatrist in the system*

Currently, the place of the psychiatrist in the healthcare system is not clear. This specialized practitioner, who in fact belongs to the second line of care, is directly accessible - even for first line approaches. The new model that we propose gives the opportunity to make the place of the psychiatrist in the system more coherent. Therefore, we propose that, while direct access for a citizen to a **psychiatrist** can remain in the system, it should be financially discouraged by a "soft echeloning" mechanism. This could be structured as followed:

- Patients who access a psychiatrist directly, or via referral by private psychologist, will have to pay the 'classical' OOP payment, i.e. 12€/3€ according to the social status.
- Patients referred to a psychiatrist by a medical doctor, by a first line psychologist or by a specialized psychologist (employee or self-employed) in a CCG – SSM, will have to pay a reduced OOP payment, based on the reimbursement system for specialist consultations referred by a GP for patients who have a GMD – DMG (reduction of 5€ or 1€ for vulnerable groups).

9.3 Need for data to carry out calculation of costs for the first line of psychological health care in Belgium

As stated before, upon the start of the project, we were asked to make a budget impact analysis of the implementation of a first line psychological function in Belgium. However, data required to do this analysis was of extremely low quality or altogether lacking. We finally decided not to construct a complete economic model for first line and specialised psychological care in a Belgian setting.

Nevertheless, we plead for the setup of a performant data collection for psychological care in Belgium in order to make such cost estimation possible in the future. As we were confronted with important weaknesses in availability and quality of data regarding psychological health care in Belgium that hampered our cost estimation, we now describe in detail which type of data needs to be collected. For an example of a recent economic evaluation of a similar program in France, we refer the interested reader to the doctoral thesis by Dezetter (2012)[103].

The following enumeration of elements needed for a valid and scientifically sound estimation of the cost for first line psychological care in Belgium, is based on the methodology of the NHS project "Improving Access to Psychological Therapies" (IATP)[104], in collaboration with the National Institute for Health and Clinical Excellence (NICE)[105]. This model includes the following aspects and hypotheses: (1) the proportion of people in a specific region suffering from mental problems (of a certain severity), (2) the proportion of citizens consulting a health care professional to ease this problem, (3) the proportion of patients who would accept or refuse therapy/care performed by a psychologist, (4) the potential increase in health care consumption in regions where a new health programme is implemented[106]. Based on discussions with mental health care professionals in the field we decided to add an extra element in the model: (5) the proportion of patients with mental health problems who agree with psychological therapy but who choose to remain with 'their' private (not reimbursed) psychologist, they know from previous treatments and with whom they feel comfortable. Other aspects to be included in the estimation model are (a) the number of consultations that are reimbursed by the statutory health insurance, (b) the price of a consultation of a first line clinical psychologist, (c) the amount of the patient's OOP payment (co-payment) for the general and vulnerable population, and (d) the proportion of vulnerable patients in the eligible population for first line psychological care. As these aspects are already discussed in other chapters of this report, they will not be repeated here. However, they have to be taken into account for a future cost estimation.

An alternative method to estimate the private expenditure of ambulatory psychological care for 2010, used by the Belgian federation of psychologists (FBP – BFP), is reported in Calcoen et al (2015)[55]. This calculation did not build its estimates on the (potential) mental health care need in the first line, but took into account the number of self-employed registered clinical psychologists in Belgium, who provide on average 20 consultations a week, with an average cost for the patient of 50€/session and with 46 weeks of activity per year. They estimated a turnover of approximately 230 million Euro on ambulatory psychotherapy per year. To our opinion, this approach has several weaknesses for estimation of public expenditure of first line psychological care, in terms of (1) 'supply driven' versus 'demand driven' health care, (2) the lack of distinction between mild, moderate and severe psychopathology, and (3) the proportion of people with mental health problems who will choose for non-reimbursed psychological care. Therefore we did not apply this approach for this report.

An important preliminary remark regarding the elements that are discussed in the next paragraphs, is that a significant part of information concerning the (potential) mental health care needs for psychological suffering in Belgium is insufficient. Calcoen et al[55] faced the same problem and report "*Examples of missing data in the Belgian market are the figures on private expenditure for psychologists and dietitians. No aggregate data are available*." As a consequence, the figures given in the next paragraphs are merely indicative and have to be interpreted cautiously.

9.3.1 *Prevalence of mental health problems*

Because our model of the first line of psychological care serves as a point of access, we assume that civilians with a broad spectrum of psychological troubles will consult a health care provider to ease their problems. However, as severe psychological/psychiatric illness cannot be treated in a correct way in the first line, these patients have to be referred as soon as possible to specialised (residential or ambulant) psychological care. For the purpose of this study, we based our figures regarding the mental health status of the Belgian population on the results of the Belgische Gezondheidsenquête

2013/Enquête de Santé Belge 2013[1] and the 'mental health systems in EU member states, Belgium' report (2013)[2]. Data reported in these studies on the mental health status of respondents are both collected with the General Health Questionnaire (GHQ-12)[107]. A higher score on the GHQ-12 is an indicator of higher levels of self-reported mental health problems. Both studies used the same cut-offs. These reports show that 26% to 32% of the respondents reported mild to moderate psychological problems and distress while 14.2% to 18% of the respondents reported (potentially) severe mental health problems. As the model of care proposed in this study refers severe psychopathology as quick as possible to more specialised care, this group has to be excluded from the calculation.

9.3.2 *Search for help*

A certain part of the population that suffers from psychological troubles will search for care to ease their problems. The Itinera study "Hoe gezond is de geestelijke gezondheidszorg in België?" (2013)[95] estimates that on average 1/3 of patients with mental health problems will search for help, which is in line with figures from France (Dezetter et al, 2013)[106]. However, no robust data for this aspect is available. Moreover, as stated by Dezetter et al (2013)[106], it can be expected that implementation of a new health care structure will result in a (temporary) increase in health care use. Also on this aspect, no objective data are available, but it has to be kept in mind for future calculations or interpretations.

9.3.3 *Acceptance of psychological care*

It can be expected that a certain proportion of persons with mental health care problems will not agree to attend a first line psychologist (e.g. feelings of shame or stigma, taboo regarding mental diseases, specific patient's demand for somatic therapy such as medication …). The report of the Flemish pilot projects for a first line psychological function (FLPF)[40] reported a drop out at reference of 0% to 22% (Meann 9.14%, Median 11%) and 1% to 19% during ELP-care. No data were found for the French speaking part of Belgium on the proportion of patients with light to moderate mental health problems who agree/refuse to undergo first line psychological care. As this acceptance/refusal will have a significant impact on mental health care consumption, it has to be taken into account.

9.3.4 *Choice to remain with non-reimbursed psychologist*

We presume that a certain part of care seekers will refuse to step into the reimbursed first line psychological care but will choose to remain with "their" private therapist (no reimbursement), who they know from previous treatment and with whom they feel comfortable. Because of the sensitivity of the issues discussed during psychological treatment, a good interpersonal fit between patient and therapist is known to be important. As a consequence, this aspect is also an important variable in the estimation, as patients who choose to stay out of the reimbursed first line of psychological care, will not weigh on the health care expenses. However, at present, data on this aspect are non-existent for Belgium.

10 DISCUSSION AND CONCLUSIONS

10.1 Limitations

This report provides a critical discussion of the elements that need to be taken into account in order to build a new framework of psychological care in Belgium, starting from the assumptions that there is sufficient evidence in the scientific literature that a number of specific psychological treatments are effective; that the current psychological care offer in Belgium is not meeting the needs of the population in terms of accessibility and that an essential safeguard of quality of care has to be provided by adequate professional education programs and corresponding legal recognition of the right to practice that enough. This KCE study starts from an international perspective and examines the organization and reimbursement of these professions abroad, in order to draw lessons for the Belgian situation. We also included relevant information and experience from Belgian initiatives and experts. In this matter, the recent pilot projects, carried out in Flanders, provided us with precious information. In addition, to take advantage of the most accurate information and to consider very concrete issues for our country, based on our analysis of foreign examples, we consulted at 3 moments, 'informed' stakeholders (representatives of professional associations, patients, healthcare institutions, administration and health insurers) related to different aspects of the research results. The multiplicity of the sources used, their proximity with the work field and their position as 'representative' strengthen the feasibility of our model. This multi-method approach, mainly qualitative, gave us the opportunity to give nuances to our theoretical approach. We always proposed the possibilities coming from our scientific analysis, avoiding thus to be 'piloted' by the interests of one group or another. Stakeholders' views that we collected were informative and consultative.

However, some limits have to be mentioned. Firstly, methodological considerations made us focus on organizational aspects and not perform a cost-effectiveness analysis for psychotherapy. Due to the weakness (or even absence) of robust data for several aspects of psychological health care demands and health care consumption in Belgium, it was decided not to perform a cost-benefit analysis. Secondly, because of restricted (time) resources, we had to limit our international comparison to only 5 countries. We opted for the Netherlands and Germany as these are neighbouring countries where outpatient psychotherapy treatment is covered by statutory or compulsory health insurance. Given the fact that the practice of psychotherapy has developed differently in Francophone and Anglo-Saxon countries, we added England and Switzerland to our sample. Denmark was added because of its different approach to the reimbursement of psychotherapy. It is obvious that other examples could have been added in our analysis. Nevertheless, we perceived to have sufficient information to draw orientations suitable for Belgium. We did not identify a foreign model transferable 'as such' to Belgium, because of the differences in structure and organizations of the healthcare systems.

Thirdly, we did not enter deeply in the discussions on the competencies and the training of the different practitioners in the psychological health care field. As the law of 2014 regarding the recognition of health care professionals is not yet implemented and possible modifications are still under discussion, we did not clearly state the positon of the 'psychotherapist' (who is not a clinical psychologist) in our model.

Fourthly, although out of scope for this research project, the position of the informal care giver in mental health care has to be recognised. As part of the network of the patient, these people are very important for the support and empowerment of frail and vulnerable people, during a psychological treatment (social support, promotion of adherence) as well as post-treatment (e.g. social rehabilitation, relapse prevention, early detection)[108, 109].

Finally, we deliberately left the psychologist working 'in-hospital' out of the scope for this project, because of the current process of reviewing hospital funding.

In conclusion, we had the opportunity but also the difficult task, to propose an organizational and financing model 'from scratch', taking into account a long tradition of private and unregulated practice of psychological care in Belgium, with little evidence available. The use of several methodologies, the iterative process, and the combination of information coming from several valid sources, allowed us to propose an innovative organizational model for psychological care. We are conscious that the implementation of this model will need some modification/fine-tuning, which will take time to make it operational.

10.2 Final model

Our proposal is to create a system in Belgium consisting of two components (levels of access):

1. A first line of 'generalist' psychological care, accessible to all, without prescription, regardless of diagnosis, beneficiary or gravity.
2. A second line of more specialized care, reserved for those for whom this first line approach is not sufficient. This level will be accessible only on referral.

Our model is built on the principles of stepped care, a model in which care seekers initially get the least intensive treatment, corresponding to the nature and severity of their complaint. In case this approach should be insufficient, the patient is allowed to move (prescribed) to a next level of specialization ("stepping up")

The current system of private practice of psychological care, with direct access to primary as well as specialized psychological care, can remain as is today and act as an alternative pathway to psychological care, but in our model it is not eligible for a reimbursement by authorities.

10.2.1 *First line of psychological care*

10.2.1.1 *Type of intervention*

The first line of psychological care should provide tailored care, depending on the gravity of the complaints and with the option of referral to a next level depending on specific criteria. The following activities should be installed:

- Welcome and listening to all the complaints
- Establishing of a functional assessment, or if relevant, a diagnosis
- Counseling
- Support and empowerment in case of self-solvable problems
- Individual and group psycho-education (sleep problems, stress management, ...)
- Brief intervention for moderate issues (uncomplicated psychotrauma, mourning, ...)
- Early detection and redirection of (potentially) severe problems to a psychiatrist or to next levels of specialised psychological care (matched care)
- Reference to more specialized psychological care if necessary.

The types of intervention in first line psychological care should not necessarily be limited to face to face consultations: group sessions, online programs, consultations by telephone or other remote interfaces, observations in school (for orthopedagogists), home visits (for the elderly and disabled).

10.2.1.2 *Access to 1st line psychological care*

Provision of multiple entrance doors to first line psychological care should increase accessibility: OCMW – CPAS, emergency care, physicians, the school sector (CLB – PMS), CAW/Centres de Planning Familial, medical advisors, associations working with disadvantaged populations, etc. should all be encouraged to guide potential patients to the first line of psychological care if psychic distress is suspected.

The offer should be geographically well distributed and clear information has to be given to the general public and all medical and social actors.

Attention should be given that access is also guaranteed for target groups with specific needs (double diagnosis, elderly, …); taking care of these groups requires specific competencies and centres offering these should also be geographically well distributed.

10.2.1.3 *The practitioners*

The first line clinical psychologist

The clinical psychologist, recognized as an independent health care profession by the law of April 4, 2014, who in addition got a specific training for first line psychological care should be allowed to work as first line clinical psychologist. Bachelors in Psychology could be integrated in the first line function but should work under the supervision of a first line clinical psychologist.

Conditions of recognition for the first line psychological care:

- Providers should be actively inserted in the local health care network.
- Providers should comply with certain requirements for continuing education and participation in intervision groups.

The clinical orthopedagogists

The clinical orthopedagogists should be allowed intervene in the first line psychological care on the same terms and conditions as clinical psychologists, but only in relation to their specific audiences.

The GP

The GP should also be considered to act in first line psychological care but should have the opportunity to conduct a limited number of long consultations.

…with the punctual help of a psychiatrist in case of doubt

The first line practitioners as mentioned before should have the opportunity to get advice and support from a psychiatrist, via a specific nomenclature code, by means of a single advisory consultation with a psychiatrist, after which the patient should be referred back to him/her. This consultation should receive priority in the agenda of the psychiatrist and a written report has to be provided. This advice is however not related to consultation for attestation for temporary work incapacity of the patient

10.2.1.4 *Localization of the 1st line psychological care*

First line psychological care could be organized in existing structures but also in private practices. For example it could be installed in a medical house (Maison Medical/WGC), a family planning center or a CAW, an OCMW – CPAS, a PMS – CLB, but also in a CCG – SSM.

10.2.1.5 *Limitations of the sessions*

The number of reimbursed sessions should be limited. Five sessions should be enough to help the major part of the patients. It seems also sensible to install a time interval (for example 6 months) between two first-line psychology reimbursed treatment cycles with the same patient.

10.2.1.6 *Consultation of the actors and information sharing*

Collaboration and sharing of information between professionals that are involved are both needed. The professional secrecy is a crucial factor in the establishment of necessary trust, needed for an effective psychological intervention. But to avoid medical shopping and accumulated or parallel approaches, it is important that at least one practitioner is aware of which professionals are involved in relation to a certain patient (always subject to the explicit agreement of the latter), and that a single professional coordinates care. The patient's GP is probably the most suitable actor to centralize this information in the Global Medical Record or in the electronic medical record in general. The use of a centralized electronic medical record (eHealth) - with protected access based on therapeutic relationship - must be the standard. It is already foreseen by law for recognised health practitioners, including clinical psychologists and orthopedagogists.

10.2.2 *A second line of more specialized ambulatory psychological care for the people who need it*

10.2.2.1 *Type of intervention*

We do not define a list of specialized psychological care approaches that could be taken in consideration for reimbursement.

10.2.2.2 *Access to specialized ambulatory psychological care*

The access to specialized ambulatory psychological care should be reserved for people with specific therapeutic needs that exceed the possibilities of first line care. Eligibility should be based on a functional assessment, not necessarily on a diagnostic. This assessment has to be complemented by (at least) the first line psychologist and the GP and has to be documented in the electronic medical record. Urgent access to psychiatric care will not be conditioned to such assessment. Criteria for eligibility to get access to specialized care have to be defined. In case of eligibility a limited number of sessions should be reimbursed. A psychiatrist should also have the opportunity to refer a patient to specialized psychological care (for the same limited number of sessions). In this case he has to provide the functional assessment and has to document it in the electronic medical record.

Also in specialized ambulatory psychological care, attention should be paid that access is guaranteed to target groups with specific needs.

10.2.2.3 *The practitioners*

Specialized care should be given by recognized professionals (clinical psychologists, psychiatrists, other doctors) as defined by the Law, who have received additional specific training psychotherapy.

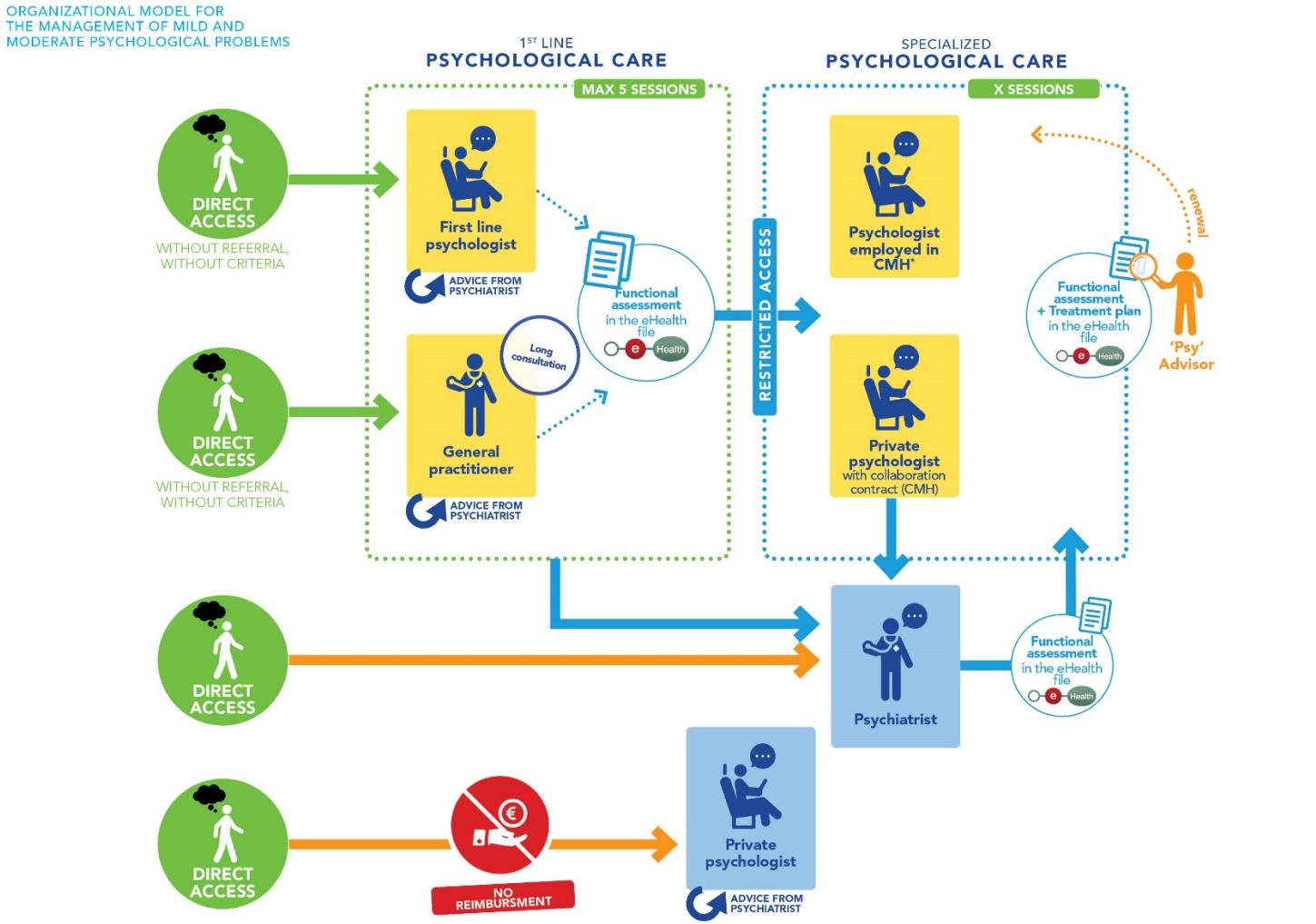
10.2.2.4 *Localization of the specialized psychological care*

The clinical psychologists in specialised care, should work **in** or **in collaboration with** an existing financed structure (CGG/SMM) (see 10.3.2 for finacial aspects). In order to increase the offer (geographicaly and in terms of therapeutic orientation), it could be considered to allow independent psychologists to set up additional private group practices in specialised psychological care, independently of the existing CGGs/SSMs. However, we plead these practices to be in line with the existing centres in terms of legal conditions, requirements and financial policy.

10.2.2.5 *Limitations of the sessions*

To keep the system financially tenable and to avoid never-ending self-referral, the number of sessions should be limited. If the treatment needs to be prolonged, an additional number of therapy sessions can be allowed. For this renewal, the opinion of a third party is needed. This ‘Psy advisor’ could be a psychologist or a psychiatrist. The ‘Psy Advisor’ has to consider the need and relevance of continuation of the treatment, based on an update of the functional assessment and a care plan (provided by the specialized psychological care provider). These reports should both be part of the electronic medical record (eHealth) of the patient (with his/her agreement).

Figure 9 — Final Organizational model for the management of mild and moderate psychological problems



10.3 System of financing the model

We propose a mixed financing of the system:

10.3.1 *For the first line*

We propose a mixed system of financing for the '**first line psychologist'**. This mixed funding consists of:

1. A fixed lump sum, called 'practice allowance', as a compensation for extra-therapeutic activities, such as networking, intervision, administration and integration in a local collaborative network. This lump sum has to be adapted on the size of the practice (minimum threshold of activity to benefit, which might be more important for practice with several practitioners,… to be defined).
2. A fixed lump sum per patient for the input/maintenance of psychological status and care data in the global electronic health care record. This sum is only payable once per patient per consultation episode.
3. A 'fee-for-service' for a limited number of consultation sessions (e.g. 5 sessions) (third-party payer, no supplements allowed).
4. The patient's own share per consultation session, which has to be limited to 1.5€/session for vulnerable groups and 6€/session for the general population. As a matter of standardisation with other reimbursements, these amounts are equal to the OOP payments for a GP consultation. A factor four ratio is applied between the general population and the vulnerable groups (the OOP payment for the general population divided by 4 for vulnerable groups).

Total remuneration of a clinical psychologist: The sum per patient of all of these components over a treatment period should not exceed the actual remuneration of a clinical psychologist consultation today for the maximum allowed number of sessions (for example: limitation to 5 sessions/patient/treatment period x 50€/session = 250€ max.).

The **GP** should have the opportunity to organize long consultations (limited to a certain number of sessions per patient) to take care for people with psychological problems.

Nomenclature for an advisory consultation of a **psychiatrist** should be installed. The fee for this consultation should be higher than for a classic one because (1) priority should be given to patients 'referred for advice' and (2) time has to be spent on consultation with the referrer (including report). This type of advice could be billed only once per patient and per year.

The **GP** should have the opportunity to organize long consultations (limited to a certain number of sessions per patient) to take care for people with psychological problems.

Nomenclature for an advisory consultation of a **psychiatrist** should be installed. The fee for this consultation should be higher than for a classic one because (1) priority should be given to patients 'referred for advice' and (2) time has to be spent on consultation with the referrer (including report). Reimbursement for this type of advice should be allowed only once per patient and per year.

Clinical psychologists who decide not to be recognized as First line Psychologists, are free to keep on working in their **private practices** but their activities will not be eligible for reimbursement.

10.3.2 *For the specialized care*

We propose also a mixed system of financing **specialised psychological care**. This financing consist of:

1. A 'lump sum' financing, as paid at present by the Federal Entities, for the activities of CGGs – SSMs. The amount should remain the same as it is today and should be used for extra-therapeutic activities such as logistics, housing, maintenance, administration, keeping up electronic health records, supportive staff, networking and collaboration, mental health promotion, prevention and education.
2. A 'fee-for-service' financing for the therapeutic acts, conducted by psychologists, orthopedagogists (and psychiatrists), paid on a nomenclature basis by the statutory health insurance.
3. The patient's OOP payment per consultation session has to be equal to reimbursement of a psychiatrist consultation today, i.e. 12 €/session for the general population and 3€ for vulnerable groups; standardisation of the OOP payment, a factor four ratio between the general population and the vulnerable groups (the OOP payment for the general population divided by 4 for vulnerable groups).

Duration of treatment (number of sessions) should be limited, with possibility of renewal of the therapy cycle.

Clinical psychologists should have the option to work for CGGs/SSMs as an employee or self-employed. In the latter situation, there has to be a legal contract of structured multidisciplinary collaboration between the parties. In both cases however the CCG – SSM should collect the nomenclature fees of therapy acts and pay the health professionals (salary or contract based remuneration). **Salaried psychologists** should be remunerated, based on negotiated salary scales, as currently used for other health care professions (e.g. nurses, midwifes, speech therapists). **Independent psychologists**, who signed a legal contract of collaboration with a CCG – SSM could agree to work in the location of the CCG – SSM or outside (as a satellite) and should be paid, based on their practice activities.

Duration of treatment (number of sessions) should be limited, with possibility of renewal of the therapy cycle (see 10.2.1.5)

10.3.3 *"Soft echeloning" to the psychiatrist*

To keep the place of the psychiatrist coherent in the system we propose to enlarge the current echeloning system to the referral by a first line psychologist. Concretely:

- Patients who access a psychiatrist directly, or via referral by private psychologist, will have to pay the 'classical' OOP payment, i.e. 12€/3€ according to the social status.
- Patients referred to a psychiatrist by a medical doctor, by a first line psychologist, will have to pay a reduced OOP payment, based on the reimbursement system for specialist consultations referred by a GP for patients who have a GMD/DMG. This is currently a reduction of 5€ (or 1€ for BIM) for one consultation per year.

10.3.4 *Economic model*

Because of very law quality of the data and even the lack of valid data, we are not able to make economic simulations of the costs (and effectiveness) of the model we propose.

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