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Psychotherapy development and regulation in Belgium: What Slovenia can learn from the Belgian contradictions

Razvoj psihoterapije in njena regulativa v Belgiji: Kaj se Slovenija lahko nauči iz belgijskih protislovij

Abstract

Although psychotherapy is well developed in Belgium, it is still not recognised as an independent profession and as an autonomous scientific discipline. Many contradictions in the development of psychological and psychotherapeutic care in the Belgian mental health system stem from the privileged position of medical doctors and clinical psychologists. On the 4th of April 2014, a law on the regulation of mental health professions was passed by Parliament, which introduced the integration of clinical psychologists, orthopedagogists and psychotherapists into the mental health care system. Although psychotherapist as a profession was not recognized as a health profession, as a practice it could be performed by practitioners who fulfilled certain conditions, including specific psychotherapy training. But there was then a sudden change in May 2015, when a new law on mental health provision was passed, which took away the rights of psychotherapists and granted a privileged position in the field of psychotherapy to doctors and psychologists. Despite the fact that in Belgium's primary mental health system psychotherapists have not yet been given the role that they deserve and that would be beneficial to users, the Belgian model of primary psychological care, which has been developed during recent years, represents a positive development. Due to the new Primary Psychological Care Convention financial investments in mental health care have risen sharply and there has been a progressively increasing influx of patients who have never been in treatment before. Patients' waiting time has been reduced, their admission to care is smoother and faster, and the clinical effectiveness of the primary psychological service has increased.

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Povzetek

Čeprav je psihoterapija v Belgiji dobro razvita, še vedno ni priznana kot samostojni poklic in avtonomna znanstvena disciplina. Številna protislovja v razvoju psihološke in psihoterapevtske pomoči v belgijskem sistemu varovanja duševnega zdravja so posledica privilegiranega položaja zdravnikov in kliničnih psihologov. 4. aprila 2014 je belgijski parlament sprejel zakon o poklicih na področju duševnega zdravja, ki je v sistem vključil klinične psihologe, specialne pedagoge in psihoterapevte. Čeprav poklic psihoterapevta ni bil priznan kot zdravstveni poklic, so psihoterapijo kot dejavnost lahko izvajali strokovnjaki, ki so opravili specializacijo iz psihoterapije. Vendar je maja 2015 prišlo do nenadne spremembe, ko je bil sprejet nov zakon o duševnem zdravju, ki je psihoterapevtom ukinil pravice in na področju psihoterapije dodelil privilegiran položaj zdravnikom in psihologom. Kljub dejstvu, da na primarni ravni sistema za varovanje duševnega zdravja psihoterapevi še danes nimajo svojega mesta in vloge, ki bi si ju zaslužili, belgijski sistem primarne psihološke skrbi, ki so ga razvili v zadnjih letih, predstavlja pozitiven razvoj. Zahvaljujoč t.i. Konvenciji o primarni psihološki skrbi so se namreč finančni vložki iz javnih sredstev močno povečali, kar je omogočilo veliko večjo dostopnost do psiholoških storitev in povečal se je pritok uporabnikov, ki do zdaj še niso iskali tovrstne pomoči. Skrajšale so se čakalne dobe, bolj gladko in hitreje potekajo sprejemni postopki, prav tako pa se je tudi povečala klinična učinkovitost psiholoških oblik pomoči na primarni ravni sistema varovanja duševnega zdravja.

Ključne besede: zakon o psihoterapiji, klinična psihologija, psihiatrija, skrb za duševno zdravje, akademizacija psihoterapije, izobraževanje iz psihoterapije, primarna psihološka skrb

1. Introduction

Belgium is one of the countries with a well-developed psychotherapy, but with many contradictions that have sometimes escalated to the absurd. Until 2014, there was no legal regulation of psychotherapy, no licensing system, no ethical supervision or accreditation system for educational institutions providing psychotherapy training. On 4th of April 2014 a law on the regulation of mental health professions was passed, but unfortunately new contradictions emerged and the solutions were not in favour of psychotherapy as an independent profession. To understand such a course of events, it is useful to take a closer look

at some of the key developments and contradictions before 2014 (Sasse & Vrancken, 2014).

2. Brief history of clinical psychology, psychotherapy, and counselling in Belgium

Clinical psychology, psychotherapy, and counselling have been included in the healthcare system in Belgium since the scientific developments of these disciplines in the 19th century. Counselling and psychotherapy developed out of residential psychiatric care. At the beginning of the 20th century, open services in psychiatric hospitals and the first ambulatory centres for 'mental hygiene' where established. Between 1945 and 1975, mental healthcare became a more important issue, and among other improvements psychiatric services in general hospitals were established. In the 1980s and 1990s, the government changed its policy from investment in residential care in psychiatric hospital beds towards more resources for ambulatory mental health services for a larger number of clients with various psychological problems. This increased the importance of clinical psychologists, psychotherapists and counsellors, and several professional organizations of psychotherapists and counsellors were established to foster the development of this professional field. They played an important role in developing training standards and enhancing the quality of practice (Van Broeck et al., 2013, p. 262).

At the beginning of the 1990s, initiatives were taken to create a legal framework for the regulation of the practice of these non-medical mental healthcare practitioners. In 1993, a law was passed to protect the title of 'psychologist'. The Belgian Federation of Psychologists, an umbrella organization that represents the majority of psychological associations, facilitated the passing of this law. This title of psychologist was awarded on the basis of training criteria and issued by the Ministry of Independent Professions, and was not associated with a regulation of the practice, control of quality, or respect of deontological rules (ibid.).

In 1998, the Belgian Association for Psychotherapy (Association Belge de Psychotherapie = ABP; https://abp-bvp.be/a-propos-de-nous/?lang=fr) was established and became a National Umbrella and Awarding Organization (NUO and NAO) of the European Association for Psychotherapy (EAP). Since its foundation, it has been striving for the regulation of psychotherapy as an independent profession, in line with the Strasbourg Declaration.

In 2004, at the request of the Public Health authorities the Superior Council of Hygiene set up a working group of experts in the psychotherapy field, which

wrote a report with the main definitions, outline of various modalities of psychotherapeutic practices in Belgium, and specification of training standards (Conseil Supérieur d'Hygiène, 2005). Psychotherapy was defined as a specific healthcare service:

> "Psychotherapy is a healthcare treatment in which a coherent set of psychological means (interventions) are anchored in a psychological and scientific frame of reference. It is practiced by a trained therapist, within a psychotherapist-patient/client relationship, with the aim of eliminating or alleviating psychological difficulties, conflicts and disorders suffered by the patient/client. The patient/client may be an isolated individual, or a social system (couple, family, group, etc.). The individual or the social system manifests problems or disorders for which it is seeking help. These disorders and problems relate to psychological, somatic and social aspects of the functioning (of the individual, or of the social system) and are apprehended from the following three angles:
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> - the patient's/client's personal subjectivity, i.e. either intra-psychic conflicts arising during development, or "life experience" problems;
> - relational problems within one or more systems to which the patient/client belongs;
> - behavioural problems and somatic symptoms.
>
> Generally speaking, these problems are mutually reinforcing and self-perpetuating" (Conseil Supérieur d'Hygiène, 2005, p. 7).

The report also presented the four main psychotherapy orientations that were generally accepted (psychodynamic, behavioural and cognitive orientation, systemic and family-oriented, and experiential and client-centred). For each of these orientations, a definition, the evolution of ideas and practices, elements for validating efficacy, and a brief description of the state of the art was presented.

The recommendations for psychotherapy education included basic training at a Master's level and a specific training (specialization) in a number of healthcare professions at a post-master's level (e.g. with a master's degree in psychology, pedagogy or medicine). The recommended subjects of basic theoretical and practical training at a Master's level were: anthropology, developmental psychology, psychodynamic psychology, learning processes, neuroscience, general pathology, introduction to psychopharmacology, psychopathology and psychiatry, general psychodiagnostics, clinical psychodiagnostics, psychological consultation, introduction to psychotherapeutic methods, deontology and professional ethics. The basic training had to include also a minimum 6-month full-time internship in the field of mental health care. If these minimum theoretical and practical criteria were not met, applicants had to follow an additional master's programme, in which the necessary basic knowledge and skills were taught.

Specific training at a post-master's level in one of four orientations had to have three pillars: theory, practice under supervision and personal therapy. It had to last at least 3 years with a minimum of 1.200 hours in mental health care, including 500 psychotherapy sessions in contact with patients/clients (minimum 4 patient/client contacts per week).

Among the providers of psychotherapy training, in addition to the various psychotherapy associations and institutes running non-academic programmes, there were and still are a number of different Belgian universities. They offer post-master training programmes in psychotherapy, which are mostly accessible to psychologists and doctors with a master's degree. These postgraduate programmes consist of three years of part-time courses. They are often the result of a partnership between a training institute and a university (Brison et al., 2015). These postgraduate programmes comply with the criteria developed by EFPA[2] (2019). However, as Belgium still has no law, which would regulate psychotherapy as an independent profession, there is no uniform university training recognized by the Ministry of Education. Therefore, different training paths can be followed to become a psychotherapist. This leads to a great diversity of professionals practising psychotherapy with widely varying levels of knowledge and skills (Brison et al., 2015).

3. Contradictions in the development of psychological and psychotherapeutic practice and training in Belgium

Many contradictions in the development of psychological and psychotherapeutic care in the mental health system stemmed from the privileged position of medical doctors and psychiatrists. Although the title of 'psychotherapist' was not protected by law, the Royal Decree No 78 of 1967 (Arrete Royal 10.11.1967 relatif a l'exercise de l'art de guerir) defined psychotherapy as part of medicine. Only physicians could practice psychotherapy legally, but psychotherapy was not recognized as a profession or a title (Foisy et al., 2002).

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2 Under the European Certificate in Psychology (EuroPsy) (EFPA, 2019), the requirements for the Specialist Certificate in Psychotherapy are:
(1) Minimum volume and content of further study: (a) At least 90 ECTS of further study, of which 400 hours should be devoted to theory; (b) The content varies with the institution's curriculum and/or the psychologists' learning trajectory.
(2) Minimum volume of supervised practice and supervision: (a) At least three years of postgraduate (post eligibility for EuroPsy Certificate) practice, of which 500 hours is supervised practice; (b) At least 150 hours of supervision (on average 50 per year).
(3) Minimum volume of personal development (personal therapy) is 100 hours.

In the 1980s, psychotherapists were mainly psychologists, social workers and psychiatrists, but only psychiatrists received official recognition to practise psychotherapy, and thus, their sessions were reimbursed by the health care system. When this decision was taken, they were required to have a certificate proving that they were properly trained. It was a contradiction, because most of their teachers in psychotherapy training were not medical doctors but psychologists or social workers. They trained psychiatrists and gave them a certificate that enabled them to be reimbursed for practising psychotherapy, but at the same time, the trainers were not reimbursed. In the 1990s, psychiatrists were not even asked to provide any certificate in order to be reimbursed (ibid., pp. 43-44) and such a situation has persisted to this day, with general practitioners and psychiatrists free to offer psychotherapy without any specialized training (Kohn et al., 2016).

Officially, all professions other than psychiatrists were only allowed to provide Psychotherapy under the supervision of psychiatrists and were not reimbursed. But this rule was far from being respected, as it created a new contradiction: How could a psychiatrist, who had no psychotherapeutic training, supervise psychologists, social workers and others who were properly trained? Despite all this nonsense, non-medical psychotherapists enjoyed a good reputation among the public and were socially quite well established (ibid., 2002).

In addition to psychotherapists, psychologists also disagreed with this subordination to doctors, and wanted to achieve professional autonomy in the health care system. They did not want to be classified as paramedical staff and to be supervised by doctors. They started an initiative to improve the regulation in the field of psychology by defining three professions: clinical psychologist, clinical sexologist and orthopedagogist. The Faculties of Psychology at Belgian universities, the Flemish Organization for Psychoanalytic Therapy and the Higher Council for Health Care (Recommendation No 7855) proposed educational standards for these three professions, requiring first the completion of a five-year university programme to a master's level, followed by an internship in health care settings. For those who wanted to practise psychotherapy, an additional 2 year 'master after master' training at university level was proposed (Avontroodt, 2010).

One of the positive developments before 2014 was that certain Belgian universities (e.g. the Catholic University of Louvain) had been working for many years to create a complete psychotherapy training in collaboration with private institutes and associations in the three main approaches – psychoanalysis, systemic family therapy and cognitive behavioural therapy. Theoretical content was taught at the universities, while supervised practice and personal experience

was provided at the institutes and associations. It was contradictory in that, according to the higher education legislation, only university diplomas were valid, thus giving public validity to theoretical education but not to practical training. Certificates from private institutes and associations did not have public validity (Foisy et al., 2002).

Another contradiction was related to the entry requirements for psychotherapy training. The candidate should already have some practical psychotherapeutic experience in order to be suitable for supervision, but how could they have it if they had not yet been trained in psychotherapy (ibid.).

Due to the lack of a legal definition of psychotherapy, there is still to this day no uniform university training recognized by the Ministry of Education. Therefore, different training paths can be followed to become a psychotherapist. This leads to a great diversity of professionals practising psychotherapy with widely varying levels of knowledge and skills (Brison et al., 2015).

4. Reasons for the Law of 4 April 2014 on the regulation of mental health professions

During the 2010-2014 parliamentary term, the need to establish a new framework for mental health became apparent. A National Health Survey highlighted the worrying state of the mental health of the Belgian population (Van der Heyden & Charafeddine, 2013). A quarter of all Belgians felt that they were plagued by depressive feelings and negative thoughts, 9% of the citizens went through a depressive period, 8% had somatic complaints, 6% suffered from anxiety symptoms and 21% (one in every five) reported sleep disturbances. Almost 14% of Belgians considered themselves as having serious mental difficulties. Moreover, every year in Belgium, more than 2.000 people committed suicide and more than 20.000 attempted to do so. With a suicide rate of nearly 19 per 100.000 inhabitants in 2013, Belgium, alongside Finland, France and Denmark, was considerably above the global average, estimated at 14.5 per 100.000 inhabitants. Similarly, the volume of psychotropics prescribed in Belgium was a concern for the parliamentarians. In 2012, almost 283 million antidepressants were consumed. Their use saw a 45% increase from 2004 to 2012. During the 2006-2008 period, Belgium consumed, per capita, 15% more sleeping pills and tranquillizers than France, approximately 3 times more than Great Britain, the Netherlands and Germany and 5 times more than Norway. These figures placed Belgium at the top in Europe for this period. Furthermore, the number of children and adolescents who were prescribed amphetamine class drugs for attention deficit hyperactivity disorder (ADHD) increased by 74% between 2004

and 2007. Given these figures, it became clear to the parliamentarians that the promotion of good mental health and the prevention of mental illnesses was one of the key challenges facing the Belgian healthcare system.

Although population-representative studies show that the majority of patients in well-developed countries first consult a healthcare professional in the general health sector for mental health problems (Wang et al., 2007), this seems to be particularly the case in Belgium, where up to 75% of patients seeking help for mental health problems do so first in the medical care sector, mostly consulting their GP (Dezetter et al., 2013ab; Wang et al., 2007). This suggests that GPs are the gatekeepers to mental healthcare, which may be quite appropriate given their role in the healthcare system more generally (Dezetter et al., 2013ab). However, as in other countries, this study also showed that there were high levels of unmet needs for mental health problems in Belgium. In addition, there were problems with the prioritization of care (e.g., overuse of medication and psychotherapy by individuals who do not meet criteria for mental disorders, but under-treatment of individuals with diagnosable mental health problems). Finally, and perhaps most disconcertingly, there was only a very weak relationship between the severity of mental health problems and follow-up, and very few patients who sought treatment actually received minimally adequate treatment (e.g., a minimum dose of pharmacotherapy or psychotherapy); this finding has been replicated in other population-representative studies (Bruffaerts et al., 2007; Demyttenaere et al., 2004; Ten Have et al., 2013; Wang et al., 2007). For major depression, for instance, only 1 in 3 patients received minimally adequate treatment (Thornicroft et al., 2017).

As a consequence, the Legislature examined the mental health care services offered in the country. It became clear that the organization of this sector was unsatisfactory and appeared totally incomprehensible to patients. It was therefore highlighted that while more and more Belgians were explicitly expressing a need for psychological support, those requesting it admitted that they did not know who and where to ask. Patients were unaware of the specific roles of the various professionals (general practitioner, psychiatrist, psychologists, psychotherapist, etc.). There were also many who, although they refused to consult their general practitioner or a psychiatrist (fearing an almost automatic prescription for a drug treatment or in an attempt to protect their privacy because of the taboo or fear of the stigma surrounding psychiatric illness), hesitated to turn to other professionals (psychologists, psychotherapists) for fear of ending up in the hands of a charlatan (Kohn et al., 2016, p. 14).

As the title of 'psychotherapist' was not protected or reserved, the patient had no guarantee as to the quality of the 'therapist' that they consulted.

This exposed them to potential abuses including a significant risk of attempts to be influenced by sectarian movements. Furthermore, the lack of any official recognition for these practitioners as professionals working in the health field has hindered the multidisciplinary biopsychosocial care of patients as recommended by the WHO. Although their position in mental health care was unregulated, psychologists, orthopedagogists and psychotherapists were de facto included in various mental health care services, institutions and programmes (e.g. oncology or psychiatric services). From a strictly legal perspective, these practices constituted an illegal practice of medicine, but on the other side, psychological and psychotherapeutic treatments have been recognized as valuable alternatives to drug treatments (ibid.).

5. The development and passing of the law on 4 April 2014 on the regulation of mental health professions

The Minister of Public Health and the Superior Council of Hygiene (Conseil Supérieur d'Hygiène), which coordinated the negotiations, tried to find a consensus between the existing proposals, while respecting the healthcare framework as it was conceived with the Royal Decree no. 78 of 1967. This consensus was reached with a series of amendments by the parliamentary majority and on the 4th of April 2014, a new law on the regulation of mental health professions was passed by Parliament (FPS, 2014a). The main innovations introduced by the law were as follows (Kohn et al., 2016, p. 15):

- the integration of clinical psychologists, orthopedagogists and psychotherapists into the framework established by Decree no. 78, which related to health professionals;
- the establishment of an advisory council (called the Federal Council) for each of the three professional groups and a Superior Mental Health Council, in which all three were associated with the aim of facilitating interdisciplinary cooperation between various mental health workers (psychiatrists, clinical psychologists, psychotherapists, general practitioners, social workers, orthopedagogists, etc.);
- the creation of an accreditation framework for the practice of psychotherapy, which was not recognized as a health profession, but as a practice which could be performed by certain practitioners (health professionals or not) under certain conditions, including specific psychotherapy training. In practical terms, psychotherapy was therefore regulated as a practice reserved for professionals trained for this purpose and only they should use this title. This framework aimed to offer better clarity for the patient seeking mental health

care, to give these service providers protection and obligations comparable to other healthcare providers and above all to protect the patient by defining the skills needed for psychotherapy practice.

In the part of the law devoted to psychotherapy, the exercise (practice, performance) of psychotherapy was defined as "the usual provision of autonomous acts that aim at or are proposed to aim at eliminating or relieving the difficulties, conflicts or mental disorders; the exercise of psychotherapeutic interventions based on a psychotherapeutic frame of reference, in respect of that individual or of a group of individuals, considered as a full system, of which that individual is a part"[3] (FPS, 2014a, Art. 35). Four psychotherapeutic frames of reference or orientations were recognized: psychoanalytic and psychodynamic-oriented psychotherapy, behavioural and cognitive-oriented psychotherapy, system- and family-oriented psychotherapy; experiential-, person- and humanistic-oriented psychotherapies.

These orientations could be practised by a broad range of practitioners (health professionals or not) as long as they were specifically trained and accredited. Other orientations or approaches needed to undergo a verification process with the Federal Council for Psychotherapy, which was established as a key decision-making body. During the transitional period (until the new law came into the force), the Council was to advise the Minister on the precise standards of psychotherapy training and practice, on the modalities to be recognized, on continuing professional development and on the grandparenting rules. The Council was composed of representatives from each of the four main psychotherapeutic orientations (see below) and from academia (all of these should be psychotherapists), and two medical doctors (one of them a psychiatrist) (FPS, 2014b).

The minimum training requirements for the qualification of psychotherapist established by law were:

- Bachelor degree in health sciences, psychology, education or social sciences of at least 180 credits (ECTS);
- basic knowledge of psychology acquired at University or High School, including general psychology, psychiatry and psychopathology, psychopharmacology, psychodiagnostics, an introduction to the main psychotherapeutic approaches, an introduction to the mental health care system;

3 A slightly different English translation of the definition of the practice or performance of psychotherapy in Article 35 is given in Kohn et al. 2019, p. 17: "The practice of psychotherapy was defined 'as the usual performance of independent acts seeking to or presented as seeking to eliminate or ease the psychological difficulties, conflicts or disorders of an individual, the performance of psychotherapeutic interventions based on a psychotherapeutic reference framework, considered as a system in its own right, for this individual or a group of individuals, including this individual'.

- after having fulfilled the requirements set out in points 1 and 2, the candidate should have completed training in the chosen psychotherapeutic approach of at least 70 credits (ECTS) over a period of 4 years in an accredited training institute (university or private); the programme should include at least 500 hours of theory and at least 1.600 hours of supervised psychotherapy clinical practice.

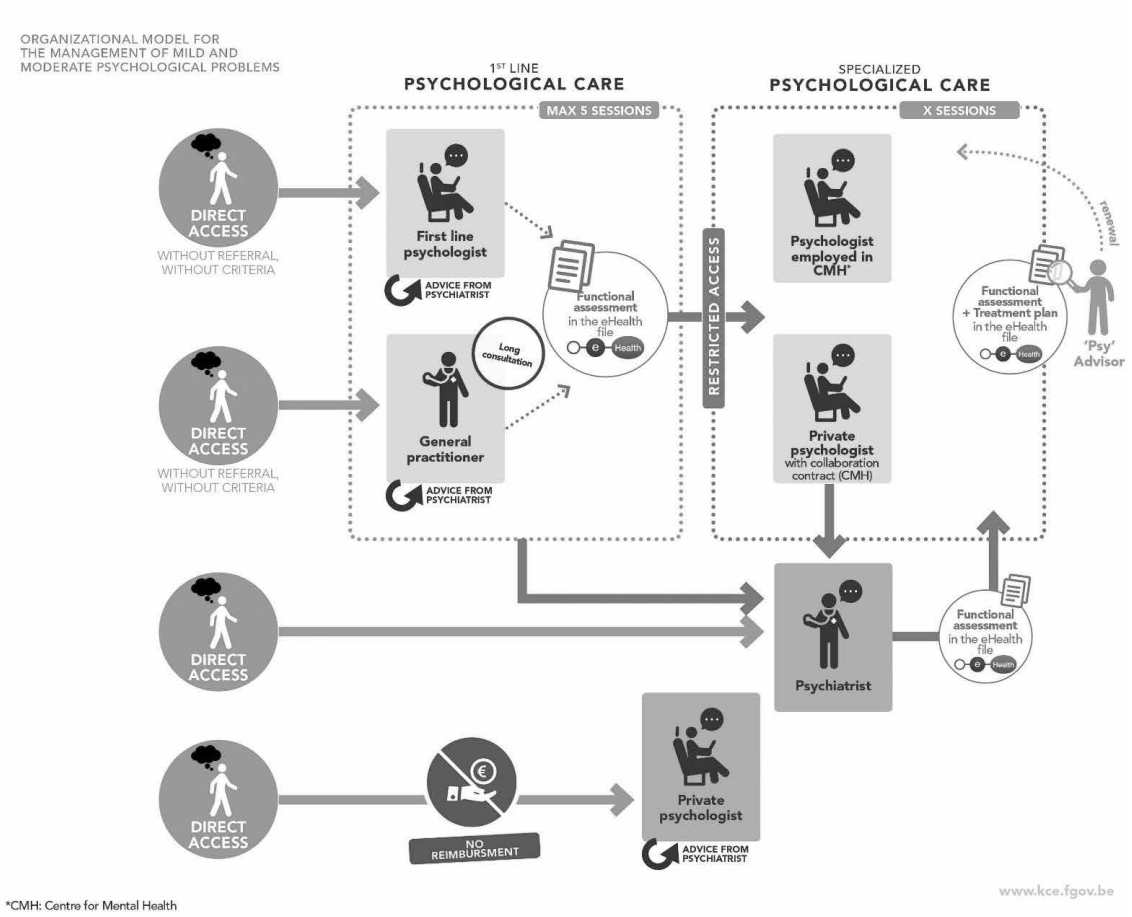
The conditions for personal experience were not specified in the law, but were left to each psychotherapy modality to formulate them and then to be approved by the Federal Council for Psychotherapy. The law also stressed the importance of adherence to a code of ethics and of cooperation with other professions in the health sector.

6. A model for the organization and reimbursement of psychological and orthopedagogical care

In parallel with the adoption of the April 2014 law the federal government announced its intention to to finance and reimburse psychotherapy in specific contexts and with certain limitations: it should be accompanied by a reduction in the use of psychotropic drugs and by a financially supported collaboration between different actors in the field. For the concretization of these plans the Belgian Health Care Knowledge Centre (KCE) made a study based on an international comparison of mental health care systems in Belgium, the United Kingdom, The Netherlands, Switzerland, Germany and Denmark, and proposed a model for the organization and reimbursement of psychological and orthopedagogical care in Belgium (Kohn et al., 2016). As the proposed regulation of psychotherapy had not yet been finally approved, psychotherapy care was not specifically included in their model, but it was planned to after the new regulation of psychotherapy came into force (figure 1).

Figure 1

Organizational model for the management of mild and moderate psychological problems (Kohn et al., 2016, p. 97)



The KCE study sought to find a solution to two problematic aspects in Belgian mental health care. First, there was the high unmet need, expressed as a low proportion of persons with mental health problems entering treatment in the short term; or expressed as the long delay before someone entered care (roughly 10-15 years). Secondly, there was the problem of overmet need, expressed as a high degree of highly specialized care, even for patients with mild mental health problems. Among other things, the consequence was a high use of psychopharmaceuticals in the Belgian general population, or a rapid flow to psychiatric hospitalization.

The proposed organizational model for the management of mild and moderate psychological problems consisted of two components (levels of access):

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

The model was built on the principles of stepped care, a model in which care seekers initially get the least intensive treatment, corresponding to the nature and severity of their complaint. In case this approach should be insufficient, the patient is allowed to move (prescribed) to a next level of specialization ('stepping up') The system of private practice of psychological care, with direct access to primary as well as specialized psychological care, could remain as it was at that time and act as an alternative pathway to psychological care, but in the model it was not eligible for reimbursement by authorities.

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

- welcome and listening to all the complaints;
- establishing of a functional assessment, or if relevant, a diagnosis;
- counselling;
- support and empowerment in case of self-solvable problems;
- individual and group psycho-education (sleep problems, stress management etc.);
- brief intervention for moderate issues (uncomplicated psychotrauma, mourning etc.);
- early detection and redirection of (potentially) severe problems to a psychiatrist or to the next levels of specialized psychological care (matched care);
- reference to more specialized psychological care if necessary.

The types of intervention in the first line psychological care should not be necessarily limited to face to face consultations, but could include: group sessions, online programmes, consultations by telephone or other remote interfaces, observations in school (for orthopedagogists), home visits (for the elderly and disabled). The first line practitioners should be a clinical psychologist, clinical orthopedagogist or general practitioner.

The model foresaw that access to specialized ambulatory psychological care should be reserved for people with specific therapeutic needs that exceed the possibilities of first line care. Eligibility should be based on a functional assessment, not necessarily on a diagnostic. This assessment should be

complemented by (at least) the first line psychologist and the GP and should be documented in the electronic medical record. Urgent access to psychiatric care should not be conditioned to such assessment. Criteria for eligibility for access to specialized care have to be defined. In case of eligibility a limited number of sessions should be reimbursed. A psychiatrist should also have the opportunity to refer a patient to specialized psychological care (for the same limited number of sessions). In this case they should provide the functional assessment and have to document it in the electronic medical record.

This model has not yet been fully implemented, but the structure and organization of ambulatory mental health care in Belgium since 2011 is developing in the direction of improved access to psychological and psychotherapeutic support (Jansen et al., 2023). It is well documented that the general practitioner (GP) plays an important role as they are often the first contact person in case of health problems and follow up. While only 5.4% of complaints in general medicine are directly linked to psychiatric difficulties, a Belgian study showed that almost half of all patients, who sought help from a GP (984 of 2.316 patients), also suffered from a proven mental disorder (major depressive disorder and dysthymia, anxiety disorders, alcohol abuse/dependence, etc.) (Ansseau et al., 2004). The coexistence of somatic and psychological disorders therefore requires comprehensive patient management. Unfortunately, there is no information on the proportion of GPs' consultations dedicated to mental healthcare, nor on the type of interventions that they carry out with their patients with mental health problems (Mistiaen et al., 2019, pp. 102, 153). A number of problems have been observed (Kohn et al., 2016, p. 27):

- GPs often exclusively prescribe drug treatment. They rarely refer patients to psychologists, psychotherapists or psychiatrists;
- the collaboration between GPs and 'psy'-professions is considered difficult. It is often unclear to GPs what support they can get from a psychiatrist. When for instance, a patient is hospitalized in a psychiatric unit, there is a relatively limited information exchange between the hospital and the GP;
- the education of GPs is insufficient to provide mental health care;
- there is no possibility to bill a longer consultation, to evaluate or diagnose the mental status, nor for multidisciplinary contacts with a psy- professional.

Because in the Belgian mental health care system there is still a lot to be done to improve the effectiveness, accessibility and quality of the gatekeeping system, this remains one of the main objectives of the health system reforms (Van Broeck et al., 2013; Mistiaen et al., 2019; Gerkens & Merkur, 2020). As many European countries have similar problems, the proposed new model of Kohn and co-workers would not only be applicable to Belgium, but to many other European countries.

7. The new Law on the Practice of Healthcare Professions in 2015

The 2014 law was due to come into force by September 2016 at the latest, but there was an unexpected turn of events during the transition period. In May 2015, a new law on mental health provision, officially called The Law on the Practice of Healthcare Professions (LHCP 2015) (also known as the'De Block Law'[4]) (FPS, 2015), was passed to come into force on the 1st of September 2016. According to this law only clinical psychologists, clinical orthopedagogists and physicians (especially general practitioners and psychiatrists) could study and practise psychotherapy. This meant that existing and practising psychotherapists would lose their autonomy in providing psychotherapeutic services and would be obliged to be supervised by clinical psychologists, clinical orthopedagogists or physicians.

Psychotherapists were of course very dissatisfied with the new law, but the Minister ignored all their objections. Then on 28th of June 2016 more than 250 professional training and care institutions as well as university teachers wrote an open letter to Prime Minister Charles Michel to suspend the De Block law on psychotherapy (FEDA, 2016). They expressed their astonishment that the Minister considered psychotherapy as a medical practice and thus suppressed the profession of psychotherapist. The main points of criticism in the open letter were:

- the inadequacy of the Minister's reductionistic view of mental health, which was based on Evidence Based Medicine (EBM) when the Superior Council of Hygiene, which argued for the 2014 Law, indicated the need to take into account, in addition to evidence based data, other criteria generally accepted in the psychotherapy field, which are 'practice based' or even 'value based' relating to the personal values of the patient/client;
- the inadequacy of the elimination of psychotherapeutic modalities (psychoanalytic and psychodynamic, CBT, systemic and humanistic), which were acknowledged in the 2014 Law, because preserving this diversity enabled more flexible and personalized treatment of each patient:
- the inadequacy of the elimination of the necessary diversity of psychotherapy training in different modalities and its minimal duration of at least four years, because this would "lead to grotesque situations where experienced psychotherapists would have to be under the supervision of someone with only a medical degree";

4 The name 'De Block Law' is linked to the name of the Minister of Social Affairs and Public Health, Maggie De Block, under whose mandate the law was passed.

- the failure to take into account consultation in a field that requires multi-disciplinarity. The de Block law was drafted in a secret manner, with only a few professionals involved, while others each time found the doors closed against them. For example, no response was given to the 70 representatives of institutions who, in February 2016, sent the Minister the Memorandum for a rigorous and patient-friendly psychotherapy. Conversely, the 2014 law was drafted in an effort to build consensus at all levels: scientifically, the law was based on the opinion of the Superior Council of Hygiene and followed extensive consultation with professionals of mental health. This legislation was also the subject of a political consensus both at the level of the Government (Laurette Onkelinx, Minister of Health) and of Parliament (except for the nationalist and conservative party The New Flemish Alliance (NVA) and the far-right party Flemish Interest (VB), all the parties were signatories). Debates, explaining delicate points, even took place in the Senate;
- the violation of procedural rules, as it was almost inconceivable that the new government had not remained committed to the implementation of the 2014 law and that the new Minister was able to secretly prepare and impose a new law.

Unfortunately, the efforts of psychotherapists were not successful, and de Block law came into force on the 1st of September 2016 (Sasse & Vrancken, 2017; Mistiaen et al., 2019; Luyten & Jeannin, 2021). It is still valid today and regulates the practice of clinical psychology (article 68/1), clinical orthopedagogy (article 68/2), and psychotherapeutic care (article 68/2/1). Psychotherapy or 'psychotherapeutic care' was defined as »a form of mental health care treatment that uses, in a logical and systematic way, a coherent set of psychological interventions, which are anchored in a psychological and scientific frame of reference, and which require an interdisciplinary collaboration« (Mistiaen et al., 2019, p. 90).

Psychotherapy or psychotherapeutic care on an autonomous basis can only be practised by so called 'LHCP professions': clinical psychologists, clinical orthopedagogists or clinical educationalists (special pedagogues)[5] and physicians. The 'non-LHCP professions' (or LHCP professions that benefit from acquired rights) can only practise psychotherapy under the supervision of a physician, clinical psychologists or a clinical educationalist and work in an interdisciplinary context (figure 2). The worst-case scenario for psychotherapists has come true: existing and practising psychotherapists have lost their autonomy in providing

5 The LHCP requirement for being registered as a clinical psychologist is a university degree in clinical psychology, comprising full-time education for at least five years or 300 ECTS, and for being registered as a clinical orthopedagogist (educationalist) is a university degree in the field of special needs education, comprising full-time education for at least five years or 300 ECTS. Clinical orthopedagogists who can demonstrate sufficient knowledge of clinical psychology, can also practice as a clinical psychologist.

psychotherapeutic services and are now obliged to be supervised by clinical psychologists, clinical orthopedagogists or physicians.

Psychotherapists had no choice but to try to repair the damage caused by the law through legal action. In September 2017, the Belgian Association for Psychotherapy started the procedure in the Constitutional Court. In December, 2017, the Court decided to delay the application of the law for existing and practising psychotherapists, and in February 2018, deleted the controversial Articles 11 and 12, and decided that:

- existing and working psychotherapists, regardless of their primary profession or even without a Bachelor degree, could continue to work autonomously;
- students who completed the first year of their first degree in June 2017 retain the right to enter psychotherapy training after completing their first degree; but only at universities, and no longer at private institutions; they would not be able to practise their profession autonomously, but only under the supervision of doctors or psychologists; and they would only be able to see patients referred to them by general practitioners or psychologists;
- students who started their first cycle studies in September 2017 were not allowed to continue their training in psychotherapy.

Psychotherapists have only succeeded in partially mitigating the damage that the new version of the previously well-intentioned law has already caused and has continued to cause. However, Belgian psychotherapists are continuing their efforts for the recognition of psychotherapy as an independent profession.

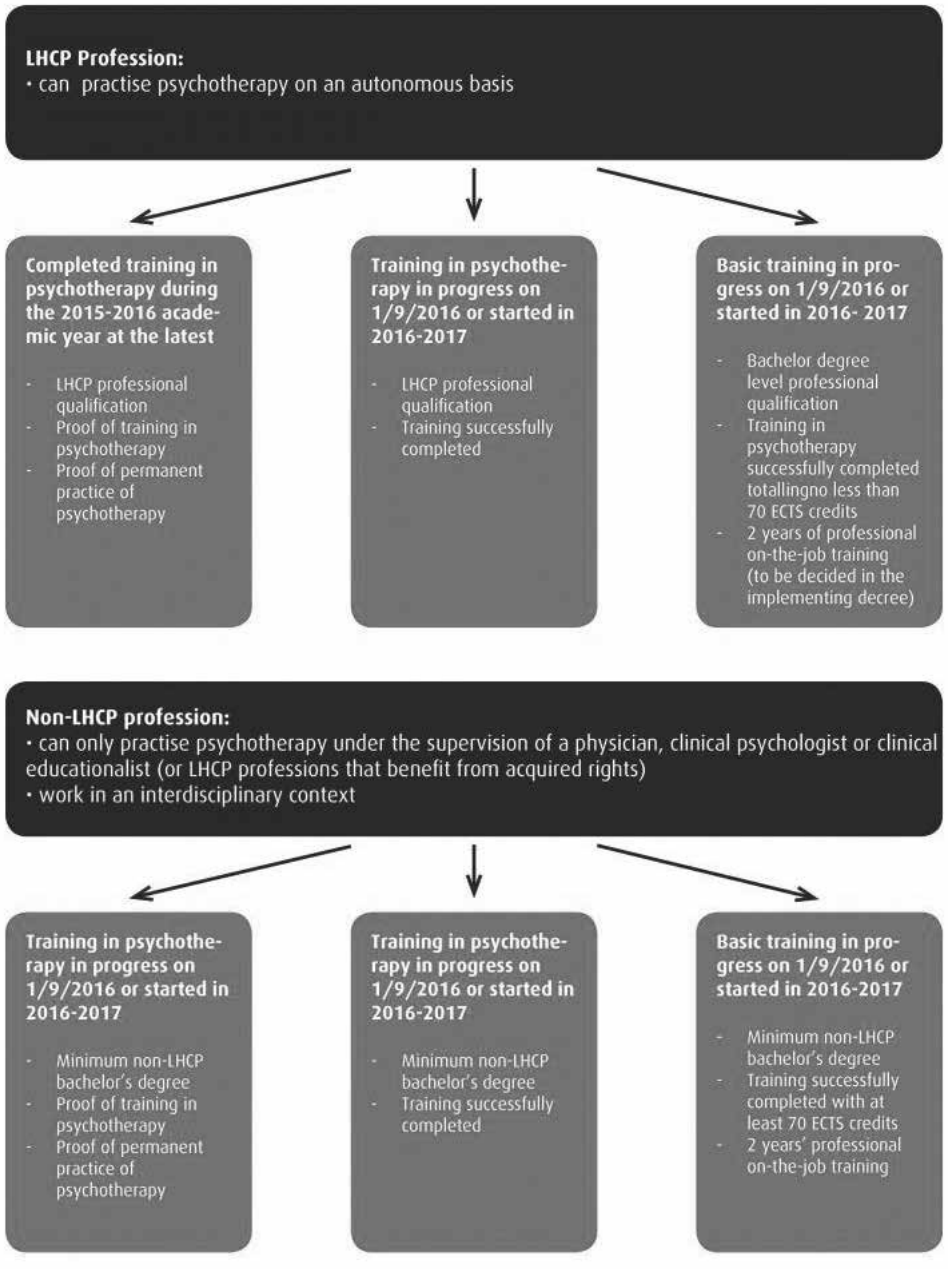
Today there are two groups of professionals who can practice psychotherapy (FPS, 2023a):

1. Those who started their studies in the 2017-2018 academic year onwards should meet the following requirements:
   - hold registration as a physician, clinical psychologist or clinical educationalist;
   - have followed additional training in psychotherapy of at least 70 ECTS at a university or college of higher education;
   - have followed professional on-the-job training for at least two years full
   - time in the field of psychotherapy (or equivalent in the event of practising part-time).
2. Those who are already practising as psychotherapists or who started their studies by the 2016-2017 academic year at the latest have acquired rights.

These acquired rights apply to both those who hold a health care professional qualification (LHCP qualification) and to those who do not hold a health care professional qualification (no LHCP qualification). There is a difference concerning practice, depending on whether or not the psychotherapy practitioner has this qualification (figure 2).

Figure 2

Outline of acquired rights according to The Law on the Practice of Healthcare Professions (LHCP, 2015) for LCHP professions and non-LHCP professions (FPS, 2023a).



There are three categories of acquired rights (FPS, 2023a):

1. Those who completed their studies at the latest during the 2015-2016 academic year. can (continue to) practise psychotherapy if they:
   - have a LHCP qualification or a non-LHCP qualification of at least bachelor's degree level;
   - have successfully completed specific training in psychotherapy.
   - can provide proof, by the 1th September of 2018 at the latest, that they have practised psychotherapy.
2. Those who started specific training in psychotherapy during the 2016-2017 academic year at the latest can (continue to) practise psychotherapy if they have:
   - a LHCP qualification or a non-LHCP qualification of at least bachelor's degree level;
   - they have successfully completed specific training in psychotherapy.
3. Those who start training at bachelor degree level at the latest during the 2016-2017 academic year can practise psychotherapy if they have:
   - a LHCP qualification or a non-LHCP qualification of at least bachelor's degree level;
   - successfully completed specific training in psychotherapy;
   - completed at least two years' professional on-the-job training in the field of psychotherapy.

8. Clinical psychologists as a healthcare profession within the frame of the new law

In 2017, an Interuniversity Consortium was formed in response to the new law (LHCP 2015), which consists of representatives of Belgian universities that offer MSc programmes in Clinical Psychology, Educational Sciences, and School and Educational Psychology. The Consortium has joined forces with the Belgian Commission of Psychologists to carry out a national survey study among psychologists and educationalists in Belgium (Luyten & Jeannin, 2021). In 2018, the number of Belgian psychologists with MSc in psychology ranged between 38.481 and 40.167, or 152 per 100.000 inhabitants (ibid., p. 208). In the study 4.304 clinical psychologists with an MSc in psychology or a joint degree in psychology and educational sciences participated, because the focus of the study was mental health provision as offered by psychologists.

The results of the study showed that the majority of psychologists continue their education in the broad domain of psychology, which is often related to the LHCP. There is a high degree of diversity in further training, in terms of

duration and in orientation, so that training and work setting do not always meet the requirements demanded by the LHCP. Psychologists also participate in multiple forms of continuous professional development (CPD), although a subgroup of them does not participate in intervision nor in supervision. Psychologists most often work in the mental healthcare sector and in sectors where mental healthcare is offered (such as social welfare, healthcare and education). Self-employment is very common, especially as a secondary occupation. There is currently no one-on-one relationship between working in the field of psychology and using the job title of 'psychologist', nor between obtaining an MSc in clinical psychology and working in the clinical field. Client care is the most important task in the field of work of clinical psychology, and this is even more pronounced in self-employment (ibid., p. 222-223).

According to the LHCP, "under the exercise of clinical psychology is understood, the common use of independent acts which have for purpose or are proposed to have for purpose, with a human and within the scientific based framework of clinical psychology, the prevention, the evaluation, the screening or the composition of a psycho diagnosis of real or supposed psychic or psychosomatic suffering and the treatment or counselling of that person" (BFP, 2018). In the study sample, 78.4% of psychologists working in the clinical field obtained an MSc in clinical psychology, and 37.3% completed a postgraduate psychotherapy training.

Clinical psychologists are typically young (61.4% are younger than 40) and mostly female (83.7% in the study). More than half (52.1%) reported to be working in self-employment (either full-time or part-time), indicating the importance of self-employed psychologists in the availability of mental healthcare in Belgium (Luyten & Jeannin, 2021, p. 211). With regard to the tasks relevant to the practice of clinical psychology as defined in the LHCP, prevention, diagnostic assessment, and treatment were part of the tasks of about four out of five psychologists who contributed to people's wellbeing or development and/or provided client care, and more than nine out of 10 reported to engage in counselling.

The characteristics of psychologists who provide psychotherapeutic care in the sample (n = 2.216) were:

- 90.2% have obtained an MSc in clinical psychology;
- 57.6% have completed a psychotherapy training;
- 28.9% of self-employed psychologists work in a multidisciplinary group practice, and 46.8% work alone in private practice;
- 90.2% participate in interdisciplinary consultation (at least quarterly);
- 88.2 participate in intervision or supervision (at least once in the past year);
- 52.6% reported having had personal therapy;
- 75.5% hold membership of a general professional association or a psychotherapy organization.

The LHCP attaches importance to CPD and multidisciplinary collaboration. Psychologists who provide psychotherapeutic care reported the following characteristics (ibid., p. 217):

- 28.9% of self-employed psychologists worked in a multidisciplinary setting;
- 90.2% of psychologists participated in interdisciplinary consultation at least quarterly, with a median frequency of weekly consultations in salaried jobs and a median frequency of monthly consultations in self-employed jobs;
- 88.2% had participated in intervision or supervision since graduation;
- 75.5% have a membership of a general professional association or a psychotherapy organization.

Concerning intervision and supervision, 65.2% participated in intervision and 49.1% invested to some extent in receiving supervision. However, 23.9% had never received intervision or supervision since they graduated, and in the past year 36.7% of participants working in the clinical field had not participated in intervision and 55.3% not in supervision.

Self-employed psychologists tended to identify more strongly with the clinical field of work and to be more involved in tasks described by the LHCP, such as offering client care, a job focus on psychological wellbeing, the provision of prevention, diagnostic assessment, counselling, treatment, and psychotherapeutic care, working with patients with DSM-defined problems, and involvement in training related to the LHCP. They more often identified as a 'psychologist', based on their use of this job title, than psychologists in salaried employment. Concerns about the LHCP were also higher among self-employed psychologists. Self-employed psychologists were more engaged in CPD, including intervision and supervision, and they were more likely to hold membership of a professional or psychotherapy association. These forms of peer contact were important sources of support for self-employed psychologists. On the other hand, interdisciplinary consultation was less frequent in self-employed psychologists.

9. New developments in the field of primary psychological care

In terms of financing, in Belgium reimbursement is more limited in the mental health sector than in other health care sectors. There is an insufficient access to ambulatory mental health care and affordable psychotherapy, which leads to (inappropriate) referrals to other care providers/organizations (Mistiaen et al., 2019).

Two issues are central to the psychological well-being of the general population in Belgium. First, mental disorders are common: nearly 28% of the population has had at least one mental disorder at some point in their lives and 13% have had one in the past 12 months (Bonnewyn et al., 2008). Secondly, people with mental disorders often appear to seek professional help for them late: only 43% sought professional help within 12 months (Bruffaerts et al., 2007). In the long run, the majority of people with mental disorders do eventually enter treatment. Thus, the treatment gap is more a matter of delaying care. On average, it takes 10-15 years to effectively seek professional help for mental disorders.

There have been two major shifts in the Belgian care landscape regarding mental disorders over the past two decades (Jansen et al., 2022). First, the proportion of individuals seeking effective help increased by about 1% per year, and that specifically in low-threshold and primary care settings. Secondly, the place and role of the clinical psychologist has been strengthened: with the development of a legal framework for clinical psychology, this proportion has more than doubled compared to the early 20th century.

There have also been changes in mental health policy in recent years: since 2011, care is now organized in networks in which multidisciplinary and integrated care should be tailored to the patient (www.psy107.be). Since January 1, 2019, to improve the accessibility of ambulatory psychological care, the National Institute for Sickness and Disability Insurance (NIHDI) (www.inami.fgov.be) has provided reimbursement for clinical psychologists and orthopedagogues, who have joined the Primary Psychological Care Convention of NIHDI[6]. After being included into a network of the NIHDI, they have been paid for up to 8 sessions per patient per calendar year: (1) for adults aged between 18 and 64 years; (2) for those who suffer from common mental health disorders (depression, anxiety and alcohol abuse), and (3) for those who are referred by a GP or psychiatrist (Gerkens & Merkur, 2020, p. 164; Jansen et al., 2022).

Although the Convention prescribed that the target group consists of persons with moderately severe psychological problems who do not (yet) meet the diagnosis of mental disorder and have not yet been treated or have already been treated to a very limited extent, the question is which patients are actually treated in the primary psychological care system. It is against this background that the Evaluation of Primary Care Psychology (EPCAP) study was established, which provides an evaluation of the reimbursement measure (www.kuleuven.

6 Furthermore, conventioned clinical psychologists and orthopedagogues have to attend peer review and training sessions within their own mental health network. However, there are no requirements on attending training and courses to maintain accreditation, and therefore we are not talking about accredited clinical psychologists/orthopedagogues.

be/epcap). For the study of Jansen et al. (2022) the following research questions were investigated: What patient population is reached? What care pathways have primary psychological care users previously completed? How long does the average primary psychological user delay seeking professional help? What are the reasons for this delay?

A total of 447 patients completed the questionnaire online between November 2020 and August 2021, and since the EPCAP study is a longitudinal study, the patients were also contacted again after 3, 6, 12 and 18 months to complete the online questionnaire again. The clinical profile of patients (mean age 40.7; 69,7% women) were:

- nearly 90% of patients had a DSM-5 mental disorder sometime in their lives and in the past year with often severe limitations in daily functioning. Most often there were mood disorders (63.3% ever; 59.4% in the past year), anxiety disorders (61.4% ever; 57.3% in the past year), substance dependency (17.6% ever; 9.6% in the past year), eating disorders (30% ever; 21.9% in the past year), suicidal thoughts (33% in the past year) and attempted suicide (1,2% in the past year), PTSD (75,5% that lasted one month or longer during their lifetime; 68,8% in the past year), and there was a great deal of psychiatric comorbidity;
- half of the patients had been in treatment before; psychological primary care was the first treatment for 49.1 % of patients;
- patients reported a median delay time of 6 years between the onset of mental health problems and when they sought professional help. 45% of patients first wanted to solve the problem themselves and 33.4% thought that the symptoms would go away on their own. In addition, cost (33.7%) and not knowing where to go for professional help (17%) played a role in patients' procrastination. Finally, a significant proportion of patients had less than good past experiences with professional help (19.6%) and 13.3% of patients were concerned about what others would think if they received professional help.

Of the patients who were already receiving treatment for a mental health problem prior to the current primary care treatment (50.9%), the majority of them had received it more than 12 months ago (41.9%). It was mostly in an outpatient setting (41.4%), but 6.1% of patients also reported a past hospital admission. More than a quarter of all patients had previously been treated by a clinical psychologist/orthopedagogue, 24% had already been in treatment with a general practitioner and 11.3% with a psychiatrist. In the year prior to current primary care treatment, 9% were receiving treatment for a psychological problem. Over 42% had ever been prescribed medication as part of the treatment of a psychological problem, and for 41% this was the case in the past year.

According to the patients, the main reasons for referral to current primary care were learning to cope with emotional problems (62.4%), stress (59.8%), recent stressful events (46.8%) and acceptance of the past (42.1%). They also hoped to get help in making important decisions (23.4%), wanted control over behavioural problems (17.1%) or sought help in dealing with physical symptoms (12.9%).

In 2022, a new reform in the approach, organization and financing of Belgian mental health primary care was set in motion in line with the KCE model presented earlier (Kohn et al., 2016). The new organizational structure took shape on the basis of a new Primary Psychological Care Convention, developed in close consultation with all stakeholders in the mental health care system. At the end of July 2021, this new convention was ratified by the members of the Insurance Committee of the NIHDI, and since September 1, 2021, 32 different mental health networks (11 for youth, 20 for adult and 1 mixed) have signed the new convention. Since January 1, 2022, this new convention came into force in practice (FPS, 2023b).

Under the new Convention, financial investments in mental health care have risen sharply. Before the new Convention, a budget of 42.8 million euros was available for psychological care in primary care, which was used very little. Since January 1, 2022 the budget has been increased by 122.2 million euros, making an investment of in total 165 million euros per year, or four times the initial budget. A third of this goes specifically to children, youth and adolescents.

In the frame of the new Convention (Testaankoop gezond, 2023), anyone can receive care in individual or group sessions, in the consulting room of the clinical psychologist/orthopedagogist, in 'outreach' (at homes, at school, at the work place etc.) or online. Reimbursement is available to anyone, who experiences a psychological vulnerability in their life. This renewed offer is mainly aimed at people with a vulnerability in terms of psychological well-being, or with more serious psychological problems. To better meet individual needs, the networks are divided according to two types of care, but also according to two age categories: networks 'children and adolescents' (up to 23 years) and networks 'adults' (from 15 years). These age categories overlap to ensure a more appropriate offer for young people aged 15 to 23, who can choose their network according to the nature of their needs.

Payment for the sessions goes directly through the third-party payer Convention scheme. Users do not have to do anything themselves for this allowance. They only pay the personal share: for individual sessions 11 euros per session and if they are entitled to an increased allowance, they only pay 4 euros; for group

sessions, they pay 2.5 euros per session. For primary psychological care, the first individual session is free. The number of reimbursed sessions per 12-month period depends on the user's age, the type of received care, and the type of sessions attended (tables 1 and 2).

Table 1

The reimbursement schema in a network 'children and adolescents' (up to 23 years) (Testaankoop gezond, 2023).

Primary care	**Maximum 10 individual sessions, or**	**Maximum 8 group sessions, or**
Primary care	Maximum 18 individual and group sessions of which maximum 10 individual sessions, or	
Primary + Specialized care	Maximum 10 First-line individual sessions + Maximum 15 Specialized group sessions	
Specialized care	On average 10 individual sessions (maximum 20), or	Maximum 15 group sessions, or
Specialized care	On average 10 individual sessions (maximum 20) + maximum 15 group sessions, or	
Specialized + First-line care	On average 10 specialized individual sessions (maximum 20) + maximum 8 primary care group sessions	

Table 2

The reimbursement schema in an 'adult' network (from 5 years) (Testaankoop gezond, 2023).

Primary care	**Maximum 8 individual sessions, or**	**Maximum 5 group sessions, or**
Primary care	Maximum 13 individual and group sessions of which a maximum of 8 individual sessions, or	
Primary + Specialized care	Maximum 8 primary care individual sessions + Maximum 12 specialized group sessions	
Specialized care	On average 8 individual sessions (maximum 20), or	Maximum 12 group sessions, or
Specialized care	On average 8 individual sessions (maximum 20) + maximum 12 group sessions, or	
Specialized + First-line care	On average 8 specialized individual sessions (maximum 20) + maximum 5 primary care group sessions	

To follow the schema of the reimbursed psychological sessions no prescription is needed, a user must simply go to a clinical psychologist or orthopedagogist in a mental health network that has signed the new convention (2021) with the NIHDI. Primary psychological care is immediately accessible. Specialized psychological care is accessible after a functional balance sheet has been drawn up after an initial session. This functional assessment is drawn up by the network's contracted psychologist or orthopedagogist. They can contact the user's general practitioner for this, with the user's permission.

At the end of June 2023, the first evaluation study on the effects of the Convention was carried out (Jansen et al., 2023). Within one year about 147.000 patients have been treated under the Convention, which has generated about 850.000 sessions (equivalent to 6 sessions per care pathway). From this group, a sample of 2.750 patients was selected (with data collection between November 2020 and March 2023) and patients were included in a questionnaire survey that probed for clinical profiles (i.e., sociodemographic characteristics, diagnosis of mental disorders, quality-of-life, absenteeism and resilience) and past care use (Jansen et al., 2022). Patients were followed up at 3, 6 and 12 months after index treatment. The mean age of patients was 39; sample data were statistically weighted to be representative of the population of treated patients (N = 147.000) using population parametres obtained by the NIHDI.

The results of the first year and a half of the Convention primary care are positive and show that there has been a progressively increasing influx of patients who have never been in treatment before. Patients delayed seeking care for less time: persons with psychological problems/mental disorders thus entered care remarkably faster. The patient's admission to care was thus smoother and faster. The data also shows clinical effectiveness: after an average period of 4 years of mental problems or mental disorders, after an average of 6 sessions, mental symptoms decreased and there was an increased daily quality of life and resilience of treated patients for at least 6 months after treatment initiation.

At the patient and community level, the following findings were presented:

- 34% of the patients treated within the Convention were patients without mental disorders or with mental disorders that arose less than a year ago;
- for 44% of the patients, the treatment was the first ever and the delay time between onset of mental problems and the time to effectively seek help was 4 years;
- 28% of the treated patients were in a precarious vulnerable socio-economic or socio-demographic position;
- about a quarter of patients required further outpatient or residential care after conventional treatment;

- 10% of all sessions took place in a group and 1 in 6 sessions at a resource site;
- site-based work increased access to care, especially for reaching vulnerable populations (especially those in more precarious situations);
- 6 months after starting treatment with an average of 6 sessions, there was a 41% decrease in absenteeism from work (from 5 to 2 days per month) and improvement in general daily functioning.

At the clinical psychologist/orthopedagogue level, the findings were as following:

- the clinical practice of conventional primary care psychology was conducted by clinical psychologists/orthopedagogues who had an average of 10 years of experience;
- collaboration with primary care actors was important and considered very valuable and
- should be further encouraged;
- clinical psychologists/orthopedagogues were open to but were often not yet sufficiently familiar with group interventions, working at referral sites or working in primary care in general and have a related need for training, education, intervision/supervision;
- in the year 2023, Conventional psychologists/orthopedagogues were open to making the shift to working in primary care and at referral sites, provided a number of conditions are met. The mindset seems to be changing to a more socially anchored treatment in which the needs of patients and thus the needs of society are central.

Based on the results of the evaluation study, for further development of primary psychological care recommendations were made for three levels: the care delivery level, the network level and the macro level. Their implementation will depend critically on whether the Convention is extended, as it is currently valid only until the end of 2023. As the positive effects of the Convention have been empirically confirmed after the first year and a half, there is hope for its extension, at least in 2024 and 2025.

The recommendations, based on the study (Jansen et al., 2023) for the future development of primary care psychological care at the care delivery level include:

- the improvement of the *distinction between primary and specialized psychological care*. At the conceptual level, two forms of intervention have emerged, both from the research findings and from the clinical practices conducted. These have less to do with the severity of symptoms or disorders than with the type of intervention indicated for the patient. The primary care is based on early intervention that is preventive in nature and refers to a short-term generalist care approach. It involves a limited series of sessions focused on mobilizing the patient's resources and preventing symptoms from worsening.

The specialized care leans closer to the clinical profile and needs of patients with pre-existing psychiatric histories, with more clinical goals beyond resource mobilization. The practitioner then uses the dedicated number of sessions for medium-term follow-up, spreading the sessions over a longer period of time so that medium-term follow-up is possible;

- the necessity of working with *clinical instruments and questionnaires*. These do not aim to be a triage for a possible inclusion/exclusion of the patient, but help the professional with an adequate indication of the reported patient (such as primary or secondary psychological care, psychotherapy and, subsequently, individual/group intervention). This recommendation includes three central elements. First, the purpose of clinical tools will be to describe the patient's goals, as well as psychiatric elements (such as mental disorders), resilience and quality-of-life (McDaniel et al., 2014). In this way, such a tool can also be used as an attrition tool, providing insight into the evolution of the patient in question. Secondly, this clinical tool will provide a personalized indication, with predictive validity regarding the care needed for this or that patient. The above, thirdly, creates a framework for data collection and monitoring of patients treated within the Convention, both at the network and policy level. Such a monitoring system provides an answer to the necessity of capturing broad patient-centred and -reported data from treatments at the population and network levels and thus concretely working towards a value-based health policy (Porter & Guth, 2012; Porter & Teisberg 2006; Summergrad & Kathol, 2014);
- the stimulation of *online interventions* and *self-help*. This relates to the broad social pre-treatment pathway within a primary care psychiatric pathway in terms of developing a continuum of interventions. Against the background of a societal pathway to care (i.e., the provision of specific community-based interventions that enable individuals with mild and/or incipient mental health problems to receive timely, low-threshold, and brief treatment through referral sites) and the known barriers with respect to seeking professional help for mental health problems, the further stimulation of online interventions and self-help is essential. There is sufficient scientific evidence to argue that self-help and online interventions are 'precursors' to treatment (Andrews et al., 2018; Moshe et al., 2021; Palacios et al., 2022; Richards et al., 2020; Timulak et al., 2022; Wright et al., 2019). A portfolio for the individual psychologist with existing evidence-based online interventions and self-help initiatives for specific or broad problem areas could be developed here;
- the improvement of *site-based and outreach interventions*, which are not fully utilized yet. Such interventions enable the uptake of vulnerable patients (e.g., 25% of vulnerable patients are treated at a resource site compared to 17% overall). Group interventions as opportunities to organize low-threshold psychological care (Kaldo et al., 2020; Sundquist et al., 2020; Dolan et al., 2021; Rogiers et al., 2022) could also be developed to a greater extent.

The recommendations for the future development of primary psychological care at the network level include:

- the organization of *training and education* on evidence-based treatments and clinical instruments for primary and secondary psychological care, and on evidence-based treatment models for group interventions, site-based, outreach, and multidisciplinary work;
- the stimulation of the *cooperation with the networks* in order to be able to undertake more outreach work (e.g. the provision of an absenteeism compensation in case of a no-show), to have a better knowledge about referral possibilities within one's own network, about the possibilities for exchange of good practices and about the possibilities for optimal communication between the stakeholders.

The recommendations for the future development of primary psychological care at the macro level include:

- the improvement of a *population management tool*, i.e. a policy that interprets and clinically validates the place of primary psychological care in society in a substantive and quantifiable way. Within this recommendation, it is crucial to work towards (1) population data on prevalence and utilization of mental disorders and emotional problems at the population and network level, which articulate the needs of the population and its vulnerable groups, (2) care pathways that take place within networks, and (3) a sustainability of population-based distribution of financial resources in which vulnerability and precarity are guiding principles at the regional, local and municipal levels;
- the development of a *step-by-step guide for the ongoing development of primary psychological care*, articulated in the development and pursuit of (1) standards in implementation pathways of primary psychological care; (2) standards in primary psychological care (including good/best practices, evidence-based interventions at the individual and group level) and monitoring; (3) standards in collaborative and referral pathways within networks. By analogy with the High and Intensive Care (HIC) monitor and Active Recovery Triad (ART) monitor for the treatment of persons with severe psychiatric problems (Van Melle et al., 2019; Zomer et al., 2022), a version for primary psychological care monitor could serve as a guide for implementation, quality and model fidelity, ensuring a set of standards-of-care and identifying and evaluating quality indicators for the practice and organization of care; and (4)

a standard in allocation of financial resources at the level of networks, taking into account the specific characteristics of the population of communities, regions and networks in terms of precarity, vulnerabilities and inequalities of the population in order to develop a distribution key according to a solidarity principle.

It is not difficult to see how psychotherapists, on an equal level with psychologists and orthopedagogists, could play an important role in this excellent Belgian development project of primary psychological care. It is therefore to be hoped that, with the appropriate change in the de Block law, Belgian psychotherapists will succeed in achieving a position of parity between healthcare professions.

10. What can Slovenia learn from Belgium?

Slovenian psychotherapists are also aware of contradictions similar to those in Belgium, stemming from the privileged position of doctors and clinical psychologists. Slovenian psychiatrists and clinical psychologists:

- want to have a monopoly on psychotherapy and do not want psychotherapists to become one of the health professions;
- want psychotherapy to remain a psychological method that only they can practise and are against psychotherapy as a profession in its own right;
- want to have the possibility to carry out psychotherapy and to be paid for it, without being properly trained for this work. Since they can present it as one of the psychiatric or psychological methods that they apply in their work, it is entirely up to their discretion and responsibility how much and how they actually apply it. This anomaly is possible because in the health system there is no control over the fulfilment of educational standards for psychotherapy as an autonomous profession, nor is there any control over the quality of psychotherapeutic services provided by psychiatrists and clinical psychologists;
- treat professional psychotherapists working outside the health service as inferior and as incompetent to treat people diagnosed with mental disorders;
- reject direct two-level (bachelor and master) academic training in psychotherapy immediately after secondary school, as this would make psychotherapy education pathways parallel to those of psychology and medicine.

Slovenian psychotherapists could therefore learn from the negative experiences of their Belgian colleagues. Many would say it is inconceivable that a law that has already been adopted could be secretly replaced by a new one by the Minister for Health, and yet the Belgian case shows that this can happen. A similar, but not identical, event occurred in the Netherlands, where the law already in force

regulating psychotherapy as an independent profession has been replaced by a new one that stripped psychotherapy of this status. And in Croatia, where the proposed law was about to be adopted in Parliament was secretly changed to maintain the privileged position of doctors. Such things as have happened in Belgium, the Netherlands and Croatia, are possible because of the dominance of the biomedical model and the medical lobby in the healthcare sector. The lesson for Slovenian psychotherapists is therefore that it can get complicated at any stage: at the stage before the proposed law is discussed in Parliament (Croatia) (Prevendar, 2018, 2019), at the stage after the law is passed and before it is implemented (Belgium), or after the law has been passed and has been in force for many years (the Netherlands) (Možina & Kranjc, 2021).

The Belgian case is also instructive in the sense that, for all the efforts made over more than a century to establish the biopsychosocial model, biomedicine has only become more entrenched in the saddle in the last twenty years. Multinational corporations, which make fabulous profits from the sale of medical devices and medicines, financially support all those structures of the biomedical approach in healthcare systems that enable them to continue to market their products successfully. Although they are declaratively in favour of the biopsychosocial model and the strengthening of the primary level of healthcare, without which this model cannot really function, the cash flows of their businesses do not confirm that. Neoliberalism has established a strong link with the biomedical model, and the remarkable scientific and technological achievements of the biomedical model are being turned in a destructive direction by neoliberal ideology, in particular into the decay of ethics, justice and solidarity.

The current Belgian Minister for Health is therefore a shining and, unfortunately, rare example of supporting the strengthening of primary psychological care through concrete and successful measures, but it remains to be seen whether he will succeed in extending the new funding regime of the Convention into the coming years. What we have learned in more than forty years of the rise of neoliberalism is that multinationals are more powerful than states and that they are taking the rule of law into their own hands.

Despite the fact that in the Belgian primary mental health system psychotherapists have not yet been given the role that they deserve and that would be beneficial to users, the Belgian model could serve as a good starting point for the development of psychological/psychotherapeutic primary care in Slovenia as well.

Another important lesson is that Belgian psychotherapists have so far not advocated that psychotherapy could also be the first profession to which a direct academic pathway after secondary school would lead. There is thus considerable confusion in the field of psychotherapy education. However, as the

academization of psychotherapy studies at a post-master level is already well developed, Belgium may follow the German example (as should Slovenia). On this basis, it would be easier for psychotherapists to gain equal status alongside psychologists, orthopedagogists and doctors in the health system and other sectors relevant to mental health care.

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