

The provision of psychotherapy – an international comparison

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Background

There has been a recent initiative in England to establish a wider provision of psychotherapy, in particular CBT. The main target group are patients with anxiety and depressive disorders. The planned wider provision will require substantial new funding, and the expectation is that there will be economic benefits in terms of more employment of people with mental health disorders and savings in other areas of health care.

Whilst two pilot projects have been planned for Doncaster and Newham, various aspects of the commissioning and provision of psychological treatments are still under consideration, and the debate on the best model to deliver psychotherapy may benefit from experiences made elsewhere.

In some other countries in the industrialised world, psychological treatments have been provided on a larger scale than in England for more than 20 years. Studying their models and experiences may enable policy makers in England to learn lessons and avoid pitfalls.

Purpose of the paper

Against this background, the paper assesses and compares the provision of psychotherapy in a limited number of European and non-European countries. The range of countries to be studied should include countries with different traditions of mental health care and different health care systems.

A comprehensive picture of the provision of psychotherapy in different countries would require analysing and understanding the principles and various details of each national health care system in which the psychotherapy provision is embedded. This paper does not attempt to do that and has a much more limited scope. It focuses on a limited number of features of the psychotherapy provision in different countries and compares them without considering wider aspects of the given health and social care systems. The purpose of the comparison is to highlight issues and trends that might be of relevance for the current considerations to implement more psychotherapy in England. The features that the paper studies are the number of psychotherapists and their professional qualification, the settings and models of psychotherapy, the referral procedures, commissioning and funding arrangements, regulations, quality management and outcome assessments.

Method

The selection of countries was purposive and intended to capture different traditions of health care, e.g. the German and Italian traditions of psychiatry, different health care systems, e.g. the state provision as in England and the more private organisation as in Switzerland, and different cultures with the anglo-phone world, e.g. Australia and Canada, and major European

countries, e.g. France and Russia. Yet, the selection was also influenced by convenience, most importantly the availability of sufficiently reliable information and the familiarity of the author with the given system. Information was obtained through personal contacts with experts and from sources on the web. Through the Network of European Capitals on Mental Health Care further information was obtained from other countries (e.g. Czech Republic, Serbia), but this was not presented in a separate description if not sufficiently complete and/or reliable. It was, however, considered in the discussion if appropriate.

A structured list of psychotherapy features was used to collect the information from each country. If possible, all issues were further discussed and clarified with an expert from each country.

In the following report of findings, the situation in each country is summarised (A synopsis of the information is provided in table 1 at the end of the paper). When an expert insider provided a view of the strengths and weaknesses of the given national situation, this is reported at the end of the national summary. The brief descriptions of the national situations – in alphabetical order to avoid any ranking of importance - are followed by a summary of characteristics of the psychotherapy provision in the UK and aspects of European regulations. The paper ends with a discussion of the aspects studied and conclusions of what the implications for current debate in England might be.

Psychotherapy in other countries

Australia

In Australia, psychotherapy is not regulated by a specific government body as more traditional health professions are. There are no single compulsory training path and no formal requirements to work as a psychotherapist, with many professional associations and Registration Boards that are related to the practice of psychotherapy and counselling. Thus an individual can train to become a psychotherapist or counsellor through various paths. Health professionals from disciplines such as social work, nursing, psychology, psychiatry or medicine may undertake post-graduate training in psychotherapy and counselling.

The Psychotherapy and Counselling Federation of Australia (PACFA) is an umbrella association comprising affiliated professional associations that represent various modalities within the disciplines of Psychotherapy and Counselling in Australia. It has set standards and guidelines but these are not supported by government regulations - the government has moved away from regulation and wants these professions to 'self-regulate'. PACFA has provided a forum for people who have training in psychotherapy or counselling that fall outside of the formal health professional associations.

PACFA provides a registry of psychotherapists who have undergone a rigorous application process during which their qualifications, relevant training and supervised experience have been verified as meeting PACFA-defined standards. It also confirms that they meet the PACFA requirements for on-going supervision and professional development, and that they belong to a PACFA recognised professional association. There are a number of sections to the Register: Psychoanalysis and Psychoanalytic, General Counselling and Psychotherapy Practitioners, Family/Relationship, Integrative Psychodynamic, Expressive Arts, Hypnotherapy, Experiential, Body Oriented, Psychotherapy and Counselling Educators.

In order to come under the PACFA umbrella, the training course needs to meet minimum PACFA standards. Whilst there are no legal restrictions on use of the terms 'counsellor' or 'psychotherapist', national standards (PACFA) hold that a practitioner should meet minimum requirements for training, supervision, and experience. Formal training must occur over a period of at least 3 years and contain a minimum of 50% experiential training.

There is no formal referral process for psychological treatment, as treatment is either provided free through various government agencies or through private practice fee-for-service. The referral process is dependent upon the referrer, some may refer to a psychiatrist, or a clinical psychologist, or local community services that offer counselling or psychotherapy. In some states programmes have been set up where psychologists or social workers are 'attached' to some general practices and offer psychological services (these are 'Medicare' funded programmes).

The number of psychotherapists is also dependent upon the definition of what makes a 'psychotherapist'. At this stage PACFA only has over three hundred on their register, The Australian Psychotherapy and Counselling Referral Directory, which covers many professional associations and registration bodies, have over 600 on their referral directory. There are 13000 psychologists in Australia, only about 1000 of these are clinical psychologists and about 900 are counselling psychologists. There are about 2500 psychiatrists in Australia but only approximately 10% of these are psychotherapists. Across all the health and welfare agencies there are a host of professionals that offer 'psychotherapy' in various forms. Much depends on the definitions of psychotherapy and counselling.

Psychological treatment is mainly financed privately or through direct government programs and services. There are no formal figures available on how many sessions each client has or on the cost as this would depend on the program that provides the public funding. Quality control and outcome assessments depend on the agency and what evaluation programs they have in place. Waiting lists depend on the agency and the service involved. Some community health centres have waiting lists for their counselling services. There are no restrictions on treatment. In private practice some practitioners have thirty sessions a week, whereas others only have eight hours a week. Therapists employed full time in government agencies usually carryout approximately twenty hours of direct client contact.

A potential problem with the system is the strong 'turf' wars – between the different health professionals offering psychotherapy.

Canada

In Canada, counselling or psychotherapy is provided through the national health care system. Teams are usually multi-disciplinary, consisting of family physicians, psychiatrists, and mental health counsellors. Patients are typically referred to mental health counsellors or psychotherapists from family physicians. However, cutbacks in the Canadian health care system have reduced the number of salaried and government positions for counsellors and psychologists. Private practice for counsellors and psychotherapists is therefore becoming increasingly popular. In addition, a shift from public to private funding, a rise in the number of third party payers for mental health services, and a greater demand for private practitioners have all contributed to more counsellors working in private practices.

Counsellors usually come from a variety of backgrounds, including psychiatric nursing, social work, or psychology and have completed a graduate programme in counselling. Mental health counsellors spend almost two thirds of their time with clients. Counsellors usually provide short-term work, on average seeing a client for 6 sessions.

Professional rates range from 41-63 Euros per hour. Individual appointments are 50 minutes in length.

France

In France, in 2004 an amendment was passed in the French Parliament to an ancient law designed to protect the public from the 'magical doings of Gypsies and cults'. The amendment added psychotherapy to that ancient law, making psychotherapy henceforth a 'medical treatment', which may be practised, only by physicians and those with a qualification in clinical psychology. There will be a national register of psychotherapists for all those psychotherapists who are not qualified in medicine or clinical psychology. Access to the register will be granted only to candidates who completed a training recognised by associations of psychoanalysts. Practising without such state-registration or a qualification in medicine or clinical psychology will become a criminal offence. The professions that currently practise psychotherapy and go on the training courses include psychologists, doctors, social workers, educational workers with further specialisation, and nurses.

According to the Declaration of Rights to Psychotherapy written by the French Federation of Psychotherapy and adopted by L'European Association of Psychotherapy, (June 25, 1998) everyone has the right to the free choice of a psychotherapist and free access to all the recognised methods of psychotherapy.

According to the French Federation of Psychotherapy (FFdP) there are approximately 8 000 - 12 000 psychotherapists in France. Some are members of the four principal interdisciplinary professional organizations, whereas others are independent, and are not affiliated or regulated with any of these organisations or federal structures.

There are no limits to the number of sessions provided. Psychotherapy and counselling cost approximately 44-59 Euros per hour, which is based on a sliding scale of short and long term work. Fees and methods of payment are open to negotiation. Costs for psychotherapy are refunded by social insurance only if the therapist is a doctor; otherwise the patient pays for the treatment; the costs of which often vary depending on the income of the patient. Some private insurance companies will also refund costs.

Germany

In Germany, the number of accredited psychotherapists rose by 10% each year from 1980 to 2000. Since 2000, no exact figures are available anymore. Yet, since then a specific law ('psychotherapists law') regulates the accreditation of psychotherapists and the provision of treatments. All psychotherapists are either doctors (i.e. usually, but not always psychiatrists) or psychologists and have an additional training of several years in an accredited institute. As a specialty, Germany has a wide provision of inpatient psychotherapy, often in specific

'psychosomatic' hospitals. Most of these psychosomatic hospitals are in leafy or rural areas and provide fixed treatments of 4-6 weeks funded by health insurance companies and/or pension insurance schemes. Outpatient psychotherapy is provided in private offices in which psychotherapists work either alone or in small groups. The number of such practices for each region is capped. Anyone can refer patients for psychotherapy, and self-referrals are common. If the psychotherapist is a psychologist, a psychiatrist has to confirm the indication. The decision on whether psychotherapy for a given patient will or will not be funded is taken by the insurance company following an application by the psychotherapist. Psychotherapy is free at the point of entry and covered by health insurance companies, which pay 77 Euros per session (private companies pay more). There are approximately 16,000 psychological psychotherapists and 3,500 medical psychotherapists accredited. The accepted methods are psychoanalysis/psychodynamic approaches and behaviour therapy. Insurance companies will cover a minimum of 25 sessions and – depending on further applications of the psychotherapist – up to 100 or more. Quality insurance is attempted through strict rules for accreditation and requirements for further training of psychotherapists. There is no routine outcome assessment.

The strength of the system is that psychotherapy is widely provided and fully covered. It is easily available. Referrals are to individual psychotherapists and not to psychotherapy in general which makes the decision to take up a given psychotherapy a personal choice. Yet, some psychotherapists are very sought after and, in extreme cases, have waiting lists of up to 8 months. Weaknesses are the difficulty to stop the increase of psychotherapy provision and costs and the absence of precise data on provision and outcome.

Italy

In Italy, psychotherapy is provided as part of the generic mental health care within the national health services, and there also is a well-established private provision. Within the national health services, psychotherapy is provided by professionals who are regularly involved in other aspects of care and treatment. All psychotherapists are either psychiatrists or psychologists, both with additional training. Patients can be referred by anyone, and self-referrals are frequent depending on the region of Italy in which the service is based. In any case, the local mental health team and the psychotherapists will always discuss the patient and take a decision on whether psychotherapy will be provided or not. All costs are covered by the National Health Service. The accepted schools are psychoanalysis/psychodynamic approaches, CBT and family therapy. Psychotherapists require 6 years specific training to practise psychoanalysis, 3 years for CBT, and 4 years for family therapy. The courses must be accredited by state authorities. In the private market, insurance companies usually pay for 30-50 sessions (for psychoanalysis often many more) with roughly 70-100 Euros for each session. In the NHS, 25-40 sessions are commonly provided. An exact number of psychotherapists was not available, and is difficult to establish in the NHS anyway, because qualified professionals do psychotherapy only for part of their time, which may vary.

Quality insurance is achieved through strict regulation of accreditation and, sometimes in the NHS, job evaluations. Scientific societies provide further training on a voluntary basis. Outcome assessments are not conducted.

Strengths of the system are the absence of waiting lists, i.e. in the NHS the referral procedure might take up to 3 months, but there is no formal waiting list, and in the private sector

psychotherapy is available immediately although not from every individual psychotherapist. Psychotherapy is fully covered in the NHS and through some health insurance companies, but many people have to pay for psychotherapy themselves in the private sector. Within NHS, a major strength is the psychotherapeutic qualification of staff that does both psychotherapy and other tasks and, therefore, establishes psychotherapeutic expertise and approaches throughout the service, including the care for patients with severe mental illness and psychotic disorders. Weaknesses are the absence of outcome data, the difficulty to establish quality criteria, and the limitations of the provision within the NHS.

The Netherlands

Since 1998, regulations on the training and registration of psychotherapists in The Netherlands have been tightened. The Dutch Association for Psychotherapy (NVP) was established in order to promote quality in psychotherapy through the development and review of training. The NVP supports the development and implementation of regulated standards, guidelines and protocols for training and practice. With more than 3000 members, the NVP represents a broad field of professionals, including both state and self-employed members. The NVP is an umbrella organisation for eight psychotherapy associations. Psychotherapy training lasts four or five year and consists of theory, practical training and supervision. The most common psychotherapy schools are behavioural and cognitive therapy, psychoanalytic/psychodynamic approaches, and client-centred psychotherapy. The frequency of sessions can vary, but usually is one session per week. The duration of psychotherapy can range from a few months to several years.

Each client pays a contribution to the cost of psychotherapy. In October 2004 the number of sessions for which the costs were fully reimbursed was limited to a maximum of 25. For children up to 18 years and for patients with a personality disorder it was a maximum of 50 sessions. After reaching this maximum, it is possible, after a year, to again request state compensation for costs of therapy. Individuals pay a small contribution of 15 Euros per session with a maximum yearly contribution of 675 Euros for 45 sessions. However some insurers may also cover these contribution costs. A large majority of the private psychotherapists also have a state contract.

The Netherlands has approximately 5000 psychotherapists. Accessing a psychotherapist can either be through the workplace or through referral from a general practitioner or health worker. Quality assurance is achieved through rules for accreditation but there is no routine outcome assessment.

The strengths of the system are that psychotherapy is easily accessible and the majority of costs are covered. The weaknesses are the lack of any quality control and the focus on patients who are sufficiently skilled to use the system to receive psychotherapy with a minimum of own financial contributions.

Russia

In Russia, the referral procedure to state employed psychotherapists is usually through the General Practitioner. Psychotherapy is provided by either medically trained psychotherapists or medical psychologists.

All psychotherapy training must be recognised by the Russian Ministry of Health Care. Training can only be provided by medical educational centres of higher or further vocational education accredited through a specific government licence. There are many methods used in psychotherapy. Psychological treatment provided by State medical establishments and financed by the patient is at a reduced cost per session as compared with the private sector. State services charge 29 Euros per 35-45 minutes for the first consultation and 18 Euros per hour thereafter. Private psychotherapy costs from 29-366 Euros per 20 minutes for the first consultation (depending on geographical location), and thereafter the same amounts per 40 minute session. State outpatient services and hospitals have restrictions on the length of the treatment. Private psychotherapists are able to negotiate their fee independently with the patient.

The training and practice of psychotherapists is governed by legislation of the Russian Federation. This system provides almost total control under the practice for both private and state psychotherapists.

Spain

In Spain, psychotherapists are usually health professionals, such as a psychologists or psychiatrists, who have undertaken additional and specific training in psychotherapy. However, there is no legal regulation on professional practise or any established Register of Certified Psychotherapists. In order to address this situation The Spanish Federation of Psychotherapist Association (FEAP) was established in 1964, under the Spanish Constitution, to bring together psychotherapists from relevant professional societies and associations. The aim of the FEAP is to develop minimum standards for the training and accreditation of psychotherapists. The FEAP has established a Register of Psychotherapists, where members are required to have a university degree, a minimum of three-year post-graduate training in psychotherapy with a minimum of six hundred hours of teaching in theory, techniques and clinical practice, and at least two years of professional supervised practice. The practiced methods are psychoanalytical, behavioural and cognitive, body, system oriented, and humanistic psychotherapy.

The referral process is through the Mental Health Centre, via a psychiatrist or psychologist. Most psychological and psychotherapeutic treatments at Mental Health Centres are carried out by psychologists. However, because of high demand and time pressures, this practice is not available in all Mental Health Outpatient Centres and regular psychotherapeutic treatment, especially psychodynamic psychotherapies, are difficult to conduct.

The psychological treatment in Spain is publicly funded; no psychotherapeutic treatments outside of the public mental health system are funded. There are no quality controls or outcome assessments carried out. No information on costs was forthcoming.

Switzerland

Psychotherapy is provided in private offices and widely available. All psychotherapists are psychiatrists or psychologists. Psychiatrists do not require further training; psychologists have a two-year course in addition to their academic degree. There are approximately 1264 adult psychiatrists and 2461 psychological psychotherapists in Switzerland. Patients commonly self-refer to the psychotherapist in the given practice, and the insurance company takes a decision about the funding, which, however, is almost always positive. The rate is 132 Euros per session, and insurance companies pay for approximate 30 sessions, ranging from 20 to huge numbers. The accredited schools are psychoanalysis, behaviour therapy and systemic therapy. There is no quality management beyond accreditation, and no outcome assessment. The strength of the system is the wide and easy availability of psychotherapy and the personal choice of the given psychotherapist. Weaknesses are the separation of psychotherapy from mainstream psychiatric services, and the absence of quality controls and exact data on provision and outcomes.

Psychotherapy in the United Kingdom

In the United Kingdom, psychotherapists working within the NHS usually come from a range of core professional backgrounds which may be either medical (psychiatry) or non-medical (general psychology, nursing, social work or other health professionals who have had further specialist training in psychotherapy). Psychotherapists working within the NHS usually form part of a specialist psychotherapist department or service.

There are three national registers for psychotherapists and counsellors in the UK that are maintained by the three leading umbrella bodies in the fields of psychotherapy and counselling. The United Kingdom Council for Psychotherapy (UKCP), the British Association for Counselling and Psychotherapy (BACP), and the British Psychoanalytic Council (BPC) for psychoanalytic psychotherapists. None of these bodies are part of the NHS, but are responsible for setting standards and training for all professionals working in these fields, within the NHS and outside of it. However, psychotherapists may also be members of the Register of Psychologists working as psychotherapists with The British Psychological Society.

Currently there is no legal registration or licensing requirement for psychotherapists in the UK, so there are no specific legal qualifications required for private practice. In 2004 the Department of Health agreed to commission a research project directed towards the possibility that the professions of psychotherapy and counselling might be regulated by the Health Professions Council (HPC) by 2008. This report found that in the UK there are approximately 38 000 members of 34 professional associations covering both psychotherapists and counsellors. There is no one route of entry to either psychotherapy or counselling in the UK through training. There are approximately 570 different training courses, with two-thirds not having professional body recognition although many are validated through the Further or Higher Education system.

The generic training requirements for the UKCP for a practitioner to be registered are that they must have completed a postgraduate level course in psychotherapy of at least 4 years part time duration or equivalent. However, each type of psychotherapy has slightly different training requirements. For BACP accreditation it is a minimum of three years part-time of taught and supervised practice. The UKCP contains 80 psychotherapy organisations with a

register of over 6000 approved psychotherapists. The BACP register contains approximately 6000 accredited counsellors and psychotherapists.

Over two-thirds of psychotherapists and over a third of counsellors work in private or independent practice. Only a third of counsellors and psychotherapists work in the health sector, with a higher proportion of counsellors working in primary care and a higher proportion of psychotherapists work in secondary care. More than half of psychotherapists and counsellors work over 20 hours per week.

Psychotherapy and counselling are available on the NHS. Referral for psychotherapy in the NHS varies from area to area. Some only accept GP referrals whilst others will accept referrals from other health related professionals. However, there is usually a long waiting list. The number of medical psychotherapists in NHS in England is around 100.

Private sessions vary in price. The number of sessions provided by the NHS does vary from 6-40, depending on the problem and the policy of the given service. The costs for a session usually range from 37-117 Euros depending on the therapist.

The European Association for Psychotherapy (EAP)

In 2004, the European Commission issued a Directive in order to standardise psychotherapy throughout all member-states. The purpose of this Directive was to standardise training and ethical guidelines to enable psychotherapists who have qualified in one member-state to practice in any other EU country. It appears that the EC has agreed, in principle, to issue the Directive on the basis of the European Certificate for Psychotherapy (ECP) promoted by the European Association for Psychotherapy (EAP).

In the UK the United Kingdom Council for Psychotherapists (UKCP) on behalf of the EAP, awards ECPs, based on the state regulated Austrian non-medical definition of psychotherapy, that is as an 'independent psycho-social activity'. This definition is contrary to other state regulated European countries, such as Germany and Italy, where psychotherapy and psychoanalysis is defined as a form of medical treatment to be practised only by doctors (usually psychiatrists) and some psychologists. In fact, with the exception of Austria all European countries that have adopted a statutory regulation in line with the anticipated European legislation limit the practise of psychotherapy to those with a qualification in medicine or psychology and further accredited training.

The European Association for Psychotherapy (EAP) represents 128 organisations (26 national umbrella associations, 18 European associations for psychotherapy) from 41 European countries and more than 120 000 psychotherapists. The ECP has a minimum requirement of a first degree in a health related subject, in addition to specific psychotherapy training.

Discussion

The level of provision

The most difficult feature to compare across countries is the level of provision because the available figures are inconsistent, and the reliability of the data shown in this paper must remain doubtful in some cases. Also, the exact definitions used in each country for the

national registers – if they exist – vary and are difficult to compare. This problem is not new and has been encountered in similar exercises before. The recent green paper of the European Commission on mental health also emphasised this point and demanded more reliable and comparable data on service provision in different countries. This applies to all regulated practice in mental health care. Yet, in psychotherapy, the situation is even more complicated as there is an increasing market of unregulated practice in some countries. This paper has touched on this unregulated psychotherapy provision for some countries, but cannot systematically consider it as a significant part of it is totally private, i.e. patients pay out of their own pocket for a service they find and use outside the established health care system. The reports suggest that at least in other EU countries psychotherapy – i.e. psychotherapy that is more or less free at the point of entry - is more widely available than in England. Numbers of psychotherapists are much higher in countries like Germany and Switzerland (although the number of registered psychotherapists/counsellors in the UK appears sufficient to provide services more widely than is currently the case, if more of them would work in mental health). If England intends to reach the same levels of provision, psychotherapy services have to expand requiring substantial further investment.

A further conclusion from the comparison of provision levels is that psychotherapy receives funding in different health care system with different funding arrangements. Particularly in insurance based systems such as Germany and Switzerland the demand for psychotherapy appears to have led to increasing supply and funding. In the light of this, it is likely that – once psychotherapy is more widely available – it will be used and GPs will not refrain from referring patients to save expenditure.

The demand for and provision of psychotherapy has consistently risen in most of the studied countries. If patients are requested to contribute to the funding, this may or may not slow down the growth of demand, but does not bring it to a halt as the example of The Netherlands demonstrates. The extensive private provision in several countries is further evidence for the strong consumer demand for psychotherapy, and for the willingness of ever larger groups of the population in Western societies to pay for it.

Type of psychotherapy provided and restrictions

The dominating psychotherapy schools are psychoanalysis, mainly in form of shorter types of psychodynamic approaches, and behavioural and cognitive treatments. Further forms of accredited and funded psychotherapy vary and depend on national characteristics, e.g. family therapy in Italy reflecting the strong orientation on families in Southern European societies and the tradition of systemic and other family therapies in Italy for more than three decades.

It should be noted that – wherever possible – clinicians and patients prefer referrals to individual psychotherapists (rather than to services or a treatment method). Some psychotherapists are so much sought after that waiting lists are created, but generally psychotherapy is available without waiting lists and without any other restriction. Patients can receive any form of drug treatment at the same time. The medication is prescribed by the psychotherapist (possible in most countries if the psychotherapist is medically qualified or – alternatively - by a GP or psychiatrist who collaborates with the psychotherapist). Imposing any such restrictions in England will hardly be feasible, and competitive forms of psychotherapy provision are unlikely to work with waiting lists.

Settings of psychotherapy and referrals

Treatment centres as planned in England are not the norm in any other of the studied countries. Psychotherapists are either part of mainstream mental health services or work in individual practices. The strength of the former model appears a stronger psychotherapy mindedness and expertise throughout the service that all patients – including those with severe mental illnesses – benefit from. Strengths of the separate provision might be the higher degree of transparency and focus. The setting also appears to influence the number of sessions a psychotherapist conducts per day. In private settings this varies and can be dictated by economic pressures (usually around 30 sessions per week). In general, however, psychotherapists who do not do psychotherapy every day are more likely to conduct 7-8 sessions per day than those who exclusively deliver psychotherapy without any other tasks. This may indicate a potential disadvantage of specialised single handed practices and treatment centres in which clinicians work in psychotherapy full-time.

Although health insurance companies – where they exist - have the final say on funding, psychotherapy is relatively easily accessible in more privately organised health care systems. In some systems, GPs and psychiatrists formally have to refer patients, but in most countries patients factually can and do self-refer. It can be anticipated that patients in England will not accept complicated and time consuming referral procedures. The system of simple referrals is associated with a further problem that might affect the economic effects of psychotherapy: A significant number of patients self-refer or make their GPs refer them who do not have a clear mental disorder that is likely to improve under psychotherapy. This is not restricted to the ‘worried well’. It applies to at least two groups of patients. One group are those with complex and often chronic disorders who become burdensome to their GPs and make them feel helpless. Such patients can get passed on to psychotherapy sometimes with the hope that psychotherapy would at least secure the required personal attention for them. The larger group are increasing parts of the population who expect to be provided with psychotherapy as the answer to various life style problems. Many of these patients are very assertive and skilled in their attempts to get psychotherapy (sometimes repeatedly). Thus, specific and rigid plans should be designed for how to limit this and ensure that publicly funded psychotherapy focuses on those patients who might draw significant health gains from it, rather than be misused. This is arguably one of the most difficult challenges for the planning of psychotherapy provision, and no country with easy referral systems has yet found a satisfactory solution. The problem becomes even more complicated when psychotherapists/services are flexibly paid by their activities and have a financial incentive to increase their workload.

Economic aspects

The price of a psychotherapy treatment depends on the costs per session and the number of sessions per treatment. The costs for one session in Germany and Switzerland may appear high, but include all on-costs and overheads. Thus, such arrangements facilitate transparent planning and comparisons, and the costs in those and other countries can and should be used to benchmark costs also for the UK.

The number of sessions in all countries –independently of the psychotherapy school - is much higher than planned for England. Throughout the history of psychotherapy there has been a

tendency for various schools to start with relatively short treatments and increase the number of sessions over time (e.g. client-centred therapy). Even therapies that were explicitly set up as brief, or ultra-brief, show this tendency. Whether patients really take up all sessions or in practice frequently drop out early (as some evidence suggests) is a different issue.

As compared to the plans for CBT in England, the length of treatment is longer in every other studied country, regardless of other features of the health care system and/or psychotherapy provision. Thus, a tendency to argue for longer treatments may also be anticipated for England. As this will substantially affect the economic equation, specific plans might have to be made to ensure the limit to the number of sessions. Also provisions have to be made for what happens if patients and clinicians feel more sessions are required or even that a new therapy should be conducted (in Germany, The Netherlands and Switzerland it is common that patients receive several successive therapies with different therapists). It can be assumed that some patients simply do not respond well to psychotherapy (i.e. there is no effect, or the effect is not sufficient or not lasting) in which case some of them receive more of it because of the insufficient improvement. Repeated provision of a similar treatment to non responders will diminish the overall efficiency of psychotherapy, and policies should be designed to avoid that. Yet, no satisfactory policy for this exists in any of the studied countries; only insurance companies may limit the number and frequency of funded treatments.

Evidence on potential saving effects of psychotherapy on a system level does not exist in any of the studied countries. In Germany and Switzerland, the argument was prominently used at the time that more psychotherapy would reduce the costs for inappropriate physical care for people with mental health disorders. Yet, such effect has never been demonstrated (and is unlikely given that the costs in the German and Swiss health care system are mainly driven by supply and not demand).

Quality assurance

The requirements for the qualification and training of psychotherapists are higher in most countries than in the UK. In some countries the accreditation of psychotherapists depends on ongoing further training, and this is regarded as a major element of quality assurance. In case European regulations come into place, the current rules in the UK may have to be adjusted. For various reasons, a statutory regulation of the accreditation of psychotherapists may make sense for the UK, and a wider establishment of NHS funded psychotherapy should be linked to a proposal for the most appropriate regulations. The timescale for developing such statutory regulations and incorporating them in national legislation is much longer than for the pilot projects of psychotherapy. Nevertheless, plans for the wider implementation of psychotherapy following the pilots might benefit from close collaboration with initiatives to regulate the profession and practice of psychotherapists.

Regular outcome assessments are not conducted in any country (although there are sporadic attempts mainly in Anglophone countries), and not demanded by insurance companies which otherwise function as formal gatekeepers and regulators of funding. Public health experts tend to lament about this total lack of outcome assessment in every country, but practitioners and patients alike appear reluctant to fill in questionnaires if they do not have to. If regular outcome assessment is to become a feature throughout NHS funded psychotherapy, it has to be tested what percentage of patients (and practitioners) can realistically be expected to comply with it, and what the most effective incentives are. Also it has to be clarified what the precise purpose of the regular outcome assessment is - e.g. who analyses the data and how,

who uses them and in what way, and what the implications of different findings are - and all this has to be shared with the relevant stakeholders.

Conclusions

Several foreign experts expressed dissatisfaction with various aspects of the psychotherapy provision in their countries, most notably with the unregulated growth of psychotherapy and the lack of data on provision and effects. Yet, most of these aspects are more linked to problems of the general health care system in the given countries than specific features of psychotherapy. Despite the limited enthusiasm for the existing forms of provision, some specific features were valued. Particularly in Italy, the incorporation of psychotherapy in mainstream services was seen as extremely positive for the acceptability, culture and effectiveness of mental health services in general, and the strict rules introduced for the accreditation of psychotherapists in some countries were also regarded as a major advancement in quality assurance.

However, if some aspects of the psychotherapy provision have developed in a similar way in various other countries (with obvious traditional differences between the Anglophone countries and central Europe), there are probably reasons for such a relatively uniform development, even if they are difficult to identify without further research. There is no reason why England should not implement much better and more efficient psychotherapy than other countries. However, in case psychotherapy in England is to be implemented in a way that significantly differs from the provision elsewhere, it should be carefully considered how to achieve the intended difference in practice and avoid being driven in the same direction as other countries. The plans currently being discussed in England differ in several facets from what is provided in most of the other countries investigated in this paper. The differences include the lack of strict and statutory accreditation rules, the whole concept of treatment centres, the low number of sessions, and the regular assessment of outcome data. It might be naïve not to anticipate difficulties implementing psychotherapy with all these features, and based on the international comparison the necessity of these features, their priority and possible alternatives and modifications should be re-considered.

At the same time, the comparison provides good reasons to believe that the demand of patients and clinicians will promote wider psychotherapy provision in England, even if the NHS moves towards a more liberalised market with free negotiations between funders/commissioners and providers. The challenge is to steer the development facilitating best quality treatment for those patients who are likely to benefit from psychotherapy. This will require a focus on central and most relevant elements, since detailed and prescriptive guides such as the PIGs for functional teams in the community are unlikely to work within the new arrangements.

Major lessons from those countries that experienced significant psychotherapy growth in the recent past are that the provision will absorb large amounts of funding and that the demand will not stop increasing once a certain level of provision has been reached. Thus, all efforts should be made to ensure that the available public funding in England is spent in the most efficient way. Among other factors, referral procedures ensuring that only those patients who are likely gain significant health benefits from it receive psychotherapy, the efficient configuration of services, appropriate accreditation of professionals and services, and quality management mechanisms are central to this endeavour. To what extent and in what way the

publicly funded psychotherapy will be complemented by a more or less regulated private market in psychotherapy will be difficult to influence anyway (beyond general frameworks for private health care provision and statutory regulations for the profession).

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Table 1: Number of psychotherapists, required training, schools of accredited psychotherapy, referrers, number of funded sessions, and quality assessments in psychotherapy in different countries

Country	Number of Psychotherapists (public)	Training required	Schools of Psychotherapy	Possible referrers	Number of sessions funded	Quality and Outcome assessment
United Kingdom	38 000 members of professional associations covering psychotherapy and counselling, although not all are accredited members. Two main accreditation bodies BACP and UKCP have approximately 12000 accredited members (20 per 100 000 population) Psychotherapists work in NHS multidisciplinary teams, voluntary organisations, and independently	Range of backgrounds; psychiatry, psychology, social work, nursing, other related areas, with 3-4 years additional training Number of professional accreditation bodies but no legal registration or licensing requirements	Integrative, person centred, psychodynamic and cognitive-behavioural	Via GP, health professional	Varies depending on problem: 6-40 Costs from 37-117 Euros per session covered by NHS	Quality assurance only through accreditation rules, limited outcome assessment (CORE counsellors)
Australia	Approximately 900 registered psychotherapists and counsellors, 1000 clinical psychologists, 900 counselling psychologists, 250 psychiatrists practicing psychotherapy (15 per 100 000 population)	Range of backgrounds; psychiatry, psychology, social work, nursing, other related areas, with 3 years additional training Number of professional accreditation bodies, each 'self-regulate', there are no legal registration or licensing requirements	Psychoanalysis/ psychodynamic and cognitive-behavioural, integrative	No formal referral process	No restrictions on treatment length No formal figures on costs	Existence and level of quality control and outcome assessment varies from programme to programme
Canada	Numbers not known	Range of backgrounds; psychiatry, psychology, social work, nursing, other related	Family therapy, client centred, psychoanalysis/	Usually from GPs but also	Usually 5-7 sessions Costs 41-63 Euros per	Rules for accreditation. Outcome

		areas, with additional training	psychodynamic therapy	other sources	session	assessment depends on location
France	Exact figures unknown, approximately 8000-12000 psychotherapists (13-20 per 100 000 population)	Soon to be enacted state law – only psychiatrists, clinical psychologists and others suitably trained with state registration may practice	All recognised methods	No formal referral process	No limits placed on number of sessions Costs 44-59 Euros per session	No formal quality control, partial control through Psychotherapeutic Unions
Germany	16000 psychological psychotherapists and 3500 medical psychotherapists accredited (24 per 100 000 population) Usually work alone	Either psychiatrists or psychologists with additional training	Psychoanalysis/ psychodynamic approaches and behaviour therapy	Self or professional referral	Insurers cover minimum 25 sessions and up to 100 more 77 Euros per session	Strict rules for accreditation. No outcome assessment.
Italy	Numbers not known Work as part of mental health care team or in private practice	Either psychiatrists or psychologists with additional training. All courses are accredited by state authorities -Psychoanalysis 6 years -CBT 3 years -Family therapy 4 years	Psychoanalysis/ psychodynamic, CBT and family therapy	Self or professional referral	Insurers cover 30-50 sessions 70-100 Euros per session	No quality controls or outcome assessment
The Netherlands	Approximately 5000 psychotherapists (30 per 100 000 population)	Health professionals, such as psychologists or psychologists with further 4-5 years specialist training. No statutory regulation of the profession	Psychoanalysis, behavioural, cognitive, client-centred	Via workplace, GP or health worker	Maximum of 25 sessions paid by state Contribution of 15 Euros per session paid by client	Quality assurance only through accreditation rules, no outcome assessment More recently, data on cost/ benefit of treatment is required
Russia	Approximately 3278 state	State psychotherapy provided	Psychoanalysis/	Via GP,	No limits, but usually	Quality control

	psychotherapists (2 per 100 000 population) and 6155 private psychotherapists (4 per 100 000 population).	by psychiatrists or medical psychologists All training must be recognised by the Russian Ministry of Health Care	psychodynamic, client-centred, hypnotherapy, cognitive-behavioural, positive psychotherapy, family therapy	health professional or self referral	10 sessions. Costs 18 Euros per session Private: 29-366 Euros per session	through state legislation Outcome assessment unknown
Spain	Numbers not known	Health professionals, such as psychologists or psychologists with additional training. However, no legal or statutory regulation of the profession at present	Psychoanalysis, behavioural, cognitive, system-orientated, humanistic	Via psychiatrist or psychologist	Costs unknown	No legal quality controls or outcome assessment
Switzerland	1264 adult psychiatrists, 2461 psychological psychotherapists (49 per 100 000 population) Usually work alone	Either psychiatrists (no additional training) or psychologists with 2 years additional training.	Psychoanalysis, behaviour therapy, systemic therapy	Self referral	Insurers cover approx. 30 sessions 132 Euros per session	Rules for accreditation. No outcome assessment.