The provision of psychotherapy: an international comparison

Keywords
psychotherapy provision
country comparisons
regulation
accreditation
CBT

There has been a recent initiative in England to establish a wider provision of psychotherapy. Studying the models of psychological treatment and experiences in other countries may enable policy makers in England to learn lessons and avoid pitfalls. This paper assesses and compares the provision of psychotherapy for adults in a selected number of European and non-European countries. A structured list of psychotherapy features was used to collect information from each country on the number of psychotherapists, professional qualifications, the settings and models of psychotherapy, the referral procedures, funding arrangements, quality management and outcome assessments. These data were then compared in a non-systematic way. Comparison of levels of provision was the most difficult to establish, but the findings suggest that psychotherapy that is broadly free at the point of entry is more widely available in other EU countries than in England. They also show that the plans currently being discussed for a psychotherapy service in England differ from those provided in most of the other countries in this study. The differences include the lack of statutory accreditation rules and lower qualification thresholds for psychotherapists, the concept of treatment centres, the low number of sessions, and the regular assessment of outcome data. Therefore, based on this comparison, the necessity of these features, their priority and possible alternatives may need to be considered.

RESEARCH

Stefan Priebe
Professor of social and community psychiatry
Barts and the London School of Medicine
Queen Mary, University of London

Donna Wright
Researcher
Barts and the London School of Medicine
Queen Mary, University of London

Correspondence to:
Professor Stefan Priebe
Unit for Social and Community Psychiatry
Newham Centre for Mental Health
London E13 8SP

s.priebe@qmul.ac.uk

There has been a recent initiative in England to establish a wider provision of psychotherapy, in particular cognitive-behavioural therapy (CBT), with the main target group being adult patients with anxiety and depressive disorders (DH, 2006a; Centre for Economic Performance Mental Health Policy Group, 2006). Pilot schemes are being implemented and tested in Doncaster and the East London borough of Newham. 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 (Layard, 2004).

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. Against this background, the paper assesses and compares the provision of psychotherapy for adults in some selected European and non-European countries. This paper does not attempt to provide a comprehensive picture of the provision of psychotherapy in different countries; it focuses instead on a limited number of features of 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 to considerations about implementing more psychotherapy in England. The features that the paper studies are:

- the number of psychotherapists
- their professional qualifications
- the settings and models of psychotherapy

- referral procedures
- commissioning and funding arrangements
- regulations
- quality management
- outcome assessments.

Each of these aspects is considered in a broad sense, taking – as far as possible – the perspective of the given country. Thus, we did not restrict the comparison to the provision of CBT, on which current debates in the United Kingdom (UK) often focus, and we did not specifically look for models matching the pilot schemes in Doncaster and Newham. We aimed, rather, to find specific as well as common aspects of and experiences with the psychotherapy provision in countries with different traditions and health care systems, and subsequently conclude on what trends can be expected and what issues may have to be addressed in future policies on psychotherapy in the UK.

Method

The selection of countries was purposive and intended to capture different traditions of health care (eg. the German and Italian traditions of psychiatry); different health care systems (eg. the state provision as in England and the more private organisation as in Switzerland); different cultures with the Anglophone world (eg. Australia and Canada), and major European countries (eg. France and Russia). Yet, the selection was also influenced by convenience: most importantly, the availability of sufficiently reliable information and the familiarity of the authors with the given system. Information was obtained through personal contacts with experts and from sources on the web.

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 the findings, the situation in each country is summarised, and a synopsis of the information is provided in table 1. The brief descriptions of the national situations – in alphabetical order – 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 what the implications for the current debate in England might be.

Psychotherapy in other countries

Australia

Psychotherapy in Australia, unlike more traditional health professions, is not regulated by a specific government body. There is no single, compulsory training path, and no formal qualifications required to work as a psychotherapist, with professionals from a range of different backgrounds undertaking post-graduate training in psychotherapy and counselling (PsychOz Publications, 2006).

There is also a number of professional associations and registration boards that are related to the practice of psychotherapy and counselling. The Psychotherapy and Counselling Federation of Australia (PACFA) is an umbrella association comprising affiliated professional organisations representing various modalities within the disciplines of psychotherapy and counselling. It has set standards and guidelines for self-regulation and provides a forum for psychotherapists and counsellors who fall outside the formal health professional associations (PACFA, 2006). The PACFA also provides a registry of psychotherapists who meet its standards of training and requirements for on-going supervision and professional development (PsychOz Publications, 2006).

The number of psychotherapists practising in Australia is also dependent on the definition of a 'psychotherapist'. At present the PACFA has approximately 300 registered psychotherapists and the Australian Psychotherapy and Counselling Referral Directory, which covers many professional associations and registration bodies, has over 600 registered therapists (approximately 15 per 100,000 population). Across all the health and welfare agencies there are a host of professionals that offer 'psychotherapy' in various forms (PsychOz Publications, 2006).

Psychological treatment is mainly financed through direct government programs or funded privately. Quality control, outcome assessments and waiting lists are dependent on the agency and on the evaluation programs each organisation has in place (PACFA, 2006).

Canada

Two of the main professional associations in Canada that provide accredited membership both to counsellors and psychotherapists are the Canadian Professional Counsellors Association (CPCA) and the Canadian Counselling Association (CCA). While there is no statutory regulation of counselling or psychotherapy practice at present, there is a move towards greater regulation in some provinces, with the recommendation in Ontario that psychotherapy practice should be regulated under a proposed Psychotherapy Act. However, as CPCA members are considered to be counsellors and psychotherapists,

this may lead to a conflict with title and profession in these provinces. Counselling or psychotherapy is provided through the national health care system and private practice, and it is estimated that there are approximately 40,000 'health counsellors' across Canada (approximately 124 per 100,000 population) (Regulation of Counsellors across Canada, 2005). Counsellors usually come from a variety of backgrounds, including psychiatric nursing, social work or psychology, and have completed a graduate programme in counselling or psychotherapy. Patients are typically referred to health counsellors or psychotherapists by family physicians. However, recent cutbacks in the Canadian health care system have reduced the number of positions for counsellors and psychologists. This shift away from public funding has led to a greater demand for private practitioners.

France

Prior to 2004 there were no legal restrictions on the practice of psychotherapy in France. However, in 2004 an amendment was passed by the French parliament that, when implemented, will make psychotherapy a medical treatment that can only be practised by medical doctors, those with a qualification in clinical psychology, or psychotherapists without a qualification in medicine or clinical psychology but who are eligible to be included on a new national register. Access to the register will be limited to those whose training courses are recognised by the Association of Psychoanalysts. It will therefore become a criminal offence to practise without such state registration or a qualification in medicine or clinical psychology (Oakley, 2004).

Currently there are approximately 8000–12,000 psychotherapists in France (approximately 13–20 per 100,000 population). Some are members of the four principal interdisciplinary professional organisations; others practise independently (French Federation of Psychotherapy, 2006; Nguyen, 2000). The cost of psychotherapy is only refunded by social insurance companies if the therapist is qualified as a medical doctor (van Deurzen, 2001).

Germany

In 2000 a specific law was introduced in Germany regulating the accreditation of psychotherapists and the provision of treatments. All psychotherapists are either doctors (ie. usually, but not always, psychiatrists) or psychologists who have undertaken additional training at an accredited institute. There are approximately 16,000 accredited psychological psychotherapists and 3500 medical psychotherapists in Germany (approximately 24 per 100,000 population). However, since 2000 no exact figures have been available. There is also a wide provision of inpatient psychotherapy, often in specific 'psychosomatic' hospitals, which provide fixed treatments of four to six weeks, funded by health insurance companies and/or pension insurance schemes. Outpatient psychotherapy is provided in private practices, but the number of practices for each region is capped.

Psychotherapy is free at the point of entry and costs are covered by health insurance companies (the exact rate varies and depends on the regional budget of the main health insurer). Quality assurance is attempted through strict rules for accreditation and requirements for further training of psychotherapists.

Psychotherapy is therefore widely available and the practice of referring people to individual psychotherapists provides greater choice for patients. Some psychotherapists, however, may have waiting lists of up to eight months. Potential weaknesses of the system include the difficulty in limiting the increasing costs of psychotherapy, and also the absence of precise data on provision and outcome.

Italy

The practice of psychotherapy is regulated under Italian law and all training must be accredited by state authorities (Gemignani & Giliberto, 2005). Psychotherapy is provided as part of the generic mental health care within the Italian national health service, but there is also well-established private provision. Within the national health service, psychotherapy is provided by professionals who are regularly involved in other aspects of care and treatment. There are approximately 35,000 accredited psychotherapists in Italy (approximately 60 per 100,000 population); all psychotherapists are either qualified psychiatrists or psychologists.

In the Italian national health service, while there are no formal waiting lists, the referral procedure may take up to three months. In the private sector, psychotherapy is usually available immediately. The cost of psychotherapy is fully covered by the health service and through some health insurance schemes. In the private sector, however, psychotherapy usually has to be paid for by the individual. Quality assurance is achieved through strict regulation of accreditation. Potential weaknesses of the system are the absence of outcome data, the difficulty in establishing quality criteria, and the limitations of provision within the health service.

The Netherlands

Since 1998, stricter regulations on the training and registration of psychotherapists have been introduced in the Netherlands, with only those psychotherapists trained in one of the four state-registered psychotherapeutic modalities and with a background in psychiatry or psychology being officially recognised. There are approximately 6000 psychotherapists in the Netherlands (approximately 37 per 100,000 population), with 2000 belonging to one of the four state-registered psychotherapeutic modalities and 2500 to modalities not registered by the state.

The Dutch Association for Psychotherapy (NVP), an official psychotherapy organisation, was established in order to promote quality in psychotherapy and support the development and implementation of regulated standards, guidelines and protocols for training and practice (Dutch Association for Psychotherapy, 2006). However, there is also an independent organisation (NAP) for independent psychotherapists, which follows the standards of the European Certificate of Psychotherapy (ECP) (Netherlands Association for Psychotherapy, 2006).

Psychotherapy is easily accessible and the majority of costs are covered by the state, with each individual paying only a small contribution (Netherlands Association for Psychotherapy, 2006). Quality assurance is achieved through rules for accreditation, but there is no routine outcome assessment.

Russia

The practice of psychotherapy is governed by legislation of the Russian Federation, with training being accredited through a specific government licence by the Russian Ministry of Health Care and the All Russian Psychotherapy League (PPL). This system provides almost total control over both private and state psychotherapists. There are approximately 3278 state psychotherapists (approximately two per 100,000 population) and 6155 private psychotherapists (approximately four per 100,000 population) in Russia, with psychotherapy usually being provided either by medically trained psychotherapists or psychologists. More recently, the qualification criteria introduced by the European Association of Psychotherapy have been adopted as the standard level of training required for all practising psychotherapists. Psychological treatment provided by state medical establishments costs the patient less than that provided by the private sector. However, state outpatient services and hospitals usually impose restrictions on the length of treatment (Institute of Psychotherapy and Clinical Psychology, 2006).

Spain

At present there are no legal regulations for professional practice or any established register of psychotherapists in Spain. To address this situation, the Spanish Federation of Psychotherapist Associations (FEAP) was established, under the Spanish Constitution, to bring together psychotherapists from relevant professional societies and associations and to establish a register of psychotherapists where members are required to meet minimum standards of training and supervised practice. In Spain, psychotherapists are usually health professionals (eg. psychologists or psychiatrists) who have undertaken additional and specific training in psychotherapy. There are approximately 3000 psychologists who practise psychotherapy in Spain (approximately seven per 100,000 population), and about 2000 of these are registered with the FEAP (Spanish Federation of Psychotherapist Associations, 2006).

Most psychological and psychotherapeutic treatments take place at mental health centres. While psychological treatment in Spain is publicly funded, it is not available in all regions because of high demand and time pressures, and most people use private practices. However, few insurance companies will reimburse these costs. There are no quality controls or outcome assessments completed.

Switzerland

In Switzerland, practice is at present governed by state laws, but there is an intention to introduce a Federal Psychotherapy Law by the end of 2006. There are two professional organisations: the Swiss Psychotherapists Association and the Swiss Federation of Psychologists. These both give licences to psychotherapists. All psychotherapists are psychiatrists or psychologists, with the latter having undertaken a further two-year course in addition to their academic degree. There are approximately 1700 psychiatrists and 2600 psychological psychotherapists in Switzerland (approximately 59 per 100,000 population) (Federation of Swiss Psychologists, 2006).

Psychotherapy is provided in private offices and is widely available, although the separation of psychotherapy from mainstream psychiatric services may be viewed as a potential weakness of this system. Patients usually self-refer to the psychotherapist in the practice, and social insurance

companies will reimburse the cost only if the psychotherapist is a medical doctor. This may restrict access to psychotherapy to only those who can afford it. There is no quality management beyond accreditation and no exact data on provision and outcomes.

Psychotherapy in the United Kingdom

In the UK, psychotherapists working within the NHS usually form part of a specialist psychotherapy department or service and come from a range of professional backgrounds, which may be either medical or non-medical.

The three national registers for psychotherapists and counsellors are maintained by three main 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 is part of the NHS, but each is responsible for setting standards and training for all professionals working in these fields, both within the NHS and outside it. Psychotherapists may also be members of the British Psychological Society, and listed on its register of psychologists working as psychotherapists.

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 examining the possible regulation of the professions of psychotherapy and counselling 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, with no single training route to either psychotherapy or counselling. 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 (Department of Health, 2006b).

The generic training requirement for a practitioner to be registered with the UKCP is a postgraduate level course in psychotherapy of at least four years part-time duration or equivalent. For BACP accreditation, it is a minimum of three years part-time taught and supervised practice. For BPC registration, it takes four to six years part-time study. However, each type of psychotherapy has slightly different training requirements. The UKCP comprises 80 psychotherapy organisations and has a total register of over 6000 approved psychotherapists (UKCP, 2006). The BACP register contains approximately 6000 accredited counsellors and psychotherapists (BACP, 2006). The BPC register contains over 1400 psychoanalytic psychotherapists (BPC, 2006). This gives a UK-wide total of 23 registered counsellors and psychotherapists per 100,000 population. The number of medical psychotherapists working in the NHS in England is around 100.

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 more counsellors working in primary care and more psychotherapists working in secondary care.

Psychotherapy and counselling are available on the NHS. However, only a quarter of those estimated to be suffering from depression or chronic anxiety are receiving any form of treatment – usually medication. Referral for psychotherapy in the NHS varies from area to area, but there is usually a waiting list of approximately nine months (Centre for Economic Performance Mental Health Policy Group, 2006).

It has been estimated that, over the next five years, the NHS needs to train an additional 5000 psychological therapists in order to meet growing demand (Layard, 2004).

The European Association for Psychotherapy (EAP)

In 2004, the European Commission issued a directive with the aim to standardise training and ethical guidelines for psychotherapy throughout all member states. The purpose of this directive was to enable psychotherapists who have qualified in one member state to practise in any other EU country. It appears that the EC has agreed, in principle, to base the standard of training on that of the European Certificate for Psychotherapy (ECP) promoted by the European Association for Psychotherapy (EAP) (European Association for Psychotherapy, 2006).

The United Kingdom Council for Psychotherapists (UKCP) is the official UK awarding body for the ECP, which adopts the Austrian, non-medical definition of state-regulated psychotherapy (that is, an 'independent psycho-social activity'). This definition is contrary to other state-regulated European countries, such as Germany and Italy, where psychotherapy and psychoanalysis are defined as types of medical treatment to be practised only by doctors (usually psychiatrists) and some psychologists. In fact, with

the exception of Austria, all European countries have adopted a statutory regulation in line with the anticipated European legislation to limit the practice of psychotherapy to those with a qualification in medicine or psychology and further accredited training (Meignant, 1999).

The 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 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 in some cases may be unreliable. The exact definitions used in each country for the national registers – if they exist – also vary and are difficult to compare. This issue was also highlighted in the recent green paper of the European Commission on mental health (Commission of the European Communities, 2005), which demanded more reliable and comparable data on service provision in different countries. This applies to all regulated practice in mental health care. Yet the situation is even more complicated in psychotherapy, 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 is in the private sector, for which exact data are rarely available.

This study suggests that psychotherapy (that is, psychotherapy that is broadly free at the point of entry) is more widely available in other EU countries 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 if more of them worked in mental health in the NHS). If the UK intends to reach the same levels of provision, psychotherapy services will have to expand, and this will require substantial further investment.

A further conclusion from the comparison of provision levels is that the funding arrangements for psychotherapy differ between the various health care systems. The demand for psychotherapy, particularly in insurance-based systems such as Germany and Switzerland, appears to have led to increased supply and funding. In 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 have 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 is unlikely to bring it to a halt, as the example of the Netherlands demonstrates. The extensive private provision in several countries is further evidence of the strong consumer demand for psychotherapy, and for the willingness of ever-larger groups of the population in western societies to pay for it.

Types of psychotherapy provided and restrictions

The dominating psychotherapy schools are psychoanalytically-based treatments, mainly in the 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 (eg. family therapy in Italy reflects the strong orientation in southern European societies towards families and the tradition of systemic and other family therapies in Italy for more than three decades). The strong focus on CBT that characterises the current debate in the UK has not been found elsewhere.

It should be noted that – wherever possible – clinicians and patients make 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, which is possible in most countries if the psychotherapist is medically qualified, or by a GP or psychiatrist who collaborates with the psychotherapist.

Settings of psychotherapy and referrals

Treatment centres as planned in England and tested in Newham 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 to be a stronger psychotherapy mindedness and expertise throughout the service, from which all patients – including those with severe mental illnesses – benefit. Also, an integration of psychotherapy into mainstream services can facilitate

Table 1: Comparative data on psychotherapy provision

Country	United Kingdom	Australia	Canada	France	Germany
Number of psychotherapists (public)	38,000 members of professional associations covering psychotherapy and counselling, although not all are accredited members. Some 13,400 accredited practitioners (23 per 100,000 population) Psychotherapists work in NHS multidisiciplinary teams, voluntary organisations and independently	Approximately 900 registered psychotherapists and counsellors, 1000 clinical psychologists, 900 counselling psychologists, 250 psychiatrists practising psychotherapy (15 per 100,000 population)	Approximately 40,000 'counsellors' (124 per 100,000 population)	Approximately 8000–12,000 psychotherapists (13–20 per 100,000 population)	16,000 psychological psychotherapists and 3500 medical psychotherapists accredited (24 per 100,000 population)
Training required	Range of backgrounds: psychiatry, psychology, social work, nursing, other related areas, with 3-4 years additional training. A number of professional accreditation bodies but no legal registration or licensing requirements	Range of backgrounds: psychiatry, psychology, social work, nursing, other related areas, with 3 years additional training. A number of professional accreditation bodies; each self-regulate. There are no legal registration or licensing requirements	Range of backgrounds: psychiatry, psychology, social work, nursing, other related areas, with additional training	Soon to be enacted state law – only psychiatrists, clinical psychologists and others suitably trained with state registration may practise	Either psychiatrists or psychologists with additional training
Schools of psychotherapy	Integrative, person centred, psychodynamic and cognitive-behavioural, integrative	Psychoanalysis/ psychodynamic and cognitive-behavioural, integrative	Family therapy, client centred, psychoanalysis/ psychodynamic therapy	All recognised methods	Psychoanalysis/ psychodynamic approaches and behaviour therapy
Possible referrers	Via GP, health professional	No formal referral process	Usually GPs but also other sources	No formal referral process	Self or professional referral
Number of sessions funded	Varies depending on problem: 6-40 Costs from €37–117 per session, covered by NHS	No restrictions on treatment length No formal figures on costs	Usually 5–7 sessions Costs €41–63 per session	No limits placed on number of sessions Costs €44–59 per session	Insurers cover a minimum of 25 sessions and up to 100 more €77 per session
Quality and outcome assessment	Quality assurance only through accreditation rules; limited outcome assessment	Existence and level of quality control and outcome assessment varies from programme to programme	Rules for accreditation Outcome assessment depends on location	No formal quality control; partial control through Psychotherapeutic Unions	Strict rules for accreditation; no outcome assessment

Country	Italy	The Netherlands	Russia	Spain	Switzerland
Number of psychotherapists (public)	Approximately 35,000 psychotherapists accredited in regional registers in Italy (60 per 100,000 population). 12–13,000 received full training Work as part of mental health care team or in private practice	Approximately 6000 psychotherapists (37 per 100,000 population)	Approximately 3278 state psychotherapists (2 per 100,000 population) and 6155 private psychotherapists (4 per 100,000 population)	Approximately 3000 psychologists (7 per 100,000 population)	1700 adult psychiatrists, 2600 psychological psychotherapists (59 per 100,000 population) Usually work alone
Training required	Either psychiatrists or psychologists with additional training. All courses are accredited by state authorities: - Psychoanalysis 6 years - CBT 3 years - Family therapy 4 years	Health professionals, such as psychologists or psychologists with further 4–5 years specialist training	State psychotherapy provided by psychiatrists or psychologists. All training must be recognised by the Russian Ministry of Health Care	Health professionals, such as psychologists or psychologists with additional training. However, no legal or statutory regulation of the profession at present	Either psychiatrists (no additional training) or psychologists with 2 years additional training
Schools of psychotherapy	Psychoanalysis/ psychodynamic, CBT and family therapy	Psychoanalysis, behavioural, cognitive, client-centred	26 officially recognised modalities including: psychoanalysis/ psychodynamic, client-centred, hypnotherapy, cognitive-behavioural, Gestalt therapy, transactional analysis, family therapy	Psychoanalysis, behavioural, cognitive, system-orientated, emotional, body, humanistic	Psychoanalysis, cognitive and behavioural, humanistic, systemic therapy
Possible referrers	Self or professional referral	Via workplace, GP or health worker	Via GP, health professional or self-referral	Via GP, psychiatrist or psychologist	Self-referral
Number of sessions funded	Insurers cover 30–50 sessions €70–100 per session	Maximum of 25 sessions paid by state. Contribution of €15 per session paid by client	No limits, but usually 10 sessions. Public: €18 per session Private: €29–366 per session	Costs unknown	Insurers cover approx 30 sessions €132 per session
Quality and outcome assessment	No quality controls or outcome assessment	Quality assurance only through accreditation rules; no outcome assessment	Quality control through state legislation and new trainees through ECP regulations. Outcome assessment unknown	No legal quality controls or outcome assessment	Rules for accreditation; no outcome assessment

a flexible long-term management of patients with chronic or recurrent disorders. 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: the average appears to be around 30 or more sessions per week. In general, however, psychotherapists who do not practise full-time are more likely to conduct more sessions – 7–8 sessions – per day. This may indicate a potential disadvantage of specialised individual 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 more easily accessible in health care systems that are not state-funded. In some systems GPs and psychiatrists have to refer patients, but in most countries patients can and do self-refer. The system of simple referrals is associated with a further problem that might affect the economic effects of psychotherapy. A significant number of those patients who self-refer (or who make their GPs refer them) do not have a clear mental disorder that is likely to improve under psychotherapy. Thus, specific and rigid plans should be designed to limit this and ensure that publicly funded psychotherapy focuses on those patients who might draw significant health gains from it. 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 for their activities and have a financial incentive to increase their workload.

Economic aspects

The price of psychotherapy depends on the costs per session and the number of sessions per treatment. The cost for one session in Germany and Switzerland may appear high (see table 1), but includes all on-costs and overheads. Thus, such arrangements facilitate transparent planning and comparisons, and the costs in those and other countries can and should also be used to benchmark costs 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 (eg. 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.

Compared with the plans for CBT in England, the length of treatment is longer in every other studied country, regardless 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 a limit to the number of sessions. Also, provisions have to be made for when patients and clinicians feel more sessions are required or that a new therapy should be commenced (in Germany, the Netherlands and Switzerland it is common for patients to receive several successive therapies with different therapists). However, repeated provision of a similar treatment may 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 of potential saving effects of psychotherapy at 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 health treatments 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, not demand).

Quality assurance

The requirements for the qualification and training of psychotherapists are higher in most other 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. If European regulations are put in 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, and not demanded by insurance companies that otherwise function as formal gatekeepers and regulators of funding. Public health experts tend to lament this 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, studies will need to be made concerning the percentage of patients (and practitioners) that can realistically be expected to comply with it, and what the most effective incentives are. The precise purpose of the regular outcome assessment will also need to be clarified – eg. who analyses the data and how, who uses them and in what way, and what the implications of different findings are – and all this will need 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 linked more 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 advance 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 English-speaking 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, if psychotherapy in England is to be implemented in a way that significantly differs from the provision elsewhere, careful consideration will be required in order to achieve the intended difference in practice and to avoid being driven in the same direction as other countries. The plans currently being discussed in England differ in several respects 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 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 demand from 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 in order to facilitate the best quality treatment for those patients who are likely to benefit from psychotherapy. This will require a focus on the central and most relevant elements, since detailed and prescriptive guidance, such as the policy implementation guides issued by the Department of Health to functional mental health teams in the community, are unlikely to work with the new arrangements.

Major lessons from those countries that have 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. In any case, 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 (beyond general frameworks for private health care provision and statutory regulations for the profession). ✪

Acknowledgements

For their contributions to this paper, we thank Kerstin Adamczak, Juergen Fritze, Andrea Gaddini, Christoph Lauber, Dusica Lecic-Tosevski, Francisco Ferre Navarrete, Inmaculada Palanca, Jiri Raboch, Olga Randles, Liz Sheean, and the Network of European Capitals on Mental Health Care.

REFERENCES

British Association for Counselling and Psychotherapy (2006). http://www.bacp.co.uk (accessed 23 March 2006).

British Psychoanalytic Council (2006). http://www.bcp.org.uk/BCP_register.html (accessed 23 March 2006).

Centre for Economic Performance Mental Health Policy Group (2006) *The depression report: a new deal for depression and anxiety disorders*. London: Centre for Economic Performance, London School of Economics and Political Science. http://cep.lse.ac.uk/textonly/research/mentalhealth/DEPRESSION_REPORT_LAYARD.pdf (accessed 06 September 2006).

Commission of the European Communities (2005) *Improving the mental health of the population: towards a strategy on mental health for the European Union*. COM(2005)484. European Communities. http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2005:0484:FIN:EN:PDF (accessed 3 August 2006).

Department of Health (2006a) *Our health, our care, our say: a new direction for community services*. The Stationery Office: London:

Department of Health (2006b) *Interim report on initial mapping project for psychotherapy & counselling*. London: Department of Health. http://www.bacp.co.uk/regulation/DoH_interim-rep_jun 05.doc

Dutch Association for Psychotherapy (De Nederlandse Vereniging voor Psychotherapie, NVP) (2006). http://www.psychotherapie.nl (in Dutch) (accessed 03 Febuary 2006).

European Association for Psychotherapy (2006). http://www.europsyche.org/ (accessed 03 Febuary 2006).

French Federation of Psychotherapy (Fédération Française de Psychotherapie, FFdP) (2006). http://www.ff2p.fr/ (in French) (accessed 02 Febuary 2006).

Federation of Swiss Psychologists (Föderation der Schweizer Psychologinnen und Psychologen, FSP) (2006). www.psychologie.ch. (in German) (accessed 23 March 2006).

Gemignani M, Giliberto M (2005) Counselling and psychotherapy in Italy: a profession in constant change. *Journal of Mental Health Counselling* **27** (2) 168–184.

Institute of Psychotherapy and Clinical Psychology (2006). http://www.psycinst.ru/ (in Russian) (accessed 02 Febuary 2006).

Layard R (2004) *Mental health: Britain's biggest social problem?* London: The Strategy Unit. http://www.strategy.gov.uk/seminars/mental_health/index.asp (accessed 13 March 2006).

Meignant M (1999) Psychotherapy in Europe. I*nternational Journal of Psychotherapy* **4** (2) 225–228.

Netherlands Association for Psychotherapy (Nederlanse Associatie voor Psychtherapie, NAP) (2006). http://www.nap-psychotherapie.com/ (in Dutch) (accessed 27 Febuary 2006).

Nguyen T (2000) Psychotherapy in France: the legacy and the future. *European Journal of Psychotherapy, Counselling & Health* **3** (1) 111–122.

Oakley H (2004) *Who will remember February 11th?* http://www.psychoanalysts.org.uk/papers%20for%20publication.html (accessed 27 Febuary 2006).

Psychotherapy and Counselling Federation of Australia (PACFA) (2006). http://www.pacfa.org.au (accessed 15 Febuary 2006).

PsychOz Publications (2006) *Resources for effective psychotherapy and counselling*. http://www.psychotherapy.com.au (accessed 12 March 2006).

Regulation of Counsellors across Canada (2005) *National Symposium on Counsellor Regulation. Overview and policy questions*. Vancouver, British Columbia. http://www.ccacc.ca/CEBRIEF.pdf (accessed 15 Febuary 2006).

Spanish Federation of Psychotherapist Associations (Federación Española de Asociaciones de Psicoterapeutas, FEAP) (2006). http://www.feap.es/e_questions.htm (accessed 21 Febuary 2006).

United Kingdom Council for Psychotherapy (2006). http://www.psychotherapy.org.uk (accessed 21 March 2006).

van Deurzen E (2001) Psychotherapy training in Europe: similarities and differences. *European Journal of Psychotherapy, Counselling and Health* **4** (3) 357–371.