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La prise en charge des psychothérapies dans les pays de l'OCDE

Bibliographie thématique

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Sommaire

Problématique

Au début des années 2000, le gouvernement australien a mis en place une réforme de santé publique visant à permettre un meilleur accès, gratuit ou peu coûteux, aux psychothérapies brèves, en soins primaires, pour les personnes souffrant de troubles psychiques fréquents. Cette réforme reconnaît l'importance du rôle du médecin généraliste dans la prise en charge des troubles, et la nécessaire collaboration avec les professionnels de santé mentale non uniquement psychiatres. Deux programmes ont successivement été mis en œuvre : *Access to Allied Psychological Services* en 2003 et *Better Access* en 2006. Des évaluations ont montré des résultats positifs de ces programmes sur l'amélioration de l'accès aux soins de santé mentale primaires et sur la santé des patients. Cependant, ces évaluations ont été critiquées pour avoir peu considéré l'évolution de l'état de santé des patients et la qualité des services proposés. Presque dans le même temps, l'Angleterre a mis en place le programme *Improving Access to psychological Therapies (IAPT)* en 2008 en offrant un service de psychothérapies brèves pour les personnes souffrant de troubles psychiques fréquents de sévérité limitée. L'approche graduée mise en place, qui vise à répondre aux besoins du patient en fonction de la gravité de ses troubles, suit lesrecommandations cliniques du National Institute for Health and Clinical Excellence (Nice). Ainsi ,le type de professionnel ('counselors' ou psychothérapeutes), le nombre de séances (4 à 13) et la méthode thérapeutique varient selon la sévérité du trouble. Ce programme se distingue des programmes australiens par la formation spécifique préalable des professionnels impliqués, l'absence d'adressage obligatoire par un médecin et par la rigueur des évaluations menées sur la base de données collectées systématiquement en routine auprès des patients bénéficiant du programme dès son lancement. Un million de patients ont ainsi été traités et les évaluations ont démontré l'amélioration de leur état de santé mentale suite au programme.

En France, si on se réfère à la cartographie médicalisée des dépenses de santé élaborée par la Caisse nationale d'assurance maladie (Cnam)[1], le poids de la santé mentale est chaque année particulièrement marquant, tant en termes d'effectifs de patients concernés que de dépenses. Ainsi, en 2017, plus de 7 millions de personnes - soit plus d'un Français sur 10 - ont eu recours à des soins ou des prestations que l'on peut rattacher soit à une maladie psychiatrique soit à un traitement chronique par psychotrope. Les dépenses correspondantes se sont élevées à près de 20 milliards d'euros pour les bénéficiaires du régime général, une somme extrapolable à 23 milliards d'euros pour correspondre aux dépenses de tous les régimes, soit 14 % des dépenses d'Assurance Maladie. Sur les 5,8 milliards d'euros affectés à la prise en charge de personnes recevant un traitement chronique par psychotrope sans diagnostic repéré, 80 % sont affectées à la prise en charge de deux groupes de médicaments : les antidépresseurs et les anxiolytiques[2][3]. Face à ce fardeau épidémiologique et économique, la santé mentale est de plus en plus une priorité de santé publique et le ministère chargé de la santé a publié en 2018 une feuille de route qui lui est dédiée (Ministère chargé de la santé, 2018). Par ailleurs, l'Assurance

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[1] Cnam. Cartographie des pathologies et des dépenses 2017. Site d'Ameli
[2] Cnam(2019). Charges et produits pour 2019.
[3] Cnam (2019). Charges et produits pour 2020.

Maladie en a fait un thème majeur de ses propositions 2019 sur l'amélioration du système de soins (Cnam, 2018). Devant le constat que les antidépresseurs étaient probablement trop fréquemment prescrits de manière inadéquate dans la population générale et qu'il y avait inversement une sous-prescription chez les patients ayant un épisode dépressif modéré à sévère (Fagot et al., 2016), l'Assurance Maladie a lancé deux expérimentations concernant la prise en charge de la psychothérapie, une alternative aux traitements médicamenteux recommandée par la Has, mais dont le remboursement n'était pas assuré par l'Assurance Maladie, à la différence d'autres pays européens. La première expérimentation, lancée en 2017, concerne la prise en charge psychique des jeunes de 11 à 21 ans[4], qui peuvent se voir rembourser des consultations psychologiques dans la limite d'un forfait. La seconde porte sur la prise en charge des troubles psychiques d'intensité légère à modérée chez l'adulte comme soutenu par les recommandations françaises et internationales.[5] Déployé depuis l'automne 2017 dans quatre départements français (Bouches-du-Rhône, Haute-Garonne, Landes et Morbihan), ce dispositif est inscrit dans le Plan National de Santé Publique « Prévention pour lutter contre les inégalités de santé » et sera expérimenté durant trois ans[6]. Une évaluation de cette expérimentation sera réalisée, incluant un volet médico-économique, afin de mettre en évidence l'impact de cette prise en charge, en particulier en termes de retour à l'emploi et de moindre consommation d'indemnités journalières maladie[7].

L'objectif de cette bibliographie est de recenser la littérature scientifique portant sur les expérimentations de programmes de psychothérapie mis en place en Australie, au Royaume-Uni et dans d'autres pays de l'OCDE et remboursés par l'Assurance Maladie. Les recherches bibliographiques ont été effectuées sur les bases de données et portails suivants : Irdes, Bdsp, Medline, Econlit, Science direct, Cairn, Erudit, Googlescholar sur la période allant de 2000 à avril 2019. Les références bibliographiques sont accompagnées de résumés et classées par ordre alphabétique d'auteurs. Cette bibliographie ne prétend pas à l'exhaustivité.

Les mots-clés interrogés sont les suivants :

Psychothérapie

"psychological treatment"[Title/Abstract] OR "psychological treatments"[Title/Abstract] OR "psychological therapy"[Title/Abstract] OR "psychological therapies"[Title/Abstract] OR "psychotherapy"[Title/Abstract] OR "psychotherapies'"[Title/Abstract] OR "Mental disorders/Therapy"[MeshTerms] OR "Anxiety disorders/Therapy"[Mesh terms]

Prise en charge, remboursement

"health insurance reimbursement"[Title/Abstract] OR "insurance, health, reimbursement""[MeshTerms] OR "financing""[Title/Abstract] OR "economics""[Title/Abstract] OR "funding"[Title/Abstract]

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[4] Décret n° 2017-813 du 5 mai 2017 relatif aux expérimentations visant à organiser la prise en charge de la souffrance psychique des jeunes ; complété par l'arrêté du 19 décembre 2017 et selon l'article 68 de la loi n° 2016-1827 du 23 décembre 2016 de financement de la sécurité sociale pour 2017.

[5] HAS. Recommandation de bonnes pratiques, Épisode dépressif caractérisé de l'adulte : prise en charge en soins de premier recours, octobre 2017 ; et NICE, Clinical guideline, Depression in adults: recognition and management, 2009.

[6] Ce dispositif expérimental a été élaboré en association avec le ministère de la santé, le Collège de la médecine générale (CMG), le Collège national des professionnels de psychiatrie (CNPP), le Collège national pour la qualité des soins en psychiatrie (CNQSP), des représentants de psychologues cliniciens et l'Association française des thérapies cognitives et comportementales (AFTCC).

[7] Gandré, C., Rosenberg, S., Coldefy, M., et al. (2019). "Experimenting locally with a stepped-care approach for the treatment of mild to moderate mental disorders in France: Challenges and opportunities." Health Policy **123**(11): 1021-1027.

Cnam (2018). Rapport sur les charges et produits de l'Assurance Maladie pour 2019 : Améliorer la qualité du système de santé et maîtriser les dépenses : propositions de l'Assurance Maladie pour 2019.

Les dispositifs en vigueur en Australie

Deux programmes de prise en charge des psychothérapies

2003

- Australia's Better Outcomes in Mental Health Care (BOiMHC)
- Access to Allied Psychological Services (ATAPS)
- GB Psych Support

2006

- Better Access to Psychiatrists and General Practitioners

Austin, D., Pier, C., Mitchell, J., Schattner, P., Wade, V., Pierce, D. et Klein, B. (2006). "Do GPs use electronic mental health resources? - a qualitative study." Aust Fam Physician **35**(5): 365-366.

> BACKGROUND: The Better Outcomes in Mental Health Care (BOMHC) initiative encourages general practitioners to use electronic mental health resources (EMHRs) during consultation with patients requiring psychological assistance. However, there is little data on GPs' acceptance and use of EMHRs. METHOD: Semistructured interviews were conducted with 27 GPs to determine their attitude toward EMHRs, and their use during consultation with patients. RESULTS: Few GPs reported frequently using EMHRs in consultation. Identified barriers to use included lack of familiarity with information technology, and insufficient knowledge of available resources. Identified advantages of electronic resources included high patient acceptance, time efficiency, and improved quality of information. DISCUSSION: General practitioners recognise several advantages of utilising electronic resources for managing patients with mental illness. However, GPs are not sufficiently familiar with electronic resources to use them effectively. This could be overcome by education.

Barton, C. A., Opolski, M., Cleland, E., Cotton, A., Briggs, N., Taylor, M. et Howell, C. (2008). "Allied mental health referral. Trends in the Adelaide Hills Division of General Practice." Aust Fam Physician **37**(10): 888-891.

> BACKGROUND: Referrals to allied health professionals as part of Access To Allied Psychological Services (ATAPS) and More Allied Health Services (MAHS) at the Adelaide Hills Division of General Practice were examined to gain insight into the characteristics of referred patients and the characteristics of referring general practitioners. METHODS: Data held by the division for the two allied mental health programs was extracted for the period July 2001 to December 2005. The analysis identified characteristics of patients and GPs that were associated with referrals to each program. RESULTS: One hundred and sixteen GPs made 2451 referrals. Female patients accounted for 72% of referrals. Men were more likely to be referred to MAHS than women, and were more likely to be referred by a male GP. Mean Kessler Psychological Distress Scale scores were 31.3 for ATAPS and 27.7 for MAHS referred patients. DISCUSSION: This study identified significant trends in the use of these programs. Further research is needed to understand factors driving these trends.

Bartram, M. et Stewart, J. M. (2019). "Income-based inequities in access to psychotherapy and other mental health services in Canada and Australia." Health Policy **123**(1): 45-50.
http://www.sciencedirect.com/science/article/pii/S0168851018305992

> This paper compares income-based inequities in access to psychotherapy and other mental health services in Canada and Australia, two federal parliamentary systems with sharply contrasting responses to high rates of unmet need. Income-based inequity is measured by need-standardized

concentration indices, using comparable data from the Canadian Community Health Survey 2011–2012 and the Australian National Survey of Mental Health and Well-Being 2007. The results indicate that utilization of psychologist services is more concentrated at higher income levels (i.e. pro-rich) than the other provider groups in both countries, and may be more pro-rich in Canada than in Australia. While the distribution of unmet need for psychotherapy was expected (as a negative indicator of access) to be more concentrated at lower income levels (i.e. pro-poor) under Canada's two-tier system, unmet need was not more equitable in Australia despite expanded public insurance coverage. As psychotherapy was made universally affordable for the first time in Australia in 2006, a possible backlog effect may have driven up both service utilization and unmet need, particularly among lower-income Australians. The impact of different Medicare co-payment policies also warrants further exploration.

Bassilios, B., Nicholas, A., Reifels, L., King, K., Fletcher, J., Machlin, A., Ftanou, M., Blashki, G., Burgess, P. et Pirkis, J. (2016). "Achievements of the Australian Access to Allied Psychological Services (ATAPS) program: summarising (almost) a decade of key evaluation data." Int J Ment Health Syst **10**: 13.

Background: Introduced in July 2001, Australian Access to Allied Psychological Services (ATAPS) was the inaugural national policy initiative to provide community access to government-funded psychological services in primary care. Our aim was to examine the achievements of ATAPS in relation to its stated objectives using a set of indicators that largely drew on data from a minimum data set that we designed for the evaluation of ATAPS. Methods: We used de-identified professional-, consumer- and session-level data from the minimum dataset, and secondary analyses of our quantitative and qualitative data collected for a series of specific evaluation studies. Available data covered the period from 1 July 2003 to 31 December 2012. Results: Approximately 350,000 referrals were made to the ATAPS program over the 9.5 year analysis period, 79 % of which resulted in services. Over 1.4 million sessions were offered. Overall, 29 % of consumers were male, 4 % children, and 3 % Aboriginal people; 54 % of consumers had depression and 41 % an anxiety disorder; at least 60 % were on low incomes; and around 50 % resided outside of major cities. The most common interventions delivered were cognitive and behavioural therapies. Selected outcome measures indicated improvement in mental health symptoms. Conclusions: Access to Allied Psychological Services achieved its objectives within a decade of operation. The program delivered evidence-based services to a substantial number of consumers who were disadvantaged and historically would not have accessed services. Importantly, where data were available, there were indications that ATAPS achieved positive clinical outcomes for consumers. This suggests that ATAPS carved an important niche by successfully addressing unmet need of hard-to-reach consumers and through means that were not available via other programs. It will be interesting to see the effects from July 2016 of the reform of ATAPS, which will see ATAPS subsumed under psychological services commissioned by regional primary care organisations.

Bassilios, B., Nicholas, A., Reifels, L., King, K., Spittal, M. J., Fletcher, J. et Pirkis, J. (2016). "Improving access to primary mental health care for Australian children." Aust N Z J Psychiatry **50**(11): 1074-1084.

OBJECTIVE: This study examines the uptake by children aged predominantly 0-11 years of an Australian primary mental health service - the Access to Allied Psychological Services programme - which began in 2001. In particular, it considers access to, and use of, the child component of Access to Allied Psychological Services, the Child Mental Health Service, introduced in 2010. METHOD: Using routinely collected programme data from a national minimum dataset and regional population data, we conducted descriptive and regression analysis to examine programme uptake, predictors of service reach and consumer- and treatment-based characteristics of service. RESULTS: Between 2003 and 2013, 18,631 referrals for children were made and 75,178 sessions were scheduled via Access to Allied Psychological Services, over 50% of which were via the Child Mental Health Service in its first 3 years of operation. The rate of referrals for children to the Child Mental Health Service was associated with the rate of Access to Allied Psychological Services referrals for consumers aged 12+ years. CONCLUSIONS: The Child Mental Health Service has increased services provided within the Access to

> Allied Psychological Services programme for children with emotional and behavioural issues and their families, and is potentially filling a service gap in the area of prevention and early intervention for children who have significant levels of need but are unable to access other mental health services. Our findings are policy-relevant for other developed countries with a similar primary mental health care system that are considering means of improving service access by children.

Bassilios, B., Nicholas, A., Reifels, L. et Pirkis, J. (2014). "Uptake of a national primary mental health program by young people in Australia." Int J Ment Health Syst **8**(1): 10.

> BACKGROUND: The purpose of this study was to examine the uptake of an Australian primary mental health care program (Access to Allied Psychological Services) by young people aged 12 to 25 years and the characteristics of consumers and the treatments received. Data were sourced from a national web-based minimum dataset. RESULTS: Between 1 July 2003 and 30 June 2012, 51 716 young consumers received 245 704 sessions via the primary mental health program. Around two thirds were female and the average age was 19 years. The majority had depressive and/or anxiety disorders.Most services were delivered to individuals (including just the young person and/or the young person with one or both parents), in a face-to-face context and free of charge. Cognitive and behavioral strategies were the most common interventions delivered. CONCLUSIONS: The primary mental health care program has been well utilized by people aged 12 to 25 years. Similar programs in other developed countries may improve access to primary mental health care for young people.

Bassilios, B., Pirkis, J., Fletcher, J., Burgess, P., Gurrin, L., King, K., Kohn, F. et Blashki, G. (2010). "The complementarity of two major Australian primary mental health care initiatives." Aust N Z J Psychiatry **44**(11): 997-1004.

> OBJECTIVE: Two pivotal Australian Government primary mental health reforms are the Access to Allied Psychological Services (ATAPS) projects, introduced in July 2001 and implemented by Divisions of General Practice, and the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (Better Access) programme, introduced in November 2006. This research explores the reciprocal impact of the uptake of psychological treatment delivered by these two initiatives and the impact of location (rurality and socioeconomic profile) on the uptake of both programmes since the inception of the Better Access programme. ATAPS session delivery, before and after the introduction of the Better Access program, is also examined. METHOD: General Practice Division-level data sources included a minimum dataset containing uptake data of ATAPS services, Medicare Benefits Schedule uptake data supplied by the Medicare Benefits Branch of the Department of Health and Ageing, a Rural, Remote and Metropolitan Area classification, and Indices for Relative Socio Economic Disadvantage (IRSD). Regression analyses were conducted to examine the reciprocal impact of the two programmes and the impact of rurality and socioeconomic status up to December 2008. RESULTS: A dramatic uptake of Better Access sessions, particularly in urban areas, coincided with a temporary reduction in sessions provided under ATAPS, with an overall small positive relationship detected between the two programmes. A greater proportion of ATAPS sessions (45%) have been delivered in rural areas compared with Better Access (18%). The combination of socioeconomic profile, rurality, and Better Access sessions accounted for a small but significant percentage of variance (7%) in the number of ATAPS sessions delivered, with a non-significant independent contribution of Better Access sessions to the prediction of ATAPS sessions. Weak but significant relationships between ATAPS sessions and each of socioeconomic profile (r = 0.22) and rurality (r = -0.24), respectively, were identified. In comparison, socioeconomic profile, rurality, and ATAPS sessions accounted for a much larger and significant percentage of variance (46%) in number of Better Access sessions delivered, with a non-significant independent contribution of ATAPS sessions to the prediction of Better Access sessions. Moderate significant relationships between Better Access sessions and each of socioeconomic profile (r = 0.46) and rurality (r = -0.66), respectively, were identified. The introduction of Better Access appears to have halted the steady increase in the number of ATAPS sessions previously observed. This finding should be interpreted alongside the fact that ATAPS funding is capped. CONCLUSIONS: The findings are policy relevant. ATAPS projects have been

successfully providing equity of geographic and socioeconomic access for consumers most in need of subsidized psychological treatment. The uptake of psychological treatment under Better Access has been dramatic, suggesting that the programme is addressing an unmet need.

Bassilios, B., Pirkis, J., King, K., Fletcher, J., Blashki, G. et Burgess, P. (2014). "Evaluation of an Australian primary care telephone cognitive behavioural therapy pilot." Aust J Prim Health **20**(1): 62-73.

A telephone-based cognitive behavioural therapy pilot project was trialled from July 2008 to June 2010, via an Australian Government-funded primary mental health care program. A web-based minimum dataset was used to examine level of uptake, sociodemographic and clinical profile of consumers, precise nature of services delivered, and consumer outcomes. Key informant interviews with 22 project officers and 10 mental health professionals elicited lessons learnt from the implementation of the pilot. Overall, 548 general practitioners referred 908 consumers, who received 6607 sessions (33% via telephone). The sessions were delivered by 180 mental health professionals. Consumers were mainly females with an average age of 37 years and had a diagnosis of depressive and/or anxiety disorders. A combination of telephone and face-to-face sessions of 1 h in duration were conducted, delivering behavioural and cognitive interventions, usually with no cost to consumers. Several implementation issues were identified by project officers and mental health professionals. Although face-to-face treatment is preferred by providers and consumers, the option of the telephone modality is valued, particularly for consumers who would not otherwise access psychological services. Evidence in the form of positive consumer outcomes supports the practice of multimodal service delivery.

Bassilios, B., Telford, N., Rickwood, D., Spittal, M. J. et Pirkis, J. (2017). "Complementary primary mental health programs for young people in Australia: Access to Allied Psychological Services (ATAPS) and headspace." Int J Ment Health Syst **11**: 19.

OBJECTIVE: Access to Allied Psychological Services (ATAPS) was introduced in 2001 by the Australian Government to provide evidence-based psychological interventions for people with high prevalence disorders. headspace, Australia's National Youth Mental Health Foundation, was established in 2006 to promote and facilitate improvements in the mental health, social wellbeing and economic participation of young people aged 12-25 years. Both programs provided free or low cost psychological services. This paper aims to describe the uptake of psychological services by people aged 12-25 years via ATAPS and headspace, the characteristics of these clients, the types of services received and preliminary client outcomes achieved. METHODS: Data from 1 July 2009 to 30 June 2012 were sourced from the respective national web-based minimum datasets used for routine data collection in ATAPS and headspace. RESULTS: In total, 20,156 and 17,337 young people accessed two or more psychological services via ATAPS and headspace, respectively, in the 3-year analysis period. There were notable differences between the clients of, and the services delivered by, the programs. ATAPS clients were less likely to be male (31 vs 39%) and to reside in major cities (51 vs 62%) than headspace clients; ATAPS clients were also older (18-21 vs 15-17 years modal age group). There was some variation in the number and types of psychological sessions that young people received via the programs but the majority received at least one session of cognitive behavioural therapy. Based on limited available outcome data, both programs appear to have produced improvements in clients' mental health; specifically, psychological distress as assessed by the Kessler-10 (K-10) was reduced. CONCLUSIONS: ATAPS and headspace have delivered free or low-cost psychological services to 12-25 year olds with somewhat different characteristics. Both programs have had promising effects on mental health. ATAPS and headspace have operated in a complementary fashion to fill a service gap for young people.

Berk, M. (2019). "Better research, better evidence, better access." Aust N Z J Psychiatry **53**(2): 97-98.

Blashki, G., Hickie, I. B. et Davenport, T. A. (2003). "Providing psychological treatments in general practice: how will it work?" Med J Aust **179**(1): 23-25.

Provision of "Focussed Psychological Strategies" by general practitioners is one component of the recent Better Outcomes in Mental Health Care (BOiMHC) initiative. The BOiMHC initiative requires GPs to undertake minimum training requirements before they may provide services under the new Medicare Benefits Schedule item number. We argue that GPs need further training and ongoing clinical interaction with mental health specialists (beyond the minimum training requirements) for refinement of psychological skills. Research focusing on GP training and how GPs interact with specialist services in the provision of psychological treatments is urgently required.

Carson, D., Bidargaddi, N., Schrader, G., Allison, S., Jones, G. M., Bastiampillai, T. et Strobel, J. (2016). "Geography of primary mental health care through the Better Access initiative in South Australia 2006-2010." Aust J Rural Health **24**(3): 188-192.

OBJECTIVE: To examine how the rates of the use of particular face-to-face primary mental health care services changed in the first 4 years (2006-2010) of the Better Access initiative in both urban and rural regions of South Australia. DESIGN: Time-series analysis of the number of psychology session, psychiatry assessment and general practitioner care plan services recorded in Medicare Australia data. SETTING: South Australia. Pre-existing data set of South Australian residents who accessed Medicare between 2006 and 2010 MAIN OBJECTIVE MEASURE: Number of services per 100 000 population (service rate). RESULTS: Psychology session service rates increased in all regions, but continued to follow a 'location gradient', being higher in areas closer to Adelaide and lower in areas more distant from Adelaide. Psychiatry assessment service rates increased in Adelaide but did not change in other regions. Rates in remote areas were subject to substantial variation over time. General practitioner care plan service rates increased in Adelaide and in the Riverland, but declined in the Murray Mallee region. CONCLUSIONS: Overall, service rates increased in Adelaide and nearby regions, but the results for rural and remote regions were mixed. Possible explanations for the geographical variability include population characteristics (such as socio-economic status), methods of service delivery (visiting practitioners, telepsych), the relative proportion of total health services provided by general practitioners versus other practitioners, or real variations in the need for primary mental health services.

Christensen, H., Batterham, P. J., Griffiths, K. M., Gosling, J. et Hehir, K. K. (2013). "Research priorities in mental health." Aust N Z J Psychiatry **47**(4): 355-362.

OBJECTIVE: Over the last decade, Australia has seen an increase in investment in mental health services, primarily through the funding of headspace and Better Access to Mental Health Outcomes programs. Concurrently there has been a policy focus on prevention and early intervention, suicide reduction and 'hard-to-target' groups such as Indigenous groups. It is not clear, however, whether research funding targeting health services or prevention or promotion has been prioritized, or whether funding priorities in general have shifted over the last decade. METHODS: A total of 1008 Australian-authored research publications and 126 competitive research grants in 2008 were coded in terms of their target of research, research goal setting and target group. These characteristics were compared with the research priorities of 570 stakeholders, burden of disease estimates and similar data collected 10 years earlier. RESULTS: The proportion of research funding for affective disorders, dementia and psychosis has increased, but not for anxiety disorders or suicide. Funding for childhood disorders has decreased. Funding for prevention and promotion is low and decreasing. With respect to research publications, substance abuse was associated with the most publications, followed by affective disorders, anxiety disorders and psychosis. When publications and funding are compared to stakeholder priorities and the burden of disease, the areas of suicide and self-harm, personality disorders, anxiety disorders, childhood conditions and dementia are all insufficiently funded. CONCLUSION: Despite mental health policy reforms through the last decade, there has been little change in the focus of research funding or publication output. There is modest evidence for a shift in support towards affective disorders as a major focus for research. However, the remaining gaps were very similar to those identified 10 years earlier showing that suicide, personality disorders and anxiety disorders are under-researched.

Christensen, H., Griffiths, K. M. et Gulliver, A. (2008). "Plenty of activity but little outcome data: a review of the "grey literature" on primary care anxiety and depression programs in Australia." Med J Aust **188**(12 Suppl): S103-106.

OBJECTIVE: To identify reports in the "grey literature" of programs conducted in Australian primary care to improve depression and anxiety outcomes, and to examine these reports for evidence of effectiveness. METHODS: A systematic search was undertaken for grey literature reports using primary health care research databases, community and professional websites, clearinghouse sources, government reports, and reports from the Australian General Practice Network. Reports were included if they related to programs targeting depression or anxiety, contained qualitative or quantitative effectiveness data, and were published during 1995-2006. RESULTS: In total, 642 reports were identified, of which 43 met inclusion criteria. Of the 43 programs described, 30 were delivered in general practice, five in the community or residential care, three in schools, and five were Internet or computer based. Nine programs were also reported in the formal "black" literature, but most, including the Better Outcomes in Mental Health Care initiative, were not. Limited data on effectiveness or patient outcomes were available in the grey literature. CONCLUSIONS: There is currently no single service that identifies, describes and catalogues the range and effectiveness of mental health initiatives in Australia. There may be a role for a mental health information "clearinghouse" to facilitate dissemination and education, and to promote collaboration among researchers, practitioners, consumers and policymakers. Innovative schemes to disseminate evidence-based models and to encourage the collection of data on patient outcomes in such programs are needed.

Cromarty, P., Drummond, A., Francis, T., Watson, J. et Battersby, M. (2016). "NewAccess for depression and anxiety: adapting the UK Improving Access to Psychological Therapies Program across Australia." Australas Psychiatry **24**(5): 489-492.

OBJECTIVE: NewAccess is a Low Intensity Cognitive Behaviour Therapy (LiCBT) early intervention pilot, for mild to moderate depression and anxiety. In November 2015 the Australian Government Review of Mental Health Programmes and Services specifically highlighted the program, stating, "Primary Health Networks will....be encouraged and supported to work towards better utilisation of low intensity 'coaching' services for people with lesser needs, building on evaluations of programmes such as the NewAccess model of care, and the Improving Access to Psychological Therapies model of stepped care implemented in the United Kingdom." NewAccess runs in three sites (Adelaide, Canberra and North Coast New South Wales) based on the successful UK Improving Access to Psychological Therapies (IAPT) model. NewAccess involves training in evidence-based interventions, regular clinical supervision and recording outcome measures every session. Key performance indicators include functional recovery,loss of diagnosis, return to employment and early intervention. CONCLUSIONS: Adaptation to Australia accommodated contextual issues such as geographical isolation and infrastructure of the healthcare system. Initial recovery rates and projected economic viability for NewAccess are very promising, supporting wider adoption of an IAPT model across Australia. In addition it has resulted in the emergence of a new Australian workforce in community mental health with the LiCBT 'Coach'.

Diminic, S. et Bartram, M. (2019). "Does Introducing Public Funding for Allied Health Psychotherapy Lead to Reductions in Private Insurance Claims? Lessons for Canada from the Australian Experience." Can J Psychiatry **64**(1): 68-76.

OBJECTIVE : Provincial and territorial governments are considering how best to improve access to psychotherapy from the current patchwork of programmes. To achieve the best value for money, new funding needs to reach a wider population rather than simply replacing services funded through insurance benefits. We considered lessons for Canada from the relative uptake of private insurance

and public funding for allied health psychotherapy in Australia. METHOD:: We analysed published administrative claims data from 2003-2004 to 2014-2015 on Australian privately insured psychologist services, publicly insured psychotherapy under the 'Better Access' initiative, and public grant funding for psychotherapy through the 'Access to Allied Psychological Services' programme. Utilisation was compared to the prevalence of mental disorders and treatment rates in the 2007 National Survey of Mental Health and Wellbeing. RESULTS:: The introduction of public funding for psychotherapy led to a 52.1% reduction in private insurance claims. Costs per session were more than double under private insurance and likely contributed to individuals with private coverage choosing to instead access public programmes. However, despite substantial community unmet need, we estimate just 0.4% of the population made private insurance claims in the 2006-2007 period. By contrast, from its introduction, growth in the utilisation of Better Access quickly dwarfed other programmes and led to significantly increased community access to treatment. CONCLUSIONS:: Although insurance in Canada is sponsored by employers, psychology claims also appear surprisingly low, and unmet need similarly high. Careful consideration will be needed in designing publicly funded psychotherapy programmes to prepare for the high demand while minimizing reductions in private insurance claims.

Doessel, D. P. et Williams, R. F. G. (2011). "Resource Misallocation in Australia's Mental Health Sector under Medicare: Evidence from Time-Series Data." Economic Papers **30**(2): 253-264.
http://search.ebscohost.com/login.aspx?direct=true&db=ecn&AN=1243189&lang=fr&site=ehost-live
http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291759-3441/issues

Evidence of poor correspondence between resources and "need" in mental health sectors is accumulating. This non-correspondence relates to the tendency for some people with mental disorders not to receive services and some people without mental disorders to use services subsidised under Medicare. Time-series Australian data are examined here and an appropriate approach is applied to measure the correspondence of Australian Bureau of Statistics (ABS) epidemiological surveys of mental disorders and the enumeration of consumers of mental health services under Medicare. The extent of this "structural imbalance" is determined to be extensive. This result reflects a sector beset with incomplete information. Diagnostic efficacy, and funding efficacious processes, is vital economically for the allocation of scarce mental health resources, not just clinically for efficacious therapy. Relevant policy is yet to be formulated.

Doessel, D. P., Williams, R. F. G. et Whiteford, H. (2010). "Structural Imbalance and Resource Shortage in the Australian Mental Health Sector." Journal of Mental Health Policy and Economics **13**(1): 3-12.
http://search.ebscohost.com/login.aspx?direct=true&db=ecn&AN=1120203&lang=fr&site=ehost-live
http://www.icmpe.org/test1/journal/journal.htm

This study develops an approach to measuring 'structural imbalance' in Australia's mental health sector, i.e., the non-correspondence between service use and mental illness diagnosis ('need'). The approach fully cross-classifies data on consumers, and non-consumers, of mental health services, with those having a diagnosis of mental illness, and those without a diagnosis. Venn diagrams are also constructed. The data are from Australia's epidemiological survey, Mental Health and Wellbeing . . . 'People' are a proxy for resources (given that monetary data are unavailable). Extensive structural imbalance is found. Mentally ill people receiving no mental health services ('unmet need') is enumerated; likewise, people consuming mental health services who do not meet the criteria of mental illness ('met non-need'). Government-subsidised services are being used not just for mental illness but for performance (sport, executive etc), by 'the worried well', etc. Resource insufficiency in this sector is also found. Some policy options are discussed.

Dolja-Gore, X., Loxton, D. J., D'Este, C. A. et Byles, J. E. (2014). "Mental health service use: is there a difference between rural and non-rural women in service uptake?" Aust J Rural Health **22**(3): 92-100.

This study examines differences in uptake of the Medicare items rolled out in 2006 under the 'Better Access Scheme' (BAS) between rural and non-rural Australian women. It compares differences in

> women's uptake of the BAS services by area of residence (ARIA+) across time using the Australian Longitudinal Study of Women's Health (ALSWH) survey data linked to Medicare data. Women aged 28-33 years at the time the BAS was introduced that responded to the self-reported question on depression/anxiety and consented to linkage of their survey data with Medicare data (n=4,316). Participants were grouped by ARIA+ according to BAS use, diagnoses of anxiety/depression but no BAS use and other eligible women. Across all areas, women born 1973-1978 with a self-reported diagnosis of depression/anxiety or having treatment under the BAS had a significantly lower mean mental health score compared to other women. Significantly more women living in non-rural areas had used at least one service provided under the BAS initiative compared to women in outer regional, inner regional or remotes areas (21% versus 18% versus 13% versus 7%, respectively), and across all areas, 12% of women reported having a diagnosis of depression/anxiety but not been treated under the BAS. While there is a gradual uptake of the new BAS services, a large percentage of women who have a diagnosis of depression/anxiety have not been treated under the BAS. The data suggest that women in urban areas have been better able to take up the services compared to non-urban women.

Dunbar, J. A., Hickie, I. B., Wakerman, J. et Reddy, P. (2007). "New money for mental health: will it make things better for rural and remote Australia?" Med J Aust **186**(11): 587-589.

> New Australian government funding for the Better Outcomes in Mental Health Care initiative is a significant step forward for mental health, with general practitioners now able to offer direct referrals to psychologists, social workers, occupational therapists and Aboriginal health workers. Incentives for better teamwork between GPs and other mental health professionals have been introduced, but may have unintended consequences, including an exacerbation of workforce shortages in rural and remote areas. Possible solutions to these shortages include rural scholarships for students in the mental health professions; recruitment and retention of students coordinated by university departments of rural health; better access to continuing professional development; and federally funded rural positions and additional financial incentives for rural mental health practitioners.

Fletcher, J. R., Bassilios, B., Kohn, F., Naccarella, L., Blashki, G. A., Burgess, P. M. et Pirkis, J. E. (2008). "Meeting demand for psychological services for people with depression and anxiety: recent developments in primary mental health care." Med J Aust **188**(12 Suppl): S107-109.

> OBJECTIVE: To examine whether there was a reduction in demand for psychological services provided through the Access to Allied Psychological Services (ATAPS) projects after the introduction of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) program, and whether any such reduction was greater in urban than rural areas. DESIGN AND SETTING: A Division-level correlation analysis examining the relationship between the monthly number of sessions provided by allied health professionals through the ATAPS projects run by Divisions of General Practice, and allied health professional services reimbursed by Medicare Australia under the Better Access program, between 1 November 2006 and 31 March 2007. MAIN OUTCOME MEASURES: Uptake of each program, assessed by the number of sessions provided. RESULTS: Overall, despite dramatic uptake of the Better Access program in the first 5 months after its introduction, the demand for ATAPS services was not reduced. The correlations between the numbers of sessions provided by both programs overall ($r = -0.078$; $P = 0.074$) and in rural Divisions ($r = 0.024$; $P = 0.703$) were not significant. However, there was a significant negative correlation between the numbers of sessions provided by both programs in urban Divisions ($r = -0.142$; $P = 0.019$). CONCLUSIONS: For the first 5 months of the Better Access program, the two programs seemed to operate relatively independently of each other in terms of service provision, but in urban Divisions there was a move towards services provided through the Better Access program. Early indications are that the two programs are providing complementary services and are working together to address a previously unmet need for mental health care.

Fletcher, J. R., Bassilios, B., Kohn, F., Naccarella, L., Blashki, G. A., Burgess, P. M. et Pirkis, J. E. (2008). "Meeting demand for psychological services for people with depression and anxiety: recent developments in primary mental health care." Medical Journal of Australia **188**(12): S107-S109.

> Objective: To examine whether there was a reduction in demand for psychological services provided through the Access to Allied Psychological Services (ATAPS) projects after the introduction of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) program, and whether any such reduction was greater in urban than rural areas. Design and setting: A Division-level correlation analysis examining the relationship between the monthly number of sessions provided by allied health professionals through the ATAPS projects run by Divisions of General Practice, and allied health professional services reimbursed by Medicare Australia under the Better Access program, between 1 November 2006 and 31 March 2007. Main outcome measures: Uptake of each program, assessed by the number of sessions provided. Results: Overall, despite dramatic uptake of the Better Access program in the first 5 months after its introduction, the demand for ATAPS services was not reduced. The correlations between the numbers of sessions provided by both programs overall (r = -0.078; P = 0.074) and in rural Divisions (r = 0.024; P = 0.703) were not significant. However, there was a significant negative correlation between the numbers of sessions provided by both programs in urban Divisions (r = -0.142; P = 0.019). Conclusions: For the first 5 months of the Better Access program, the two programs seemed to operate relatively independently of each other in terms of service provision, but in urban Divisions there was a move towards services provided through the Better Access program. Early indications are that the two programs are providing. complementary services and are working together to address a previously unmet need for mental health care.

Fletcher, J. R., Pirkis, J. E., Bassilios, B., Kohn, F., Blashki, G. A. et Burgess, P. M. (2009). "Australian primary mental health care: improving access and outcomes." Aust J Prim Health **15**(3): 244-253.

> The progressive achievements over time of the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care program are examined using a web-based, purpose-designed minimum dataset that collects provider-, consumer- and session-level data on the projects. Findings indicate that the ATAPS projects have established themselves over time as a cornerstone of mental health service provision in Australia. Despite the more recent introduction of the complementary Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule program, the ATAPS projects have continued, since 2001, to attract substantial numbers of general practitioners and allied health professionals and deliver services to significant numbers of consumers. The pro. le of consumers being referred to the projects is now very consistent, with the majority being women with high prevalence disorders who may have had difficulty accessing mental health care in the past. The nature of sessions being delivered through the projects has also reached a point of consistency, with the majority being individual-level, cognitive behavioural therapy-based sessions of around 1 h in length. The only variation in session delivery is related to the charging of a co-payment. There is good evidence that the projects are achieving positive outcomes for consumers.

Ftanou, M., Williamson, M., Machlin, A., Warr, D., Christo, J., Castan, L., Harris, M., Bassilios, B. et Pirkis, J. (2014). "Evaluating the Better Access Initiative: What do Consumers Have to Say?" Australian Social Work **67**(2): 162-178.

> The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative (Better Access) aims to improve outcomes for people with common mental disorders by encouraging a multidisciplinary approach to their mental health care. The current paper presents consumers' views on Better Access. A total of 936 consumers completed a structured survey or took part in an interview about their experiences with Better Access. Participants appreciated the fact that Better Access made psychological care affordable. They accessed services because they had clear mental health symptoms, often exacerbated by stressful life events. Most were

impressed by the quality of care available through Better Access, and found that the number of available sessions was sufficient to meet their needs. Most importantly, the vast majority experienced significant reductions in symptoms and improvements in coping abilities, and they attributed these changes to the care they received through Better Access. Consumers are the most important stakeholders in any debate about mental health care delivery. However, until now they have not been well-represented in discussions about Better Access. Our study gave them the opportunity to air their views, and their first-hand impressions of the initiative were generally very positive.

Gerrand, V., Bloch, S., Smith, J., Goding, M. et Castle, D. (2007). "Reforming mental health care in Victoria: a decade later." Australas Psychiatry **15**(3): 181-184.

OBJECTIVE: From 1994, the Australian State of Victoria began a major transformation of its public mental health service system. In June 2006, St Vincent's Mental Health hosted a conference to reflect on the changes and identify steps to be taken over the next decade. METHOD: Participants came from Victoria's 21 adult mental health services, consumer and carer groups, and psychiatric disability rehabilitation and support organizations. They met in small groups, and discussed pre-set topics. Their observations were pooled in plenary sessions. RESULTS: Participants agreed the changes had had many positive outcomes. People most affected by mental illness had priority for treatment. Services were better structured to meet their needs, and staff were more familiar with community-based care. Negatives included restricted service access for some groups, insufficient resourcing to meet increased service demand and clinical staff not maintaining specialist skills. CONCLUSIONS: The conference enabled experiences to be shared and ideas exchanged about improvements.

Harris, M. G., Burgess, P. M., Pirkis, J. E., Slade, T. N. et Whiteford, H. A. (2011). "Policy initiative to improve access to psychological services for people with affective and anxiety disorders: population-level analysis." Br J Psychiatry **198**(2): 99-108.

BACKGROUND: In 2006, Australia introduced new publicly funded psychological services for people with affective and anxiety disorders (the Better Access programme). Despite massive uptake, it has been suggested that Better Access is selectively treating socioeconomically advantaged people, including some who do not warrant treatment, and people already receiving equivalent services. AIMS: To explore potential disparities in Better Access treatment using epidemiological data from the 2007 National Survey of Mental Health and Wellbeing. METHOD: Logistic regression analyses examined patterns and correlates of service use in two populations: people who used the new psychological services in the previous 12 months; and people with any ICD-10 12-month affective and anxiety disorder, regardless of service use. RESULTS: Most (93.2%) Better Access psychological services users had a 12-month ICD-10 mental disorder or another indicator of treatment need. Better Access users without affective or anxiety disorders were not more socioeconomically advantaged, and received less treatment than those with these disorders. Among the population with affective or anxiety disorders, non-service users were less likely to have a severe disorder and more likely to have anxiety disorder, without a comorbid affective disorder, than Better Access users. Better Access users comprised more new allied healthcare recipients than other service users. A substantial minority of non-service users (13.5%) had severe disorders, but most did not perceive a need for treatment. CONCLUSIONS: Better Access does not appear to be overservicing individuals without potential need or contributing to social inequalities in mental healthcare. It appears to be reaching people who have not previously received psychological care. Treatment rates could be improved for some people with anxiety disorders.

Harrison, C. M. et Britt, H. (2004). "The rates and management of psychological problems in Australian general practice." Aust N Z J Psychiatry **38**(10): 781-788.

OBJECTIVE: General practitioners (GPs) provide the majority of care for people's mental health problems. The recently introduced Better Outcomes in Mental Health Care initiative aims to improve the quality of mental health care in general practice. This study examines current GP management of psychological problems and any changes in their management in the decade leading up to this initiative. METHOD: Current practice was examined through a secondary analysis of the Bettering the Evaluation and Care of Health (BEACH) (2000-02) data. We compared BEACH data with the Australian Morbidity and Treatment Survey (1990-1991) to investigate management changes over the past decade. RESULTS: Between April 2000 and March 2002, psychological problems were managed at a rate of 11.5/100 encounters. Problems most commonly managed were mood disorders, stress-related disorders, behavioural syndromes and disorders due to psychoactive substances. Prescriptions occurred at a rate of 69.5/100 contacts and clinical treatments at a rate of 50.0/100 contacts with psychological problems from 1990 to 1991. The management rate of psychological problems increased from 9683/100,000 encounters (95% CI=9129- 10,237) in 1990-1991 to 11 557 (11,136-11 977) in 2000-2002. Prescription rates (from 63.3, 95% CI=60.5-66.1 to 69.1, 95% CI=67.1-71.1) and clinical treatments (from 36.0, 95% CI =33.4-38.7 to 53.1, 95% CI =51.3-54.9) increased. CONCLUSIONS: This study shows that prior to the introduction of the Better Outcomes in Mental Health initiative changes had already occurred in rates and management of psychological problems in general practice. It also provides a baseline from which future research can measure the impact of the recent reforms on mental health care.

Harrison, C. M., Britt, H. C. et Charles, J. (2012). "Better Outcomes or Better Access -- which was better for mental health care?" Med J Aust **197**(3): 170-172.

OBJECTIVE: To compare the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative with the Better Outcomes in Mental Health Care initiative, to test contentions that Better Access is used more often by advantaged major city patients and that the role of GPs has been reduced to that of referrers. DESIGN AND SETTING: Analysis of Bettering the Evaluation and Care of Health data relating to management of depression from April 1998 to March 2011, with the Better Outcomes period defined as January 2002 to October 2006 and the Better Access period defined as November 2006 to December 2011. MAIN OUTCOME MEASURES: Rates of depression management by GPs, including rates of mental health care item claims, referrals, prescribing and counselling, by patient location and socioeconomic group. RESULTS: During the study period, rates of depression management increased and rates of referrals to psychiatrists halved. Compared with Better Outcomes, Better Access resulted in: increased depression management for advantaged major city and disadvantaged non-major city patients (16.0% and 21.5% increases, respectively); a small decrease in prescribing for advantaged major city patients; decreases in GP counselling; increases in referrals to psychologists for all patient groups (three- to fourfold increases), with advantaged major city patients referred more often than patients in other groups; and increases in mental health care item claims for all patient groups (44-65-fold increases), with more claims for advantaged major city patients than both non-major city patient groups. CONCLUSION: Far from becoming "glorified referrers", GPs remain heavily involved in the management of depression. Better Access brought about an enormous increase in access to primary care management of depression, although advantaged major city patients gained most. Any changes to the system must not compromise the strong improvements in access that have occurred for all groups.

Hickie, I. B., Davenport, T. A., Naismith, S. L. et Scott, E. M. (2001). "SPHERE: a national depression project. SPHERE National Secretariat." Med J Aust **175 Suppl**: S4-5.

Hickie, I. B., Pirkis, J. E., Blashki, G. A., Groom, G. L. et Davenport, T. A. (2004). "General practitioners' response to depression and anxiety in the Australian community: a preliminary analysis." Med J Aust **181**(7 Suppl): S15-20.

OBJECTIVES: To examine the uptake by general practitioners (GPs) of the five key components of the Better Outcomes in Mental Health Care (BOiMHC) initiative: education and training for GPs; the three-step mental health process; focussed psychological strategies; access to allied health services; and access to psychiatrist support. SETTING: All Australian states and territories during the first 15 months of the initiative (1 July 2002 - 30 September 2003). DESIGN: Retrospective survey of de-identified registration data held by the General Practice Mental Health Standards Collaboration (training uptake), de-identified Health Insurance Commission (HIC) billing data (provision of the three-step mental health process, focussed psychological strategies and case conferences with psychiatrists), and reports from "access to allied health services" projects to the Australian Department of Health and Ageing (project participation). MAIN OUTCOME MEASURES: Number and percentage of Australian GPs certified as eligible to participate in the initiative; provision of the three-step mental health process and focussed psychological strategies by GPs; participation in allied health pilot projects; and access to psychiatrist support. RESULTS: Within 15 months of the BOiMHC initiative commencing, 3046 GPs (about 15% of Australian GPs) had been certified as eligible to participate, including 387 who had registered to provide focussed psychological strategies. GPs had completed 11 377 three-step mental health processes and 6472 sessions of focussed psychological strategies. Sixty-nine "access to allied health services" projects had been funded, with the original 15 pilot projects enabling 346 GPs to refer 1910 consumers to 134 individual allied health professionals and 10 agencies. In contrast, the "access to psychiatrist support" component was less successful, with the HIC billed for 62 case conferences at which a psychiatrist and a GP were present. CONCLUSION: The level of uptake of the main components of the BOiMHC initiative has expanded the national capacity to respond to the needs of people with common mental disorders, such as depression and anxiety.

Hickie, I. B., Rosenberg, S. et Davenport, T. A. (2011). "Australia's Better Access initiative: still awaiting serious evaluation?" Aust N Z J Psychiatry **45**(10): 814-823.

Hodgins, G., Judd, F., Davis, J. et Fahey, A. (2007). "An integrated approach to general practice mental health training: the importance of context." Australas Psychiatry **15**(1): 52-57.

OBJECTIVE: The high prevalence of mental disorders and the barriers to detection and treatment of these in general practice are well recognized. As such, the government has placed great emphasis on training general practitioners (GPs) in primary care mental health and on the provision of support for GPs in the delivery of such services. The current paper aims to evaluate a local, rural training program in mental health for GPs. We hypothesized that local 'context-driven' training would lead to increased knowledge and reported change in practice by GPs with mental health patients. METHOD: Locally developed and delivered 'Level 1' training was offered to GPs through the Better Outcomes in Mental Health Care initiative. The training was provided with 6-hour workshops covering mental health assessment and management planning. The training was evaluated through pre- and 6-week post-questionnaires assessing attitudes and practice with respect to treatment of patients with mental health problems. RESULTS: Forty-nine GPs from the Loddon Campaspe Southern Mallee region of Victoria participated in the training. Following the 6-hour workshop, there was an increase in reported use of psychoeducation for patients with depression, use of cognitive behavioural therapy for patients with anxiety, and ease in obtaining advice to assist with the management of psychosis. CONCLUSIONS: GP mental health education should take into consideration the local context, cover systems issues as well as skills development, and aim to develop personal relationships between mental health clinicians and GPs to enhance outcomes.

Hopkins, J. E., Loeb, S. J. et Fick, D. M. (2009). "Beyond satisfaction, what service users expect of inpatient mental health care: a literature review." J Psychiatr Ment Health Nurs **16**(10): 927-937.

To provide efficient and effective inpatient mental health services, it is imperative to not only ascertain if service users are satisfied with the care received from nurses, but also the degree to which initial expectations are being met. Ten reports of primary research on service users' experiences, perceptions and expectations of inpatient mental health care were examined to understand what service users' expect of inpatient mental health care and the implications for nursing practice. The World Health Organization's description of responsiveness to service users' non-medical expectations of care was used as a framework for retrieving literature and organizing the research outcomes. Responsiveness includes seven categories of healthcare performance ranging from respect for the dignity of the person, to adequacy of amenities, and choice of provider. Service users expect to form interpersonal relationships with nurses; however, non-clinical responsibilities serve as barriers which consume considerable available nursing time that otherwise could be spent developing therapeutic relationships. In addition, inpatient programming ideas are identified for the provision of better services. Hospitals' expectations of mental health nurses will need to be reconsidered if these nurses are to provide the time and resources necessary to meet current service users' expectations.

Johnson, C. (2007). "Managing mental health issues in general practice." Aust Fam Physician **36**(4): 202-205.

BACKGROUND: The Australian Federal Government has invested in initiatives aimed at enhancing the general practitioner's role in mental health care. Potential benefits for general practice include better remuneration for longer consultations and improved access to support from other mental health care professionals. OBJECTIVE: This article discusses some of the practical strategies that may assist GPs to deliver quality mental health care in the context of the Australian Commonwealth Government's new 'Better Access to Mental Health Care' initiative. DISCUSSION: General practitioners have a vital role to play in supporting their patients experiencing mental health issues. There are many practical strategies that have the potential improve the delivery of primary mental health care, but further research is required to elucidate optimal approaches.

Jorm, A. F. (2018). "Australia's 'Better Access' scheme: Has it had an impact on population mental health?" Aust N Z J Psychiatry **52**(11): 1057-1062.

BACKGROUND:: Australia introduced the Better Access scheme in late 2006, which resulted in a large increase in the provision of mental health services by general practitioners (GPs), clinical psychologists, other psychologists and allied health professionals. It is unknown whether this increase in services has had an effect on the mental health of the population. METHODS:: The following data were examined: per capita use of mental health services provided by GPs, clinical psychologists, other psychologists, allied health professionals and psychiatrists from 2006 to 2015 according to the Australian Government Department of Human Services; prevalence of psychological distress in adults (as measured by the K10) from National Health Surveys in 2001, 2004-2005, 2007-2008, 2011-2012 and 2014-2015; and the annual suicide rate from 2001 to 2015 according to the Australian Bureau of Statistics. RESULTS:: The large increase in the use of mental health services after the introduction of the Better Access scheme had no detectable effect on the prevalence of very high psychological distress or the suicide rate. CONCLUSION:: Better Access has not had a detectable effect on the mental health of the Australian population.

Judd, F. et Davis, J. (2019). "Better Access - Necessary but not sufficient." Aust N Z J Psychiatry **53**(3): 256-257.

King, K., Nicholas, A., Fletcher, J., Bassilios, B., Reifels, L., Blashki, G. et Pirkis, J. (2015). "Why did Divisions of General Practice implement some Access to Allied Psychological Services mental health initiatives and not others?" Aust Health Rev **39**(1): 18-25.

OBJECTIVE: The Access to Allied Psychological Services (ATAPS) programs implemented through Divisions of General Practice (now Medicare Locals) enables general practitioners (GPs) to refer consumers with high-prevalence mental disorders for up to 12 individual and/or group sessions of evidence-based mental health care. The great strength of ATAPS is its ability to target vulnerable and hard-to-reach populations. Several initiatives have been introduced that focus on particular at-risk populations. This study aimed to determine the factors that had influenced Divisions' decisions to implement the various Tier 2 initiatives. METHODS: An online survey was sent to all Divisions. The survey contained mostly multiple choice questions and sought to determine which factors had influenced their decision-making. RESULTS: The most common factors influencing the decision to implement an initiative were the perception of local need and whether there was an existing service model that made it easier to add in new programs. The most commonly cited factors for not implementing were related to resources and administrative capacity. CONCLUSIONS: This research provides valuable insights into the issues that primary care organisations face when implementing new programs; the lessons learnt here could be useful when considering the implementation of other new primary care programs.

Kisely, S. et Chisholm, P. (2009). "Shared mental health care for a marginalized community in inner-city Canada." Australas Psychiatry **17**(2): 130-133.

OBJECTIVES: This paper describes the experience and evaluation of a shared care project targeted at marginalized individuals living in the North End of Halifax, Nova Scotia. This population has high rates of psychiatric disorder, often comorbid with chronic medical conditions, and people have difficulty in obtaining the help they need. This primary care liaison service covers all ages and includes outreach to emergency shelters, transitional housing and drop-in centres. Collaborative care improved access, satisfaction and outcomes for marginalized individuals in urban settings. Primary care providers with access to the service reported greater comfort in dealing with mental health problems, and satisfaction with collaborative care, as well as mental health services in general. Results were significantly better than those of control practices when such data were available. The median wait time was 6 days in comparison with 39.5 days for the comparison site. CONCLUSIONS: This model can complement other initiatives to improve the health of marginalized populations, and may be relevant to Australia.

Klimidis, S., Minas, H. et Kokanovic, R. (2006). "Ethnic minority community patients and the Better Outcomes in Mental Health Care initiative." Australas Psychiatry **14**(2): 212-215.

OBJECTIVE: To compare general practitioners registered under the Better Outcomes in Mental Health Care initiative (BOiMHC) and those not registered, in addressing mental disorders in members of ethnic minority communities (EMCs). METHODS: We conducted a cross-sectional survey of 597 Melbourne metropolitan general practitioners, leading to 311 meeting criteria for having seen EMC patients with a mental disorder in the last 3 months. Comparisons were made between those registered (n = 61) and those not registered (n = 205) within the BOiMHC on measures of difficulties in: accessing bilingual allied health, accessing interpreters, accessing translated materials, patient compliance, accessing guidelines for working effectively with interpreters, accessing guidelines on cultural and migration factors affecting mental health. RESULTS: Significantly less of those registered in the BOiMHC endorsed problems of access to bilingual allied health, interpreters and translated materials compared with those not registered. No differences between groups were observed in relation to access to guidelines and patient compliance. Those registered with the BOiMHC reported significantly less problems than those not registered. The most prevalent problems of the full sample included lack of access to bilingual allied health (70%), access to translated materials (58%) and low EMC patient compliance with mental health assessment and treatment (64%). CONCLUSIONS: Possible impacts of the BOiMHC appear to be modest in relation to EMC patients with mental disorders. The BOiMHC may require additional strategies for its application to EMCs, especially for patient engagement in mental health assessment and treatment. There is a need for a more comprehensive evaluation of EMC issues within the BOiMHC.

Kohn, M., Hitch, D. et Stagnitti, K. (2012). "Better Access to Mental Health program: influence of mental health occupational therapy." Aust Occup Ther J **59**(6): 437-444.

BACKGROUND/AIM: The Better Access to Mental Health program has enabled eligible occupational therapists to provide services to people with a mental health condition. No studies have yet reported the influence of occupational therapy under this scheme. The aim of this study was to investigate whether attending an occupational therapist under this initiative influences change in psychological distress of clients as measured by the Kessler Psychological Distress Scale (K10). METHOD: A quasi-experimental pretest-posttest design, using pre-existing data collected in the process of regular treatment was used. Data from a total of 31 clients (mean = 17.13 years, SD = 3.603) were accessed for this study. Pre- and post-intervention scores on the K10 were used to determine if psychological distress had changed over the course of intervention. RESULTS: Highly significant improvements (P <

> 0.001) were found between the K10 pre-intervention score (mean = 25.68, SD = 9.944) and the K10 post-intervention score (mean = 21.00, SD = 9.212). Male K10 post-intervention scores (mean = 17.64, SD = 5.3) significantly improved (P = 0.05), whereas results for females were not statistically significant. Medication use, diagnosis, age, number of sessions and prior contact with health services did not influence the results. Results from specific evidence-based interventions were not able to be considered in this study. CONCLUSION: The results of this study demonstrate effectiveness of occupational therapy services for adolescents and provide support for the ongoing participation of occupational therapists in this scheme.

Lee, C. W. et Frost, A. D. (2019). "Where Australia's Better Access scheme has had an impact on mental health: A commentary on Jorm (2018)." Aust N Z J Psychiatry **53**(3): 259-261.

Lee, S., Castella, A., Freidin, J., Kennedy, A., Kroschel, J., Humphrey, C., Kerr, R., Hollows, A., Wilkins, S. et Kulkarni, J. (2010). "Mental health care on the streets: An integrated approach." Aust N Z J Psychiatry **44**(6): 505-512.

> BACKGROUND: Mental illness can be both a cause of and a reaction to being homeless. When homelessness co-exists with mental illness, the provision of care for very vulnerable people is significantly complicated. Our initiative built on a model of assertive outreach and embedded mental health staff into the daily operations of Hanover Welfare Services and Sacred Heart Mission welfare services in inner Melbourne. The initiative's aim was to facilitate closer collaboration between mental health and welfare services and develop staff capacity to better identify and support people living homeless with a mental illness. METHOD: The project involved studying the impact of our assertive outreach model on consumer and service outcomes. Demographic, clinical and service usage details for consumers engaged by the initiative were recorded. Changes to the rate of admission of people from both welfare services to The Alfred Inpatient Psychiatry Unit and requests for support from The Alfred Crisis Assessment and Treatment Service were also recorded. RESULTS: People engaged by this initiative had high levels of previous emergency medical or psychiatric service usage, but relatively low levels of current community mental health engagement. There were also high levels (almost 52%) of comorbid substance misuse. The initiative was, however, able to engage more people in ongoing community mental health care, which particularly when provided in collaboration between mental health and welfare staff, achieved improvements in accommodation stability. The initiative also resulted in improved identification and prevention of mental illness crises through supporting a more rapid onsite mental health response. CONCLUSIONS: Embedding mental health staff into the daily operations of two welfare services in inner Melbourne improved inter-service collaboration and the identification and care for people living homeless with a mental illness.

Maddock, G. R., Startup, M. et Carter, G. L. (2012). "Patient characteristics associated with GP referral to the Access to Allied Psychological Services Program: a case-control study." Aust N Z J Psychiatry **46**(5): 435-444.

> BACKGROUND: GPs have referred patients for psychological treatment under the Better Outcomes in Mental Health Care, Access to Allied Psychological Services (ATAPS) Program since 2003. It is not known how GPs might select patients for referral. We explored which characteristics identified ATAPS patients compared to usual GP patients. METHODS: The study was conducted in GP Access, a Division of General Practice (Newcastle and Lower Hunter) in NSW, Australia. It was a case-control design with 63 cases (ATAPS patients), and 64 controls (GP patients never referred to ATAPS). Unadjusted and sequentially adjusted logistic regressions were used to identify independent predictors of being an ATAPS case based on official referral guidelines: ICD-10 diagnosis of depression or anxiety and scores on the K-10 (psychological distress) and DASS-21 (psychological symptoms). A multivariable logistic regression was also used to determine the best minimum set of predictor variables. RESULTS: Eighty-three per cent of ATAPS cases had anxiety or depression. In unadjusted models, any mood disorder, OR 7.68 (95% CI: 3.47, 17.01), any anxiety disorder, OR 2.88 (95% CI: 1.37, 6.05), higher K-10 score, OR 1.06 (95% CI: 1.04, 1.14) and higher DASS-21 score, OR 1.06 (95% CI: 1.03, 1.09) were associated with being an ATAPS case. Any mood disorder, any anxiety disorder, K-10 score and DASS-21 scores

> remained significant in most adjusted analyses and all models showed change when adjusted for mental disability and physical disability. Three variables predicted being an ATAPS case in the multivariable regression: greater mental disability, lesser physical disability and greater number of substances misused. CONCLUSION: Cases had higher levels of mental disability and greater substance misuse, but lower levels of physical disability. This may reflect GP referral decision making and have implications for policy development.

Mathews, R. (2018). "Better Access Growing Pains." Canadian Psychology-Psychologie Canadienne **59**(4): 382-386.
<Go to ISI>://WOS:000448792300009

> The provision of psychological services for mental health disorders under the Australian universal health scheme, Medicare, provides access to mental health treatment for the Australian population and has drawn considerable attention and commentary both in Australia and internationally. The initiative, known as Better Access to Psychiatrists, Psychologists and General Practitioners has had broad uptake and has demonstrated positive outcomes including reducing levels of psychological distress and providing treatment to population groups that would not have otherwise been in a position to access psychological services. Along with the many benefits provided by the initiative, there have also been some challenges. This article raises some of the key challenges that have emerged out of the initiative, some of which have resulted in unforeseen consequences, for the community, but particularly for the psychology profession. Many of these challenges remain and it is hoped that in identifying and discussing these there may be impetus for change in the future, as part of the Australian initiative, and also as part of similar models being considered in other countries.

McAuliffe, C. et Wells, L. (2003). "Better Outcomes in Mental Health Care Initiative 12 months on." Australian Journal of Psychology **55**: 196-196.

McCormack, J. et Thomas, J. (2004). "Better outcomes--a case study." Aust Fam Physician **33**(11): 943-945.

> It is estimated that mental health problems will affect more than 20% of the Australian adult population in their lifetime. The 2001 Australian Commonwealth budget provided dollars 120.4 million over 4 years to improve the quality of care provided through general practice to Australians with a mental health illness. The Better Outcomes in Mental Health Care (BOMHC) initiative--which forms part of the National Mental Health Strategy--began in 2001 and aimed to improve the quality of care provided through general practice to patients with a mental health problem. This article reviews the uptake of education and training initiatives of the BOMHC initiative and good uptake by general practitioners across Australia. Well over 3600 GPs have completed the first 'level' of training associated with the initiative, representing 16.5% of the GP population. Access by consumers to mental health trained and registered GPs also significantly improved, with one in four practices employing a GP registered with the BOMHC initiative.

Meadows, G. N., Enticott, J. C., Inder, B., Russell, G. M. et Gurr, R. (2015). "Better access to mental health care and the failure of the Medicare principle of universality." Med J Aust **202**(6): 297.

Meehan, T. et Robertson, S. (2013). "Clinical profile of people referred to mental health nurses under the Mental Health Nurse Incentive Program." Int J Ment Health Nurs **22**(5): 384-390.

> The Mental Health Nurse Incentive Program (MHNIP) was established in Australia during 2007. The program enables mental health nurses to work in partnership with general practitioners (GPs) in the assessment and treatment of people with severe mental health problems. This paper provides insights into the demographic and clinical profile of 403 people enrolled in the MHNIP in the Ipswich area of Queensland. The clinical presentation (illness severity and symptoms) of those referred to the MHNIP is compared to that of: (i) people referred to a related program known as Access to Allied Psychological Services (ATAPS); and (ii) to clients admitted to acute inpatient care in Queensland.

While people referred to the MHNIP presented with more severe problems than those referred to ATAPS, they had less severe problems than those admitted to acute inpatient care. The findings indicate that the MHNIP is meeting the needs of people with complex mental and physical health problems. Further evaluation work is required to determine if the findings from this study can be generalized more broadly. At the national level, consideration should be given to the routine collection of clinical, cost, and demographic data to enable the ongoing monitoring of the program.

Morley, B., Pirkis, J., Naccarella, L., Kohn, F., Blashki, G. et Burgess, P. (2007). "Improving access to and outcomes from mental health care in rural Australia." Aust J Rural Health **15**(5): 304-312.

OBJECTIVE: Rural Australians face particular difficulties in accessing mental health care. This paper explores whether 51 rural Access to Allied Psychological Services projects, funded under the Better Outcomes in Mental Health Care program, are improving such access, and, if so, whether this is translating to positive consumer outcomes. DESIGN AND METHOD: The paper draws on three data sources (a survey of models of service delivery, a minimum dataset and three case studies) to examine the operation and achievements of these projects, and makes comparisons with their 57 urban equivalents as relevant. RESULTS: Proportionally, uptake of the projects in rural areas has been higher than in urban areas: more GPs and allied health professionals are involved, and more consumers have received care. There is also evidence that the models of service delivery used in these projects have specifically been designed to resolve issues particular to rural areas, such as difficulties recruiting and retaining providers. The projects are being delivered at no or low cost to consumers, and are achieving positive outcomes as assessed by standardised measures. CONCLUSION: The findings suggest that the rural projects have the potential to improve access to mental health care for rural residents with depression and anxiety, by enabling GPs to refer them to allied health professionals. The findings are discussed with reference to recent reforms to mental health care delivery in Australia.

Morley, B., Pirkis, J., Sanderson, K., Burgess, P., Kohn, F., Naccarella, L. et Blashki, G. (2007). "Better outcomes in mental health care: impact of different models of psychological service provision on patient outcomes." Aust N Z J Psychiatry **41**(2): 142-149.

OBJECTIVE: One hundred and eight Access to Allied Psychological Services projects have been funded under Australia's Better Outcomes in Mental Health Care programme since July 2001. All projects are run by Divisions of General Practice and enable general practitioners (GPs) to refer patients to allied health professionals for evidence-based care. They differ in the models they use to retain, locate and direct referrals to their allied health professionals. This paper examines the extent to which the projects are achieving positive patient outcomes, and explores the association between different models of service delivery and varying levels of patient outcomes. METHOD: The paper draws on two data sources (a purpose-designed minimum dataset and a survey of models of service delivery) to examine the level of patient outcomes within and across projects, and variations in the level of patient outcomes by models of service delivery. RESULTS: The projects are achieving positive effects and these are mostly of large or medium magnitude. The projects do not differ markedly in terms of the patient outcomes they are achieving, despite differences in the models of service delivery they are using. However, those projects implementing a direct referral model, where the GP refers the patient directly to the allied health professional, have significantly greater effect sizes, indicating that they are achieving greater improvements in patient outcomes. In addition, there are non-significant trends toward direct employment of allied health professionals by Divisions being predictive of greater improvements in patient outcomes, and delivery of services from allied health professionals' own rooms being predictive of weaker patient outcomes. CONCLUSIONS: Overwhelmingly, the Access to Allied Psychological Services projects are having a positive impact for patients in terms of their level of functioning, severity of symptoms and/or quality of life. Preliminary indications suggest that a service delivery model incorporating the use of a direct referral system may be associated with superior outcomes. The findings are discussed in the light of the imminent listing of psychologists' services on the Medicare Benefits Schedule.

Murrihy, R. et Byrne, M. K. (2005). "Training models for psychiatry in primary care: a new frontier." Australas Psychiatry **13**(3): 296-301.

> OBJECTIVE: Under policies implemented by the Australian Government, the success of community mental health care has increasingly relied upon general practitioners (GPs) assuming an enhanced role in the delivery of evidence-based psychological treatment. In undertaking this role, it is crucial that GPs significantly build upon limited training in evidence-based psychological therapies such as cognitive behaviour therapy (CBT). This pilot study investigates the potential role of CBT group supervision as a training model. METHOD: Two groups of GPs (n = 9) and one comparison group of psychiatric registrars (n = 4) completed eight 1.5 h sessions of CBT group supervision over an 8 month period. Pre- to post-training measures were taken of GP performance (skills, knowledge and confidence) and the mental health outcomes of their patients. On the completion of group supervision, focus groups were conducted for in-depth feedback. RESULTS: Randomization tests indicated that GPs' confidence and knowledge in using CBT had improved over the course of group supervision. Results from focus groups confirmed that GPs' CBT skills had improved. CONCLUSIONS: Findings suggest that group supervision is a promising training model for psychiatry in primary care. Cognitive behaviour therapy should be replaced, however, with a briefer therapy model, such as brief CBT, better suited to a general practice environment. Future research needs to replicate these findings on a larger scale.

Naccarella, L., Pirkis, J., Morley, B., Kohn, F., Blashki, G. et Burgess, P. (2008). "Managing demand for psychological services within an Australian primary mental healthcare initiative." Primary Care & Community Psychiatry **13**(3): 126-133.

> Background: The Australian Better Outcomes in Mental Health Care (BOiMHC) program commenced in 2001, with the aim of improving primary mental healthcare delivery. One component of the BOiMHC program involves 108 Access to Allied Psychological Services (ATAPS) projects which enable GPs to refer patients to allied health professionals for low-cost, evidence-based care. The projects have improved access to psychological care, but referrals are outstripping their capacity to provide psychological services. This study examined the demand management strategies that projects have used, and how well these strategies are working. Method: A survey was emailed to the project officers of the 108 ATAPS projects. Results: The most commonly used demand management strategies were: informing/training GPs; putting in place systems and/or administrative procedures; and monitoring and limiting referrals. Most projects used combined broad demand management strategies, employing many approaches within each strategy. Monitoring and limiting referrals and putting in place systems and/or administrative procedures were ranked as the most useful. Demand strategies were underpinned by strong partnerships and solid infrastructure. Conclusion: The ATAPS projects are using demand management strategies. Strategies tend to be supply-side strategies instituted where the patient makes contact with the GP and/or approaches the GP-allied health professional interface, rather than demand-side strategies aimed at the patient-practice interface. Strategies appear to be working well when supported by collaborations and infrastructure. The need for demand management strategies reflects resourcing issues that impact on providers' morale and patients' satisfaction. Findings are discussed in relation to other recent developments in Australian primary mental healthcare.

Nicholas, A., Bassilios, B., King, K., Ftanou, M., Machlin, A., Reifels, L. et Pirkis, J. (2019). "An Evaluation of the Implementation of the Australian ATAPS Suicide Prevention Services Initiative." Journal of Behavioral Health Services & Research **46**(1): 99-115.

> The Access to Allied Psychological Services (ATAPS) Suicide Prevention Services initiative is an Australian Government-funded primary mental healthcare initiative providing free intensive psychological intervention for consumers at moderate risk of self-harm or suicide. Findings from a multi-method evaluation aimed at identifying whether the initiative is being implemented as stipulated within the operational guidelines, barriers and facilitators to implementation, and

preliminary outcomes suggest that the Suicide Prevention Services are largely being implemented as stipulated in the Guidelines, but with some exceptions. In particular, service delivery barriers unique to rural and remote areas place limitations on implementation. Uptake of the ATAPS Suicide Prevention Services is high (10,428 consumers were referred to the Suicide Prevention Services between October 2008 and April 2013, and 86% of those attended at least one session), as is acceptance from organizations involved in its implementation.

OCDE (2015). Mental health and work : Australie. Santé mentale et emploi**:** 171 , fig., tabl.
http://www.oecd.org/fr/els/emp/leprojetdelocdesurlasantementaleetlemploi.htm

This report on Australia is the last in a series that looks at how selected OECD countries address those policy challenges. Through the lenses of mental health and work, it covers issues such as the transition from education to employment, the workplace, employment services for jobseekers, the drift into permanent disability, and the capacity of the health system.

Ollerenshaw, A. (2009). "Internet tool box for rural GPs to access mental health services information." Rural Remote Health **9**(2): 1094.

INTRODUCTION: Rural GPs play a significant role in the mental health care of their patients. It is therefore crucial that they have access to reputable support and advice that enhances their existing knowledge. This article outlines a recent project initiated by the Australian rural Ballarat and District Division of General Practice (BDDGP) to develop and implement an online resource to facilitate local implementation and delivery of the 'Better Access to Mental Health Care' (BAMHC) program. This 12 month project was initiated in response to a request from local GPs for additional information about and support in using the BAMHC program. The project is the culmination of significant collaboration among key stakeholders that includes local GPs, GP advisors from BDDGP, BDDGP staff, and two University of Ballarat research centres (the Centre for Health Research and Practice, and the Centre for Electronic Commerce and Communication). This article documents the key stages involved in the project from initiation to implementation, and reports on the use of this resource 12 months after its launch. METHOD: The BDDGP represents 107 GPs and six GP registrars and covers a large rural/semi-rural area of 7300 km2 and a catchment population of more than 120,000. The format and design of the project entailed four distinct but interrelated stages of development: (1) developing the program specifications and localising it to the BDDGP catchment; (2) constructing a decision-making support tool with 7 sequential steps comprising key questions and links to detailed answers; (3) developing and populating an online service directory of local allied health professionals; and (4) constructing the website for easy access and navigation for GPs and other service providers. RESULTS: The website was publicly launched in December 2007 and is hosted by BDDGP. Since then it has received strong support. In the 12 months since its launch the website received regular and continuous visits (2847 visits/11,500 pages accessed). In addition, anecdotal evidence and other feedback (positive comments; requested changes to entries in the service directory from allied mental health professionals) indicate that the website is being recognised as an important resource of and hub for local information relating to the BAMHC program for GPs and allied health professionals. CONCLUSIONS: Integral to the website's success and sustainability is the close and continued monitoring and updating of the information provided. A formal, longitudinal evaluation 18 months to 2 years after the website's launch is recommended to provide a more rigorous assessment of the tool, and examine possible improvements. While the project does not address the problem of the supply of allied mental health providers in rural areas, it does provide assistance with responsive service system expansion and the provision of a localized tool for accessing appropriate information about mental health services.

Phillips, N., Oldmeadow, M. J. et Krapivensky, N. (2002). "SPHERE: a national depression project." Med J Aust **176**(4): 193; author reply 194.

Pirkis, J., Bassilios, B., Fletcher, J., Sanderson, K., Spittal, M. J., King, K., Kohn, F., Burgess, P. et Blashki, G. (2011). "Clinical improvement after treatment provided through the Better Outcomes in Mental Health Care (BOiMHC) programme: do some patients show greater improvement than others?" Aust N Z J Psychiatry **45**(4): 289-298.

> OBJECTIVE: Australia's Better Outcomes in Mental Health Care (BOiMHC) programme enables GPs to refer patients with common mental disorders to allied health professionals for time-limited treatment, through its Access to Allied Psychological Services (ATAPS) projects. This paper considers whether patients who receive care through the ATAPS projects make clinical gains, if so, whether particular patient-related and treatment-related variables are predictive of these outcomes. METHOD: Divisions of General Practice (Divisions), which run the ATAPS projects, are required to enter de-identified data into a minimum dataset, including data on patients' socio-demographic and clinical characteristics, the sessions of care they receive, and their clinical outcomes. We extracted data from January 2006 to June 2010, and examined the difference between mean pre- and post-treatment scores on the range of outcome measures being used by Divisions. We then conducted a linear regression analysis using scores on the most commonly-used outcome measure as the outcome of interest. RESULTS: Pre- and post-treatment outcome data were available for 16 700 patients from nine different outcome measures. Across all measures, the mean difference was statistically significant and indicative of clinical improvement. The most commonly-used measure was the Kessler-10 (K-10), and pre- and post-treatment K-10 data were available for 7747 patients. After adjusting for clustering by Division, outcome on the K-10 was associated with age, levels of income and education, previous receipt of mental health care, number of sessions, treatment received and pre-treatment K-10 score. The benchmark was sufficiently high, however, that even the groups that fared relatively less well still showed strong improvement in absolute terms. CONCLUSIONS: Patients who receive care through the ATAPS projects are making considerable clinical gains. A range of socio-demographic, clinical and treatment-based variables are associated with the levels of outcomes achieved, but improvements are still substantial even for those in the relatively disadvantaged groups.

Pirkis, J., Burgess, P., Kohn, F., Morley, B., Blashki, G. et Naccarella, L. (2006). "Models of psychological service provision under Australia's Better Outcomes in Mental Health Care program." Aust Health Rev **30**(3): 277-285.

> The Access to Allied Psychological Services component of Australia's Better Outcomes in Mental Health Care program enables eligible general practitioners to refer consumers to allied health professionals for affordable, evidence-based mental health care, via 108 projects conducted by Divisions of General Practice. The current study profiled the models of service delivery across these projects, and examined whether particular models were associated with differential levels of access to services. We found: 76% of projects were retaining their allied health professionals under contract, 28% via direct employment, and 7% some other way; Allied health professionals were providing services from GPs' rooms in 63% of projects, from their own rooms in 63%, from a third location in 42%; and The referral mechanism of choice was direct referral in 51% of projects, a voucher system in 27%, a brokerage system in 24%, and a register system in 25%. Many of these models were being used in combination. No model was predictive of differential levels of access, suggesting that the approach of adapting models to the local context is proving successful.

Pirkis, J., Ftanou, M., Williamson, M., Machlin, A., Spittal, M. J., Bassilios, B. et Harris, M. (2011). "Australia's Better Access initiative: an evaluation." Aust N Z J Psychiatry **45**(9): 726-739.

> BACKGROUND: Australia's Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative involves a series of Medicare Benefits Schedule (MBS) item numbers which offer a rebate for selected services delivered by eligible clinicians. There has been considerable debate about the appropriateness and effectiveness of Better Access, much of which has been based on limited evidence. The current paper contributes to this debate by presenting the findings of a study which profiled the clinical and treatment characteristics of Better Access patients and examined the outcomes of their care. METHOD: We approached a

> stratified random sample of providers who had billed for at least 100 occasions of service under the Better Access item numbers in 2008 (509 clinical psychologists, 640 registered psychologists, 1280 GPs) and invited them to participate. Those who agreed were asked to recruit 5-10 Better Access patients according to a specific protocol. We collected data that enabled us to profile providers, patients and sessions. We also collected pre- and post-treatment patient outcome data, using the Kessler-10 (K-10) and the Depression Anxiety Stress Scales (DASS-21). RESULTS: In total, 883 patients were recruited into the study (289 by 41 clinical psychologists, 317 by 49 registered psychologists and 277 by 39 GPs). More than 90% of participating patients had diagnoses of depression and/or anxiety (compared with 13% of the general population). More than 80% were experiencing high or very high levels of psychological distress (compared with 10% of the general population). Around half of all participating patients had no previous history of mental health care. Patients experienced statistically significant improvements in average K-10 and DASS-21 scores from pre- to post-treatment. CONCLUSIONS: The findings suggest that Better Access is playing an important part in meeting the community's previously unmet need for mental health care.

Pirkis, J., Harris, M., Hall, W. D. et Ftanou, M. Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative Centre for health policy, programs and economics. Summary evaluation. Final report. Melbourne : The University of Melbourne**:** 61p.

Pirkis, J., Morley, B., Kohn, F., Blashkl, G., Burgess, P. et Headey, A. (2004). "Improving access to evidence-based mental health care: general practitioners and allied health professionals collaborate." Primary Care Psychiatry **9**(4): 125-130.

> This study evaluated whether projects conducted through the Access to Allied Health Services component of the Australian Better Outcomes in Mental Health Care initiative are improving access to evidence-based, non-pharmacological therapies for people with depression and anxiety. Synthesising data from the first 29 projects funded through the initiative, the study found that the models utilised in the projects have evolved over time. The projects have achieved a high level uptake; at a conservative estimate, 710 GPs and 160 allied health professionals (AHPs) have provided care to 3,476 consumers. The majority of these consumers have depression (77%) and/or anxiety disorders (55%); many are low income earners (57%); and a number have not previously accessed mental health care (40%). The projects have delivered 8,678 sessions of high quality care to these consumers, most commonly providing CBT-based cognitive and behavioural interventions (55% and 41%, respectively). In general, GPs, AHPs and consumers are sanguine about the projects, and have reported positive consumer outcomes. However, as with any new initiative, there are some practical and professional issues that need to be addressed. The projects are improving access to evidence-based, non-pharmacological therapies. The continuation and expansion of the initiative should be a priority.

Pirkis, J., Stokes, D., Morley, B., Kohn, F., Mathews, R., Naccarella, L., Blashki, G., Shandley, K., Littlefield, L. et Burgess, P. (2006). "Impact of Australia's Better Outcomes in Mental Health Care program on psychologists." Australian Psychologist **41**(3): 152-159.

> The aim of this paper was to consider the impact on psychologists of one component of the Australian Government's Better Outcomes in Mental Health Care (BOiMHC) program, namely the Access to Allied Psychological Services (ATAPS) component. This supports psychologists and general practitioners (GPs) to work together to provide optimal mental health care, via 102 projects being conducted by Divisions of General Practice. The paper was informed by data from five sources: a project-based minimum dataset; local project evaluation reports; a forum; a survey of projects: and a survey of Australian Psychological Society (APS) members. Taken together, the data from these sources showed that a significant number of psychologists are providing services through the projects, and the majority are finding it a positive and professionally rewarding experience. There is considerable variability regarding models of retaining, locating and referring to psychologists, and there are pros and cons associated with each. The major problem identified by psychologists is the level of remuneration. BOiMHC is currently moving into a new phase of continuation and expansion, and consideration was

given to whether the data point to any changes that could be made to the ATAPS projects during this period of transition. In the main, the data suggest that the status quo should be retained, but the issue of remuneration must be addressed.

Pirkis, J. E., Blashki, G. A., Murphy, A. W., Hickie, I. B. et Ciechomski, L. (2006). "The contribution of general practice based research to the development of national policy: case studies from Ireland and Australia." Aust New Zealand Health Policy **3**: 4.

BACKGROUND: This paper aims to describe the influence of general practice based research on the development of two specific policy initiatives, namely the Heartwatch Programme in Ireland and the Better Outcomes in Mental Health Care (BOiMHC) program in Australia. A case study approach was used to explore the extent to which relevant general practice based research shaped these initiatives. RESULTS: In both case studies, a range of factors beyond general practice based research shaped the initiative in question, including political will, the involvement of stakeholders (including key opinion leaders), and the historical context. Nonetheless, the research played an important role, and was not merely put to 'symbolic use' to support a position that had already been reached independently. Rather, both case studies provide examples of 'instrumental use': in the case of Heartwatch, the research was considered early in the piece; in the case of the BOiMHC program, it had a specific impact on the detail of the components of the initiative. CONCLUSION: General practice based research can influence policy-making and planning processes by strengthening the foundation of evidence upon which they draw. This influence will not occur in a vacuum, however, and general practice researchers can maximise the likelihood of their work being 'picked up' in policy if they consider the principles underpinning knowledge transfer.

Pirkis, J. E. et Harris, M. G. (2011). "Were the budgetary reforms to the Better Access to Mental Health Care initiative appropriate?--yes." Med J Aust **194**(11): 594.

Mental health researchers Jane Pirkis and Meredith Harris say the government got it right.

Piterman, L., Jones, K. M. et Castle, D. J. (2010). "Bipolar disorder in general practice: challenges and opportunities." Med J Aust **193**(4 Suppl): S14-17.

General practitioners are involved in the continuing care and shared care of patients with chronic mental illness, including bipolar disorder. Psychiatrists are particularly reliant on GPs to monitor and treat comorbidities as well as the psychiatric condition itself. Management of chronic mental illness is compromised by a number of factors, including problems with diagnosis, physical comorbidity, erratic attendance and poor compliance with treatment. Diagnosis of bipolar disorder is often delayed, and differential diagnoses to be considered include unipolar depression, anxiety disorder, drug and alcohol dependence, personality disorder, attention deficit hyperactivity disorder, and general medical and central nervous system diseases. New Medicare items have been introduced under the Better Access to Mental Health Care initiative. However, uptake for patients with chronic psychiatric illness, including bipolar disorder, is low. Patients with bipolar disorder may be prone to a range of comorbid psychological, social and physical problems, and GPs need to be vigilant to detect and manage comorbidity and social problems as part of the overall plan. This includes assistance with certification for sickness and unemployment benefits. GPs may become involved during crises affecting patients and this may pose significant problems for GPs who need to provide ongoing care following patient discharge from hospital. Despite these difficulties, opportunities exist for GPs to play a vital and ongoing role in the management of patients with bipolar disorder.

Ralph, S. et Ryan, K. (2017). "Addressing the Mental Health Gap in Working with Indigenous Youth: Some Considerations for Non-Indigenous Psychologists Working with Indigenous Youth." Australian Psychologist **52**(4): 288-298.
<Go to ISI>://WOS:000405874500006

> It has long been recognised that Indigenous youth between the ages of 15-24 years are one of the most vulnerable and disadvantaged groups in contemporary Australian society. There is a plethora of available reports and statistical information gathered over the past 20 years that highlights the perilous situation of Indigenous youth and the specific challenges that confront this group. This article provides a review of the state of our knowledge regarding Indigenous youth with a particular focus upon their mental health needs and their broader social and emotional well-being. This article examines the relevance and potential effectiveness of focused psychological strategies as applied under the Access to Allied Psychological Services program in addressing the needs of Indigenous youth. There is a clear and important role for non-Indigenous Psychologists to play in closing the mental health gap, but practitioners need to have at least an adequate degree of cultural competence in order to engage with Indigenous young people, and be able to deliver psychological interventions that are culturally appropriate and safe and consistent with Indigenous world views. This article provides some guidance for non-Indigenous Psychologists in working with Indigenous youth.

Reifels, L., Bassilios, B., King, K. E., Fletcher, J. R., Blashki, G. et Pirkis, J. E. (2013). "Innovations in primary mental healthcare." Aust Health Rev **37**(3): 312-317.

> OBJECTIVE: We review the evidence on innovations in Tier 2 of the Access to Allied Psychological Services (ATAPS) program, which is designed to facilitate the provision of primary mental healthcare to hard-to-reach and at-risk population groups (including women with perinatal depression, people at risk of self-harm or suicide, people experiencing or at risk of homelessness, people affected by the 2009 Victorian bushfires, people in remote locations, Aboriginal and Torres Strait Islanders and children with mental disorders) and the trialling of new modalities of service delivery (e.g. telephone-based or web-based CBT). The primary focus is on the uptake, outcomes and issues associated with the provision of ATAPS Tier 2. METHODS: Drawing on data from an ongoing national ATAPS evaluation, including a national minimum dataset, key informant interviews and surveys, the impact of ATAPS innovations is analysed and illustrated through program examples. RESULTS: ATAPS Tier 2 facilitates access to, uptake of and positive clinical outcomes from primary mental healthcare for population groups with particular needs, although it requires periods of time to implement locally. CONCLUSIONS: Relatively simple innovations in mental health program design can have important practical ramifications for service provision, extending program reach and improving mental health outcomes for target populations. What is known about the topic? It is recognised that innovative approaches are required to tailor mental health programs for hard-to-reach and at-risk population groups. Divisions of General Practice have implemented innovations in the Access to Allied Psychological Services (ATAPS) program for several years. What does this paper add? Drawing on data from an ongoing national ATAPS evaluation, this paper presents a systematic analysis of the uptake, outcomes and issues associated with provision of the innovative ATAPS program. What are the implications for practitioners? The findings highlight the benefits of introducing innovations in primary mental healthcare in terms of increased access to care and positive consumer outcomes. They also identify challenges to and facilitators of the implementation process, which can inform innovation efforts in other primary care contexts.

Reifels, L., Bassilios, B., Nicholas, A., Fletcher, J., King, K., Ewen, S. et Pirkis, J. (2015). "Improving access to primary mental healthcare for Indigenous Australians." Aust N Z J Psychiatry **49**(2): 118-128.

> OBJECTIVE: To examine the uptake, population reach and outcomes of primary mental healthcare services provided to Indigenous Australians via the Access to Allied Psychological Services (ATAPS) program between 2003 and 2013, with particular reference to enhanced Indigenous ATAPS services introduced from 2010. METHOD: Utilising ATAPS program data from a national minimum data set and comparative population data, we conducted descriptive analyses, regression analyses and t-tests to examine the uptake of ATAPS services, provider agency level predictors of service reach, and preliminary outcome data on consumer level outcomes. RESULTS: Between 2003 and 2013, 15,450 Indigenous client referrals were made that resulted in 55,134 ATAPS sessions. National Indigenous service volume more than doubled between 2010 and 2012, following the introduction of enhanced

Indigenous ATAPS services. Non-Indigenous ATAPS service volume of primary care agencies was uniquely predictive of Indigenous service reach. Preliminary analysis of limited consumer outcome data indicated positive treatment gains and the need to enhance future outcome data collection. CONCLUSIONS: Concerted national efforts to enhance mainstream primary mental healthcare programs can result in significant gains in access to mental healthcare for Indigenous populations.

Reifels, L., Bassilios, B., Spittal, M. J., King, K., Fletcher, J. et Pirkis, J. (2015). "Patterns and Predictors of Primary Mental Health Service Use Following Bushfire and Flood Disasters." Disaster Med Public Health Prep **9**(3): 275-282.

OBJECTIVE: To examine patterns and predictors of primary mental health care service use following 2 major Australian natural disaster events. METHODS: Utilizing data from a national minimum dataset, descriptive and regression analyses were conducted to identify levels and predictors of the use of the Access to Allied Psychological Services (ATAPS) program over a 2-year period following 2 major Australian bushfire and flood/cyclone disasters. RESULTS: The bushfire disaster resulted in significantly greater and more enduring ATAPS service volume, while service delivery for both disasters peaked in the third quarter. Consumers affected by bushfires (IRR 1.51, 95% CI 1.20-1.89), diagnosed with depression (IRR 2.57, 95% CI 1.60-4.14), anxiety (IRR 2.06, 95% CI 1.21-3.49), or both disorders (IRR 2.15, 95% CI 1.35-3.42) utilized treatment at higher rates. CONCLUSIONS: The substantial demand for primary mental health care services following major natural disasters can vary in magnitude and trajectory with disaster type. Disaster-specific ATAPS services provide a promising model to cater for this demand in primary care settings. Disaster type and need-based variables as drivers of ATAPS use intensity indicate an equitable level of service use in line with the program intention. Established service usage patterns can assist with estimating capacity requirements in similar disaster circumstances.

Reifels, L., Nicholas, A., Fletcher, J., Bassilios, B., King, K., Ewen, S. et Pirkis, J. (2018). "Enhanced primary mental healthcare for Indigenous Australians: service implementation strategies and perspectives of providers." Glob Health Res Policy **3**: 16.

Background: Improving access to culturally appropriate mental healthcare has been recognised as a key strategy to address the often greater burden of mental health issues experienced by Indigenous populations. We present data from the evaluation of a national attempt at improving access to culturally appropriate mental healthcare for Indigenous Australians through a mainstream primary mental healthcare program, the Access to Allied Psychological Services program, whilst specifically focusing on the implementation strategies and perspectives of service providers. Methods: We conducted semi-structured interviews with 31 service providers (primary care agency staff, referrers, and mental health professionals) that were analysed thematically and descriptively. Results: Agency-level implementation strategies to enhance service access and cultural appropriateness included: the conduct of local service needs assessments; Indigenous stakeholder consultation and partnership development; establishment of clinical governance frameworks; workforce recruitment, clinical/cultural training and supervision; stakeholder and referrer education; and service co-location at Indigenous health organisations. Dedicated provider-level strategies to ensure the cultural appropriateness of services were primarily aimed at the context and process of delivery (involving, flexible referral pathways, suitable locations, adaptation of client engagement and service feedback processes) and, to a lesser extent, the nature and content of interventions (provision of culturally adapted therapy). Conclusions: This study offers insights into key factors underpinning the successful national service implementation approach. Study findings highlight that concerted national attempts to enhance mainstream primary mental healthcare for Indigenous people are critically dependent on effective local agency- and provider-level strategies to optimise the integration, adaptation and broader utility of these services within local Indigenous community and healthcare service contexts. Despite the explicit provider focus, this study was limited by a lack of Indigenous stakeholder perspectives. Key study findings are of direct relevance to inform the future implementation and

delivery of culturally appropriate primary mental healthcare programs for Indigenous populations in Australia and internationally.

Richards, D. A. et Bower, P. (2011). "Equity of access to psychological therapies." Br J Psychiatry **198**(2): 91-92.

Improving access to psychological treatments for common mental disorders is a priority in a number of countries worldwide. We consider the evidence presented by Harris et al on the Australian Better Access initiative, and discuss the challenges of delivering such intitiatives and evaluating their impact.

Rosenberg, S. et Hickie, I. (2010). "How to tackle a giant: creating a genuine evaluation of the Better Access Program." Australas Psychiatry **18**(6): 496-502.

OBJECTIVE: This paper proposes a framework for a systematic evaluation of the Better Access Program, the largest single component of mental health reform announced under the Council of Australian Governments National Action Plan on Mental Health 2006-11. METHOD: The article explores the genesis of the Program and considers extant data sets and information available with which to establish the impact of the Program on consumers and service providers. RESULTS: There are useful data available in Australia from which to derive pre- and post-implementation analysis about the impact of the Better Access Program. There is doubt as to whether these data form part of the Federal Government's current approach to evaluation of the Program. CONCLUSIONS: Anything less than a genuine and comprehensive evaluation will leave Australia unable to assess the real impact of the Better Access Program. The merit of further expenditure in the vital area of primary mental health care will be in doubt as a consequence.

Rosenberg, S. et Salvador-Carulla, L. (2017). "Accountability for Mental Health: The Australian Experience." Journal of Mental Health Policy and Economics **20**(1): 37-54.
http://search.ebscohost.com/login.aspx?direct=true&db=ecn&AN=1648810&lang=fr&site=ehost-live
http://www.icmpe.org/test1/journal/journal.htm

Australia was one of the first countries to develop a national policy for mental health, with a strong commitment to accountability. But twenty years later what have we achieved? Can we tell if anybody is getting better? This article reviews Australia's progress in applying the concept of accountability to mental health. We find a plethora of administrative and health service data but little in relation to the health outcomes of people with a mental illness. Australia's approach has been characterised at 'outcome blind'. The article considers emerging international efforts at accountability. The components of a better approach are described, focusing on the establishment of new and defined processes of accountability, designed to more effectively reveal the true state of the health and welfare of people living with mental illness.

Rosenberg, S. P. et Hickie, I. B. (2019). "The runaway giant: ten years of the Better Access program." Med J Aust **210**(7): 299-301.e291.

Sankaranarayanan, A., Allanson, K. et Arya, D. K. (2010). "What do general practitioners consider support? Findings from a local pilot initiative." Aust J Prim Health **16**(1): 87-92.

This paper reports the findings of a local pilot that was aimed to assess if making a local psychiatrist available would improve GP satisfaction with regard to responsiveness and access to specialist mental health services. A psychiatrist was made available via a telephone advice line for 1 h every day. Pre- and post-survey of all GPs was conducted to elicit GP satisfaction and suggestions. The pilot was conducted from Maitland, the base of Hunter Valley Mental Health Service. A total of 202 GPs in the area were contacted and surveyed; 17% responded to the pre-survey and 27% to the post-survey. Only 8% of the GPs used the telephone advice service. Despite low use, most responding GPs indicated that they would like to see the services continue. Most of the responding GPs (both users and non-users of this service) were not aware of or had not used the Royal Australian College of General

Practitioners' GP Psych Support initiative. Results from this pilot indicate that making a local psychiatrist available improves GP satisfaction with regard to responsiveness and access, despite low use. Further research is needed to establish if such a service can be made available at an area level and whether this would be cost effective.

Saurman, E., Lyle, D., Perkins, D. et Roberts, R. (2014). "Successful provision of emergency mental health care to rural and remote New South Wales: an evaluation of the Mental Health Emergency Care-Rural Access Program." Aust Health Rev **38**(1): 58-64.

OBJECTIVE: To evaluate a rural emergency telepsychiatry program, the Mental Health Emergency Care-Rural Access Program (MHEC-RAP), which aims to improve access to emergency mental health care for communities throughout western New South Wales (NSW). METHODS: A descriptive analysis of service activity data from the introduction of the MHEC-RAP in 2008 to 2011 using Chi-squared tests and linear regression modelling to assess change and trends over time. RESULT: There were 55959 calls to the MHEC-RAP, 9678 (17%) of these calls initiated an MHEC-RAP service (~2500 each year). The use of video assessment increased over 18 months, then levelled off to an average of 65 each month. Health care provider use increased from 54% to 75% of all contacts, and 49% of MHEC-RAP patients were triaged 'urgent'. Most (71%) were referred from the MHEC-RAP for outpatient care with a local provider. The proportion of MHEC-RAP patients admitted to hospital initially increased by 12%, then declined over the next 2 years by 7% (by 28% for admissions to a mental health inpatient unit (MHIPU)). CONCLUSION: The MHEC-RAP is well established. It has achieved acceptable levels of service activity and continues to be as used as intended. Further research is required to confirm how the MHEC-RAP works in terms of process and capacity, how it has changed access to mental health care and to document its costs and benefits. WHAT IS KNOWN ABOUT THE TOPIC? Rural and remote communities have poorer access to and use of mental health services. Telehealth care is a reliable and accepted means for providing non-urgent mental health care. WHAT DOES THIS PAPER ADD? The MHEC-RAP is a practical and transferable solution to providing specialist emergency mental health care, and support for local providers, in rural and remote areas via telehealth. There is a possible impact upon the problem of recruiting and retaining a mental health workforce in rural and remote areas. WHAT ARE THE IMPLICATIONS FOR PRACTITIONERS? Providing reliable remote access to specialist mental health assessment and advice while supporting providers in rural communities can result in better outcomes for patients and services alike.

Segal, L., Guy, S. et Furber, G. (2018). "What is the current level of mental health service delivery and expenditure on infants, children, adolescents, and young people in Australia?" Aust N Z J Psychiatry **52**(2): 163-172.

OBJECTIVES: The study aim was to estimate the current level of ambulatory mental health service delivery to young people aged 0-24 years in Australia and associated government expenditure. Recognising the importance of the early years for the development of mental illness and socioeconomic outcomes, we were particularly interested in service access by infants and young children. METHODS: We extracted information from government administrative datasets on the number of people who received mental health services, number of services and expenditure through the health sector for 2014-2015. Results are primarily reported by age groups 0-4, 5-11, 12-17 and 18-24 years. RESULTS: Less than 1% of 0- to 4-year-olds received a mental health service in any one service setting, whereas nearly 11% of 18- to 24-year-olds received a mental health service through the Medicare Benefits Schedule Better Access programme alone. Many more services were delivered to 12- to 24-year-olds (>4 million) than to 0- to 11-year-olds (552,000). Medicare Benefits Schedule Better Access delivers services to more children and youth than do state/territory community mental health services, although the latter provide more services per client. In 2013-2014, Australian Government expenditure on ambulatory mental health services for 0- to 24-year-olds was AUD428 million, similar to the AUD491 million spent by state/territory governments. CONCLUSION: The study provides a benchmark for data-driven service planning to ensure that the mental health needs of infants, children and young people are met. Our results indicate that the youngest age group are underserviced relative to need, even noting infants and children may receive services for behavioural/mental health issues from providers not captured in our study (such as paediatricians). The developmental origins of mental illness underlies the urgency of adequate provision by governments of perinatal, infant and child mental health services to avoid loss of life potential and reduce the pressures on the justice, child protection and welfare systems.

Stokes, D., Mathews, R., Grenyer, B. F. S. et Stokes, K. (2010). "The Australian Psychology Workforce 4: An analysis of psychologists in private practice providing Medicare-funded services." Australian Psychologist **45**(3): 189-196.

> There have always been independent private psychology practitioners in Australia, yet in the past payment of their services was largely by a user-pays model. The introduction of Medicare Benefits for patients, under the Enhanced Primary Care program in 1999, and Better Access in Mental Health Care in 2006, along with Government-funded mental health initiatives such as Better Outcomes in Mental Health Care introduced in 2001, has provided an alternative funding model for independent private psychological services. Introduction of these and other Government-funded programs has raised questions about the responsiveness of the psychology workforce to meet the changing demands for psychological services created by these reforms. This study aimed to profile the characteristics of 3,587 independent private psychologists who provide services to clients under these schemes by analysing their responses to the Australian Psychology Workforce Survey. Of the 44% of psychologists completing the survey who indicated that they had a Medicare Provider Number, only 61% were in private practice as their main job. The remainder conducted services for Medicare-funded clients as part of a private practice in a second job. The demographic characteristics, work roles, client groups and income of psychologists with Medicare provider numbers are reported.

Thielking, M., Skues, J. et Le, V. A. (2018). "Collaborative Practices Among Australian School Psychologists, Guidance Officers and School Counsellors: Important Lessons for School Psychological Practice." Educational and Developmental Psychologist **35**(1): 18-35.

> In Australia, policies such as the Better Outcomes in Mental Health Care initiative have been the impetus for improved collaboration between medical practitioners and psychologists in general. However, policies that promote collaboration between school psychologists and community mental health, health, justice and/or human services professionals are yet to occur. This is despite known benefits arising from integrated service delivery to people with complex needs, including young people. School psychologists are an integral part of the service mix and are in an excellent position to promote collaborative practices and to assist students and families to navigate and access school-based and community-based support. This study, conducted in Queensland, Australia, investigated school psychologists', guidance officers' and school counsellors' current and preferred levels of collaboration, their perceptions of the drivers and barriers to collaborative practices, and their views on how collaborative practices affect students. Results revealed that participants engaged more fully in within-school collaboration than collaboration with professionals and agencies outside of the school; they had a desire to collaborate more fully both internally and externally; and that concerns regarding confidentiality, time restrictions, and lack of access to appropriate services can sometimes make collaboration and information sharing difficult. Implications for school psychological practice are discussed.

Thomas, J. E., Jasper, A. et Rawlin, M. (2006). "Better outcomes in mental health care--a general practice perspective." Aust Health Rev **30**(2): 148-157.

Vagholkar, S., Hare, L., Hasan, I., Zwar, N. et Perkins, D. (2006). "Better access to psychology services in primary mental health care: an evaluation." Aust Health Rev **30**(2): 195-202.

> INTRODUCTION: The Access to Allied Psychological Services program was introduced as part of the Better Outcomes in Mental Health Care initiative in 2001-2002. Divisions of General Practice are

funded to establish programs that allow GPs to refer patients for psychological treatments. The University of New South Wales evaluated programs run by the Southern Highlands and Illawarra Divisions of General Practice. This paper presents the findings of these evaluations. METHOD: Both evaluations analysed process and patient outcomes. This was obtained from a combination of program data and qualitative satisfaction data. RESULTS: The two program models differed in the mechanism of retention of the psychologists and the method of referral of patients. Anxiety and depression were the main reasons for referral, and clinical data showed there was improvement in patient outcomes. Patients, GPs and psychologists expressed satisfaction with the programs. DISCUSSION: The Access to Allied Psychological Services programs in both Divisions have proven popular. Flexibility in the program structure allows Divisions to develop a model which suits their local circumstances. There is support for ongoing Commonwealth funding and the challenge is to find the most effective and financially sustainable model of delivery for psychological services in primary care.

Vasiliadis, H. M. et Dezetter, A. "[Publicly funded programs of psychotherapy in Australia and England]." Sante Ment Que **40**(4): 101-118.

Quebec's HealthCommissioner on the performance of the health system clearly highlighted gaps in the collaboration between primary care physicians and mental health specialists, decreased accessibility and inequity in access to effective mental health services such as psychotherapy.Objectives The aim of this article was to describe the implementation of two publicly funded programs of psychotherapy in Australia and England with similar gatekeeper systems to the one in Quebec.Findings Following the Access to Allied Psychological Services (ATAPS) program introduced in Australia in 2003, one of the most important initiatives from the Council of Australian Governments' National Action Plan on Mental Health 2006-2011 was the Better Access Initiative which commenced in 2006. The plan included AUD1.2 billion in funding for integrating and improving the mental health care system. The purpose of Better Access was to improve the treatment and management of mental illnesses and increasing community access to mental health professionals and providing more affordable mental health care. GPs were encouraged to work more closely with mental health professionals. Under this program, these professionals are able to provide mental health services on a fee-for-service basis subsidized through Medicare. Access to psychological therapies is provided through private providers, rather than through fund holding arrangements. As of 2009 in Australia, 2 million people (1 in 11) had received over 11.2 million subsidized mental health services. A recent study showed clinical improvements in patients with depression associated with Better Access, concluding that the program is meeting previously unmet mental health needs.In the case of England, the IAPT - Improving Access to psychological Therapies-program enabled primary care trusts (PCTs) to implement evidence-based psychological therapies as recommended by National Institute for Health and Clinical Excellence for people suffering from depression and anxiety. In October 2007, the Secretary of State for Health announced additional funds totalling pound173 million between 2008 and 2011 that would be used to deliver a major training program that would build a skilled workforce of qualified psychological therapists in 4 therapy areas for adults and children: cognitive behaviour therapy; psychodynamic psychoanalytic therapy; systemic and family therapy; humanistic therapy. The main goals of the program were to have: (i) 3,600 newly trained therapists with an appropriate skill mix and supervision arrangements; (ii) 900,000 more people treated; (iii) 50% of people who leave treatment are recovered; (iv) 25,000 fewer people on sick pay and benefits.Conclusion To date, the results in both countries have shown clinical improvements in symptoms associated with depression and anxiety for people entering the programs and at a population level, decreasing the unmet mental health needs of the population by allowing self-referrals to the program, and therefore rendering access to services to populations otherwise not reached.

Vasiliadis, H. M. et Dezetter, A. (2015). "[Publicly funded programs of psychotherapy in Australia and England]." Sante Ment Que **40**(4): 101-118.

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and inequity in access to effective mental health services such as psychotherapy.Objectives The aim of this article was to describe the implementation of two publicly funded programs of psychotherapy in Australia and England with similar gatekeeper systems to the one in Quebec.Findings Following the Access to Allied Psychological Services (ATAPS) program introduced in Australia in 2003, one of the most important initiatives from the Council of Australian Governments' National Action Plan on Mental Health 2006-2011 was the Better Access Initiative which commenced in 2006. The plan included AUD1.2 billion in funding for integrating and improving the mental health care system. The purpose of Better Access was to improve the treatment and management of mental illnesses and increasing community access to mental health professionals and providing more affordable mental health care. GPs were encouraged to work more closely with mental health professionals. Under this program, these professionals are able to provide mental health services on a fee-for-service basis subsidized through Medicare. Access to psychological therapies is provided through private providers, rather than through fund holding arrangements. As of 2009 in Australia, 2 million people (1 in 11) had received over 11.2 million subsidized mental health services. A recent study showed clinical improvements in patients with depression associated with Better Access, concluding that the program is meeting previously unmet mental health needs.In the case of England, the IAPT - Improving Access to psychological Therapies-program enabled primary care trusts (PCTs) to implement evidence-based psychological therapies as recommended by National Institute for Health and Clinical Excellence for people suffering from depression and anxiety. In October 2007, the Secretary of State for Health announced additional funds totalling pound173 million between 2008 and 2011 that would be used to deliver a major training program that would build a skilled workforce of qualified psychological therapists in 4 therapy areas for adults and children: cognitive behaviour therapy; psychodynamic psychoanalytic therapy; systemic and family therapy; humanistic therapy. The main goals of the program were to have: (i) 3,600 newly trained therapists with an appropriate skill mix and supervision arrangements; (ii) 900,000 more people treated; (iii) 50% of people who leave treatment are recovered; (iv) 25,000 fewer people on sick pay and benefits.Conclusion To date, the results in both countries have shown clinical improvements in symptoms associated with depression and anxiety for people entering the programs and at a population level, decreasing the unmet mental health needs of the population by allowing self-referrals to the program, and therefore rendering access to services to populations otherwise not reached.

Whiteford, H. A. et Buckingham, W. J. (2005). "Ten years of mental health service reform in Australia: are we getting it right?" Med J Aust **182**(8): 396-400.

We summarise the most recent data available on changes to the public and private mental health sectors from the commencement of the National Mental Health Strategy in 1993 to 2002. There has been substantial service system change in the directions agreed by governments under the Strategy, supported by a 65% growth in government spending on mental health. Despite this there is growing public and professional concern about deficiencies in the mental health service system. We review the current call for change in light of increased community expectations and growth in demand for services. Given broad national and international support for Australia's policy directions, the problems lie with the pace and extent of change and ensuring better outcomes from the increased investment in mental health care.

Whiteford, H. A., Buckingham, W. J., Harris, M. G., Burgess, P. M., Pirkis, J. E., Barendregt, J. J. et Hall, W. D. (2014). "Estimating treatment rates for mental disorders in Australia." Aust Health Rev **38**(1): 80-85.

OBJECTIVE: To estimate the percentage of Australians with a mental disorder who received treatment for that disorder each year between 2006-07 and 2009-10. METHODS: We used: (1) epidemiological survey data to estimate the number of Australians with a mental disorder in any year; (2) a combination of administrative data on people receiving mental health care from the Commonwealth and State and Territories and epidemiological data to estimate the number receiving treatment; and (3) uncertainty modelling to estimate the effects of sampling error and assumptions on these estimates. RESULTS: The estimated population treatment rate for mental disorders in Australia increased from 37% in 2006-07 to 46% in 2009-10. The model estimate for 2006-07 (37%) was very similar to the estimated treatment rate in the 2007 National Survey of Mental Health and Wellbeing (35%), the only data available for external comparison. The uncertainty modelling suggested that the increased treatment rates over subsequent years could not be explained by sampling error or uncertainty in assumptions. CONCLUSIONS: The introduction of the Commonwealth's Better Access initiative in November 2006 has been the driver for the increased the proportion of Australians with mental disorders who received treatment for those disorders over the period from 2006-07 to 2009-10. WHAT IS KNOWN ABOUT THE TOPIC? Untreated mental disorders incur major economic costs and personal suffering. Governments need timely estimates of treatment rates to assess the effects of policy changes aimed at improving access to mental health services. WHAT DOES THIS PAPER ADD? Drawing upon a combination of epidemiological and administrative data sources, the present study estimated that the population treatment rate for mental disorders in Australia increased significantly from 37% in 2006-07 to 46% in 2009-10. WHAT ARE THE IMPLICATIONS FOR PRACTITIONERS? Increased access to services is not sufficient to ensure good outcomes for those with mental disorders. It is also important to ensure that evidence-based treatment is provided to those Australians accessing these services.

Williams, R. F. G. et Doessel, D. P. (2016). "Reallocating Australia's Scarce Mental Health Resources." Agenda **23**(1): 47-69.
http://search.ebscohost.com/login.aspx?direct=true&db=ecn&AN=1620569&lang=fr&site=ehost-live
http://epress.anu.edu.au/titles/agenda-a-journal-of-policy-analysis-and-reform-2

This paper applies some simple analytical tools from the economists' toolbox to shed some light on a sleeper issue in Australia's mental health sector. The problem is that there are large numbers of people with no diagnosed mental health condition who consume mental health services. Simultaneously, there are large numbers of people who have very serious mental health problems who receive no mental health services. This untreated group is often referred to as those with 'unmet need', a much-heard term. We refer to the first group as people with 'met non-need', a term hardly ever heard. Although the solution to the unmet-need problem is the oft-heard call for increased government expenditure, no attention is directed to the wasted expenditure associated with the 'met non-need' group: the met non-need issue is 'the elephant in the room'. We point to an alternative policy response; that is, a reallocation of resources from the met non-need group to the unmet need group. To achieve this, we direct focus upon a structural reform in the processes of supplying mental health services.

Wilson, I. et Howell, C. (2004). "Small group peer support for GPs treating mental health problems." Aust Fam Physician **33**(5): 362-364.

Peer support groups are a mutual aid system in which the facilitator helps group members to help each other. General practice peer support is seen as the provision of support in small groups by general practitioner colleagues. As part of the Better Outcomes in Mental Health Care Initiative, funding was made available to develop a unique model of peer support for GPs involved in mental health care. It aimed to meet the needs of GPs for support, sharing of knowledge and skills, ongoing education and skills development, while fostering self care. The model involved a GP facilitator training program and manual, which is now available for wider use.

Winefield, H. R., Turnbull, D. A., Seiboth, C. et Taplin, J. E. (2007). "Evaluating a program of psychological interventions in primary health care: consumer distress, disability and service usage." Aust N Z J Public Health **31**(3): 264-269.

OBJECTIVE: To evaluate a Better Outcomes of Mental Health Care Access to Allied Psychological Services Program for general practice patients referred for high-prevalence mental disorders. METHODS: Participants were South Australian general practitioners (GPs; n=26) and their patients referred for treatment of high-prevalence psychological disorders, of whom 229 provided baseline measures, 106 provided post-treatment measures, and 85 provided follow-up data three months after termination of treatment. Interventions were Focused Psychological Strategies supplied by mental health specialists; outcome variables included GP satisfaction, patient satisfaction, psychological distress, life impairment, and health service usage. RESULTS: Satisfaction with the treatment program was high for both the GPs and the referred patients. Patients who attended three or more treatment sessions showed reduced distress and disability, and gains were maintained three months later. Health service usage declined with acceptance of referral regardless of treatment experience. CONCLUSIONS: Lack of controls and missing data were methodological weaknesses. Results support the effectiveness of integrated primary mental health care to reduce psychological distress and disability, while impact on service usage warrants further investigation. IMPLICATIONS: Reduction of suffering and increased economic productivity may both result from this public health initiative to increase access to effective treatments for common chronic mental conditions.

Woods, R. (2011). "Behavioural concerns--assessment and management of people with intellectual disability." Aust Fam Physician **40**(4): 198-200.

BACKGROUND: General practitioners often care for people with an intellectual disability, and challenging behaviours are a common presentation, whether the patient lives with their family or in a group home. OBJECTIVE: This article aims to give practical advice on the assessment and treatment of behavioural issues in patients with intellectual disabilities. DISCUSSION: General practitioners can make a significant contribution to improving the quality of life of intellectually disabled persons. Collecting a careful description of the behaviour, assessing for physical causes and considering specific psychiatric diagnoses will help the GP target appropriate intervention. Psychological support under the Better Outcomes in Mental Health Care program can assist in developing behavioural strategies. The role of medication is also discussed.

Zhang, C., Harrison, C., Britt, H. et Charles, J. (2012). "Psychological encounters in general practice." Aust Fam Physician **41**(9): 659.

In November 2001, Focussed Psychological Strategy (FPS) Medicare item numbers were created under the Better Outcomes in Mental Health Care initiative to reimburse general practitioners trained in the provision of evidence based psychological therapies.

Les dispositifs en vigueur au Royaume-Uni

Un programme de psychothérapie

2007

Improving access to psychological therapies (IAPT)

Amos, R., Morris, L., Mansell, W., et al. (2018). "Clients' experiences of one-to-one low-intensity interventions for common mental health problems: An interpretative phenomenological analysis." Psychol Psychother.

OBJECTIVES: Common mental health disorders such as depression and anxiety are highly prevalent and carry significant health care and economic burdens. The UK's improving access to psychological therapies (IAPT) initiative was developed as a cost-effective way of reducing the pernicious effects of these disorders. IAPT interventions, such as guided self-help, have been subjected to considerable quantitative evaluation. However, there has been minimal investigation into clients' experiences of the one-to-one low-intensity interventions (LIIs), which form a key component of IAPT service

> provision. Qualitative exploration could provide rich data regarding experiences of psychological change and factors affecting therapeutic experiences. This will enable informative, client led insights into how low-intensity therapy can be improved. METHODS: Interpretative phenomenological analysis of eight semi-structured interviews was used to develop an idiosyncratic understanding of clients' experiences of one-to-one LIIs following entry into a randomized control trial (RCT). RESULTS: Four superordinate themes were identified from clients' accounts: goals and expectations of therapy, beneficial aspects of therapy, non-beneficial aspects of therapy, and the experience of psychological change. A heuristic model of interrelationships between factors is proposed. CONCLUSIONS: Both therapeutic techniques and relationships contribute to beneficial therapeutic experiences. The results reported here can be used to inform practice by harnessing the most beneficial aspects of therapy, such as developing adaptive therapeutic approaches to clients' clinical needs and facilitating idiosyncratic processes of psychological change. Due to limited qualitative research in this area, further research should be conducted in different service settings to assess differences and similarities in clients' experiences. PRACTITIONER POINTS: Therapists who adapted to clients' individual needs were perceived as more effective than those who did not. Effective therapeutic experiences were exemplified by a personal therapeutic approach, enough time to discuss issues and normalizing client's experiences. Clients develop idiosyncratic models of change which should be encouraged by therapists over and above clinical models.

Andrews, W., Twigg, E., Minami, T., et al. (2011). "Piloting a practice research network: a 12-month evaluation of the Human Givens approach in primary care at a general medical practice." Psychol Psychother **84**(4): 389-405.

> OBJECTIVE: To investigate the effectiveness of the Human Givens (HG) approach to the management of emotional distress in a primary care setting. To investigate whether or not the use of a shorter version (i.e., CORE-10) of a well-established psychometric instrument (i.e., Clinical Outcome in Routine Evaluation (CORE) CORE-outcome measure, CORE-OM) for sessional data collection is feasible for large-scale implementation of a practice research network (PRN). DESIGN: All clients who chose to opt into assessment for treatment with three accredited HG therapists following referral for management of psychological distress, primarily anxiety and depression, by General Medical Practitioners (GPs) or GP practice nurses working in a primary care general medical practice over a 12-month period were included. METHODS: The primary outcome measures were the CORE-OM and CORE-10. Pre-post effect sizes (Cohen's d) were calculated using pre, post, and pooled standard deviations to facilitate comparison with previously published studies. Mixed-design analysis of variance (ANOVA) was used to look at differences in pre- and post-treatment symptoms and potential treatment effects based on type of termination and gender. Observed intent-to-treat pre-post effect size using the CORE-OM was also benchmarked against data from Clark et al. (2009) improving access to psychological therapies (IAPT) pilot site data. Results obtained using CORE-OM were compared with those obtained using CORE-10 to evaluate the feasibility of using the CORE-10 for routine use in real-world clinical settings. RESULTS: Pre- to post-treatment changes measured with the CORE-OM and CORE-10 suggested that the therapy was highly effective, with clients remaining in treatment to completion demonstrating the greatest benefit. Reliable change and recovery rates comparisons between the CORE-OM and CORE-10 indicated that the CORE-10 is a viable alternative to the CORE-OM. Result of the benchmarking indicated that the observed pre-post effect size was clinically equivalent to IAPT data published by Clark et al. (2009). CONCLUSIONS: Although replications are warranted as the current investigation is a pilot study, the HG approach appears to be an effective treatment. CORE-10 is a satisfactory generic sessional assessment to use in place of the 34-item CORE-OM. Use of a shorter yet reliable outcome measure is likely to increase assessment completion rates. PRNs appear to be a suitable mechanism to establish treatment effectiveness across a wide range of treatments in different settings.

Baucom, D. H., Fischer, M. S., Worrell, M., et al. (2018). "Couple-based Intervention for Depression: An Effectiveness Study in the National Health Service in England." Fam Process **57**(2): 275-292.

> This study represents an effectiveness study and service evaluation of a cognitive behavioral, couple-based treatment for depression (BCT-D) provided in London services that are part of the "Improving Access to Psychological Therapies" (IAPT) program in England. Twenty-three therapists in community clinics were trained in BCT-D during a 5-day workshop, followed by monthly group supervision for 1 year. The BCT-D treatment outcome findings are based on 63 couples in which at least one partner was depressed and elected to receive BCT-D. Eighty-five percent of couples also demonstrated relationship distress, and 49% of the nonclient partners also met caseness for depression or anxiety. Findings demonstrated a recovery rate of 57% with BCT-D, compared to 41% for all IAPT treatments for depression in London. Nonclient partners who met caseness demonstrated a 48% recovery rate with BCT-D, although they were not the focus of treatment. BCT-D was equally effective for clients regardless of the clinical status of the nonclient partner, suggesting its effectiveness in assisting both members of the couple simultaneously. Likewise, treatment was equally effective whether or not both partners reported relationship distress. The findings are promising regarding the successful application of BCT-D in routine clinical settings.

Bendall, C. et McGrath, L. (2018). "Contending with the minimum data set: Subjectivity, linearity and dividualising experiences in Improving Access to Psychological Therapies." Health (London): 1363459318785718.

> Improving Access to Psychological Therapies has lead to a huge increase in the delivery of psychological therapy within the United Kingdom over the past 10 years. Central to the culture of Improving Access to Psychological Therapies is outcome monitoring, brought into every therapeutic encounter through the compulsory collection of the minimum data set in each session. This article explores the role of compulsory outcome monitoring in service users' experiences of using Improving Access to Psychological Therapies, with a focus on how these forms are folded into distress, therapy and recovery. Data from a small-scale qualitative study are drawn upon. Thematic analysis was conducted on multimodal interviews with current service users. The article explores the ways in which the minimum data set acted as a 'quasi object', exploring three main roles of the minimum data set: as an authorising mediator, an alienating adversary and a deferring gatekeeper. Pictures of therapeutic progress, as presented via outcome measures, often ran counter to users' reported experience of distress. We conclude that far from being a neutral and objective assessment tool, the minimum data set functions as a living actant in the therapeutic encounter.

Boyd, L., Baker, E. et Reilly, J. (2019). "Impact of a progressive stepped care approach in an improving access to psychological therapies service: An observational study." PLoS One **14**(4): e0214715.

> England's national Improving Access to Psychological Therapies (IAPT) programme advocates stepped care as its organizational delivery of psychological therapies to common mental health problems. There is limited evidence regarding the efficacy of stepped care as a service delivery model, heterogeneity of definition and differences in model implementation in both research and routine practice, hence outcome comparison in terms of effectiveness of model is difficult. Despite sound evidence of the efficacy of low intensity interventions there appears to be a perpetuation of the notion that severity and complexity should only be treated by a high intensity intervention through the continuation of a stratified care model. Yet no psychotherapy treatment is found to be more superior to another, and not enough is known about what works for whom to aid the matching of treatment decision. In the absence of understanding precise treatment factors optimal for recovery, it may be useful to better understand the impact of a service delivery model, and whether different models achieve different outcomes. This study aims to contribute to the discussion regarding the stepped care definition and delivery, and explores the impact on clinical outcomes where different types of stepped care have been implemented within the same service. An observational cohort study analysed retrospective data (n = 16,723) over a 4 year period, in a single IAPT service, where delivery changed from one type of stepped care model to another. We compared the outcomes of treatment completers with a stratified care model and a progression care model. We also explored the assumption that patients who score severe on psychological measures, and therefore are potentially

complex, would achieve better outcomes in a stratified model. Outcomes in each model type were compared, alongside baseline factor variables. A significant association was observed between a recovery outcome and model type, with patients 1.5 times more likely to recover in the progression delivery model. The potential implications are that with a progression stepped care model of service delivery, more patients can be treated with a lower intensity intervention, even with initial severe presentations, ensuring that only those that need high intensity CBT or equivalent are stepped up. This could provide services with an effective clinical model that is efficient and potentially more cost effective.

Branson, A., Myles, P., Mahdi, M., et al. (2018). "The Relationship between Competence and Patient Outcome with Low-Intensity Cognitive Behavioural Interventions." Behav Cogn Psychother **46**(1): 101-114.

BACKGROUND: Little is understood about the relationship between therapist competence and the outcomes of patients treated for common mental health disorders. Furthermore, the evidence is yet to extend to competence in the delivery of low-intensity cognitive behavioural interventions. Understanding this relationship is essential to the dissemination and implementation of low-intensity cognitive behavioural interventions. AIMS: The aim of this study was to explore the relationship between Psychological Well-being Practitioner (PWP) competence and patient outcome within the framework of the British government's Improving Access to Psychological Therapies (IAPT) initiative. METHOD: Forty-seven PWPs treating 3688 patients participated. Relationships between PWP scores on three observed standardized clinical examinations and reliable change in patients' symptoms of anxiety and depression were explored at two time points: during the year-long training phase, and over a 12-month follow-up. RESULTS: Results indicated that patients treated by qualified PWPs achieved superior outcomes than those treated by trainees. Little support was found for a general association between practitioner competence in delivering low-intensity cognitive behavioural interventions and patient outcome, either during or post-training; however, significantly more patients of the most competent PWPs demonstrated reliable improvement in their symptoms of anxiety and depression than would be expected by chance alone and fewer deteriorated compared with those treated by the least competent PWPs. CONCLUSION: Results were indicative of a complex, non-linear relationship, with patient outcome affected by PWP status (trainee or qualified) and by competence at its extremes. The implications of these results for the dissemination and implementation of low-intensity cognitive behavioural interventions are discussed.

Branson, A., Shafran, R. et Myles, P. (2015). "Investigating the relationship between competence and patient outcome with CBT." Behav Res Ther **68**: 19-26.

Little is understood about the relationship between therapist competence and the outcome of patients treated for common mental health disorders. Understanding the relationship between competence and patient outcome is of fundamental importance to the dissemination and implementation of Cognitive Behavioural Therapy (CBT). The current study extends existing literature by exploring the relationship between CBT competence and patient outcome in routine clinical practice within the framework of the British Government's Improving Access to Psychological Therapies (IAPT) programme. Participants comprised 43 therapists treating 1247 patients over a training period of one year. Results found little support of a general association between CBT competence and patient outcome; however significantly more patients of the most competent therapists demonstrated a reliable improvement in their symptoms of anxiety than would be expected by chance alone, and fewer experienced no reliable change. Conversely, significantly more patients treated by the least competent therapists experienced a reliable deterioration in their symptoms than would be expected. The implications of these results for the dissemination and implementation of CBT are discussed.

Brown, J., Boardman, J. et Whittinger, N. (2010). "Can a self-referral system help improve access to psychological treatments?" British Journal of General Practice **60**(574).

Referrals for psychological treatment have been problematic for many years. Even though GPs have attempted to limit access into the small psychological treatment services, long waiting lists have developed which have deterred referrals and deferred psychological care. GPs have understandably been frustrated. In addition, the consultation rate for psychological problems is low when compared with the rate of identified mental health problems in population surveys. Possible reasons include patients' failure to recognise the problem as psychological and thus not consulting one's GP, and/or the problem not being detected by the GP. While a self-referral system may be seen as a way of trying to allow non-consulters to receive treatment, this has been viewed with some scepticism since it may allow the `worried well' to access already limited services. However, a study has shown that those self-referring to advertised psychological workshops had high levels of psychological morbidity and also were more representative of the population, in terms of ethnicity, than GP referrals. The government has set up the Increasing Access to Psychological Therapies (IAPT) programme to address some of the service shortfalls by expanding the provision of psychological therapists. Notably, the IAPT programme is allowing self-referrals such that any member of the public can access the service directly, bypassing general practice. Although not available at all the sites, this represents a radical shift from the present system in which access to talking therapy is generally only available through direct referral by the GP. The implications of this new development are discussed. [Abstract]

Brown, J. S., Boardman, J., Whittinger, N., et al. (2010). "Can a self-referral system help improve access to psychological treatments?" Br J Gen Pract **60**(574): 365-371.

Referrals for psychological treatment have been problematic for many years. Even though GPs have attempted to limit access into the small psychological treatment services, long waiting lists have developed which have deterred referrals and deferred psychological care. GPs have understandably been frustrated. In addition, the consultation rate for psychological problems is low when compared with the rate of identified mental health problems in population surveys. Possible reasons include patients' failure to recognise the problem as psychological and thus not consulting one's GP, and/or the problem not being detected by the GP. While a self-referral system may be seen as a way of trying to allow non-consulters to receive treatment, this has been viewed with some scepticism since it may allow the 'worried well' to access already limited services. However, a study has shown that those self-referring to advertised psychological workshops had high levels of psychological morbidity and also were more representative of the population, in terms of ethnicity, than GP referrals. The government has set up the Increasing Access to Psychological Therapies (IAPT) programme to address some of the service shortfalls by expanding the provision of psychological therapists. Notably, the IAPT programme is allowing self-referrals such that any member of the public can access the service directly, bypassing general practice. Although not available at all the sites, this represents a radical shift from the present system in which access to talking therapy is generally only available through direct referral by the GP. The implications of this new development are discussed.

Brown, J. S., Ferner, H., Wingrove, J., et al. (2014). "How equitable are psychological therapy services in South East London now? A comparison of referrals to a new psychological therapy service with participants in a psychiatric morbidity survey in the same London borough." Soc Psychiatry Psychiatr Epidemiol **49**(12): 1893-1902.

PURPOSE: Psychological therapy services are sometimes characterised as being small and inequitable, with an over-representation of white middle class women. The 'Improving Access to Psychological Therapies (IAPT)' initiative is a programme in England that attempts to make evidence-based therapies accessible to more people more equitably. The aim of this study is to assess whether an IAPT service is delivering an equitable service a London borough. Patients using services at the Southwark IAPT service (n = 4,781) were compared with a sub-group of participants in the South East London Community Health study (SELCOH) with diagnosable mental health problems and who were also resident in Southwark (n = 196). METHODS: We compared Southwark IAPT patients and SELCOH participants on equity criteria of age, gender, ethnicity, occupational status and benefits status. To investigate if referral pathways influenced equity, patients referred by their general practitioner (GP pathway) (n = 3,738) or who self-referred (self-referral pathway) (n = 482) were compared with SELCOH participants. RESULTS: Southwark IAPT patients significantly differed from SELCOH participants on all our equity criteria and similar differences were found with GP pathway patients. However, self-referrals did not differ from the SELCOH group on age, gender, ethnicity and benefit status. CONCLUSIONS: When compared to a community sample with diagnosable mental disorders, health disparities were found with the overall Southwark IAPT service and with GP pathway patients. Although unemployed people did access IAPT, fewer disparities were found with the self-referral pathway patients, suggesting that the IAPT self-referral pathway may be important in reducing inequitable access to services.

Buckman, J. E. J., Naismith, I., Saunders, R., et al. (2018). "The Impact of Alcohol Use on Drop-out and Psychological Treatment Outcomes in Improving Access to Psychological Therapies Services: an Audit." Behav Cogn Psychother **46**(5): 513-527.

BACKGROUND: The impact of alcohol use disorders (AUD) on psychological treatments for depression or anxiety in primary care psychological treatment services is unknown. AIMS: To establish levels of alcohol misuse in an Improving Access to Psychological Therapies (IAPT) service, examine the impact of higher risk drinking on IAPT treatment outcomes and drop-out, and to inform good practice in working with alcohol misuse in IAPT services. METHOD: 3643 patients completed a brief questionnaire on alcohol use pre-treatment in addition to measures of depression, anxiety and functioning. Symptom and functioning measures were re-administered at all treatment sessions. RESULTS: Severity of alcohol misuse was not associated with treatment outcomes, although those scoring eight or more on the AUDIT-C were more likely to drop out from treatment. CONCLUSIONS: IAPT services may be well placed to offer psychological therapies to patients with common mental disorders and comorbid AUD. Patients with AUD can have equivalent treatment outcomes to those without AUD, but some higher risk drinkers may find accessing IAPT treatment more difficult as they are more likely to drop out. Alcohol misuse on its own should not be used as an exclusion criterion from IAPT services. Recommendations are given as to how clinicians can: adjust their assessments to consider the appropriateness of IAPT treatment for patients that misuse alcohol, consider the potential impact of alcohol misuse on treatment, and improve engagement in treatment for higher risk drinkers.

Buckman, J. E. J., Saunders, R., Fearon, P., et al. (2019). "Attentional Control as a Predictor of Response to Psychological Treatment for Depression and Relapse up to 1 year After Treatment: A Pilot Cohort Study." Behav Cogn Psychother **47**(3): 318-331.

BACKGROUND: Identifying depressed patients unlikely to reach remission and those likely to relapse after reaching remission is of great importance, but there are few pre-treatment factors that can help clinicians predict prognosis and together these explain relatively little variance in treatment outcomes. Attentional control has shown promise in studies to date, but has not been investigated prospectively in routine clinical settings with depressed patients. AIMS: This study aimed to pilot the use of a brief self-report measure of attentional control in routine care and investigate the associations between attentional control, psychological treatment response and relapse to depression up to 1 year post-treatment. METHOD: Depressed patients were recruited from two primary care psychological treatment (IAPT) services and completed the Attentional Control Scale (ACS) alongside routine symptom measures at every therapy session. Participants were tracked and followed up for 1 year post-treatment. RESULTS: Baseline ACS scores were associated with remission and residual depressive symptoms post-treatment, and relapse within 12 months of ending treatment, all independent of pre-treatment depressive symptom severity, and the latter also independent of residual symptoms. CONCLUSION: A self-report measure of attentional control can potentially be used to predict levels of depressive symptoms post-treatment and can contribute to predicting risk of relapse to depression in IAPT services, without affecting rates of therapy completion/drop-out or data completion of standard IAPT measures. However, this pilot study had a small overall sample size and a very small number of observed relapses, so replication in a larger study is needed before firm conclusions can be made.

Burns, P., Kellett, S. et Donohoe, G. (2016). ""Stress Control" as a Large Group Psychoeducational Intervention at Step 2 of IAPT Services: Acceptability of the Approach and Moderators of Effectiveness." Behav Cogn Psychother **44**(4): 431-443.

> BACKGROUND: "Stress Control" (SC) has been adopted as a core intervention in step 2 of Improving Access to Psychological Therapies (IAPT) services, but contemporary evidence of effectiveness has lagged behind service uptake. AIMS: To investigate the acceptability and effectiveness of SC and to explore moderators of outcome. METHOD: Analysis of acceptability (via attendance rates) and effectiveness (via IAPT minimum dataset). RESULTS: SC was well tolerated with 73.3% of all patients and 75.4% of "clinical cases" attending three or more sessions. Of the 546 "clinical cases" attending SC and not in receipt of other interventions, 37% moved to recovery. Attendance improved outcome; for those patients attending all SC sessions the recovery rate rose to 59.2%. CONCLUSION: SC appears a well-tolerated and effective intervention that enables large numbers to gain access to treatment in an organizationally efficient manner. Attendance is important in facilitating SC outcomes and research evaluating attendance interventions are needed.

Calderwood, B. et Derry, B. (2011). IAPT data standard and reporting. London :, DH
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126471.pdf

> This letter from the Director Mental Health and Disability, Department of Health and the Director of the NHS Information Centre states that the Information Standards Board has approved the IAPT [Improving Access to Psychological Therapies] dataset as a national operational standard. All IAPT services will be expected to return data to a central reporting system from April 2012. During 2011, IAPT services should make required changes to information systems and processes in readiness for mandation in 2012. [Introduction]

Center for Mental Healh (2017). Adult and older adult mental health services 2012-2016 : : an analysis of Mental Health NHS Benchmarking Network data for England and Wales. London :, Centre for Mental Health

> The NHS Benchmarking Network have made their mental health data available to the Centre for Mental Health to provide an independent commentary on what the data suggests about mental health provision in England and Wales between 2012 and 2016. This briefing is the result of our analysis, and highlights some key findings: Acute inpatient services had 15 per cent fewer beds in 2016 than they did in 2012, but only four per cent fewer people were admitted to hospital. Community mental health services also reduced slightly during that time (by about six per cent). Types of community service have also changed: early intervention and crisis resolution teams initially fell, for example, but then grew again in response to national policy focus in these two areas. A growing proportion of people admitted to hospital were detained under the Mental Health Act. At the same time there was significant investment in talking therapy services through the Improving Access to Psychological Therapies programme. And in many areas primary mental health care teams are emerging to offer an alternative to community care for some people. The biggest reduction in community mental health services between 2013 and 2016 was in assertive outreach, while the biggest rise was in assessment and brief intervention teams. In 2016, a new strategy, the Five Year Forward View for Mental Health brought with it a pledge of extra investment in both IAPT and community mental health services. This will be vital to build robust support for the full range of people's mental health needs across the country

Chan, S. W. et Adams, M. (2014). "Service use, drop-out rate and clinical outcomes: a comparison between high and low intensity treatments in an IAPT service." Behav Cogn Psychother **42**(6): 747-759.

> BACKGROUND: The IAPT services provide high and low intensity psychological treatments for adults suffering from depression and anxiety disorders using a stepped care model. The latest national evaluation study reported an average recovery rate of 42%. However, this figure varied widely between services, with better outcomes associated with higher "step-up" rates between low and high

intensity treatments. AIMS: This study aimed to compare the two intensity groups in an IAPT service in Suffolk. METHOD: This study adopted a between groups design. A sample of 100 service users was randomly selected from the data collected from an IAPT service in Suffolk between May 2008 and February 2011. The treatment outcomes, drop-out rate, and other characteristics were compared between those who received high and low intensity treatments. RESULTS: The high intensity group received, on average, more sessions and contact time. They received more CBT sessions and less guided self-help. There were no group differences in terms of the drop-out and appointment cancellation rates. Analyses on clinical outcomes suggested no group difference but demonstrated an overall recovery rate of 52.6% and significant reduction in both depression and anxiety symptoms. CONCLUSIONS: Despite methodological limitations, this study concludes that the service as a whole achieved above-average clinical outcomes. Further research building upon the current study in unpacking the relative strengths and weaknesses for the high and low intensity treatments would be beneficial for service delivery.

Chinn, D. et Abraham, E. (2016). "Using 'candidacy' as a framework for understanding access to mainstream psychological treatment for people with intellectual disabilities and common mental health problems within the English Improving Access to Psychological Therapies service." J Intellect Disabil Res **60**(6): 571-582.

BACKGROUND: The Improving Access to Psychological Therapies (IAPT) service was established to address common mental health problems among the English population in a timely manner in order to counter the social and economic disadvantage accompanying such difficulties. Using the concept of candidacy, we examined how the legitimacy of claims by people with intellectual disabilities to use this service is facilitated or impeded. METHOD: We used a sequential mixed methods design. We completed 21 interviews with a range of stakeholders, including people with intellectual disabilities and their carers. Themes from the interviews were used to design an online survey questionnaire that was returned by 452 staff from IAPT and specialist intellectual disability services. RESULTS: Using the candidacy framework, we noted that eligibility and access to IAPT were achieved through dynamic and iterative processes of negotiation involving people with intellectual disabilities and their supporters on one side and IAPT staff and service structures on the other. Barriers and facilitators were apparent throughout the seven dimensions of candidacy (identification, navigation, permeability of services, appearances, adjudications, offers and resistance and operating conditions) and were linked to discourses relating to the character and purpose of IAPT and specialist intellectual disability services. CONCLUSIONS: Opportunities exist for some people with intellectual disabilities to assert their candidacy for IAPT input, although there are barriers at individual, professional, organisational and structural levels. More attention needs to be paid to how principles of inclusiveness are operationalised within IAPT teams and to the mental health facilitation role of specialist intellectual disability staff.

Clark, D. M. (2011). "Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience." Int Rev Psychiatry **23**(4): 318-327.

The Improving Access to Psychological Therapies (IAPT) programme is a large-scale initiative that aims to greatly increase the availability of NICE recommended psychological treatment for depression and anxiety disorders within the National Health Service in England. This article describes the background to the programme, the arguments on which it is based, the therapist training scheme, the clinical service model, and a summary of progress to date. At mid-point in a national roll-out of the programme progress is generally in line with expectation, and a large number of people who would not otherwise have had the opportunity to receive evidence-based psychological treatment have accessed, and benefited from, the new IAPT services. Planned future developments and challenges for the programme are briefly described.

Clark, D. M. (2018). "Realizing the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program." Annu Rev Clin Psychol **14**: 159-183.

> Empirically supported psychological therapies have been developed for many mental health conditions. However, in most countries only a small proportion of the public benefit from these advances. The English Improving Access to Psychological Therapies (IAPT) program aims to bridge the gap between research and practice by training over 10,500 new psychological therapists in empirically supported treatments and deploying them in new services for the treatment of depression and anxiety disorders. Currently IAPT treats over 560,000 patients per year, obtains clinical outcome data on 98.5% of these individuals, and places this information in the public domain. Around 50% of patients treated in IAPT services recover, and two-thirds show worthwhile benefits. The clinical and economic arguments on which IAPT is based are presented, along with details of the service model, how the program was implemented, and recent findings about service organization. Limitations and future directions are outlined.

Clark, D. M., Canvin, L., Green, J., et al. (2018). "Transparency about the outcomes of mental health services (IAPT approach): an analysis of public data." Lancet **391**(10121): 679-686.

> BACKGROUND: Internationally, the clinical outcomes of routine mental health services are rarely recorded or reported; however, an exception is the English Improving Access to Psychological Therapies (IAPT) service, which delivers psychological therapies recommended by the National Institute for Health and Care Excellence for depression and anxiety disorders to more than 537 000 patients in the UK each year. A session-by-session outcome monitoring system ensures that IAPT obtains symptom scores before and after treatment for 98% of patients. Service outcomes can then be reported, along with contextual information, on public websites. METHODS: We used publicly available data to identify predictors of variability in clinical performance. Using beta regression models, we analysed the outcome data released by National Health Service Digital and Public Health England for the 2014-15 financial year (April 1, 2014, to March 31, 2015) and developed a predictive model of reliable improvement and reliable recovery. We then tested whether these predictors were also associated with changes in service outcome between 2014-15 and 2015-16. FINDINGS: Five service organisation features predicted clinical outcomes in 2014-15. Percentage of cases with a problem descriptor, number of treatment sessions, and percentage of referrals treated were positively associated with outcome. The time waited to start treatment and percentage of appointments missed were negatively associated with outcome. Additive odd ratios suggest that moving from the lowest to highest level on an organisational factor could improve service outcomes by 11-42%, dependent on the factor. Consistent with a causal model, most organisational factors also predicted between-year changes in outcome, together accounting for 33% of variance in reliable improvement and 22% for reliable recovery. Social deprivation was negatively associated with some outcomes, but the effect was partly mitigated by the organisational factors. INTERPRETATION: Traditionally, efforts to improve mental health outcomes have largely focused on the development of new and more effective treatments. Our analyses show that the way psychological therapy services are implemented could be similarly important. Mental health services elsewhere in the UK and in other countries might benefit from adopting IAPT's approach to recording and publicly reporting clinical outcomes. FUNDING: Wellcome Trust.

Clark, D. M., Layard, R. et Smithies, R. (2008). Improving access to psychological therapy: initial evaluation of the two demonstration sites. Londres : LSE.
http://cep.lse.ac.uk/pubs/download/dp0897.pdf

> The Government's Improving Access to Psychological Therapy (IAPT) programme aims to implement NICE Guidance for people with depression and anxiety disorders. In the first phase of the programme, two demonstration sites were established in Doncaster and Newham with funding to provide increased availability of cognitive-behaviour therapy-based (CBT) services to those in the community who need them. The services opened in late summer 2006. This report documents the achievements of the sites up to September 2007 (roughly their first year of operation) and makes recommendations for the future roll out of IAPT services.

Clark, D. M., Layard, R., Smithies, R., et al. (2009). "Improving access to psychological therapy: Initial evaluation of two UK demonstration sites." Behav Res Ther **47**(11): 910-920.

> Recently the UK Government announced an unprecedented, large-scale initiative for Improving Access to Psychological Therapies (IAPT) for depression and anxiety disorders. Prior to this development, the Department of Health established two pilot projects that aimed to collect valuable information to inform the national roll-out. Doncaster and Newham received additional funds to rapidly increase the availability of CBT-related interventions and to deploy them in new clinical services, operating on stepped-care principles, when appropriate. This article reports an evaluation of the new services (termed 'demonstration sites') during their first thirteen months of operation. A session-by-session outcome monitoring system achieved unusually high levels of pre to post-treatment data completeness. Large numbers of patients were treated, with low-intensity interventions (such as guided self-help) being particularly helpful for achieving high throughput. Clinical outcomes were broadly in line with expectation. 55-56% of patients who had attended at least twice (including the assessment interview) were classified as recovered when they left the services and 5% had improved their employment status. Treatment gains were largely maintained at 10 month follow-up. Opening the services to self-referral appeared to facilitate access for some groups that tend to be underrepresented in general practice referrals. Outcomes were comparable for the different ethnic groups who access the services. Issues for the further development of IAPT are discussed.

Clark, M., Ryan, T. et Dixon, N. (2015). "Commissioning for better outcomes in mental health care: testing Alliance Contracting as an enabling framework." Mental Health and Social Inclusion **19**(4): 191-201.
<Go to ISI>://WOS:000410316700006

> Purpose - Commissioning has been a central plank of health and social care policy in England for many years now, yet there are still debates about how effective it is in delivering improvements in care and outcomes. Social inclusion of people with experience of mental health is one of the goals that commissioners would like to help services to improve but such a complex outcome for people can often be undermined by contractual arrangements that fragment service responses rather than deliver holistic support. The purpose of this paper is to discuss a form of commissioning, Alliance Contracting, and how it has been allied with a Social Inclusion Outcomes Framework (SIOF) in Stockport to begin to improve services and outcomes. Design/methodology/approach - The paper is a conceptual discussion and case description of the use of Alliance Contracts to improve recovery services and social inclusion in mental health care in one locality. Findings - The paper finds that the Alliance Contracting approach fits well with the SIOF and is beginning to deliver some promising results in terms of improving services. Research limitations/implications - This is a case study of one area and, as such, it is hard to generalise beyond that. Practical implications - The paper discusses a promising approach for commissioners to develop locally to guide service improvements and better social inclusion outcomes for people. Social implications - Rather than developing good services but fractured pathways of care across providers and teams, the Alliance Contracting approach potentially delivers more holistic and flexible pathways that ought to better help individuals in their recovery journeys. Originality/value - This is the first paper to set out the use of Alliance Contracting and social inclusion measures to help improve services and outcomes for people experiencing mental health problems.

Clarkson, P., Giebel, C. M., Challis, D., et al. (2016). "Outcomes from a pilot psychological therapies service for UK military veterans." Nurs Open **3**(4): 227-235.

> AIM: To evaluate the outcomes of participants attending a psychological therapies service for military veterans. BACKGROUND: The UK Military Veterans' Improving Access to Psychological Therapies Service (North West) (MV IAPT) provided a clinical psychological therapies service for military veterans. Outcomes of depression, anxiety and social adjustment were assessed after treatment in the service's pilot phase. DESIGN: An observational, prospective cohort study examined changes in depression, anxiety and social adjustment during receipt of the service. METHODS: Changes in

depression (PHQ-9), anxiety (GAD-7) and social adjustment (WSAS) were examined in 952 veterans referred over 20 months from September 2011. Data were collected using the IAPT clinical information system plus additional fields. Changes for patients who completed treatment, remained in treatment and dropped out were compared. RESULTS: Seven hundred and seven veterans received an initial assessment, from which 505 received two or more appointments. Of these, 156 completed treatments, 179 remained in treatment and 170 dropped out. The majority of veterans had been operationally deployed and were similar in risk characteristics to those in other military cohort studies. There were highly significant improvements on all measures (p<.01), with completers improving more and having higher rates of recovery from depression and anxiety than those remaining and drop outs. Recovery rates compared favourably with evaluations of general IAPT services and also exceeded reported natural recovery rates.

CMH (2013). The NHS Mandate and its implications for mental health. London :, CMH

Collins, N. et Corna, L. (2018). "General practitioner referral of older patients to Improving Access to Psychological Therapies (IAPT): an exploratory qualitative study." BJPsych Bull **42**(3): 115-118.

Aims and methodTo understand general practitioner (GP) reticence to refer older patients to a local Improving Access to Psychological Therapies (IAPT) service providing mostly cognitive-behavioural therapy (CBT)-based interventions. Semi-structured, hour-long interviews were conducted with eight GPs and then analysed by modified grounded theory and thematic analysis. RESULTS: GP views regarding the treatability of older adults with CBT influenced their willingness to refer to a CBT-based IAPT service. Perceptions of local IAPT assessment processes being distressing and onerous to older patients also motivated referral inaction. GPs expressed a preference to treat depressed older patients themselves (with medication and psychological approaches such as watchful waiting).Clinical implicationsAny strategy to increase referral rates of older adults to CBT-based IAPT services should address local GP concerns regarding assessment processes and the effectiveness of offered treatments.Declaration of interestNone.

Cooper, B. (2009). "Strange bedfellows: economics, happiness and mental disorder." Epidemiol Psichiatr Soc **18**(3): 208-213.

AIM: The high economic and social costs associated with the 'common mental disorders', and the need to scale up appropriate care services, are now widely recognized, but responses vary from country to country. In Britain, a current government initiative to promote psychological therapy is driven both by economic pressures and by research on the factors of happiness, or life-satisfaction. This article provides a short critical review of the project. METHOD: A health policy analysis, with regard to problem definition; objectives; sources of information; criteria for evaluation; impact on existing services, and comparison with alternative strategies. RESULTS: The new programme, Improving Access to Psychological Therapies (IAPT), aims to expand treatment services by training 3,600 'psychological therapists' in cognitive behavioural therapy (CBT), which they will then apply in the wider community. This service, with an initial budget of 173 million pounds sterling, will provide treatment for depression and chronic anxiety from local centres across the country. The programme is intended to pay for itself by reducing incapacity costs. Closer examination, however, raises questions concerning the project's theoretical basis, logistics and research methodology, and casts doubt on its advantages over alternative approaches. CONCLUSIONS: The IAPT project is ill-designed to achieve its objectives and unsuitable as a model for treatment and care of the common mental disorders in other countries. An alternative strategy, based on closer integration of community mental health and primary health care, should be tested and on previous experience seems likely to prove more cost-effective.

Coventry, P. A., Lovell, K., Dickens, C., et al. (2012). "Collaborative Interventions for Circulation and Depression (COINCIDE): study protocol for a cluster randomized controlled trial of collaborative care for depression in people with diabetes and/or coronary heart disease." Trials **13**: 139.

BACKGROUND: Depression is up to two to three times as common in people with long-term conditions. It negatively affects medical management of disease and self-care behaviors, and leads to poorer quality of life and high costs in primary care. Screening and treatment of depression is increasingly prioritized, but despite initiatives to improve access and quality of care, depression remains under-detected and under-treated, especially in people with long-term conditions. Collaborative care is known to positively affect the process and outcome of care for people with depression and long-term conditions, but its effectiveness outside the USA is still relatively unknown. Furthermore, collaborative care has yet to be tested in settings that resemble more naturalistic settings that include patient choice and the usual care providers. The aim of this study was to test the effectiveness of a collaborative-care intervention, for people with depression and diabetes/coronary heart disease in National Health Service (NHS) primary care, in which low-intensity psychological treatment services are delivered by the usual care provider - Increasing Access to Psychological Therapies (IAPT) services. The study also aimed to evaluate the cost-effectiveness of the intervention over 6 months, and to assess qualitatively the extent to which collaborative care was implemented in the intervention general practices. METHODS: This is a cluster randomized controlled trial of 30 general practices allocated to either collaborative care or usual care. Fifteen patients per practice will be recruited after a screening exercise to detect patients with recognized depression (>/=10 on the nine-symptom Patient Health Questionnaire; PHQ-9). Patients in the collaborative-care arm with recognized depression will be offered a choice of evidence-based low-intensity psychological treatments based on cognitive and behavioral approaches. Patients will be case managed by psychological well-being practitioners employed by IAPT in partnership with a practice nurse and/or general practitioner. The primary outcome will be change in depressive symptoms at 6 months on the 90-item Symptoms Checklist (SCL-90). Secondary outcomes include change in health status, self-care behaviors, and self-efficacy. A qualitative process evaluation will be undertaken with patients and health practitioners to gauge the extent to which the collaborative-care model is implemented, and to explore sustainability beyond the clinical trial. DISCUSSION: COINCIDE will assess whether collaborative care can improve patient-centered outcomes, and evaluate access to and quality of care of co-morbid depression of varying intensity in people with diabetes/coronary heart disease. Additionally, by working with usual care providers such as IAPT, and by identifying and evaluating interventions that are effective and appropriate for routine use in the NHS, the COINCIDE trial offers opportunities to address translational gaps between research and implementation. TRIAL REGISTRATION NUMBER: ISRCTN80309252 TRIAL STATUS: Open.

Cromarty, P., Drummond, A., Francis, T., et al. (2016). "NewAccess for depression and anxiety: adapting the UK Improving Access to Psychological Therapies Program across Australia." Australas Psychiatry **24**(5): 489-492.

OBJECTIVE: NewAccess is a Low Intensity Cognitive Behaviour Therapy (LiCBT) early intervention pilot, for mild to moderate depression and anxiety. In November 2015 the Australian Government Review of Mental Health Programmes and Services specifically highlighted the program, stating, "Primary Health Networks will....be encouraged and supported to work towards better utilisation of low intensity 'coaching' services for people with lesser needs, building on evaluations of programmes such as the NewAccess model of care, and the Improving Access to Psychological Therapies model of stepped care implemented in the United Kingdom." NewAccess runs in three sites (Adelaide, Canberra and North Coast New South Wales) based on the successful UK Improving Access to Psychological Therapies (IAPT) model. NewAccess involves training in evidence-based interventions, regular clinical supervision and recording outcome measures every session. Key performance indicators include functional recovery,loss of diagnosis, return to employment and early intervention. CONCLUSIONS: Adaptation to Australia accommodated contextual issues such as geographical isolation and infrastructure of the healthcare system. Initial recovery rates and projected economic viability for NewAccess are very promising, supporting wider adoption of an IAPT model across Australia. In addition it has resulted in the emergence of a new Australian workforce in community mental health with the LiCBT 'Coach'.

CSIP (2008). Commissioning IAPT for the whole community : : improving access to psychological therapies. London :, CSIP.

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CSIP (2008). Improving access to psychological therapies (IAPT) commissioning toolkit. London : CSIP.
https://www.england.nhs.uk/mental-health/adults/iapt/

Dagnan, D., Masson, J., Thwaites, R., et al. (2018). "Training therapists to work with people with intellectual disability in Improving Access to Psychological Therapies (IAPT) services." J Appl Res Intellect Disabil **31**(5): 760-767.

> BACKGROUND: Current policy in the England suggests that people with intellectual disabilities should, where possible, access mainstream mental health services; this should include access to mainstream therapy services. It is likely that mainstream therapists will need training and support to work with people with intellectual disabilities. METHOD: Sixty-eight therapists working in an English Improving Access to Psychological Therapies (IAPT) service received one- or 2-day training on working with people with intellectual disabilities. Measures of confidence, general therapeutic self-efficacy and attitudes to people with intellectual disabilities' use of mainstream mental health services were completed pre-training, post-training and at 3-month follow-up; at which time, 12 participants were interviewed about the impact of the training on their practice. RESULTS: There was a significant positive change in all measures immediately post-training which was maintained at 3-month follow-up. CONCLUSIONS: Training considerations for mainstream therapists who may work with people with intellectual disabilities are discussed.

Dash, S. R., Meeten, F., Jones, F., et al. (2015). "Evaluation of a brief 4-session psychoeducation procedure for high worriers based on the mood-as-input hypothesis." J Behav Ther Exp Psychiatry **46**: 126-132.

> BACKGROUND & OBJECTIVES: Given the ubiquity of worrying as a consuming and distressing activity at both clinical and sub-clinical levels, it is important to develop theory-driven procedures that address worrying and allow worriers to manage this activity. This paper describes the development and testing of a psychoeducation procedure based on mood-as-input hypothesis, which is a transdiagnostic model that describes a proximal mechanism for perseverative worrying. The study used nonclinical participants meeting IAPT criteria indicating GAD symptomatology. METHODS: In 4 sessions, participants in experimental groups received psychoeducation about the basic principles of the mood-as-input hypothesis and received guidance on how to identify and change worry-relevant goal-directed decision rules and negative moods. Participants in the psychoeducation conditions were compared with participants in a befriending control group. RESULTS: Psychoeducation about the model significantly reduced PSWQ scores at follow-up compared with the befriending control condition (a between-groups large effect size, Cohen's d = 1.05), and the homework tasks undertaken by the psychoeducation groups raised mood and reduced worry immediately. At follow up 48.2% of participants in the psychoeducation groups were below the recommended cut-off for identifying GAD symptomatology compared with 20% of participants in the control condition. LIMITATIONS: This study was conducted on a small sample, high-worry student population, without a formal diagnosis. CONCLUSIONS: This brief, low-intensity procedure is potentially adaptable to online or self-help procedures, and can be integrated into fuller cognitive therapy packages.

Davies, F. (2014). "Viewpoint. The IAPT programme is providing results." Ment Health Today: 22.

de Lusignan, S., Chan, T. et Parry, G. (2012). "Referral to a new psychological therapy service is associated with reduced utilisation of healthcare and sickness absence by people with common mental health problems : : a before and after comparison." J Epidemiol Community Health. **66**(6).

> BACKGROUND: Improving Access to Psychological Therapies (IAPT) is a new programme designed to reduce disease burden to the individual and economic burden to the society of common mental health problems (CMHP). This is the first study to look at the impact of IAPT on health service utilisation and sickness absence using routine data. METHOD: The authors used pseudonymised secure and privately linked (SAPREL) routinely collected primary, secondary care and clinic computer data from two pilot localities. The authors explored antidepressant prescribing, accident and emergency and outpatients attendances, inpatient stays, bed days, and sick certification. The authors compared the registered population with those with CMHP. The authors then made a 6 months before and after comparison of people referred to IAPT with age–sex and practice-matched controls. RESULTS: People with CMHP used more health resources than those without CMHP: more prescriptions of antidepressants 5.25 (95 per cent CI 5.38 to 5.13), inpatient episodes 4.89 (95 per cent CI 5.0 to 4.79), occupied bed days 1.25 (95 per cent CI 0.95 to 1.55), outpatient 1.5 (95 per cent CI 1.40 to 1.63) and emergency department attendances 0.34 (95 per cent CI 0.31 to 0.37), and medical certificates 0.29 (95 per cent CI 0.26 to 0.32). Comparison of service utilisation 6 months before and after referral to IAPT was associated with reduced use of emergency department attendances (mean difference: 0.12 (95 per cent CI 0.06 to 0.19, p<0.001)). However, the number of prescriptions of antidepressants increased mean difference −0.15 (95 per cent CI 0.02–0.29, p=0.028). CONCLUSIONS: People with CMHP use more healthcare resources. Referral to the IAPT programme is associated with a subsequent reduction in emergency department attendances, sickness certification and improved adherence to drug treatment. [Abstract]

de Lusignan, S., Chan, T., Parry, G., et al. (2012). "Referral to a new psychological therapy service is associated with reduced utilisation of healthcare and sickness absence by people with common mental health problems: a before and after comparison." J Epidemiol Community Health **66**(6): e10.

> BACKGROUND: Improving Access to Psychological Therapies (IAPT) is a new programme designed to reduce disease burden to the individual and economic burden to the society of common mental health problems (CMHP). This is the first study to look at the impact of IAPT on health service utilisation and sickness absence using routine data. METHOD: The authors used pseudonymised secure and privately linked (SAPREL) routinely collected primary, secondary care and clinic computer data from two pilot localities. The authors explored antidepressant prescribing, accident and emergency and outpatients attendances, inpatient stays, bed days, and sick certification. The authors compared the registered population with those with CMHP. The authors then made a 6 months before and after comparison of people referred to IAPT with age-sex and practice-matched controls. RESULTS: People with CMHP used more health resources than those without CMHP: more prescriptions of antidepressants 5.25 (95% CI 5.38 to 5.13), inpatient episodes 4.89 (95% CI 5.0 to 4.79), occupied bed days 1.25 (95% CI 0.95 to 1.55), outpatient 1.5 (95% CI 1.40 to 1.63) and emergency department attendances 0.34 (95% CI 0.31 to 0.37), and medical certificates 0.29 (95% CI 0.26 to 0.32). Comparison of service utilisation 6 months before and after referral to IAPT was associated with reduced use of emergency department attendances (mean difference: 0.12 (95% CI 0.06 to 0.19, p<0.001)). However, the number of prescriptions of antidepressants increased mean difference -0.15 (95% CI 0.02-0.29, p=0.028). CONCLUSIONS: People with CMHP use more healthcare resources. Referral to the IAPT programme is associated with a subsequent reduction in emergency department attendances, sickness certification and improved adherence to drug treatment.

de Lusignan, S., Chan, T., Tejerina Arreal, M. C., et al. (2013). "Referral for psychological therapy of people with long term conditions improves adherence to antidepressants and reduces emergency department attendance: controlled before and after study." Behav Res Ther **51**(7): 377-385.

> BACKGROUND: Referral to psychological therapies is recommended for people with common mental health problems (CMHP) however its impact on healthcare utilisation in people with long term conditions (LTCs) is not known. METHOD: Routinely collected primary care, psychological therapy clinic and hospital data were extracted for the registered population of 20 practices (N = 121,199). These data were linked using the SAPREL (Secure and Private Record Linkage) method. We linked the 1118 people referred to psychological therapies with 6711 controls, matched for age, gender and

practice. We compared utilisation of healthcare resources by people with LTCs, 6 months before and after referral, and conducted a controlled before and after study to compare health utilisation with controls. We made the assumption that collection of a greater number of repeat prescriptions for antidepressants was associated with greater adherence. RESULTS: Overall 21.8% of people with an LTC had CMHP vs. 18.8% without (p < 0.001). People with LTCs before referral were more likely to use health care resources (2-tailed t-test p < 0.001). Cases with LTCs showed referral to the psychological therapies clinic was associated with increased antidepressant medication prescribing (mean differences 0.62, p < 0.001) and less use of emergency department than controls (mean difference -0.21, p = 0.003). CONCLUSIONS: Referral to improved access to psychological therapies (IAPT) services appears of value to people with LTC. It is associated with the issue of a greater number of prescriptions for anti-depressant medicines and less use of emergency services. Further studies are needed to explore bed occupancy and outpatient attendance.

Delgadillo, J., Asaria, M., Ali, S., et al. (2016). "On poverty, politics and psychology: the socioeconomic gradient of mental healthcare utilisation and outcomes." Br J Psychiatry **209**(5): 429-430.

Since 2008, the Improving Access to Psychological Therapies (IAPT) programme has disseminated evidence-based interventions for depression and anxiety problems. In order to maintain quality standards, government policy in England sets the expectation that 50% of treated patients should meet recovery criteria according to validated patient-reported outcome measures. Using national IAPT data, we found evidence suggesting that the prevalence of mental health problems is greater in poorer areas and that these areas had lower average recovery rates. After adjusting benchmarks for local index of multiple deprivation, we found significant differences between unadjusted (72.5%) and adjusted (43.1%) proportions of underperforming clinical commissioning group areas.

Delgadillo, J., McMillan, D., Leach, C., et al. (2014). "Benchmarking routine psychological services: a discussion of challenges and methods." Behav Cogn Psychother **42**(1): 16-30.

BACKGROUND: Policy developments in recent years have led to important changes in the level of access to evidence-based psychological treatments. Several methods have been used to investigate the effectiveness of these treatments in routine care, with different approaches to outcome definition and data analysis. AIMS: To present a review of challenges and methods for the evaluation of evidence-based treatments delivered in routine mental healthcare. This is followed by a case example of a benchmarking method applied in primary care. METHOD: High, average and poor performance benchmarks were calculated through a meta-analysis of published data from services working under the Improving Access to Psychological Therapies (IAPT) Programme in England. Pre-post treatment effect sizes (ES) and confidence intervals were estimated to illustrate a benchmarking method enabling services to evaluate routine clinical outcomes. RESULTS: High, average and poor performance ES for routine IAPT services were estimated to be 0.91, 0.73 and 0.46 for depression (using PHQ-9) and 1.02, 0.78 and 0.52 for anxiety (using GAD-7). Data from one specific IAPT service exemplify how to evaluate and contextualize routine clinical performance against these benchmarks. CONCLUSIONS: The main contribution of this report is to summarize key recommendations for the selection of an adequate set of psychometric measures, the operational definition of outcomes, and the statistical evaluation of clinical performance. A benchmarking method is also presented, which may enable a robust evaluation of clinical performance against national benchmarks. Some limitations concerned significant heterogeneity among data sources, and wide variations in ES and data completeness.

Delgadillo, J., Overend, K., Lucock, M., et al. (2017). "Improving the efficiency of psychological treatment using outcome feedback technology." Behav Res Ther **99**: 89-97.

AIMS: This study evaluated the impact of applying computerized outcome feedback (OF) technology in a stepped care psychological service offering low and high intensity therapies for depression and anxiety. METHODS: A group of therapists were trained to use OF based on routine outcome monitoring using depression (PHQ-9) and anxiety (GAD-7) measures. Therapists regularly reviewed

expected treatment response graphs with patients and discussed cases that were "not on track" in clinical supervision. Clinical outcomes data were collected for all patients treated by this group (N = 594), six months before (controls = 349) and six months after the OF training (OF cases = 245). Symptom reductions in PHQ-9 and GAD-7 were compared between controls and OF cases using longitudinal multilevel modelling. Treatment duration and costs were compared using MANOVA. Qualitative interviews with therapists (N = 15) and patients (N = 6) were interpreted using thematic analysis. RESULTS: OF technology was generally acceptable and feasible to integrate in routine practice. No significant between-group differences were found in post-treatment PHQ-9 or GAD-7 measures. However, OF cases had significantly lower average duration and cost of treatment compared to controls. CONCLUSIONS: After adopting OF into their practice, this group of therapists attained similar clinical outcomes but within a shorter space of time and at a reduced average cost per treatment episode. We conclude that OF can improve the efficiency of stepped care.

DepartmentofHealth (2007). Improving access to psychological therapies (IAPT) programme : computerised cognitive behavioural therapy (cCBT) implementation guidance. London : DH.

DepartmentofHealth (2007). Improving access to psychological therapies : positive practice guide. London : DH.

DepartmentofHealth (2010). Realising the benefits: the IAPT programme at full roll out. London, DH

Di Bona, L., Saxon, D., Barkham, M., et al. (2014). "Predictors of patient non-attendance at Improving Access to Psychological Therapy services demonstration sites." J Affect Disord **169**: 157-164.

BACKGROUND: Improving Access to Psychological Therapy (IAPT) services have increased the number of people with common mental health disorders receiving psychological therapy in England, but concerns remain about how equitably these services are accessed. METHOD: Using cohort patient data (N=363) collected as part of the independent evaluation of the two demonstration sites, logistic regression was utilised to identify socio-demographic, clinical and service factors predictive of IAPT non-attendance. RESULTS: Significant predictors of IAPT first session non-attendance by patients were: lower non-risk score on the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM); more frequent thoughts of "being better off dead" (derived from the CORE-OM); either a very recent onset of common mental health disorder (1 month or less) or a long term condition (more than 2 years); and site. LIMITATIONS: The small sample and low response rate are limitations, as the sample may not be representative of all those referred to IAPT services. The predictive power of the logistic regression model is limited and suggests other variables not available in the dataset may also be important predictors. CONCLUSIONS: The clinical characteristics of risk to self, severity of emotional distress, and illness duration, along with site, were more predictive of IAPT non-attendance than socio-demographic characteristics. Further testing of the relationship between these variables and IAPT non-attendance is recommended. Clinicians should monitor IAPT uptake in those they refer and implement strategies to increase their engagement with services, particularly when referring people presenting with suicidal ideation or more chronic illness.

Edginton, E., Walwyn, R., Burton, K., et al. (2017). "TIGA-CUB - manualised psychoanalytic child psychotherapy versus treatment as usual for children aged 5-11 years with treatment-resistant conduct disorders and their primary carers: study protocol for a randomised controlled feasibility trial." Trials **18**(1): 431.

BACKGROUND: The National Institute for Health and Care Excellence (NICE) recommends evidence-based parenting programmes as a first-line intervention for conduct disorders (CD) in children aged 5-11 years. As these are not effective in 25-33% of cases, NICE has requested research into second-line interventions. Child and Adolescent Psychotherapists (CAPTs) address highly complex problems where first-line treatments have failed and there have been small-scale studies of Psychoanalytic Child Psychotherapy (PCP) for CD. A feasibility trial is needed to determine whether a confirmatory trial of manualised PCP (mPCP) versus Treatment as Usual (TaU) for CD is practicable or needs refinement. The aim of this paper is to publish the abridged protocol of this feasibility trial. METHODS AND

> DESIGN: TIGA-CUB (Trial on improving Inter-Generational Attachment for Children Undergoing Behaviour problems) is a two-arm, pragmatic, parallel-group, multicentre, individually randomised (1:1) controlled feasibility trial (target n = 60) with blinded outcome assessment (at 4 and 8 months), which aims to develop an optimum practicable protocol for a confirmatory, pragmatic, randomised controlled trial (RCT) (primary outcome: child's behaviour; secondary outcomes: parental reflective functioning and mental health, child and parent quality of life), comparing mPCP and TaU as second-line treatments for children aged 5-11 years with treatment-resistant CD and inter-generational attachment difficulties, and for their primary carers. Child-primary carer dyads will be recruited following a referral to, or re-referral within, National Health Service (NHS) Child and Adolescent Mental Health Services (CAMHS) after an unsuccessful first-line parenting intervention. PCP will be delivered by qualified CAPTs working in routine NHS clinical practice, using a trial-specific PCP manual (a brief version of established PCP clinical practice). Outcomes are: (1) feasibility of recruitment methods, (2) uptake and follow-up rates, (3) therapeutic delivery, treatment retention and attendance, intervention adherence rates, (4) follow-up data collection, and (5) statistical, health economics, process evaluation, and qualitative outcomes. DISCUSSION: TIGA-CUB will provide important information on the feasibility and potential challenges of undertaking a confirmatory RCT to evaluate the effectiveness and cost-effectiveness of mPCP. TRIAL REGISTRATION: Current Controlled Trials, ID: ISRCTN86725795 . Registered on 31 May 2016.

Elison, S., Ward, J., Williams, C., et al. (2017). "Feasibility of a UK community-based, eTherapy mental health service in Greater Manchester: repeated-measures and between-groups study of 'Living Life to the Full Interactive', 'Sleepio' and 'Breaking Free Online' at 'Self Help Services'." BMJ Open **7**(7): e016392.

> OBJECTIVES: There is increasing evidence to support the effectiveness of eTherapies for mental health, although limited data have been reported from community-based services. Therefore, this service evaluation reports on feasibility and outcomes from an eTherapy mental health service. SETTING: 'Self Help Services', an Increasing Access to Psychological Therapies (IAPT) eTherapy service in Greater Manchester. PARTICIPANTS: 1068 service users referred to the service for secondary care for their mental health difficulties. INTERVENTIONS: Participants were triaged into one of three eTherapy programmes: 'Living Life to the Full Interactive' for low mood, stress and anxiety; 'Sleepio' for insomnia; and 'Breaking Free Online' for substance misuse, depending on clinical need. PRIMARY OUTCOMES MEASURES: Standardised psychometric assessments of depression, anxiety and social functioning, collected as part of the IAPT Minimum Data Set, were conducted at baseline and post-treatment. RESULTS: Data indicated baseline differences, with the Breaking Free Online group having higher scores for depression and anxiety than the Living Life to the Full Interactive (depression CI 1.27 to 3.21, p<0.0001; anxiety CI 077 to 1.72, p<0.0001) and Sleepio (depression CI 1.19 to 4.52, p<0.0001; anxiety CI 2.16 to 5.23, p<0.0001) groups. Promising improvements in mental health scores were found within all three groups (all p<0.0001), as were significant reductions in numbers of service users reaching clinical threshold scores for mental health difficulties (p<0.0001). Number of days of engagement was not related to change from baseline for the Living Life to the Full or Sleepio programmes but was associated with degree of change for Breaking Free Online. CONCLUSION: Data presented provide evidence for feasibility of this eTherapy delivery model in supporting service users with a range of mental health difficulties and suggest that eTherapies may be a useful addition to treatment offering in community-based services.

Evans, L., Green, S., Howe, C., et al. (2014). "Improving patient and project outcomes using interorganisational innovation, collaboration and co-design." London J Prim Care (Abingdon) **6**(2): 29-34.

> Background Common mental disorders (CMDs) are a leading cause of disability. The Department of Health has launched a large-scale initiative to improve access to evidence-based psychological treatments, such as cognitive behavioural therapy (CBT), through the Improving Access to Psychological Therapy (IAPT) programme. Access to IAPT services by black and minority ethnic (BME) communities is lower than for other groups. Setting The London Borough of Ealing in west London; a diverse borough with areas of high BME population and relatively high deprivation. Aim To compare

the outcomes of two linked quality improvement (QI) projects undertaken by Ealing Mental Health and Wellbeing Service (MHWBS), both with the same aim of increasing access to talking therapies for BME communities. Methods Application of QI methodologies supported by the NIHR CLAHRC for northwest London in two different settings in Ealing. One, the 'Southall project', was set within a wider initiative for collaborative improvements and shared learning (the Southall Initiative for Integrated Care) in an ethnically diverse area of Ealing; it was undertaken between April 2010 and September 2011. The second, 'the Ealing project', operated in the two other Ealing localities that did not have the advantage of a broader initiative for collaborative improvements; it was undertaken between April 2011 and September 2012. Results Comparison of the monthly referral rates of BME patients (standardised per 10 000 general practitioner (GP)-registered patients) show that the Southall project was more effective in increasing referrals from BME communities than the Ealing project. Conclusion Broad local participation and ownership in the project design of the Southall project may explain why it was more effective in achieving its aims than the Ealing project which lacked these ownership-creating mechanisms.

Evans, L., Green, S. et Sharma, K. (2014). "Improving access to primary mental health services : : are link workers the answer?" London J Prim Care (Abingdon) **6**(2): 23-28.

BACKGROUND: The incidences of common mental disorders such as anxiety, depression and low-level post-traumatic stress are associated with deprivation. Since 2007, the Improving Access to Psychological Therapy (IAPT) programme in Ealing has made it easier for primary care practitioners to refer patients with common mental disorders for treatment. However, fewer patients of a black and minority ethnic (BME) background were referred than expected. SETTING: Southall, Ealing, is a diverse ethnic community; over 70 per cent of the population is classified as having a BME background. AIM: To evaluate the effect of locating mental health link workers in general practitioners' (GP) surgeries on referral of BME patients to IAPT services. METHODS: In 2009, an initiative in Southall helped practitioners and managers that served geographic areas to work with many different agencies to improve whole systems of care. One strand of this work led to mental health link workers being placed in 6 of the 23 GP practices. They provided psychological therapy and raised awareness of common mental disorders in BME groups and what mental health services can do to improve these. Referrals to the service were monitored and assessed using statistical process control. RESULTS: The mean referral rate of BME patients for GP practices without a link worker was 0.35 per week per 10 000 patients and was unchanged throughout the period of the study. The referral rates for the six practices with a link worker increased from 0.65 to 1.37 referrals per week per 10 000 patients. CONCLUSIONS: Link workers located in GP practices, as part of a collaborative network of healthcare, show promise as one way to improve the care of patients with anxiety and depression from BME communities. [Abstract]

Evans, L., Green, S., Sharma, K., et al. (2014). "Improving access to primary mental health services: are link workers the answer?" London J Prim Care (Abingdon) **6**(2): 23-28.

Background The incidences of common mental disorders such as anxiety, depression and low-level post-traumatic stress are associated with deprivation. Since 2007, the Improving Access to Psychological Therapy (IAPT) programme in Ealing has made it easier for primary care practitioners to refer patients with common mental disorders for treatment. However, fewer patients of a black and minority ethnic (BME) background were referred than expected. Setting Southall, Ealing, is a diverse ethnic community; over 70% of the population is classified as having a BME background. Aim To evaluate the effect of locating mental health link workers in general practitioners' (GP) surgeries on referral of BME patients to IAPT services. Methods In 2009, an initiative in Southall helped practitioners and managers that served geographic areas to work with many different agencies to improve whole systems of care. One strand of this work led to mental health link workers being placed in 6 of the 23 GP practices. They provided psychological therapy and raised awareness of common mental disorders in BME groups and what mental health services can do to improve these. Referrals to the service were monitored and assessed using statistical process control. Results The mean referral rate of BME patients for GP practices without a link worker was 0.35 per week per 10 000 patients and was unchanged throughout the period of the study. The referral rates for the six practices with a link worker increased from 0.65 to 1.37 referrals per week per 10 000 patients. Conclusions Link workers located in GP practices, as part of a collaborative network of healthcare, show promise as one way to improve the care of patients with anxiety and depression from BME communities.

Farrand, P., Jeffs, A., Bloomfield, T., et al. (2018). "Mental health service acceptability for the armed forces veteran community." Occup Med (Lond) **68**(6): 391-398.

Background: Despite developments in mental health services for armed forces veterans and family members, barriers to access associated with poor levels of acceptability regarding service provision remain. Adapting a Step 2 mental health service based on low-intensity cognitive behavioural therapy (CBT) interventions to represent a familiar context and meet the needs of the armed forces veteran community may serve to enhance acceptability and reduce help-seeking barriers. Aims: To examine acceptability of a Step 2 low-intensity CBT mental health service adapted for armed forces veterans and family members provided by a UK Armed Forces charity. Methods: Qualitative study using individual semi-structured interviews with armed forces veterans and family members of those injured or becoming unwell while serving in the British Armed Forces. Data analysis was undertaken using thematic alongside disconfirming case analysis. Results: Adapting a Step 2 mental health service for armed forces veterans and family members enhanced acceptability and promoted help-seeking. Wider delivery characteristics associated with Step 2 mental health services within the Improving Access to Psychological Therapies (IAPT) programme also contributed to service acceptability. However, limitations of Step 2 mental health service provision were also identified. Conclusion: A Step 2 mental health service adapted for armed forces veterans and family members enhances acceptability and may potentially overcome help-seeking barriers. However, concerns remain regarding ways to accommodate the treatment of post-traumatic stress disorder and provide support for family members.

Firth, N., Barkham, M., Kellett, S., et al. (2015). "Therapist effects and moderators of effectiveness and efficiency in psychological wellbeing practitioners: A multilevel modelling analysis." Behav Res Ther **69**: 54-62.

OBJECTIVES: The study investigated whether psychological wellbeing practitioners (PWPs) working within the UK government's Improving Access to Psychological Therapies (IAPT) initiative are differentially effective (i.e., therapist effect size) and differentially efficient (i.e., rate of clinical change), and the moderating effect of demographic and process factors on outcomes. DESIGN AND METHODS: Routine clinical outcome data (depression, anxiety, and functional impairment) were collected from a single IAPT service. A total of 6111 patients were treated by 56 PWPs. Multilevel modelling (MLM) determined the size of the therapist effect and examined significant moderators of clinical outcomes. PWPs were grouped according to below average, average, and above average patient outcomes and compared on clinical efficiency. RESULTS: Therapist effects accounted for 6-7% of outcome variance that was moderated by greater initial symptom severity, treatment duration, and non-completion of treatment. Clinically effective PWPs achieved almost double the change per treatment session. As treatment durations increased beyond protocol guidance, outcomes atrophied. Treatment non-completion was particularly detrimental to outcome. CONCLUSIONS: PWPs appear to be differentially effective and efficient despite ostensibly delivering protocol driven interventions. Implications for services, training, and supervision are outlined.

Fonagy, P. et Clark, D. M. (2015). "Update on the Improving Access to Psychological Therapies programme in England: Commentary on ... Children and Young People's Improving Access to Psychological Therapies." BJPsych Bull **39**(5): 248-251.

Professor Sami Timimi recently expressed concerns about the Improving Access to Psychological Therapies (IAPT) programme. We argue that the concerns are largely unfounded and provide readers with an update on the programme.

French, L., Moran, P., Wiles, N., et al. (2019). "GPs' views and experiences of managing patients with personality disorder: a qualitative interview study." BMJ Open **9**(2): e026616.

> OBJECTIVE: The aim of this study was to explore GPs' views and experiences of managing patients with personality disorder (PD), and their views on the role of the Improving Access to Psychological Therapies (IAPT) programme as a support service. DESIGN: In-depth interviews, analysed thematically. PARTICIPANTS: Fifteen GPs (7 women and 8 men) of varying age and clinical experience, working in practices that differed in terms of the socio-demographic characteristics of their patient populations. SETTING: Twelve general practices based in the West of England, UK. RESULTS: GPs described patients with PD as being challenging to work with and that this work required dedicated time and care. They described experiencing particular difficulty with monitoring their patient's mental health, as well as having little knowledge about the efficacy or availability of treatments for their attenders with PD. They were aware that this patient population often experienced poor mental health and reported a propensity for them to fall into the gap between primary and secondary mental health services, leaving GPs with little choice but to improvise their own management plans, which occasionally involved funding third-sector treatment options. In terms of IAPT services' role in managing these patients, GPs wanted shorter waiting times, better inter-agency communication, more highly trained therapists and more treatment options for patients with PD. They also wanted the service to be able to 'hold' patients with PD in treatment over a longer period than currently offered. CONCLUSIONS: Findings suggest that, overall, GPs did not consider National Health Service mental health services to offer an effective treatment for patients with PD. While they considered the IAPT programme to be a valuable service for patients with less complex mental health needs, such as depression and anxiety; they felt that the current service provision struggled to meet the needs of patients with more complex mental health needs, as exemplified by people with PD.

Gebert, S. (2016). Psychological therapies : : annual report on the use of IAPT services : England 2015-16. Leeds :, NHS Digital
http://www.content.digital.nhs.uk/catalogue/PUB22110

> This statistical release is the fourth annual report on the Improving Access to Psychological Therapies (IAPT) programme, and covers activity, waiting times, and outcomes such as recovery. IAPT is run by the NHS in England and offers NICE-approved therapies for treating people with depression or anxiety

Gebert, S. (2017). Psychological therapies : : annual report on the use of IAPT services : England 2016-17. Leeds :, NHS Digital
http://www.digital.nhs.uk/catalogue/PUB30157

> The fifth annual report from the IAPT dataset provides national and CCG level information about psychological therapies services in England. The report includes information about recovery and waiting times

Georgiadis, A., Duschinsky, R., Perez, J., et al. (2018). "Coproducing healthcare service improvement for people with common mental health disorders including psychotic experiences: a study protocol of a multiperspective qualitative study." BMJ Open **8**(11): e026064.

> INTRODUCTION: Some people, who have common mental health disorders such as depression and anxiety, also have some psychotic experiences. These individuals may experience a treatment gap: their symptoms neither reach the increasingly high threshold for secondary care, nor do they receive full benefit from current interventions offered by the Improving Access to Psychological Therapies (IAPT) programme. The result may be poorer clinical and functional outcomes. A new talking therapy could potentially benefit this group. Informed by principles of coproduction, this study will seek the views of service users and staff to inform the design and development of such a therapy. METHODS AND ANALYSIS: Semistructured interviews will be conducted with IAPT service users, therapists and managers based in three different geographical areas in England. Our sample will include (1)

> approximately 15 service users who will be receiving therapy or will have completed therapy at the time of recruitment, (2) approximately 15 service users who initiated treatment but withdrew, (3) approximately 15 therapists each with at least 4-month experience in a step-3 IAPT setting and (4) three IAPT managers. Data analysis will be based on the constant comparative method. ETHICS AND DISSEMINATION: The study has been approved by the London Harrow Research Ethics Committee (reference: 18/LO/0642), and all National Health Service Trusts have granted permissions to conduct the study. Findings will be published in peer-reviewed academic journals, and presented at academic conferences. We will also produce a 'digest' summary of the findings, which will be accessible, visual and freely available.

Giebel, C. M., Clarkson, P. et Challis, D. (2014). "Demographic and clinical characteristics of UK military veterans attending a psychological therapies service." Psychiatr Bull (2014) **38**(6): 270-275.

> Aims and method To investigate the demographic and clinical characteristics of subgroups of UK veterans attending a dedicated psychological therapies service following the Improving Access to Psychological Therapies (IAPT) treatment model. Veterans accessing a newly established service in the north-west were categorised into three groups: early service leavers, those with a physical disability, and substance and/or alcohol misusers. Anxiety, depression and social functioning were measured pre- and post-treatment. Results Veterans vary in their demographic and clinical characteristics as well as in treatment efficacy, as measured by the post-treatment scores on probable depression and anxiety. Therapy appears to be most effective in early service leavers, whereas veterans with a physical disability or a substance or alcohol misuse problem tend not to do as well in terms of symptoms of depression or anxiety. Clinical implications This study highlights the importance of targeting different veteran subgroups for dedicated psychological therapy.

Goddard, E., Wingrove, J. et Moran, P. (2015). "The impact of comorbid personality difficulties on response to IAPT treatment for depression and anxiety." Behav Res Ther **73**: 1-7.

> UNLABELLED: The UK's Improving Access to Psychological Therapies (IAPT) initiative provides evidence-based psychological interventions for mild to moderate common mental health problems in a primary care setting. Predictors of treatment response are unclear. This study examined the impact of personality disorder status on outcome in a large IAPT service. We hypothesised that the presence of probable personality disorder would adversely affect treatment response. METHOD: We used a prospective cohort design to study a consecutive sample of individuals (n = 1249). RESULTS: Higher scores on a screening measure for personality disorder were associated with poorer outcome on measures of depression, anxiety and social functioning, and reduced recovery rates at the end of treatment. These associations were not confounded by demographic status, initial symptom severity nor number of treatment sessions. The presence of personality difficulties independently predicted reduced absolute change on all outcome measures. CONCLUSIONS: The presence of co-morbid personality difficulties adversely affects treatment outcome among individuals attending for treatment in an IAPT service. There is a need to routinely assess for the presence of personality difficulties on all individuals referred to IAPT services. This information will provide important prognostic data and could lead to the provision of more effective, personalised treatment in IAPT.

Gowling, S., Persson, J., Holt, G., et al. (2016). "Richmond Wellbeing Service Access Strategy for Older Adults." BMJ Qual Improv Rep **5**(1).

> IAPT (Improving Access to Psychological Therapies) is a national programme aimed at increasing availability of evidence based psychological therapies in the NHS. IAPT is primarily for people who have mild to moderate, common mental health difficulties such as depression, anxiety, phobias and post traumatic stress disorder (PTSD). The programme seeks to use the least intrusive method of care possible to treat people at the time when it will be of most help to them. Individuals are able to self-refer into most IAPT services or alternatively can request to be referred by their GP or other services in the community. Richmond Wellbeing Service (RWS) is one such IAPT Service and this research is based

on our work to promote accessibility of the service to one of the harder to reach population groups - older adults. We know that IAPT services could have a positive impact on older adults as it is believed on average, 25% of over 65 year olds face common mental health problems. However, only a third of these people discuss this with their GP and so are less likely to be referred to an IAPT Service. In relation to the above, this project was designed to look at increasing access for older adults into Richmond Wellbeing Service (RWS) specifically to improve access to the RWS by older adults by 100. The overall goal was to increase older adult (65+) referral rates by 20% over a year, in raw number this would translate to an increase of 100 over a year period, and in percentage terms an average of 8% of total referrals. Results yielded an increase of 39 referrals between baseline and test period. The majority of this increase had occurred in the final five months of the projects duration(31). Interestingly the number of older adults in the older age band (85+) almost doubled within this period (from 12 to 21). In total, in percentage terms this translates to an an increase of OA referrals from 6% up to 6.7%, as above we are aiming for 8% or an additional increase of 61 patients. Thus during the duration of the project there were signals of an increase in the desired direction, as the number of OA referrals increased following the period of time the interventions were implemented. However referral rates did not fully reach the target set. The authors concluded that sustainable and meaningful change in improving access for older adults into an IAPT service is possible but does take time. (Alongside the increase of referral a continous assessment of quality is required and where neccessary improve upon the appropriateness of the service offered to Older adults).

Grant, N., Hotopf, M., Breen, G., et al. (2014). "Predicting outcome following psychological therapy in IAPT (PROMPT): a naturalistic project protocol." BMC Psychiatry **14**: 170.

BACKGROUND: Depression and anxiety are highly prevalent and represent a significant and well described public health burden. Whilst first line psychological treatments are effective for nearly half of attenders, there remain a substantial number of patients who do not benefit. The main objective of the present project is to establish an infrastructure platform for the identification of factors that predict lack of response to psychological treatment for depression and anxiety, in order to better target treatments as well as to support translational and experimental medicine research in mood and anxiety disorders. METHODS/DESIGN: Predicting outcome following psychological therapy in IAPT (PROMPT) is a naturalistic observational project that began patient recruitment in January 2014. The project is currently taking place in Southwark Psychological Therapies Service, an Improving Access to Psychological Therapies (IAPT) service currently provided by the South London and Maudsley NHS Foundation Trust (SLaM). However, the aim is to roll-out the project across other IAPT services. Participants are approached before beginning treatment and offered a baseline interview whilst they are waiting for therapy to begin. This allows us to test for relationships between predictor variables and patient outcome measures. At the baseline interview, participants complete a diagnostic interview; are asked to give blood and hair samples for relevant biomarkers, and complete psychological and social questionnaire measures. Participants then complete their psychological therapy as offered by Southwark Psychological Therapies Service. Response to psychological therapy will be measured using standard IAPT outcome data, which are routinely collected at each appointment. DISCUSSION: This project addresses a need to understand treatment response rates in primary care psychological therapy services for those with depression and/or anxiety. Measurement of a range of predictor variables allows for the detection of bio-psycho-social factors which may be relevant for treatment outcome. This will enable future clinical decision making to be based on the individual needs of the patient in an evidence-based manner. Moreover, the identification of individuals who fail to improve following therapy delivered by IAPT services could be utilised for the development of novel interventions.

Green, H., Barkham, M., Kellett, S., et al. (2014). "Therapist effects and IAPT Psychological Wellbeing Practitioners (PWPs): a multilevel modelling and mixed methods analysis." Behav Res Ther **63**: 43-54.

The aim of this research was (a) to determine the extent of therapist effects in Psychological Wellbeing Practitioners (PWPs) delivering guided self-help in IAPT services and (b) to identify factors that defined effective PWP clinical practice. Using patient (N = 1122) anxiety and depression outcomes (PHQ-9 and GAD-7), the effectiveness of N = 21 PWPs across 6 service sites was examined using multi-level modelling. PWPs and their clinical supervisors were also interviewed and completed measures of ego strength, intuition and resilience. Therapist effects accounted for around 9 per cent of the variance in patient outcomes. One PWP had significantly better than average outcomes on both PHQ-9 and GAD-7 while 3 PWPs were significantly below average on the PHQ-9 and 2 were below average on the GAD-7. Computed PWP ranks identified quartile clusters of the most (N = 5) and least (N = 5) effective PWPs. More effective PWPs generated higher rates of reliable and clinically significant change and displayed greater resilience, organisational abilities, knowledge and confidence. Study weaknesses are identified and methodological considerations for future studies examining therapist effects in low intensity cognitive behaviour therapy are provided.

Green, S., Poots, A. et Marcano-Belisario, J. (2013). "Mapping mental health service access : : achieving equity through quality improvement." London Journal of Primary Care **6**(2): 23-28.

BACKGROUND: Improving access to psychological therapies (IAPTs) services deliver evidence-based care to people with depression and anxiety. A quality improvement (QI) initiative was undertaken by an IAPT service to improve referrals providing an opportunity to evaluate equitable access. METHODS: QI methodologies were used by the clinical team to improve referrals to the service. The collection of geo-coded data allowed referrals to be mapped to small geographical areas according to deprivation. RESULTS: A total of 6078 patients were referred to the IAPT service during the period of analysis and mapped to 120 unique lower super output areas (LSOAs). The average weekly referral rate rose from 17 during the baseline phase to 43 during the QI implementation phase. Spatial analysis demonstrated all 15 of the high deprivation/low referral LSOAs were converted to high deprivation/high or medium referral LSOAs following the QI initiative. CONCLUSION: This work highlights the importance of QI in developing clinical services aligned to the needs of the population through the analysis of routine data matched to health needs. Mapping can be utilized to communicate complex information to inform the planning and organization of clinical service delivery and evaluate the progress and sustainability of QI initiatives. [Abstract]

Green, S. A., Poots, A. J., Marcano-Belisario, J., et al. (2013). "Mapping mental health service access: achieving equity through quality improvement." J Public Health (Oxf) **35**(2): 286-292.

BACKGROUND: Improving access to psychological therapies (IAPTs) services deliver evidence-based care to people with depression and anxiety. A quality improvement (QI) initiative was undertaken by an IAPT service to improve referrals providing an opportunity to evaluate equitable access. METHODS: QI methodologies were used by the clinical team to improve referrals to the service. The collection of geo-coded data allowed referrals to be mapped to small geographical areas according to deprivation. RESULTS: A total of 6078 patients were referred to the IAPT service during the period of analysis and mapped to 120 unique lower super output areas (LSOAs). The average weekly referral rate rose from 17 during the baseline phase to 43 during the QI implementation phase. Spatial analysis demonstrated all 15 of the high deprivation/low referral LSOAs were converted to high deprivation/high or medium referral LSOAs following the QI initiative. CONCLUSION: This work highlights the importance of QI in developing clinical services aligned to the needs of the population through the analysis of routine data matched to health needs. Mapping can be utilized to communicate complex information to inform the planning and organization of clinical service delivery and evaluate the progress and sustainability of QI initiatives.

Gyani, A., Pumphrey, N., Parker, H., et al. (2012). "Investigating the use of NICE guidelines and IAPT services in the treatment of depression." Ment Health Fam Med **9**(3): 149-160.

Background There is evidence that the National Institute for Health and Clinical Excellence (NICE) guidelines for mental health disorders are used to varying degrees in primary care. A lack of access to cognitive-behavioural therapy (CBT) has been found to be a barrier to their implementation. The

Improving Access to Psychological Therapies (IAPT) initiative was created in 2007 to increase the availability of NICE-recommended psychological treatments for depression and anxiety disorders within the National Health Service in England. Aim This study aims to investigate whether general practitioners (GPs) who have access to IAPT services and use NICE guidelines are more likely to use NICE concordant treatments for depression than those who do not. Depression was chosen as it is the most common mental health problem facing primary care physicians. Method Questionnaires were sent to 830 GPs in southeast England and six GPs were interviewed. The response rate to the questionnaires was 27% (n = 222). Results Ninety-five per cent of GPs were aware of the NICE guidelines for depression, and 76% had read them. Concordance with the guidelines was significantly higher when GPs had access to a local IAPT service or had read the NICE guidelines. Conclusions The interviews revealed favourable views to IAPT services when used, although access to treatments was still a common barrier to the implementation of the NICE guidelines for depression.

Gyani, A., Shafran, R., Layard, R., et al. (2013). "Enhancing recovery rates: lessons from year one of IAPT." Behav Res Ther **51**(9): 597-606.

BACKGROUND: The English Improving Access to Psychological Therapies (IAPT) initiative aims to make evidence-based psychological therapies for depression and anxiety disorder more widely available in the National Health Service (NHS). 32 IAPT services based on a stepped care model were established in the first year of the programme. We report on the reliable recovery rates achieved by patients treated in the services and identify predictors of recovery at patient level, service level, and as a function of compliance with National Institute of Health and Care Excellence (NICE) Treatment Guidelines. METHOD: Data from 19,395 patients who were clinical cases at intake, attended at least two sessions, had at least two outcomes scores and had completed their treatment during the period were analysed. Outcome was assessed with the patient health questionnaire depression scale (PHQ-9) and the anxiety scale (GAD-7). RESULTS: Data completeness was high for a routine cohort study. Over 91% of treated patients had paired (pre-post) outcome scores. Overall, 40.3% of patients were reliably recovered at post-treatment, 63.7% showed reliable improvement and 6.6% showed reliable deterioration. Most patients received treatments that were recommended by NICE. When a treatment not recommended by NICE was provided, recovery rates were reduced. Service characteristics that predicted higher reliable recovery rates were: high average number of therapy sessions; higher step-up rates among individuals who started with low intensity treatment; larger services; and a larger proportion of experienced staff. CONCLUSIONS: Compliance with the IAPT clinical model is associated with enhanced rates of reliable recovery.

Hamilton, S., Hicks, A., Sayers, R., et al. (2011). A user-focused evaluation of IAPT services in London. Report for Commissioning Support for London. London : Commissioning Support for London. https://www.researchgate.net/profile/John_Larsen/publication/279694132_A_user-focused_evaluation_of_IAPT_services_in_London/links/5597bbc008ae21086d222659.pdf

Henfrey, H. (2015). "The Management of Patients with Depression In Primary Care: an Audit Review." Psychiatr Danub **27 Suppl 1**: S201-204.

AIMS AND METHODS: The IAPT scheme was introduced in 2007 to implement the recommendations from NICE guidelines regarding psychological therapy for depression. This retrospective audit carried out across two General Practice Surgeries evaluates the care being given in relation to the standards of NICE guidelines. RESULTS: Initial audit found variable concordance, however after discussion of this at a local audit meeting and the displaying of posters and leaflets detailing the IAPT scheme this was improved on re-audit. CLINICAL IMPLICATIONS: Training should be provided to General Practitioners regarding the standards of care for patients with low mood or depression. In this training there should be an emphasis on the role of psychological therapy and details given of local resources. Posters and leaflets should be clearly displayed to allow patients to self-refer to IAPT. A close watch must be given to waiting times for the IAPT service as demands increase.

HSCIC (2014). Psychological therapies : : annual report on the use of IAPT services : England 2013/14 : experimental statistics. Leeds :, Information Centre
http://www.hscic.gov.uk/catalogue/PUB14899/psyc-ther-ann-rep-2013-14.pdf
http://www.hscic.gov.uk/catalogue/PUB14899

HSCIC (2014). Psychological therapies, England : : annual report on the use of improving access to psychological therapies services : 2012/13 : experimental statistics. Leeds :, Information Centre
http://www.hscic.gov.uk/catalogue/PUB13339

HSCIC (2015). Psychological therapies, England : : annual report on the use of IAPT services : 2014/15. Leeds :, Information Centre
http://www.hscic.gov.uk/catalogue/PUB19098

IAPT (2011). The IAPT data handbook : : guidance on recording and monitoring outcomes to support local evidence-based practice : version 2.0. London : IAPT
https://webarchive.nationalarchives.gov.uk/20160302160058/http:/www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf

Johns, L., Jolley, S., Garety, P., et al. (2019). "Improving Access to psychological therapies for people with severe mental illness (IAPT-SMI): Lessons from the South London and Maudsley psychosis demonstration site." Behav Res Ther **116**: 104-110.

> Implementation of evidence-based cognitive behavioural therapy for psychosis (CBTp) remains low in routine services. The United Kingdom Improving Access to Psychological Therapies for people with Severe Mental Illness (IAPT-SMI) initiative aimed to address this issue. The project evaluated whether existing services could improve access to CBTp and demonstrate effectiveness using a systematic approach to therapy provision and outcome monitoring (in a similar way to the Improving Access to Psychological Therapies (IAPT) model for people with anxiety and depression). We report the clinical outcomes and key learning points from the South London and Maudsley NHS Foundation Trust IAPT-SMI demonstration site for psychosis. Additional funding enabled increased therapist capacity within existing secondary care community mental health services. Self-reported wellbeing and psychotic symptom outcomes were assessed, alongside service use and social/occupational functioning. Accepted referrals/year increased by 89% (2011/12: n=106/year; 2012-2015: n=200/year); 90% engaged (attended >/=5 sessions) irrespective of ethnicity, age and gender. The assessment protocol proved feasible, and pre-post outcomes (n=280) showed clinical improvements and reduced service use, with medium effects. We conclude that, with appropriate service structure, investment allocated specifically for competent therapy provision leads to increased and effective delivery of CBTp. Our framework is replicable in other settings and can inform the wider implementation of psychological therapies for psychosis.

Jolley, S., Garety, P., Peters, E., et al. (2015). "Opportunities and challenges in Improving Access to Psychological Therapies for people with Severe Mental Illness (IAPT-SMI): evaluating the first operational year of the South London and Maudsley (SLaM) demonstration site for psychosis." Behav Res Ther **64**: 24-30.

> Despite its demonstrated clinical and economic effectiveness, access to Cognitive Behavioural Therapy for psychosis (CBTp) in routine practice remains low. The UK National Health Service (NHS England) Improving Access to Psychological Therapies for people with Severe Mental Illness (IAPT-SMI) initiative aims to address this problem. We report 14-month outcomes for our psychosis demonstration site. Primary and secondary care and self-referrals were screened to check the suitability of the service for the person. Psychotic symptoms, distress, service use, functioning and satisfaction were measured before and after therapy, by trained assessors. User-defined wellbeing and goal-attainment were rated sessionally. Access to CBTp increased almost threefold (2011/12 accepted referrals/year n = 106; 2012/13, n = 300). The IAPT-SMI assessment protocol proved feasible and acceptable to service users, with paired primary outcomes for 97% of closed cases. Therapy completion (>/=5 sessions) was high

> (83%) irrespective of ethnicity, age and gender. Preliminary pre-post outcomes showed clinical improvement and reduced service use, with medium/high effect sizes. User-rated satisfaction was high. We conclude that individual psychological interventions for people with psychosis can be successfully delivered in routine services using an IAPT approach. High completion rates for paired outcomes demonstrate good user experience, clinical improvement, and potential future cost savings.

Jones, S. H., Akers, N., Eaton, J., et al. (2018). "Improving access to psychological therapies (IAPT) for people with bipolar disorder: Summary of outcomes from the IAPT demonstration site." Behav Res Ther **111**: 27-35.

> Access to structured psychological therapy recommended for bipolar disorder (BD) is poor. The UK NHS Improving Access to Psychological Therapies initiative commissioned a demonstration site for BD to explore the outcomes of routine delivery of psychological therapy in clinical practice, which this report summarises. All clinically diagnosed patients with BD who wanted a psychological intervention and were not in acute mood episode were eligible. Patients were offered a 10-session group intervention (Mood on Track) which delivered NICE congruent care. Outcomes were evaluated using an open (uncontrolled), pre-post design. Access to psychological therapy increased compared to preceding 6 years by 54%. 202 people began treatment; 81% completed >5 sessions; median 9 sessions (range 6-11). Pre-post outcomes included personal recovery (primary outcome), quality of life, work and social functioning, mood and anxiety symptoms (secondary outcomes). Personal recovery significantly improved from pre to post-therapy; medium effect-size (d=0.52). Secondary outcomes all improved (except mania symptoms) with smaller effect sizes (d=0.20-0.39). Patient satisfaction was high. Use of crisis services, and acute admissions were reduced compared to pre-treatment. It is possible to deliver group psychological therapy for bipolar disorder in a routine NHS setting. Improvements were observed in personal recovery, symptoms and wider functioning with high patient satisfaction and reduced service use.

Kellett, S., Simmonds-Buckley, M., Bliss, P., et al. (2017). "Effectiveness of Group Behavioural Activation for Depression: A Pilot Study." Behav Cogn Psychother **45**(4): 401-418.

> BACKGROUND: The evidence base for behavioural activation (BA) is mainly grounded in the individual delivery method, with much less known about the impact of group delivery. AIMS: To conduct a pilot study of behavioural activation in groups (BAG) for depression delivered in a routine service setting, in order to explore acceptability, effectiveness and predictors of outcome. METHODS: The manualized group treatment format was delivered in a Primary Care mental health setting, at step three of an Improving Access to Psychological Therapies (IAPT) service. BAG was facilitated by cognitive behavioural psychotherapists, and outcome measures (depression, anxiety and functional impairment) were taken at each session. Seventy-three participants were referred and treated within nine groups. RESULTS: BAG was an acceptable treatment generating a low drop-out rate (7%). Significant pre-post differences were found across all measures. There was a moderate to large depression effect size (d + = 0.74), and 20% met the criteria for a reliable recovery in depression. Greater severity of initial depression and attendance of at least four BAG sessions predicted better outcomes. CONCLUSIONS: BAG appears to be an effective depression treatment option that shows some clinical promise. Further larger and more controlled studies are nevertheless required.

Kendrick, T. (2018). "Improve access to quality primary care for patients with anxiety or depression." The Lancet **392**(10155): 1308.
http://www.sciencedirect.com/science/article/pii/S0140673618318889

Liness, S., Beale, S., Lea, S., et al. (2019). "Multi-professional IAPT CBT training: clinical competence and patient outcomes." Behav Cogn Psychother: 1-14.

> BACKGROUND: There is international interest in the training of psychological therapists to deliver evidence-based treatment for common mental health problems. The UK Improving Access to Psychological Therapies (IAPT) programme, one of the largest training initiatives, relies on competent

therapists to successfully deliver cognitive behaviour therapy (CBT) and promote good patient outcome. AIMS: To evaluate an IAPT CBT training course by assessing if trainees' clinical skills improve during training and reach competency standards, and to report patient outcome for submitted training cases. To investigate a possible relationship between trainee competence and patient outcome. To explore professional differences during training. METHOD: CBT trainee (n = 252) competence was assessed via audio recordings of therapy sessions at the beginning, middle and end of training. Patient pre- to post-treatment outcomes were extracted from submitted training cases (n = 1927). Differences in professional background were examined across competence, academic final grade and tutorial support. RESULTS: CBT trainees attained competence by the end of the course with 77% (anxiety recordings) and 72% (depression recordings) improving reliably. Training cases reported pre- to post-treatment effect sizes of 1.08-2.26 across disorders. CBT competence predicted a small variance in clinical outcome for depression cases. Differences in professional background emerged, with clinical psychologists demonstrating greater competence and higher academic grades. Trainees without a core professional background required more additional support to achieve competence. CONCLUSIONS: Part of a new CBT therapist workforce was successfully trained to deliver relatively brief treatment effectively. Trainees without a core profession can be successfully trained to competence, but may need additional support. This has implications for workforce training.

Liness, S., Lea, S., Nestler, S., et al. (2017). "What IAPT CBT High-Intensity Trainees Do After Training." Behav Cogn Psychother **45**(1): 16-30.

BACKGROUND: The UK Department of Health Improving Access to Psychological Therapies (IAPT) initiative set out to train a large number of therapists in cognitive behaviour therapies (CBT) for depression and anxiety disorders. Little is currently known about the retention of IAPT CBT trainees, or the use of CBT skills acquired on the course in the workplace after training has finished. AIMS: This study set out to conduct a follow-up survey of past CBT trainees on the IAPT High Intensity CBT Course at the Institute of Psychiatry, Psychology and Neuroscience (IoPPN), King's College London (KCL), one of the largest IAPT High Intensity courses in the UK. METHOD: Past trainees (n = 212) across 6 cohorts (2008-2014 intakes) were contacted and invited to participate in a follow-up survey. A response rate of 92.5% (n = 196) was achieved. RESULTS: The vast majority of IAPT trainees continue to work in IAPT services posttraining (79%) and to practise CBT as their main therapy modality (94%); 61% have become CBT supervisors. A minority (23%) have progressed to other senior roles in the services. Shortcomings are reported in the use of out-of-office CBT interventions, the use of disorder-specific outcome measures and therapy recordings to inform therapy and supervision. CONCLUSIONS: Past trainees stay working in IAPT services and continue to use CBT methods taught on the course. Some NICE recommended treatment procedures that are likely to facilitate patients' recovery are not being routinely implemented across IAPT services. The results have implications for the continued roll out of the IAPT programme, and other future large scale training initiatives.

Manning, C. (2009). "IAPT: help or hindrance to general practice?" London J Prim Care (Abingdon) **2**(1): 52-56.

KEY MESSAGES: IAPT needs to improve how it expresses itself to the outside world.Commissioning should be concerned with activities that develop and sustain trusting and therapeutic relationships as well as treat illnesses.Polyclinics should enable local people to collaborate and themselves improve their collective mental health.IAPT should enhance and not destabilise existing good practice. WHY THIS MATTERS TO ME: For years I have been working to improve mental health provision in primary care. IAPT is potentially a powerful device to make a quantum leap forward, leaving behind poor primary care practice that medicalises appropriate distress and responses to life, and building from the best.

Marks, D. F. (2018). "IAPT under the microscope." J Health Psychol **23**(9): 1131-1135.

England's flagship 'Improving Access to Psychological Therapies' (IAPT) service has cost around pound1 billion yet Scott's (2018a) study suggests that only 9.2% of IAPT patients recover. This leaves an enormous gap of 40.8% between the observed recovery rate and IAPT's claimed recovery rate of 50.0%. The spotlight is on patients with 'medically unexplained symptoms' (MUS) and 'long-term conditions' (LTCs) such as 'diabetes, COPD and ME/CFS, yet there is no way of knowing whether IAPT is capable of yielding the promised rewards or English patients are being sold an expensive pup. An urgent independent expert review of IAPT recovery rates is necessary to answer this question.

Marshall, D., Quinn, C., Byng, R., et al. (2016). "What IAPT services can learn from those who do not attend." Journal of Mental Health **25**(1): 410-415.

BACKGROUND: Rates of non-attendance within IAPT are 45-48 per cent. Non-attendance has negative implications for patients, staff and services. AIMS: This research aimed to identify service-related factors that contribute to non-attendance. METHOD: Qualitative interviews with 14 patients recruited from six IAPT services in the South West. These were individuals who, having been referred to IAPT, never attended, or only attended one treatment contact. They were interviewed face-to-face or by telephone using semi-structured interview schedules. The resulting data were analysed thematically through an iterative qualitative analysis using data mapping sheets. RESULTS: Five themes emerged from an analysis of the data including: the waiting process, the relationship between IAPT services and GPs, expectations of assessment and treatment, rigidity of service and practitioner contributions to the relationship. CONCLUSIONS: The analysis identifies ways in which IAPT services could reduce non-attendance. It also highlights areas of interest for future non-attendance in healthcare research, particularly collaborative care and protocolisation of treatment. [Abstract]

Marshall, D., Quinn, C., Child, S., et al. (2016). "What IAPT services can learn from those who do not attend." J Ment Health **25**(5): 410-415.

BACKGROUND: Rates of non-attendance within IAPT are 45-48%. Non-attendance has negative implications for patients, staff and services. AIMS: This research aimed to identify service-related factors that contribute to non-attendance. METHOD: Qualitative interviews with 14 patients recruited from six IAPT services in the South West. These were individuals who, having been referred to IAPT, never attended, or only attended one treatment contact. They were interviewed face-to-face or by telephone using semi-structured interview schedules. The resulting data were analysed thematically through an iterative qualitative analysis using data mapping sheets. RESULTS: Five themes emerged from an analysis of the data including: the waiting process, the relationship between IAPT services and GPs, expectations of assessment and treatment, rigidity of service and practitioner contributions to the relationship. CONCLUSIONS: The analysis identifies ways in which IAPT services could reduce non-attendance. It also highlights areas of interest for future non-attendance in healthcare research, particularly collaborative care and protocolisation of treatment.

Marwood, H., Chinn, D., Gannon, K., et al. (2018). "The experiences of high intensity therapists delivering cognitive behavioural therapy to people with intellectual disabilities." J Appl Res Intellect Disabil **31**(1): 76-86.

BACKGROUND: People with intellectual disabilities (ID) should be able to access the Improving Access to Psychological Therapies (IAPT) programme, currently a main provider of mainstream mental health services in England. IAPT offer cognitive behavioural therapy (CBT) to individuals experiencing mental health problems, although its effectiveness for people with ID, when delivered within IAPT, is unclear. METHOD: Ten high-intensity therapists took part in semi-structured interviews, analysed using thematic analysis, regarding their experiences of delivering CBT to people with ID in IAPT. RESULTS: The rigidity of the IAPT model appears to offer a poor fit with the needs of people with ID. Therapists appeared uncertain about how to modify CBT and highlighted training and service development needs. CONCLUSIONS: Findings suggest barriers to accessing IAPT largely remain unaddressed where people with ID are concerned. Services may need to reconsider what constitutes appropriate reasonable adjustments to ensure equitable access.

McCrae, N. (2015). "Vantage point - A private matter." Nurs Manag (Harrow) **22**(8): 17.

> IMAGINE THAT you have been struggling with depression and your doctor has referred you for cognitive behaviour therapy (CBT). Such treatment is provided on the NHS through the Improving Access to Psychological Therapies (IAPT) programme. But there is a catch; you have been placed on a three-month waiting list.

McCrone, P. (2013). "IAPT is probably not cost-effective." Br J Psychiatry **202**(5): 383.

McDevitt-Petrovic, O., Kirby, K., McBride, O., et al. (2018). "Preliminary Findings of a New Primary and Community Care Psychological Service in Northern Ireland: Low-Intensity Cognitive Behavioural Therapy for Common Mental Health Difficulties." Behav Cogn Psychother **46**(6): 761-767.

> BACKGROUND: The prevalence of mental health difficulties in Northern Ireland (NI) is significantly higher than in England. In recent years, there have been extensive consultations, and subsequent recommendations made in NI in an effort to address this. AIMS: The current study aims to evaluate the effectiveness of an 'Improving Access to Psychological Therapies' (IAPT) stepped care service model using low-intensity cognitive behavioural therapy (LI-CBT) in primary and community care settings. METHOD: A pilot intervention trial design utilized two standardized outcome measures (PHQ-9 and GAD-7) before treatment (at baseline), during treatment (in every session) and at discharge (at final session). RESULTS: Preliminary reliable change outcomes for the pilot cohorts showed a recovery rate of 47.9%, improvement rate of 76.7% and deterioration rate of 6%. CONCLUSIONS: These findings suggest that the IAPT service model is clinically effective in the NI population. Data collection for the larger study was completed in December 2017. Future analyses will include follow-up data collected at 4 months post-treatment, and will also aim to identify individual and service level factors that potentially impact treatment effectiveness.

Mind (2010). We need to talk: getting the right therapy at the right time. London, Mind
http://www.mind.org.uk/media/280583/We-Need-to-Talk-getting-the-right-therapy-at-the-right-time.pdf

Mukuria, C., Brazier, J., Barkham, M., et al. (2013). "Cost-effectiveness of an improving access to psychological therapies service." Br J Psychiatry **202**(3): 220-227.

> BACKGROUND: Effective psychological therapies have been recommended for common mental health problems, such as depression and anxiety, but provision has been poor. Improving Access to Psychological Therapies (IAPT) may provide a cost-effective solution to this problem. AIMS: To determine the cost-effectiveness of IAPT at the Doncaster demonstration site (2007-2009). METHOD: An economic evaluation comparing costs and health outcomes for patients at the IAPT demonstration site with those for comparator sites, including a separate assessment of lost productivity. Sensitivity analyses were undertaken. RESULTS: The IAPT site had higher service costs and was associated with small additional gains in quality-adjusted life-years (QALYs) compared with its comparator sites, resulting in a cost per QALY gained of pound29 500 using the Short Form (SF-6D). Sensitivity analysis using predicted EQ-5D scores lowered this to pound16 857. Costs per reliable and clinically significant (RCS) improvement were pound9440 per participant. CONCLUSIONS: Improving Access to Psychological Therapies provided a service that was probably cost-effective within the usual National Institute for Health and Clinical Excellence (NICE) threshold range of pound20 000-30 000, but there was considerable uncertainty surrounding the costs and outcome differences.

Newbold, A., Hardy, G. et Byng, R. (2013). "Staff and patient experience of improving access to psychological therapy group interventions for anxiety and depression." Journal of Mental Health **22**(5): 456-464.

> BACKGROUND: The improving access to psychological therapy (IAPT) initiative aims to provide widespread evidence-based psychological treatments for common mental health problems in the UK. Individual services have implemented National Institute for Clinical Excellence guidelines in various ways; some provide group-based therapy, whilst others do not. AIMS: The study investigates how

patients and staff experience group-based therapy, what they find helpful and where improvements can be made. METHOD: Forty-five semi-structured interviews were undertaken with staff and patients in three IAPT services. Framework analysis was used to analyse comments relating to patient experience in group-based treatment. RESULTS: The study found that patients can feel isolated with their symptoms and group-based interventions can normalise the illness, reducing stress. Individuals experience benefits and, in some cases, difficulties, in different ways. Some patients hear of the strategies that others have found useful, and observe others' progress, which may bring hope for their own recovery. CONCLUSIONS: IAPT group-based interventions appear to aid recovery in different ways to one-to-one therapy, by normalising mental illness and increasing social contact. Greater understanding of the factors operating in group-based interventions might increase attendance and recovery facilitated by IAPT group interventions. [Abstract]

NHS (2008). Improving access to psychological therapies: Outcomes toolkit 2008-2009. London : NHS**:** 84p.
http://ipnosis.postle.net/PDFS/iapt-outcomes-toolkit-2008-november%282%29.pdf

The IAPT [Improving Access to Psychological Therapies] Programme is driven by increased investment, rising to £173 million over three years for psychological therapies, and aims to change services for people with depression and anxiety disorders. Strategic health authorities [SHAs] will establish a major training programme to expand the psychological therapists workforce. There will be a gradual expansion of the services, in a small number of PCTs at first, to provide on-the-job training for the workforce. SHAs will decide how to allocate funding in the first year in conjunction with the Care Services Improvement Partnership and the Department of Health. Some of the benefits of a psychological therapies service include: (1) a significant positive impact on the health and well-being of people with long-term conditions (2) savings from inappropriate referrals to acute physical care (3) Psychological therapies can be provided outside of hospitals, in or near people's homes, GP practices, job centres and other community settings. [Summary]

NHS (2015). Improving Access to Psychological Therapies (IAPT) waiting times guidance and FAQ's. London :, NHS England
https://www.england.nhs.uk/wp-content/uploads/2015/02/iapt-wait-times-guid.pdf

NHS (2016). 2015 adult IAPT workforce census report. London :, NHS England
https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/09/adult-iapt-workforce-census-report-15.pdf
https://www.england.nhs.uk/mentalhealth/adults/iapt/workforce/

NHS (2017). Developing an outcomes-based payment approach for IAPT services : detailed guidance. London :NHS England, , NHS
https://improvement.nhs.uk/documents/491/Developing_a_capitated_payment_approach_for_mental_health_FINAL.pdf

This guidance provides details on the new outcomes-based payment approach for IAPT services. This new approach will balance the need to pay for activity, taking into account case complexity and severity as a driver of cost, with the need to incentivise good outcomes. It builds on the IAPT model and the data that all providers of IAPT services are required to collect and submit to the national IAPT minimum dataset.

NHS (2018). The Improving Access to Psychological Therapies (IAPT) pathway for people with long-term physical health conditions and medically unexplained symptoms. London :, NHS England
https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-iapt-pathway-for-people-with-long-term-physical-health-conditions-and-medically-unexplained-symptoms/

NHS (2018). The Improving Access to Psychological Therapies manual. Leeds :, NHS England
https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/

This manual is for all commissioners, providers and clinicians of services that deliver psychological therapies. It serves as an essential manual for IAPT services, describing the IAPT model in detail and how to deliver it, with a focus on the importance of providing National Institute for Health and Care Excellence (NICE)-recommended care

NHS Digital (2018). Psychological therapies : : annual report on the use of IAPT services : England : 2017-18. Leeds :, NHS Digital
https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2017---18

This report examines activity, waiting times and outcomes in the Improving Access to Psychological Therapies (IAPT) programme from 1 st April 2017 to 31st March 2018.IAPT is run by the NHS in England and offers NICE-approved therapies for treating people with depression or anxiety.

NHS Digital (2018). Psychological therapies : : annual report on the use of IAPT services : England : further analyses on 2016-17. Leeds :, NHS Digital
http://www.digital.nhs.uk/catalogue/PUB30232

This report examines activity, waiting times and outcomes in the Improving Access to Psychological Therapies (IAPT) programme from 1 st April 2016 to 31st March 2017.IAPT is run by the NHS in England and offers NICE-approved therapies for treating people with depression or anxiety.

NMHDU (2011). Improving access to psychological therapies IAPT: guidance for commissioning IAPT training 2011/12 – 2014/15. London, NMHDU

NMHDU (2012). IAPT three-year report : : the first million patients. London :, DH
https://www.uea.ac.uk/documents/246046/11919343/IAPT+3+year+report.+The+first+million+patiets.pdf/0e0469ff-0884-4203-99de-4b61601e69dd

Parry, G., Barkham, M., Brazier, J., et al. (2011). An evaluation of a new service model: Improving Access to Psychological Therapies demonstration sites 2006-2009, Final Report. London : NIHR Service Delivery and Organisation programme.

This report describes an evaluation of the first two demonstration sites for the Improving Access to Psychological Therapies (IAPT) programme. The descriptive question: What form do the services take, how are they organised, whom do they see, what is the patient pathway and how many people are seen? The patient experience question: What is the experience of patients using the system and how satisfied are they with it? What lessons can be learned from their experience to improve services? The organisational question: What are the workforce implications of establishing an IAPT service, and what lessons on implementation and feasibility can be learned from the demonstration sites? The efficacy question: What improvements in mental health and functioning seem to follow from the implementation of an IAPT service? How do these improvements compare to those achieved historically, to those reported in randomised trials and other investigations, and to those achieved in comparable NHS mental health services? The effectiveness question: Do the new services perform any better than existing services in matched locations for the same client group? If so, is the improvement cost effective (or conversely, can the services achieve comparable outcomes at lower unit cost?)

Perez, J., Russo, D. A., Stochl, J., et al. (2018). "Common mental disorder including psychotic experiences: Trailblazing a new recovery pathway within the Improving Access to Psychological Therapies programme in England." Early Interv Psychiatry **12**(3): 497-504.

Psychotic experiences, depressive and anxiety symptoms may be manifestations of a latent continuum of common mental distress. The Improving Access to Psychological Therapies (IAPT) programme has

increased the reach of psychological treatments to people with common mental disorders in England. However, psychotic experiences are neither measured nor considered in therapy. We aimed to confirm the presence of psychotic experiences among IAPT service-users and determine whether these experiences are associated with higher depression/anxiety levels and poorer recovery. All service-users that attended the Fenland and Peterborough IAPT teams in Cambridgeshire between November 16, 2015 and January 29, 2016 participated in a service evaluation. In addition to routine mesures, such as the Generalized Anxiety Disorder-7 questionnaire (GAD-7) and the Patient Health Questionnaire-9 (PHQ-9), we introduced a shortened version of the Community Assessment of Psychic Experiences (CAPE-P15) to measure psychotic experiences. Classes of individuals were identified with latent class analysis. Associations were reported using Pearson correlation coefficient. One hundred and seventy-three services-users were included, mostly females (N = 133; 76.9%). The mean age was 36.6 (SD = 13.3). Around 30% likely belonged to a class with psychotic experiences. CAPE-P15 frequency was significantly correlated to PHQ-9 (r = 0.44; P < .001) and GAD-7 (r = 0.32; P < .001). Similarly, CAPE-P15 distress and both PHQ-9 (r = 0.43; P < .001) and GAD-7 (r = 0.38; P < .001) were highly correlated. These associations were replicated after the initial period of the therapy, indicating poor recovery. Some IAPT service-users suffer psychotic experiences. Tailoring available evidence-based psychological therapies for these people in IAPT settings might trailblaze a new care pathway to improve recovery in this group.

Pickersgill, M. (2019). "Access, accountability, and the proliferation of psychological therapy: On the introduction of the IAPT initiative and the transformation of mental healthcare." Soc Stud Sci: 306312719834070.

Psychological therapy today plays a key role in UK public mental health. In large part, this has been through the development of the (specifically English) Improving Access to Psychological Therapies (IAPT) programme. Through IAPT, millions of citizens have encountered interventions such as cognitive behaviour therapy, largely for the treatment of depression and anxiety. This article interrogates how this national response to problems of mental ill-health - and the problematization itself - was developed, accounted for, and sustained. By imbricating economic expertise with accounts of mental ill-health and mechanisms of treatment, IAPT has revivified psychological framings of pathology and therapy. However, it has done so in ways that are more familiar within biomedical contexts (e.g. through recourse to randomized controlled trial studies). Today, the initiative is a principal player in relation to which other services are increasingly developed. Indeed, in many respects IAPT has transformed from content to context within UK public mental health (in a process of what I term 'contextification'). By documenting these developments, this paper contributes to re-centring questions about the place and role of psychology in contemporary healthcare. Doing so helps to complicate assumptions about the dominance of linear forms of (de)biomedicalization in health-systems.

Prina, A. M., Marioni, R. E., Hammond, G. C., et al. (2014). "Improving access to psychological therapies and older people: findings from the Eastern Region." Behav Res Ther **56**: 75-81.

BACKGROUND: Evaluations of the Improving Access to Psychological Therapies (IAPT) scheme have not yet focused on minority subgroups. This paper aims to evaluate accessibility, waiting times and clinical outcomes of IAPT for older adults. METHODS: All referrals from six Primary Care Trusts (PCT) in the East of England were used in this analysis. During each session, the therapist recorded information on anxiety symptoms using the Generalised Anxiety Disorder Questionnaire (GAD-7) and depressive symptoms with the Patient Health Questionnaire (PHQ-9). Waiting times, type of referrals and reliable recovery rates were investigated. RESULTS: Older adults accounted for only 4% of all the IAPT referrals made between September 2008 and July 2010 in the Eastern Region. Waiting times for both IAPT assessment and treatment were slightly lower for older adult. In all centres, reliable recovery rates were higher in older adults compared to younger adults post-treatment, however these differences were not significant, with the exception of a difference in anxiety scores (chi(2)(1) = 18.6, p < 0.001). In multivariate analyses, being an older adult was associated with recovery for depression (OR = 1.30, 95% CI 1.10-1.53), anxiety (OR = 1.42, 95% CI 1.21-1.66), and overall recovery (OR = 1.31, 95% CI 1.10-1.54) after adjustment for gender, PCT region, baseline score, maximum treatment step during treatment, dropping out, and number of sessions. CONCLUSIONS: The IAPT services were shown to be beneficial to older patients, however, access to these services in later life has been lower than expected. The service pathway for older populations needs to be better researched in order to eliminate possible obstacles in accessing services.

Pybis, J., Saxon, D., Hill, A., et al. (2017). "The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2(nd) UK National Audit of psychological therapies." BMC Psychiatry **17**(1): 215.

BACKGROUND: Cognitive Behaviour Therapy (CBT) is the front-line psychological intervention for step 3 within UK psychological therapy services. Counselling is recommended only when other interventions have failed and its effectiveness has been questioned. METHOD: A secondary data analysis was conducted of data collected from 33,243 patients across 103 Improving Access to Psychological Therapies (IAPT) services as part of the second round of the National Audit of Psychological Therapies (NAPT). Initial analysis considered levels of pre-post therapy effect sizes (ESs) and reliable improvement (RI) and reliable and clinically significant improvement (RCSI). Multilevel modelling was used to model predictors of outcome, namely patient pre-post change on PHQ-9 scores at last therapy session. RESULTS: Counselling received more referrals from patients experiencing moderate to severe depression than CBT. For patients scoring above the clinical cut-off on the PHQ-9 at intake, the pre-post ES (95% CI) for CBT was 1.59 (1.58, 1.62) with 46.6% making RCSI criteria and for counselling the pre-post ES was 1.55 (1.52, 1.59) with 44.3% of patients meeting RCSI criteria. Multilevel modelling revealed a significant site effect of 1.8%, while therapy type was not a predictor of outcome. A significant interaction was found between the number of sessions attended and therapy type, with patients attending fewer sessions on average for counselling [M = 7.5 (5.54) sessions and a median (IQR) of 6 (3-10)] than CBT [M = 8.9 (6.34) sessions and a median (IQR) of 7 (4-12)]. Only where patients had 18 or 20 sessions was CBT significantly more effective than counselling, with recovery rates (95% CIs) of 62.2% (57.1, 66.9) and 62.4% (56.5, 68.0) respectively, compared with 44.4% (32.7, 56.6) and 42.6% (30.0, 55.9) for counselling. Counselling was significantly more effective at two sessions with a recovery rate of 34.9% (31.9, 37.9) compared with 22.2% (20.5, 24.0) for CBT. CONCLUSIONS: Outcomes for counselling and CBT in the treatment of depression were comparable. Research efforts should focus on factors other than therapy type that may influence outcomes, namely the inherent variability between services, and adopt multilevel modelling as the given analytic approach in order to capture the naturally nested nature of the implementation and delivery of psychological therapies. It is of concern that half of all patients, regardless of type of intervention, did not show reliable improvement.

Radhakrishnan, M., Hammond, G., Jones, P. B., et al. (2013). "Cost of improving Access to Psychological Therapies (IAPT) programme: an analysis of cost of session, treatment and recovery in selected Primary Care Trusts in the East of England region." Behav Res Ther **51**(1): 37-45.

Recent literature on Improving Access to Psychological Therapies (IAPT) has reported on improvements in clinical outcomes, changes in employment status and the concept of recovery attributable to IAPT treatment, but not on the costs of the programme. This article reports the costs associated with a single session, completed course of treatment and recovery for four treatment courses (i.e., remaining in low or high intensity treatment, stepping up or down) in IAPT services in 5 East of England region Primary Care Trusts. Costs were estimated using treatment activity data and gross financial information, along with assumptions about how these financial data could be broken down. The estimated average cost of a high intensity session was pound177 and the average cost for a low intensity session was pound99. The average cost of treatment was pound493 (low intensity), pound1416 (high intensity), pound699 (stepped down), pound1514 (stepped up) and pound877 (All). The cost per recovered patient was pound1043 (low intensity), pound2895 (high intensity), pound1653 (stepped down), pound2914 (stepped up) and pound1766 (All). Sensitivity analysis revealed that the costs are sensitive to cost ratio assumptions, indicating that inaccurate ratios are likely to influence overall estimates. Results indicate the cost per session exceeds previously reported estimates, but cost of treatment is only marginally higher. The current cost estimates are supportive of the originally proposed IAPT model on cost-benefit grounds. The study also provides a framework to estimate costs using financial data, especially when programmes have block contract arrangements. Replication and additional analyses along with evidence-based discussion regarding alternative, cost-effective methods of intervention is recommended.

Richards, D., Duffy, D., Blackburn, B., et al. (2018). "Digital IAPT: the effectiveness & cost-effectiveness of internet-delivered interventions for depression and anxiety disorders in the Improving Access to Psychological Therapies programme: study protocol for a randomised control trial." BMC Psychiatry **18**(1): 59.

BACKGROUND: Depression and anxiety are common mental health disorders worldwide. The UK's Improving Access to Psychological Therapies (IAPT) programme is part of the National Health Service (NHS) designed to provide a stepped care approach to treating people with anxiety and depressive disorders. Cognitive Behavioural Therapy (CBT) is widely used, with computerised and internet-delivered cognitive behavioural therapy (cCBT and iCBT, respectively) being a suitable IAPT approved treatment alternative for step 2, low- intensity treatment. iCBT has accumulated a large empirical base for treating depression and anxiety disorders. However, the cost-effectiveness and impact of these interventions in the longer-term is not routinely assessed by IAPT services. The current study aims to evaluate the clinical and cost-effectiveness of internet-delivered interventions for symptoms of depression and anxiety disorders in IAPT. METHODS: The study is a parallel-groups, randomised controlled trial examining the effectiveness and cost-effectiveness of iCBT interventions for depression and anxiety disorders, against a waitlist control group. The iCBT treatments are of 8 weeks duration and will be supported by regular post-session feedback by Psychological Wellbeing Practitioners. Assessments will be conducted at baseline, during, and at the end of the 8-week treatment and at 3, 6, 9, and 12-month follow-up. A diagnostic interview will be employed at baseline and 3-month follow-up. Participants in the waitlist control group will complete measures at baseline and week 8, at which point they will receive access to the treatment. All adult users of the Berkshire NHS Trust IAPT Talking Therapies Step 2 services will be approached to participate and measured against set eligibility criteria. Primary outcome measures will assess anxiety and depressive symptoms using the GAD-7 and PHQ-9, respectively. Secondary outcome measures will allow for the evaluation of long-term outcomes, mediators and moderators of outcome, and cost-effectiveness of treatment. Analysis will be conducted on a per protocol and intention-to-treat basis. DISCUSSION: This study seeks to evaluate the immediate and longer-term impact, as well as the cost effectiveness of internet-delivered interventions for depression and anxiety. This study will contribute to the already established literature on internet-delivered interventions worldwide. The study has the potential to show how iCBT can enhance service provision, and the findings will likely be generalisable to other health services. TRIAL REGISTRATION: Current Controlled Trials ISRCTN ISRCTN91967124. DOI: https://doi.org/10.1186/ISRCTN91967124 . Web: http://www.isrctn.com/ISRCTN91967124 . Clinicaltrials.gov : NCT03188575. Trial registration date: June 8, 2017 (prospectively registered).

Ruprah-Shah, B. (2009). "Setting up an IAPT site: the Ealing Mental Health & Well-Being Service." London J Prim Care (Abingdon) **2**(1): 57-60.

KEY MESSAGE: IAPT will succeed or fail on the extent to which it enables partnerships. WHY THIS MATTERS TO ME: For years I have been working to integrate mental health services in Ealing. Improving Access to Psychological Therapies (IAPT) offers the best chance I have ever known to achieve this, and to make a coordinated impact on the health of the people of Ealing. IAPT is an exciting opportunity for us in Ealing and we have grabbed it with both hands. We are incorporating it into our beliefs, values and passion to produce a service that will reflect our vision for holistic primary care services. A service which is financially sound. A service which does not believe that there is one answer to everyone's mild to moderate mental health problems. A service which recognises that working in silos is detrimental to our patients' health. A service which is constantly striving to improve relationships with our partners. A service which is mindful about the people we see, and the staff who see them.

NHS (2010). Commissioning talking therapies for 2011/12. [London], [IAPT]
https://www.uea.ac.uk/documents/246046/11991919/commissioning-talking-therapies-for-201112.pdf/50bdc585-3637-4edc-8baa-84f3c6e0b5d1

Scott, M. J. (2018). "Improving Access to Psychological Therapies (IAPT) - The Need for Radical Reform." J Health Psychol **23**(9): 1136-1147.

Improving Access to Psychological Therapies is a UK government-funded initiative to widen access to the psychological treatment of depression and anxiety disorders. The author has had the opportunity to independently assess 90 Improving Access to Psychological Therapies clients, using a standardised semi-structured interview, the Structured Clinical Diagnostic Interview for DSM Disorders (SCID) and to listen to their account of interaction with the service. The results suggest that only the tip of the iceberg fully recovers from their disorder (9.2%) whether or not they were treated before or after a personal injury claim. There is a pressing need to re-examine the modus operandi of the service.

Scott, M. J. (2018). "Transforming Improving Access to Psychological Therapies." J Health Psychol **23**(9): 1163-1172.

The three commentaries on my paper 'IAPT - The Need for Radical Reform' are agreed that Improving Access to Psychological Therapies cannot be regarded as the 'gold standard' for the delivery of psychological therapy services. Furthermore, they agreed that Improving Access to Psychological Therapies should not continue to mark its 'own homework' and should be subjected to rigorous independent evaluation scrutiny. It is a matter for a public enquiry to ascertain why pound1 billion has been spent on Improving Access to Psychological Therapies without any such an independent evaluation. What is interesting is that nocommentary has been forthcoming from the UK Improving Access to Psychological Therapies service nor have they shared a platform to discuss these issues. It is regrettable that the UK Government's National Audit Office has chosen, to date, not to publish its own investigation into the integrity of Improving Access to Psychological Therapies data. Openness would be an excellent starting point for the necessary transformation of Improving Access to Psychological Therapies.

Serfaty, M., King, M., Nazareth, I., et al. (2016). "The clinical and cost effectiveness of cognitive behavioural therapy plus treatment as usual for the treatment of depression in advanced cancer (CanTalk): study protocol for a randomised controlled trial." Trials **17**(1): 113.

BACKGROUND: The prevalence of depressive disorder in adults with advanced cancer is around 20 %. Although cognitive behavioural therapy (CBT) is recommended for depression and may be beneficial in depressed people with cancer, its use for depression in those with advanced disease for whom cure is not likely has not been explored. METHODS: People aged 18 years and above with advanced cancer attending General Practitioner (GP), oncology or hospice outpatients from centres across England will be screened to establish a DSM-IV diagnosis of depression. Self-referral is also accepted. Eligible consenters will be randomised to a single blind, multicentre, randomised controlled trial of the addition to treatment as usual (TAU) of up to 12 one-hour weekly sessions of manualised CBT versus TAU alone. Sessions are delivered in primary care through Increasing Access to Psychological Care (IAPT) service, and the manual includes a focus on issues for people approaching the end of life. The main outcome is the Beck Depression Inventory-II (BDI-II). Subsidiary measures include the Patient Health Questionnaire, quality of life measure EQ-5D, Satisfaction with care, Eastern Cooperative Oncology Group-Performance Status and a modified Client Service Receipt Inventory. At 90 % power, we require 240 participants to enter the trial. Data will be analysed using multi-level (hierarchical) models for data collected at baseline, 6, 12, 18 and 24 weeks. Cost effectiveness analysis will incorporate costs related to the intervention to compare overall healthcare costs and QALYs between

> the treatment arms. We will conduct qualitative interviews after final follow-up on patient and therapist perspectives of the therapy. DISCUSSION: This trial will provide data on the clinical and cost effectiveness of CBT for people with advanced cancer and depression. We shall gain an understanding of the feasibility of delivering care to this group through IAPT. Our findings will provide evidence for policy-makers, commissioners and clinicians in cancer and palliative care, and in the community. TRIAL REGISTRATION: Controlled Trials ISRCTN07622709 , registered 15 July 2011.

Shepherd, M. et Rosairo, M. (2008). "Low-intensity workers: lessons learned from supervising primary care mental health workers and dilemmas associated with such roles." Ment Health Fam Med **5**(4): 237-245.

> The UK government's latest primary care mental health initiative, Improving Access to Psychological Therapies (IAPT), seeks to achieve its aims partly through the extensive use of low-intensity workers (LIWs). As clinical supervisors to teams of primary care mental health workers (PCMHWs) already offering brief, evidence-based interventions in primary care mental health services, we draw on the growing body of literature and our own experience to discuss dilemmas associated with the roles of such workers. These concern clinical governance, training, supervision and integration into existing services. We discuss how IAPT service characteristics may provide solutions to some of these dilemmas. We argue that it is unlikely they will be completely resolved and that IAPT services, in addressing future challenges, could benefit from lessons learned from the PCMHW role.

Sreeharan, V., Madden, H. et Lee, J. T. (2013). "Improving access to psychological therapies and antidepressant prescribing rates in England : : a longitudinal time-series analysis." British Journal of General Practice. **63**(614): 478-479.

> BACKGROUND: Antidepressant prescribing rates in England have been increasing since the 1970s. The impact of the Improving Access to Psychological Therapies (IAPT) initiative on antidepressant prescribing rates is unknown. AIM: To investigate the impact of the establishment of IAPT services on antidepressant prescribing rates in primary care trusts (PCTs) in England. DESIGN AND SETTING: A longitudinal time-series analysis, using PCT-level data from 2008 to 2011 set in England. METHOD: A time-series analysis was conducted using PCT-level prescription data, dates of establishment of IAPT services, and covariate data for age, sex, and socioeconomic status. Statistical analysis was carried out using analysis of variance and a random-effect negative binomial model. RESULTS: Antidepressant prescribing rates in England increased by 10 per cent per year during the study period (adjusted rate ratio = 1.10, 95 per cent CI = 1.09 to 1.10). The implementation of IAPT services had no significant effect on antidepressant prescribing (adjusted rate ratio = 0.99, 95 per cent CI = 0.99 to 1.00). CONCLUSION: Introduction of a large-scale initiative to increase provision of psychological therapies has not curbed the long-term increased prescribing of antidepressants in England. [Abstract]

Steadman, K. et Thomas, R. (2015). An evaluation of the 'IPS in IAPT' psychological wellbeing and work feasibility pilot. London, The Work Foundation
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/415177/IPS_in_IAPT_Report.pdf
https://www.gov.uk/government/publications/helping-people-with-mental-health-problems-find-work

Sweeney, A., Clement, S., Gribble, K., et al. (2019). "A systematic review of qualitative studies of adults' experiences of being assessed for psychological therapies." Health Expect **22**(2): 133-148.

> OBJECTIVE: To synthesize the qualitative literature on adults' experiences of psychological therapy assessments. The review was led by people with experience of undergoing assessments, with high levels of client involvement throughout. SEARCH STRATEGY: A comprehensive search of electronic databases was undertaken, with additional search strategies employed to locate further literature. INCLUSION CRITERIA: Studies were included that qualitatively explored the experiences of people aged 16+ who had been assessed for psychological therapy services. Assessments could be structured or unstructured. Qualitative was defined as any analysed account of people's experiences, including

> qualitative survey data. DATA EXTRACTION AND SYNTHESIS: Literature quality was appraised using the Critical Appraisal Skills Program checklist, modified to include client involvement and intersectionalities. Following data extraction, thematic synthesis was used to synthesize findings across studies. RESULTS: Of 12 743 titles were screened, with 13 studies relevant to the review. Themes and subthemes were identified at three stages of the assessment process: the journey to the assessment, at the assessment, and after the assessment. Findings highlighted the emotional impact of assessments, collaboration, intersectionalities, rights, pathologization, socioeconomic restrictions, and information and support needs. Implications and limitations were indicated. DISCUSSION AND CONCLUSIONS: Findings were situated within the trauma-informed (TIA) literature. Trauma-informed assessment principles, including collaborative assessments, may be fruitful means of improving people's experiences. Whilst the benefits of collaboration appear self-evident, explicitly collaborative approaches were not the norm, nor were studies conducted independently. Further service user research is needed. A greater understanding of the experience of minority groups is also needed.

Thornicroft, G. (2011). "A new mental health strategy for England." BMJ **342**: d1346.

Thornicroft, G. (2018). "Improving access to psychological therapies in England." Lancet **391**(10121): 636-637.

Timimi, S. (2015). "Children and Young People's Improving Access to Psychological Therapies: inspiring innovation or more of the same?" BJPsych Bull **39**(2): 57-60.

> In 2007 the UK Government announced a substantial expansion of funding for psychological therapies for those presenting with common mental health problems. This 'Improving Access to Psychological Therapies' (IAPT) project was widely welcomed, however, evidence backed, economic, and conceptual critiques were voiced from the start and the project remains controversial. In 2011, the UK government announced it was extending the IAPT project to encompass services for children and young people with the aim of 'transforming' the way mental health services are delivered to them. Here I critically reflect on the problems associated first with IAPT and then with CYP-IAPT and ponder whether CYP-IAPT is significantly different to the problematic adult IAPT project or more of the same.

Timimi, S. (2015). "Update on the Improving Access to Psychological Therapies programme in England: author's reply." BJPsych Bull **39**(5): 252-253.

> Fonagy & Clark confirm in their rebuttal that they have an ideological commitment to the failed technical model of understanding and intervening in mental health problems that dominates current service provision. They fail to acknowledge the limitations and problems associated with Improving Access to Psychological Therapies (IAPT) and Children's and Young People's IAPT (CYP-IAPT) and offer an unconvincing explanation for why they did not allow some of the vast tax payers' money that they had at their dispoal to be used to implement evidence supported relational models.

Vail, L., Adams, A. et Gilbert, E. (2012). "Investigating mental health risk assessment in primary care and the potential role of a structured decision support tool, GRiST." Mental Health in Family Medicine **9**(1).

> AIM: To explore current risk assessment processes in general practice and Improving Access to Psychological Therapies (IAPT) services, and to consider whether the Galatean Risk and Safety Tool (GRiST) can help support improved patient care. BACKGROUND: Much has been written about risk assessment practice in secondary mental health care, but little is known about how it is undertaken at the beginning of patients' care pathways, within general practice and IAPT services. METHODS: Interviews with eight general practice and eight IAPT clinicians from two primary care trusts in the West Midlands, UK, and eight service users from the same region. Interviews explored current practice and participants' views and experiences of mental health risk assessment. Two focus groups were also carried out, one with general practice and one with IAPT clinicians, to review interview findings and to elicit views about GRiST from a demonstration of its functionality. Data were analysed using thematic analysis. FINDINGS: Variable approaches to mental health risk assessment were observed. Clinicians

were anxious that important risk information was being missed, and risk communication was undermined. Patients felt uninvolved in the process, and both clinicians and patients expressed anxiety about risk assessment skills. Clinicians were positive about the potential for GRiST to provide solutions to these problems. CONCLUSIONS: A more structured and systematic approach to risk assessment in general practice and IAPT services is needed, to ensure important risk information is captured and communicated across the care pathway. GRiST has the functionality to support this aspect of practice. [Abstract]

Vasiliadis, H. M. et Dezetter, A. (2015). "Les programmes de prise en charge financière des psychothérapies en Australie et en Angleterre. In : Améliorer l'accès aux psychothérapies au Québec et au Canada Expériences de pays francophones." Sante Ment Que **40**(4): 101-118.
https://www.researchgate.net/profile/Martin_Grosse_Holtforth/publication/301905621_La_psychotherapie_psychologique_en_Suisse_vers_la_transparence_et_la_qualite/links/57fb7cda08ae8da3ce60fa2d/La-psychotherapie-psychologique-en-Suisse-vers-la-transparence-et-la-qualite.pdf#page=17

L'article décrit les programmes de prise en charge financière des psychothérapies en Australie et en Angleterre. Au début des années 2000, le gouvernement australien a implanté une réforme de santé publique visant à permettre un meilleur accès, gratuit ou peu coûteux, aux psychothérapies brèves, en soin primaire, pour les personnes souffrant de troubles mentaux courants. Cette réforme reconnaît l'importance du rôle du médecin généraliste dans la prise en charge des troubles, et la collaboration avec les professionnels de santé mentale. Deux programmes ont été mis en œuvre : Access to Allied Psychological Services en 2003 et Better Access en 2006. En 2009, deux millions d'Australiens ont reçu onze millions de séances de psychothérapies. Les études ont montré des résultats positifs sur l'amélioration de l'accès aux soins de santé mentale primaires et sur la santé des patients. L'Angleterre a mis en place le programme Improving Access to psychological Therapies en 2007 en offrant un service de psychothérapies brèves pour les personnes souffrant de troubles mentaux courants. Le modèle de soin en étape suit les guides cliniques du National Institute for Health and Clinical Excellence, le type de professionnel (counselor ou psychothérapeute formés), le nombre de séances (4 à 13) et la méthode thérapeutique varient selon la sévérité du trouble. Un million de patients ont été traités depuis le début du programme. Les études ont aussi montré des résultats de santé positifs pour les patients du programme. En conclusion les programmes de prise en charge des psychothérapies s'avèrent coûts-efficaces.

Vasiliadis, H. M. et Dezetter, A. (2015). "[Publicly funded programs of psychotherapy in Australia and England]." Sante Ment Que **40**(4): 101-118.

Quebec's HealthCommissioner on the performance of the health system clearly highlighted gaps in the collaboration between primary care physicians and mental health specialists, decreased accessibility and inequity in access to effective mental health services such as psychotherapy.Objectives The aim of this article was to describe the implementation of two publicly funded programs of psychotherapy in Australia and England with similar gatekeeper systems to the one in Quebec.Findings Following the Access to Allied Psychological Services (ATAPS) program introduced in Australia in 2003, one of the most important initiatives from the Council of Australian Governments' National Action Plan on Mental Health 2006-2011 was the Better Access Initiative which commenced in 2006. The plan included AUD1.2 billion in funding for integrating and improving the mental health care system. The purpose of Better Access was to improve the treatment and management of mental illnesses and increasing community access to mental health professionals and providing more affordable mental health care. GPs were encouraged to work more closely with mental health professionals. Under this program, these professionals are able to provide mental health services on a fee-for-service basis subsidized through Medicare. Access to psychological therapies is provided through private providers, rather than through fund holding arrangements. As of 2009 in Australia, 2 million people (1 in 11) had received over 11.2 million subsidized mental health services. A recent study showed clinical improvements in patients with depression associated with Better Access, concluding that the program is meeting previously unmet mental health needs.In the case of England, the IAPT - Improving Access to psychological Therapies-program enabled primary care trusts (PCTs) to implement evidence-based psychological therapies as recommended by National Institute for Health and Clinical Excellence for people suffering from depression and anxiety. In October 2007, the Secretary of State for Health announced additional funds totalling pound173 million between 2008 and 2011 that would be used to deliver a major training program that would build a skilled workforce of qualified psychological therapists in 4 therapy areas for adults and children: cognitive behaviour therapy; psychodynamic psychoanalytic therapy; systemic and family therapy; humanistic therapy. The main goals of the program were to have: (i) 3,600 newly trained therapists with an appropriate skill mix and supervision arrangements; (ii) 900,000 more people treated; (iii) 50% of people who leave treatment are recovered; (iv) 25,000 fewer people on sick pay and benefits.Conclusion To date, the results in both countries have shown clinical improvements in symptoms associated with depression and anxiety for people entering the programs and at a population level, decreasing the unmet mental health needs of the population by allowing self-referrals to the program, and therefore rendering access to services to populations otherwise not reached.

Waltman, S. H. (2018). "Attempting to reconcile large differences in Improving Access to Psychological Therapies recovery rates." J Health Psychol **23**(9): 1153-1158.

The Improving Access to Psychological Therapies initiative has a reported 50 percent recovery rate. Recently, Scott published a scathing report asserting that 9.2 percent is the correct rate. This alarming assertion requires a closer look and further scrutiny of the Improving Access to Psychological Therapies. Scott's study is fundamentally flawed in many ways; chiefly, the small (n = 87), forensically involved, convenience sample is not representative of the Improving Access to Psychological Therapies population. Scott's study is more a limited-scope non-representative-sampled audit (or pilot study audit) of the Improving Access to Psychological Therapies. Given the large amount of public funds involved in the project, further research and a high degree of transparency is warranted.

Williams, C. H. (2015). "Improving access to psychological therapies (IAPT) and treatment outcomes: epistemological assumptions and controversies." J Psychiatr Ment Health Nurs **22**(5): 344-351.

Cognitive behaviour therapy (CBT) is recommended as a primary treatment choice in England, for anxiety and depression, by the National Institute for Health and Care Excellence (NICE). It has been argued that CBT has enjoyed political and cultural dominance and this has arguably led to maintained government investment in England for the cognitive and behavioural treatment of mental health problems. The government programme 'Improving Access to Psychological Therapies' (IAPT) aims to improve the availability of CBT. The criticism of the NICE evidence-based guidelines supporting the IAPT programme, has been the dominance of the gold standard randomized controlled trial methodology, with a focus on numerical outcome data, rather than a focus on a recovery narrative. RCT-based research is influenced by a philosophical paradigm called positivism. The IAPT culture is arguably influenced by one research paradigm and such an influence can skew services only towards numerical outcome data as the only truth of 'recovery'. An interpretative paradigm could assist in shaping service-based cultures, alter how services are evaluated and improve the richness of CBT research. This paper explores the theory of knowledge (epistemology) that underpins the evidence-based perspective of CBT and how this influences service delivery. The paper argues that the inclusion of service user narrative (qualitative data) can assist the evaluation of CBT from the user's perspective and can understand the context in which people live and how they access services. A qualitative perspective is discussed as a research strategy, capturing the lived experience of under-represented groups, such as sexual, gender and ethnic minorities. Cognitive behaviour therapy (CBT) has enjoyed political and cultural dominance within mental healthcare, with renewed government investment in England for the'Improving Access to Psychological Therapies' (IAPT) programme. The criticism of the evidence-based guidelines, published by the National Institute for Health and Care Excellence (NICE), which supports the IAPT programme has been the dominance of the gold standard randomized controlled trial methodology. The definition of 'recovery' used by IAPT is based on a positivist position, with a focus on numerical outcome data garnered through psychometric measures. An interpretative perspective of recovery, which would include a subjective individual patient/service user narrative and would include a collaborative qualitative dialogue, is arguably absent from the IAPT programme. The challenge inherent in the IAPT programme is the high demand/high turnover culture, and psychometric measures are quick to administer; however, this culture is driven from one research paradigm. An interpretative paradigm may assist in shaping service-based cultures, alter how services are evaluated, and improve the richness of CBT research.

Wroe, A. L., Rennie, E. W., Gibbons, S., et al. (2015). "IAPT and Long Term Medical Conditions: What Can We Offer?" Behav Cogn Psychother **43**(4): 412-425.

BACKGROUND: The proposal of a 4-year plan to integrate treatment of people with long term medical conditions (LTCs) into the IAPT service (Department of Health, 2011) seeks for research to understand the effectiveness of IAPT interventions for this patient group. AIM: The aim of this service development pilot work was to develop an intervention that is effective for people with Type 2 Diabetes Mellitus (T2DM). It was hypothesized that the standard IAPT intervention would not be effective, but that it can be adapted so that it is effective both in terms of mood and self-management of T2DM. METHOD: Clients (n = 95) who experienced mild to moderate depression and/or anxiety and had a diagnosis of T2DM opted to attend. The intervention was adapted over a series of cohorts from a standard Step 2 intervention. A team of Psychological Wellbeing Practitioners (PWPs), a Clinical Health Psychologist and a General Practitioner worked in collaboration, using outcomes measures and feedback from service users and facilitators. RESULTS: The standard IAPT Step 2 intervention met with challenges when specifically targeting this client group. Using paired t-tests, the modified Step 2 intervention demonstrated significant improvements from pre- to postintervention measures both in terms of psychological (n = 17) and physical (n = 9) outcomes. CONCLUSION: It is concluded that it may be possible to modify a generic Step 2 IAPT intervention to demonstrate improvements both in terms of psychological wellbeing and self-management of T2DM. The main adaptations were related to more targeted recruitment and linking of diabetes specifically into the CBT model.

York, A., Layard, R. et Zwi, M. (2009). Improving Tier 3 CAMHS, drawing on IAPT experience. London : LSE. http://cep.lse.ac.uk/textonly/_new/staff/layard/pdf/RL540AImproving-tier-3-CAMHS.pdf

Young, A., Rogers, K., Davies, L., et al. (2017). Health Services and Delivery Research. Evaluating the effectiveness and cost-effectiveness of British Sign Language Improving Access to Psychological Therapies: an exploratory study. Southampton (UK), NIHR Journals Library

BACKGROUND: Improving Access to Psychological Therapies (IAPT) is a National Institute for Health and Care Excellence-approved approach to intervention for depression and/or anxiety. This exploratory study sets the groundwork for comparing psychological therapies for Deaf sign language users experiencing anxiety and/or depression, delivered in British Sign Language (BSL) by a Deaf therapist with usual access through an interpreter within the IAPT national programme. OBJECTIVES: (1) To explore the following questions: (a) is BSL-IAPT more effective than standard IAPT for Deaf people with anxiety and/or depression? and (b) is any additional benefit from BSL-IAPT worth any additional cost to provide it? (2) To establish relevant BSL versions of assessment tools and methods to answer research questions (a) and (b). (3) To gauge the feasibility of a larger-scale definitive study and to inform its future design. DESIGN: A mixed-methods exploratory study combing an economic model to synthesise data from multiple sources; a qualitative study of understanding and acceptability of randomisation and trial terminology; statistical determination of clinical cut-off points of standardised assessments in BSL; secondary data analysis of anonymised IAPT client records; realist inquiry incorporating interviews with service providers and survey results. SETTINGS: IAPT service providers (NHS and private); the Deaf community. PARTICIPANTS: Deaf people who use BSL and who are clients of IAPT services (n = 502); healthy Deaf volunteers (n = 104); IAPT service providers (NHS and private) (n = 118). INTERVENTIONS: IAPT at steps 2 and 3. MAIN OUTCOME MEASURES: Reliable recovery and reliable improvement defined by IAPT; Deaf community views on the acceptability of randomisation; BSL terminology for trial-related language; clinical cut-off measurements for the BSL versions of the Patient Health Questionnaire-9 items (PHQ-9) and the Generalised Anxiety Disorder-7 (GAD-7); a valid BSL version of the EuroQol-5 Dimensions five-level version (EQ-5D-5L); costs, quality-adjusted life-years and incremental cost-effectiveness ratios. DATA SOURCES: IAPT service provider anonymised records of the characteristics and clinical outcomes of Deaf BSL users of BSL-IAPT and of standard IAPT; published literature. RESULTS: Randomisation may be acceptable to Deaf people who use IAPT if linguistic and cultural requirements are addressed. Specifications for effective information in BSL for recruitment have been established. A valid EQ-5D-5L in BSL has been produced. The clinical cut-off point for the GAD-7 BSL is 6 and for the PHQ-9 BSL is 8. No significant difference in rates of reliable recovery and reliable improvement between Deaf users of standard IAPT or BSL-IAPT has been found. Whether or not BSL-IAPT is more cost-effective than standard IAPT is uncertain. LIMITATIONS: The small number of participating standard IAPT services who have seen Deaf clients means that there is statistical uncertainty in the comparable clinical outcome result. Clinical cut-off scores have not been verified through gold standard clinical interview methodology. Limited data availability means that whether or not BSL-IAPT is more cost-effective than standard IAPT is uncertain. CONCLUSIONS: There is a lack of evidence to definitively compare reliable recovery and reliable improvement between Deaf users of standard IAPT and BSL-IAPT. Instrumentation and prerequisites for a larger-scale study have been established. FUTURE WORK: A prospective observational study for definitive results is justified. FUNDING: The National Institute for Health Research Health Services and Delivery Research programme.

Zala, D., Brabban, A., Stirzaker, A., et al. (2019). "The Cost-Effectiveness of the Improving Access to Psychological Therapies (IAPT) Programme in Severe Mental Illness: A Decision Analytical Model Using Routine Data." Community Ment Health J.

This is the first site level economic evaluation of the Improving Access to Psychological Therapies programme for severe mental illness (IAPT-SMI) that is funded by NHS England. It also aims to illustrate the challenges involved in evaluations based on routine data with low internal validity. Six IAPT-SMI pilot sites treated 1 of 2 clinical groups: (i) psychosis or bipolar disorder; (ii) personality disorder. A decision analytical model nested in a before-after framework- the same patients 12 months after treatment versus 12 months before treatment-was used to compare the cost-effectiveness of IAPT-SMI with treatment as usual (TAU). IAPT-SMI appears to be more costly overall but save non-psychological treatment costs. There is evidence it may improve function and lower incidence of harmful behaviour. However, there is a need for evaluations with a more conventional study design that measure a more comprehensive array of resource use and clinical outcomes.

Les dispositifs en vigueur en France

L'Assurance maladie a lancé deux expérimentations relatives à la psychothérapie comme alternatives à la prescription médicamenteuse. La première expérimentation, lancée en 2017, concerne la prise en charge psychique des jeunes de 11 à 21 ans, qui peuvent se voir rembourser des consultations psychologiques dans la limite d'un forfait (Décret n° 2017-813 du 5 mai 2017 relatif aux expérimentations visant à organiser la prise en charge de la souffrance psychique des jeunes ; complété par l'arrêté du 19 décembre 2017 et selon l'article 68 de la loi n° 2016-1827 du 23 décembre 2016 de financement de la sécurité sociale pour 2017). La seconde porte sur la prise en charge des troubles psychiques d'intensité légère à modérée chez l'adulte. Déployé depuis l'automne 2017 dans quatre départements français (Bouches-du-Rhône, Haute-Garonne, Landes et Morbihan), ce dispositif est inscrit dans le Plan National de Santé Publique « Prévention pour lutter contre les inégalités de santé » et sera expérimenté durant trois ans. Une de cette expérimentation, incluant un volet médico-économique, sera réalisée, afin de mettre en évidence l'impact de cette prise en charge, en particulier en termes de retour à l'emploi et de moindre consommation d'indemnités journalières maladie.

Bachelart, M. (2017). "L'intégration des psychothérapies : pourquoi ce rendez-vous manqué en France ?" L'Évolution Psychiatrique **82**(4): 829-842.
http://www.sciencedirect.com/science/article/pii/S001438551730021X

> Dans cet article est retracée une partie de l'histoire de l'intégration en psychothérapie. C'est une thématique qui a vu le jour dès les années 1930 aux États-Unis et elle est devenue une thématique de recherche importante à partir des années 1980. Néanmoins elle ne semble pas être une préoccupation française. Ce champ de recherche et de réflexion, qui prend racine aux États-Unis, nourrit une vision commune du soin qui ne serait pas celle de notre pays. Méthode Nous tenterons de réfléchir sur cette impossibilité française d'interroger en profondeur et sur le long terme nos pratiques sous l'angle des psychothérapies intégratives qui n'est toujours pas un champ de réflexion ou de recherche universitaire. Pour cela, nous croiserons des éléments historiques et philosophiques provenant des États-Unis et de la France concernant le développement de la psychanalyse et des psychothérapies ainsi que leurs transformations ou intégration. Résultats Des différences philosophiques et culturelles semblent expliquer cette absence de productions mais également la place d'un comportementalisme américain ayant traduit les concepts analytiques puis humanistes. Discussion Dans notre pays, nos formations universitaires, la peur de l'influence du thérapeute et la vision de la psychothérapie (place du sujet, fonction et sens du symptôme) selon la psychanalyse et la phénoménologie clinique sont des explications à notre interrogation. Conclusion Nous pensons qu'une réflexion à propos de l'intégration des psychothérapies permettrait de pouvoir aborder différemment les relations entre la clinique et les théories. Cela permettrait également d'avoir un regard d'ensemble sur les psychothérapies, au lieu d'interroger individuellement chaque école, apportant ainsi une vision critique et épistémologique.

Bradley, S., Doucet, R., Kohler, E. et Drapeau, M. (2015). "Accessibilité à la psychothérapie subventionnée par l'État : comparaisons entre les perspectives des psychologues et des psychothérapeutes." Sante Ment Que **40**(4): 175-200.
https://id.erudit.org/iderudit/1036099ar

> L'amélioration de l'accès aux traitements en santé mentale est depuis longtemps une priorité tant au Québec que sur la scène canadienne et internationale. Des initiatives pour accroître l'accès à la psychothérapie subventionnée par l'État ont entre autres été mises de l'avant en Australie et au Royaume-Uni. La présente étude a visé à documenter comment les psychologues et les psychothérapeutes se distinguent dans leurs attitudes quant aux différents aspects qui définissent ces programmes d'accès à la psychothérapie subventionnée par l'État. Les participants (N = 1 275) ont été recrutés par courriel et invités à remplir une série de questionnaires en ligne, lesquels portaient

notamment sur : les différents services et modalités de service qui devraient être assurés par l'État ; le rôle et l'autonomie des cliniciens si les services de psychothérapie devaient être assurés par l'État ; les tarifs, les modalités de remboursement et les conditions de travail des cliniciens. Les résultats indiquent que les psychothérapeutes valorisent davantage la thérapie de couple et familiale, l'aide à l'emploi et l'orientation professionnelle que les psychologues. Quant à ces derniers, ils valorisent davantage l'utilisation de pratiques fondées sur des données probantes ainsi que le suivi en continu des résultats du traitement, et la publication du niveau de satisfaction quant aux traitements reçus par la clientèle desservie. Des différences entre les deux groupes ont aussi été observées concernant leurs préférences quant aux modalités de paiement et de remboursement des services. Ces résultats peuvent avoir des implications pour l'implantation d'un programme de psychothérapie subventionnée par l'État au Québec.

Briffault, X. (2014/10/29). La situation de la psychothérapie en France est-elle à la hauteur des besoins ? Les cas du remboursement et de la formation des praticiens. . Intervention au colloque « Améliorer l'accès aux psychothérapies au Québec et au Canada : Réflexions et expériences de pays francophones » Montréal, Paris : Cermès.
http://capqc.ca/sites/capqc.ca/files/uploads/articles/2014/briffault_x.pdf

Brusset, B. (2005). "Les psychothérapies et la loi : un débat d'actualité." Revue française de psychanalyse **69**(2): 537-560.
https://www.cairn.info/revue-francaise-de-psychanalyse-2005-2-page-537.htm

Résumé — La loi du 11 août 2004 instaure le cadre légal de l'usage du titre de psychothérapeute en vue de limiter les abus. En l'absence des décrets d'application qui auront un rôle décisif, il est difficile de savoir quelle sera sa portée. Mais il est certain qu'elle prendra place dans un contexte que les vives réactions négatives à toute réglementation ont à la fois révélé et occulté. La situation est en France différente de ce qu'elle est dans d'autres pays d'Europe. Elle est envisagée ici, de manière surtout informative, selon quatre perspectives institutionnelles complémentaires : celles de la psychiatrie, de la psychologie clinique, de la psychanalyse et des psychothérapies non psychanalytiques.

Cazuvieilh, C. (2018). Évaluer et améliorer l'efficacité des psychothérapies : adaptation française d'un système de suivi des résultats thérapeutiques et étude des processus participant au changement. . Bordeaux : Université de Bordeaux, École doctorale Sociétés, Politiques, Santé publique **Doctorat en psychologie.:** 265p.

Chiche, S. (2014/09). "Faut-il rembourser les psychothérapies ?" Sciences humaines: 7p.
https://www.researchgate.net/profile/Xavier_Briffault/publication/269697885_Faut-il_rembourser_les_psychotherapies/links/5492e5760cf209fc7e9f84b3/Faut-il-rembourser-les-psychotherapies.pdf

Cnam (2018). Rapport sur les charges et produits de l'Assurance Maladie pour 2019 : Améliorer la qualité du système de santé et maîtriser les dépenses : propositions de l'Assurance Maladie pour 2019. Paris Cnamts**:** 262.
https://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/rapports-et-periodiques/rapports-charges-produits-de-l-assurance-maladie/index.php

Conrath, P. et Ouazzani, M. (2018). "Consultations et remboursements : le minimum garanti ?" Le Journal des psychologues **358**(6): 3-3.
https://www.cairn.info/revue-le-journal-des-psychologues-2018-6-page-3.htm

Dezetter, A. (2012). Analyses épidémiologiques et socioéconomiques de la situation des psychothérapies en France, en vue de propositions sur les politiques de remboursement des psychothérapies. Paris : Université Paris Descartes, Université Paris Descartes. École Doctorale de Santé Publique ED420 **Doctorat Santé publique, Économie et Sciences sociales de la santé.** .

Dezetter, A. et Briffault, X. (2005). "[Costs and benefits of a funding program for psychotherapies for French people suffering from depressive or anxious disorders]." Sante Ment Que **40**(4): 119-140.

> Objectives Depressive or anxious disorders are a major source of social and economic burden. Many international good practice guidelines recommend structured psychotherapy for treating depressive or anxious disorders. The positive impact of psychotherapy on health, quality of life, productivity, and on the direct and indirect costs has been widely demonstrated. Nevertheless, the psychotherapies provided in private practice with a non-medical psychotherapist are not reimbursed to patients by French health cover systems.This article aims (1) to assess the cost and benefit of providing a funding program for psychotherapies for the community for French adults suffering from severe or recurrent depressive or anxious disorders, and (2) to estimate the number of psychotherapists that this program would be needed.Methods Data are based on the Enquete Indicateurs de sante mentale dans quatre regions francaises: a cross-sectional survey of a representative sample of 20,777 adults in the general population conducted in 2005. The questionnaires were administered by a telephone interview with the Composite International Diagnostic Interview - short form. A financial evaluation of covering the cost of psychotherapies was performed using the methodology of the British program Improving Access for Psychological Therapies adapted to the French context. The annual cost generated by depressive disorders was estimated at EUR4,702, cost generated by anxiety disorders at EUR1,500. The remission rate attributable to psychotherapies was assessed to be 30% +/-10%. The number of sessions to be covered was defined according to clinical guidelines of the National Institute for Health and Clinical Excellence. The cost of a session was estimated at EUR41, the reimbursement rate by the compulsory health insurance system at 60%.Results The yearly cost for the cover of psychotherapeutic care - for 12.1 sessions on average was M EUR 514 (M EUR 308 for the compulsory systems) to treat 1,033M individuals in France, or 2.3% of the population. In terms of the cost-benefit ratio, EUR1 invested in psychotherapeutic treatment could, save from EUR1.14 (0.76-1.52) to EUR1.95 (1.30-2.60) for anxious or depressive disorders respectively.France has the 14,300 professionals qualified to provide the psychotherapies required to treat this population.Conclusion A funding program for psychotherapies proves to be a cost-efficient investment for the community from the short term, for both direct (health costs) and indirect (productivity, quality of life) costs, that is further that the positive impact and costs of psychotherapy on somatic disorders were not taken into account.With a view to providing appropriate care for patients, inter-professional collaboration among GPs and mental health professionals, and between clinical psychiatrists and psychologists, appears essential. These recommendations should be defined in national good practice guidelines.

Dezetter, A., Briffault, X., Ben Lakhdar, C. et Kovess-Masfety, V. (2013). "Costs and Benefits of Improving Access to Psychotherapies for Common Mental Disorders." Journal of Mental Health Policy and Economics **16**(4): 161-177.
http://search.ebscohost.com/login.aspx?direct=true&db=ecn&AN=1417841&lang=fr&site=ehost-live
http://www.icmpe.org/test1/journal/journal.htm

> Structured psychotherapies are effective and recommended treatments for mental disorders. Nevertheless, in France, psychotherapies are not reimbursed by health cover systems. A financial evaluation of covering the cost of psychotherapies was performed using the methodology of the British programme Improving Access for Psychological Therapies. The cost of a session was estimated at 41 euros, the reimbursement rate by the compulsory health insurance system at 60% for the care of individuals aged 18 to 75 presenting common, chronic and/or severe mental disorders. The annual costs of disorders were estimated to be between 4,702 euros and 1,500 euros. The remission rate attributable to psychotherapies was estimated to be 30% plus or minus 10%. Funding psychotherapies proves to be a cost-efficient investment. The yearly cost of psychotherapies for the compulsory cover system would be 308 million Euros, to treat 1.033 million patients. 1 euro spent for the psychotherapy would enable the community savings between 1.14 euros and 1.95 euros.

Dezetter, A. et Vasiliadis, H. M. (2014/05). "Les avantages économiques d'un meilleur accès aux psychothérapies : deux exemples à l'étude. ." Quintessence **6**(6): 2p.

http://www.qualaxia.org/wp-content/uploads/quintessence-v06n06-fr.pdf

Doron, C. O. (2009). "Evaluation de l'efficacité des psychothérapies entre science et société." Information Psychiatrique (L') **85**(2): 131-141.

> Cet article revient sur certains principes et problème de l'évaluation de l'efficacité des psychothérapies. Dans un premier temps, il étudie les principes constitutifs de l'épistémiologie de la recherche en psychiatrie, en montrant en quoi ils définissent une approche spécifique de l'efficacité et s'opposent à certains principes de la clinique, produisant une tension significative dans la recherche clinique. Dans un second temps, il analyse dans la confrontation de ces épistémiologies, des tentatives, qui comme les études naturalistes, visent à la dépasser, et montre comment elles risquent de reconduire à un autre niveau la même opposition. Enfin, en prenant acte des limites d'une approche uniquement épistémiologique, l'analyse se déplace du côté des techniques du gouvernement, montrant comment l'évaluation de l'efficacité, loin d'être un principe interne à la science, s'inscrit dans une rationalité de gouvernement à laquelle il est au moins légitime de résister.

Emmanuelli, J. et Schechter, F. (2019). Prise en charge coordonnée des troubles psychiques : état des lieux et conditions d'évolution. Paris Igas**:** 130 , tabl., fig.

> Près d'un quart des Français sont confrontés personnellement ou à travers leurs proches aux troubles psychiques. Ceux-ci sont classés au premier rang des maladies en termes de dépenses de soins, devant les cancers et les maladies cardiovasculaires. En forte croissance, ces troubles suscitent des interrogations sur la nature des réponses apportées par notre système de santé (avec un recours important aux médicaments psychotropes), sur la temporalité des repérages et des prises en charges, et sur l'accessibilité financière très variable des différents types de soins. Plusieurs expérimentations ont été lancées au cours des années récentes, portant sur des populations adultes ou des jeunes, afin de faciliter une prise en charge précoce des troubles psychiques d'intensité faible à modérée (anxiété, troubles dépressifs...). Si elles sont encore trop récentes pour se prêter à une évaluation, ces expérimentations ont en commun de reposer souvent sur le recours aux psychologues libéraux (en lien avec le médecin traitant) et sur l'ouverture de nouvelles prises en charge par l'assurance maladie, dans des conditions spécifiques. Dans ce contexte évolutif, l'IGAS a étudié la place des psychologues dans le système de soins – qui se révèle atypique – et son évolution possible dans le cadre de parcours de soins coordonnés donnant accès aux financements collectifs. Le rapport précise quelles pourraient en être les conditions pour ces professionnels, en termes par exemple de formation, de cadre déontologique et d'articulation avec les interventions des autres professionnels de santé.

Falissard, B. (2010). "Comment penser l'évaluation des psychothérapies dans le contexte général de l'évaluation des thérapeutiques ?" Annales Médico-psychologiques, revue psychiatrique **168**(2): 156-158.
http://www.sciencedirect.com/science/article/pii/S0003448709003655

> Résumé La méthodologie d'évaluation des thérapeutiques médicamenteuses est bien établie. Est-ce aussi le cas en ce qui concerne les psychothérapies ? Les avis sont partagés. Quatre points méthodologiques clés relatifs à l'évaluation de toute thérapeutique seront abordés dans un premier temps : quelles sont les thérapeutiques à comparer ? Quels sont les patients inclus ? Comment évaluer l'efficacité des thérapeutiques ? Comment assurer la comparabilité des groupes de traitement ? Nous verrons ainsi que l'évaluation des thérapeutiques médicamenteuses ou psychothérapeutiques relève fondamentalement de la même méthodologie. Nous verrons enfin que l'évaluation des thérapeutiques médicamenteuses vit actuellement les débuts d'une révolution avec un possible déclin du poids des essais randomisés. Cette révolution a curieusement été anticipée par certaines méthodologies d'évaluation des psychothérapies. The methodology of evaluation of medicinal products is well established. Is this also the case with psychotherapies? The opinions are divided. Four key methodological points related to the evaluation of therapeutics will be successively approached in a first time: what are the therapeutics that will be compared? Who are the patients included? How to evaluate the effectiveness of the treatments? How to ensure the comparability of the treatments

groups? We will see that the evaluation of medicinal products or psychotherapies remain basically on the same methodology. We will see in a conclusion that the evaluation of medical treatments is presently in a kind of revolution, with a decline of the role of randomized controlled trials. Curiously, this revolution has been anticipated by certain methodologies used in the evaluation of psychotherapies.

Falissard, B., Gasquet, I. et Simondon, F. (2001). "Evaluation de l'efficacité et du coût de trois stratégies de prise en charge de sujets adultes déprimés." Revue D'epidemiologie Et De Sante Publique **49**(2): 204-206.

[BDSP. Notice produite par INIST sQ4kR0xH. Diffusion soumise à autorisation].

Font, H., Roelandt, J. L., Behal, H., Geoffroy, P. A., Pignon, B., Amad, A., Simioni, N., Vaiva, G., Thomas, P., Duhamel, A., Benradia, I. et Rolland, B. (2018). "Prevalence and predictors of no lifetime utilization of mental health treatment among people with mental disorders in France: findings from the 'Mental Health in General Population' (MHGP) survey." Soc Psychiatry Psychiatr Epidemiol **53**(6): 567-576.

PURPOSE: No lifetime utilization of mental health treatment (NUMT) is an indicator of the treatment gap among people in need of treatment. Until now, the overall prevalence and predictors of NUMT have never been explored in France. METHODS: In a 39,617-respondent survey, participants were assessed for NUMT, i.e., no lifetime psychotherapy, psychopharmacotherapy, or psychiatric hospitalization. Mental disorders were investigated using the Mini International Neuropsychiatric Interview (MINI 5.0.0). MINI diagnoses were grouped into five categories: mood disorders (MDs); anxiety disorders (ADs); alcohol use disorders (AUDs); substance use disorders (SUDs); and psychotic disorders (PDs). Using multivariable logistic regression models, we explored the factors associated with NUMT among the MINI-positive respondents. The odds ratio and 95% confidence interval were calculated for each factor. RESULTS: In total, 12,818 (32.4%) respondents were MINI-positive, 46.5% of them reported NUMT (35.6% for MDs, 39.7% for PDs, 42.8% for ADs, 56.0% for AUDs, and 56.7% for SUDs). NUMT was positively associated with being male [OR 1.75 (1.59-1.91)] and practising religion [OR 1.13 (1.02-1.25)] and negatively associated with ageing [per 10-year increase: OR 0.88 (0.85-0.91)], being single [OR 0.74 (0.66-0.84)], being a French native [OR 0.67 (0.60-0.75)], and experiencing MDs [OR 0.39 (0.36-0.43)], ADs [OR 0.47 (0.43-0.52)], AUDs [OR 0.83 (0.73-0.96)], SUDs [OR 0.77 (0.65-0.91)], or PDs [OR 0.50 (0.43-0.59)]. CONCLUSIONS: In France, NUMT rates were the highest for AUDs and SUDs. Additionally, suffering from MDs or ADs increased the lifetime treatment utilization for people having any other mental disorder. This finding emphasizes the need to better screen AUDs and SUDs among people treated for MDs or ADs.

Gandre, C., Rosenberg, S., Coldefy, M., et al. (2019). "Experimenting locally with a stepped-care approach for the treatment of mild to moderate mental disorders in France: Challenges and opportunities." Health Policy **123**(11): 1021-1027.

In France, publicly funded mental care services are mostly hospital-based and focused on treating severe illnesses. Mild to moderate mental disorders are typically managed by general practitioners (GP) who often lack specific training to treat these conditions. Antidepressant prescribing levels for mild to moderate conditions are inadequately high. Public reimbursement for psychotherapies provided by psychologists is generally not available. This paper presents a local experiment with a stepped-care approach for the treatment of mild to moderate mental disorders in four French départements launched in 2018. The experiment includes the introduction of a standardized assessment protocol for GPs, clear referral guidelines, and full reimbursement of visits to psychologists upon GP referral. Seemingly simple, the policy raises several issues related to the regulation, training and reimbursement of psychologists, and illustrates the need for careful preparation and workforce planning to ensure success and stakeholder support. An independent evaluation of the local experiments is planned, which provides the opportunity to fine-tune the policy before any broader rollout. The issues raised in France and the on-going debate is relevant for other countries preparing similar policies for improving mental care.

Kleiboer, A., Smit, J., Bosmans, J., Ruwaard, J., Andersson, G., Topooco, N., Berger, T., Krieger, T., Botella, C., Banos, R., Chevreul, K., Araya, R., Cerga-Pashoja, A., Cieslak, R., Rogala, A., Vis, C., Draisma, S., van Schaik, A., Kemmeren, L., Ebert, D., Berking, M., Funk, B., Cuijpers, P. et Riper, H. (2016). "European COMPARative Effectiveness research on blended Depression treatment versus treatment-as-usual (E-COMPARED): study protocol for a randomized controlled, non-inferiority trial in eight European countries." Trials **17**(1): 387.

> BACKGROUND: Effective, accessible, and affordable depression treatment is of high importance considering the large personal and economic burden of depression. Internet-based treatment is considered a promising clinical and cost-effective alternative to current routine depression treatment strategies such as face-to-face psychotherapy. However, it is not clear whether research findings translate to routine clinical practice such as primary or specialized mental health care. The E-COMPARED project aims to gain knowledge on the clinical and cost-effectiveness of blended depression treatment compared to treatment-as-usual in routine care. METHODS/DESIGN: E-COMPARED will employ a pragmatic, multinational, randomized controlled, non-inferiority trial in eight European countries. Adults diagnosed with major depressive disorder (MDD) will be recruited in primary care (Germany, Poland, Spain, Sweden, and the United Kingdom) or specialized mental health care (France, The Netherlands, and Switzerland). Regular care for depression is compared to "blended" service delivery combining mobile and Internet technologies with face-to-face treatment in one treatment protocol. Participants will be followed up at 3, 6, and 12 months after baseline to determine clinical improvements in symptoms of depression (primary outcome: Patient Health Questionnaire-9), remission of depression, and cost-effectiveness. Main analyses will be conducted on the pooled data from the eight countries (n = 1200 in total, 150 participants in each country). DISCUSSION: The E-COMPARED project will provide mental health care stakeholders with evidence-based information and recommendations on the clinical and cost-effectiveness of blended depression treatment. TRIAL REGISTRATION: France: ClinicalTrials.gov NCT02542891 . Registered on 4 September 2015; Germany: German Clinical Trials Register DRKS00006866 . Registered on 2 December 2014; The Netherlands: Netherlands Trials Register NTR4962 . Registered on 5 January 2015; Poland: ClinicalTrials.Gov NCT02389660 . Registered on 18 February 2015; Spain: ClinicalTrials.gov NCT02361684 . Registered on 8 January 2015; Sweden: ClinicalTrials.gov NCT02449447 . Registered on 30 March 2015; Switzerland: ClinicalTrials.gov NCT02410616 . Registered on 2 April 2015; United Kingdom: ISRCTN registry, ISRCTN12388725 . Registered on 20 March 2015.

Kovess, V., Sapinho, D., Briffault, X. et Villamaux, M. (2007). "[Psychotherapeutic practices in France: results of a professional-based health insurance participant survey]." Encephale **33**(1): 65-74.

> INTRODUCTION: Today in France, little empirical data on the use of psychotherapy is available. This paper presents an empirical study of psychotherapeutic practices, from the patient's point of view. We will present results regarding frequency of psychotherapies, patients' characteristics, associations between different kinds of therapy, where they take place, and the reasons given for beginning psychotherapy. METHODOLOGY: Data is based on a general and mental health survey conducted by MGEN(1) foundation among 6,500 persons, as well as on general population data collected by the BVA survey institute. RESULTS: Depending on the population studied, between 5 to 11.5% of people have had psychotherapy sessions at least once in their lifetime. Women born at the beginning of the sixties and men born at the beginning of the fifties are those who consulted the most. The vast majority of these psychotherapies are individual, in private practice. They often last more than one year, with a frequency of once per week or more. Thirty percent declare that they have undergone several psychotherapies. The reasons for consultation reported by users are mainly depression or anxiety. There are significant differences between genders for the reasons for consultation, women being concerned by depression, problems with sleep and food, and men being concerned by obsessive thoughts and addiction (alcohol, tobacco). People undergoing psychotherapy give an average of 2.5 reasons for this psychotherapy, and only 28% gave only one reason. A relationship exists between the number of consecutive treatments and the number of reasons given for undergoing psychotherapy. More than 25% of the psychotherapies last less than 6 months. "Intensive psychotherapy" (at least 6 months and a frequency of 2 to 3 times per month) concern 5.9% of the whole population studied,

> and represent 51.4% of all psychotherapies. People are quite satisfied by their psychotherapy; 90% are satisfied with the results and 60% believe that their condition has been much improved in a durable manner. 16.6% were unsatisfied with the results. There is (in women only) an association between satisfaction and intensity of treatment; satisfaction is lower in those women undergoing intensive psychotherapy; 77. 7% of users have also used some sort of drugs for the problem (80.6% of women and 69.9% of men) with psychotropic drugs most frequently used: 70.8% of the psychotherapy users had taken such drugs for their problem (women 72.9%, men 65.4%). CONCLUSION: In France, psychotherapies are playing an important role and it is necessary to study these techniques better in order to give them the place they deserve in the French mental health policy.

Kovess-Masfety, V. et Husky, M. (2016). "Recours à la psychothérapie en France : résultats d'une enquête épidémiologique dans quatre régions." Actualite Et Dossier En Sante Publique(97): 10-15.

> [BDSP. Notice produite par EHESP Jnk8R0xA. Diffusion soumise à autorisation]. A l'heure actuelle, seules les enquêtes épidémiologiques peuvent nous renseigner sur le suivi de psychothérapies au sein de la société française. Une enquête menée dans quatre régions nous révèle que 7% de la population suivent une psychothérapie. Pour plus de la moitié, elle a été réalisée auprès d'un psychiatre et pour 30% auprès d'un psychologue. Des travaux supplémentaires sont néanmoins nécessaires pour comprendre le type de psychothérapies dispensées et établir des recommandations de bonnes pratiques.

Pham-Dinh, C., Hami, H., Aïm, P., et al. (2020). "Psychothérapie, quelle formation possible via la simulation en santé ? Retour d'expérience sur la formation en psychothérapie au Centre universitaire d'enseignement par la simulation (CUESim), université de Lorraine." L'information psychiatrique **96**(2): 123-128.
https://www.cairn.info/revue-l-information-psychiatrique-2020-2-page-123.htm

> Depuis 2013, les internes du DES de psychiatrie de la faculté de médecine de Nancy bénéficient d'enseignement via la simulation en santé dès leur prérentrée. Le bon déroulement de ces séances a inspiré la mise en place, à la rentrée 2017, de séances de simulation au sein de deux séminaires de psychothérapie du DES de psychiatrie : thérapies cognitivo-comportementales (TCC) et hypnose-thérapies brèves.Ces séances de simulations reposaient sur la collaboration entre un expert de la psychothérapie enseignée et un formateur aguerri à la pédagogie par la simulation en santé. La simulation permettait une mise en pratique des techniques de psychothérapies auprès d'un patient simulé. L'efficacité des séances de simulation nous encourage à développer encore cette modalité d'enseignement, y compris en psychothérapie. Cette observation encourage également à des recherches plus poussées pour valider l'efficacité de cette technique, notamment concernant le transfert de compétence en vie réelle.

Revranche, M., Husky, M. et Kovess-Masfety, V. (2019). "[Use of psychotherapy among adults with a history of suicide attempt: Results form a large population-based study]." Encephale **45**(6): 513-521.

> OBJECTIVES: The current study aims to identify the factors associated with the use of psychotherapy among adults with a history of suicide attempt. METHODS: A large cross-sectional survey (N=22,138) was conducted in four regions of France to characterize mental health care needs in the general population. Data were collected between April and June 2005 by trained interviewers using a computer-assisted telephone interviewing system (CATI). Sociodemographics, past-year mental disorders, lifetime and 12-month history of suicide attempts, and use of psychotherapy were assessed. RESULTS: Overall, 7.1% of adults reported having undergone psychotherapy in the course of their life, and 2.0% in the previous 12 months. While 8.3% of adults with a lifetime suicide attempt (prior to the previous 12 months) underwent a psychotherapy in the previous 12 months, 27.5% of adults with a

past-year suicide attempt underwent a psychotherapy in the previous 12 months. Psychotherapy was provided by psychiatrists (49.5%), psychologists (28.2%), and psychoanalysts (10.6%). While the frequency of psychotherapy sessions was greater among those with a prior attempt as compared to those with no prior attempt [Chi(2) (10)=21.35, P=.019], there was no difference in therapy duration [Chi(2) (8)=6.71, P=.568]. Compared to adults who did not report a prior attempt, those with a prior suicide attempt were 3,3 more likely to undergo psychotherapy with a psychologist [AOR=3.31 (2.54-4.31)]. Among adults with a prior suicide attempt, increased odds of undergoing a psychotherapy in the course of their life was predicted by higher education [AOR=2.81 (1.56-5.06)], living in the Paris region [AOR=2.06 (1.32-3.23)], and being a woman [AOR=1.50 (1.08-2.09)]. Increased odds of undergoing a psychotherapy in the previous 12 months was predicted by a major depressive disorder [AOR=2.59 (1.57-4.27)], any anxiety disorder [AOR=1.79 (1.07-2.97)], higher education [AOR=3.60 (1.29-10.0)], living in a city of 20,000 to 100,000 inhabitants [AOR=2.71 (1.13-6.50)] and more [AOR=2.50 (1.12-5.57)] (outside of the Paris region), a 2000 to 3000 euros monthly income [AOR=2.37 (1.15-4.85)]. DISCUSSION: One third of adults with a lifetime suicide attempt and close to half of those with a past-year attempt have received some form of psychotherapy in the course of their life. In line with prior work, higher education and income level predicted past-year use of psychotherapy among adults with a prior suicide attempt. These findings highlight the association between major depressive disorder or anxiety disorders and increased odds of undergoing psychotherapy in the previous 12 months among adults with prior attempt. While pharmacological treatment, inpatient hospitalizations for mental health problems, visits with a general practitioner or specialized physician are free of charge in France, psychotherapy provided by psychologists or psychotherapists is currently not covered by the French Social Security health care system. As the treatment of mental disorders plays an important role in the reduction of suicide risk, supporting evidence-based psychotherapy through its reimbursement appears to be an important public health issue.

Robin, M., Cassini, L., Cornac, X., et al. (2019). "La psychothérapie institutionnelle, terreau d'intelligence collective." L'information psychiatrique **95**(8): 653-660.
https://www.cairn.info/revue-l-information-psychiatrique-2019-8-page-653.htm

La psychothérapie institutionnelle est moribonde, appauvrie entre autres par la financiarisation des soins et l'ultrahygiénisme. Parallèlement à cette dynamique préoccupante de rapports de pouvoir laissant le soin relationnel pour compte, le contexte social laisse apparaître un mouvement de transition citoyenne qui contient dans ses principes comme dans son organisation la notion centrale d'intelligence collective. Cette forme d'organisation des groupes repose sur des bases anciennes, réactualisées depuis les années 90. L'article développe l'idée que cette forme d'intelligence sociale fait appel à des concepts très proches de ceux qui ont défini la psychothérapie institutionnelle. La clinique de l'adolescent en crise sera dans le texte le support pour mettre en lumière cette analogie selon trois axes : les liens entre les membres du groupe, l'horizontalisation des rapports de pouvoir et enfin la notion de processus émergent.

Thurin, J.-M. (2005). "Expertise collective inserm sur les psychothérapies, contexte, déroulement, enseignements et perspectives." Cliniques méditerranéennes **71**(1): 19-40.
https://www.cairn.info/revue-cliniques-mediterraneennes-2005-1-page-19.htm

RésuméL'expertise collective de l'inserm sur les psychothérapies s'inscrit dans un contexte général scientifique, de politique de santé et professionnel particuliers. L'approche finalement adoptée, de type evidence based medicine, a abouti à privilégier sur des critères méthodologiques déterminés les études ad hoc centrées sur la réduction de symptômes et de troubles isolés ou les acquisitions simples. Ce choix s'est fait aux dépens d'études portant sur les fonctionnements mentaux et le développement de la personne impliqués dans le cadre de pathologies complexes, ainsi que sur les processus de changement. Le premier résultat de l'expertise a ainsi été celui d'une communication effrénée des « gagnants » sur la base d'une généralisation abusive de résultats partiels. Les choses ne sont pas cependant aussi simples. L'analyse des résultats des psychothérapies psychanalytiques fait certes apparaître de façon impressionnante le très petit nombre d'études répondant aux critères de «

l'étalon or » des méthodologies actuelles. Mais il faut aussi considérer leurs aspects très stimulants : forte représentativité clinique, présentation et implication des modèles théoriques dans la mise en œuvre et les critères de jugement, définition associée des objectifs et des aspects techniques particuliers, mise en place d'instruments de mesure adaptés. Ces particularités, qui s'appuient sur cinquante ans de recherche d'équipes motivées, notamment dans le domaine des troubles de la personnalité borderline, ouvrent la perspective d'un renouvellement de la recherche clinique en psychanalyse. Elle concernera les approches et les modalités particulières d'intervention aux cours des différentes phases de la psychothérapie, adaptées aux constatations psychopathologiques et aux objectifs spécifiques qu'elles déterminent. Elle se centrera sur les processus de changement dans une configuration impliquant non seulement la pathologie, mais aussi la santé, et les différents acteurs et facteurs qui y participent. Cette autre façon de concevoir l'évaluation, très proche des conditions naturelles, est actuellement largement sollicitée. Complémentaire plutôt qu'antagoniste des études expérimentales contrôlées, ses bénéfices attendus tant au niveau de la connaissance générale, que de son utilité pour les patients, les cliniciens et les décideurs en santé, devraient constituer un puissant stimulant pour son développement.

Villani, M. et Kovess-Masféty, V. (2018). "Les programmes de pairs aidants en santé mentale en France : état de situation et difficultés de mise en place." Encephale **44**(5): 457-464.
http://www.sciencedirect.com/science/article/pii/S0013700618300290

Résumé Objectifs Le rétablissement, ou recovery, décrit un processus qui permet aux personnes souffrant de troubles psychiques de vivre dignement avec leur maladie, sans égard à la sévérité ou persistence éventuelle des symptômes de celle-ci, et de retrouver une place de citoyen à part entière dans la société. Dans le droit de fil de ce concept, le soutien par les pairs s'est développé rapidement dans le monde, au départ dans un contexte de bénévolat. Depuis quelques années, ce phénomène tend vers une plus grande formalisation, et des expérimentations en faveur de l'intégration de pairs aidants professionnels rémunérés dans des équipes de soins traditionnelles ouvertes à cette approche ont eu lieu dans de nombreux pays. Dans ce contexte, l'objectif de notre étude est de faire une synthèse des programmes de pairs aidants professionnels et rémunérés en France, et de tenter d'identifier les difficultés que rencontrent ces projets. Méthodes Notre travail est une revue de littérature nationale et internationale en français et anglais, effectuée à partir de bases de données médicales et psychologiques, sur une période récente : 2005–2016. Résultats En France, l'émergence de telles politiques est récente mais réelle, à travers des projets expérimentaux pour la plupart toujours en cours. Ces programmes ont suscité un vif intérêt de la part des associations d'usagers et de familles, mais également de vives tensions au sein du système de soins. Conclusions Nous terminerons notre article par des recommandations issues de l'expérience internationale mais également du contexte français. Objectives Recovery is a process through which people experiencing mental illness learn to live with their disorder and reach social insertion and citizenship. This positive approach focuses on a person's competencies and strengths rather than on the symptoms. Within this philosophy, peer support has been unevenly developing in mental health services worldwide with roots in the South-American social programs for homeless people and in the American recovery circles in the field of addiction. Therapeutic efficiency of peer support has been proven by several studies including a control group, as being at least as good as traditional services and even better in some specific areas such as reduction of need for emergency services and ability to reach "difficult" patients. The integration of former psychiatric services users in mental health services can take several forms, from the participation to scientific research studies to the direct involvement in a professional team at mental health facilities. In this context, our research aims to sum up the situation in France in comparison with other countries. Methods We conducted a worldwide literature review in English and in French on peer support experiences and policies in mental health services, using medical and psychological databases (PsycInfo, PsycArticles, SantéPsy, Cairn, Medline, Wiley Interscience and PubPsych) on a recent period: 2005–2016. In total, 32 relevant scientific papers have been included in our research. In some cases, we have also used official reports, blogs, Internet sites, and mass media articles when they were relevant. Results Our results show that this movement has been long to develop in France, with controversies having been raised since the beginning on the role that peers

> should play and confusion with existing social integration programs in the associative sector. Drawing inspiration from the Canadian model, a recent "peer mentor" initiative has been analyzed after 2 years of existence: many benefits for services users such as the optional aspect of this care process, a more authentic therapeutic relationship, a less normative frame, an active partnership, and a more optimistic philosophy aiming to make "small steps" towards improvement have been reported. Health professionals and peer mentors themselves have found benefits during the process. However, several limits such as difficulties to find a place with regards to the psychiatric team and difficulties to take advantage of the peer specificity, resulting in a significant attrition of the number of peer mentors, could be observed. A few other important initiatives focused on social insertion and using the help of professional peer support have been developed in recent years, but they seem to have encountered the same issues about positioning themselves both in terms of day-to-day integration in the professional environment and in the job title given by institutions which rarely corresponds to their experience and specificity. In addition, it remains difficult to obtain reliable information, as only a few papers have been published on this matter. Also, while some evaluation studies are currently being carried out, independent quantitative studies of the few running programs seem to lack in this field. Conclusions In our presentation, taking into account the difficulties that were raised in French programs and the lessons of practical experiences at work in other countries, we propose recommendations for larger and more effective implementations of peer support programs in France. As this new kind of care is emerging and seems promising in terms of benefits for not only the users but also the peer supporters and the teams of health professionals, we also insist on the need for a systematic scientific and objective evaluation of the programs.

Willard, M., Clément, C. et Khazaal, Y. (2015). "Pourquoi rembourser la psychothérapie est une nécessité de santé publique ?" Journal de Thérapie Comportementale et Cognitive **25**(4): 145-147.
http://www.sciencedirect.com/science/article/pii/S1155170415000774

Financement des psychothérapies et réflexions en cours dans les autres pays de l'OCDE

Notamment en Allemagne, Belgique, Suisse et Canada.

(2015). "[Concept of budget-based remuneration system for the fields of psychiatry and psychotherapy, psychosomatic medicine and psychotherapy, child and adolescent psychiatry and psychotherapy]." Nervenarzt **86**(11): 1400-1402.

> A new remuneration system is currently being developed for the hospital care of people with mental disorders. Last year, because of sharp criticism the option phase of the planned Flat-rate Charges in Psychiatry and Psychosomatics (Pauschalierende Entgelte Psychiatrie und Psychosomatik, PEPP) was extended by 2 years. During this time the Federal Ministry of Health wants to look for alternatives and possible starting points for the further development of care. Now, 16 scientific professional associations and organisations have presented a joint concept for a sustainable solution: the budget-based remuneration system. The system is suitable for ensuring that people with mental disorders are treated according to their particular needs and for promoting the appropriate further development of regional care in all treatment settings. It corresponds with the objectives as formulated in Section 17d of the Hospital Finance Act (Krankenhausfinanzierungsgesetz, KHG) and translates the PEPP system, which is currently being developed and focusses on average prices, into a performance-oriented, transparent budgetary system. The fundamental principle is the separation of the individual hospitals' budgeting on the basis of evidence-based, feature- and performance-related modules and billing in the form of advance payments from the agreed budget.

Altmann, U., Steffanowski, A., Wittmann, W. W., Kramer, D., Bruckmayer, E., Pfaffinger, I., Steyer, R. et Strauss, B. (2014). "[Extensions of the outpatient psychotherapy: a study about patient, therapist, treatment, and therapy course characteristics]." Psychother Psychosom Med Psychol **64**(5): 181-191.

> Due to the treatment costs, extensions of the standard therapy duration are a matter of critical examination. This study investigates which factors characterize patients with treatment extensions in the German health system and how effective these extensions are for a reduction of the patients' symptoms. We analysed a disorder heterogeneous sample of 810 patients. We found that therapy extensions are more common among with more severe mental disorders, when the therapeutic relationship is positive, and little therapy success has been achieved during the standard duration. Overall, the findings suggest that outpatient psychotherapy is mainly extended for patients with a low symptom reduction after the standard therapy duration and that therapy extension allows a symptom reduction that could not have been achieved otherwise.

Bandelow, B., Lueken, U., Wolff, J., Godemann, F., Wolff-Menzler, C., Deckert, J., Strohle, A., Beutel, M., Wiltink, J., Domschke, K. et Berger, M. (2016). "[Guideline-oriented inpatient psychiatric psychotherapeutic/psychosomatic treatment of anxiety disorders : How many personnel are need?]." Nervenarzt **87**(3): 302-310.

> BACKGROUND/OBJECTIVES: The reimbursement of inpatient psychiatric psychotherapeutic/psychosomatic hospital treatment in Germany is regulated by the German personnel ordinance for psychiatric hospitals (Psych-PV), which has remained unchanged since 1991. The aim of this article was to estimate the personnel requirements for guideline-adherent psychiatric psychotherapeutic hospital treatment. METHODS: A normative concept for the required psychotherapeutic "dose" for anxiety disorders was determined based on a literature review. The required staffing contingent was compared to the resources provided by the Psych-PV based on category A1. RESULTS: According to the German policy guidelines for outpatient psychotherapy, a quota of 25 sessions of 50 min each (as a rule plus 5 probatory sessions) is reimbursed. This approach is supported by studies on dose-response relationships. As patients undergoing inpatient treatment for anxiety disorders are usually more severely ill than outpatients, a contingent of 30 sessions for the average treatment duration of 5 weeks seems appropriate in order to fully exploit the costly inpatient treatment time (300 min per patient and week). In contrast, only 70 min are reimbursed according to the Psych-PV. The total personnel requirement for the normative concept is 624 min per patient and week. The Psych-PV only covers 488 min (78 %). CONCLUSION: Currently, the time contingents for evidence-based psychiatric psychotherapeutic/psychosomatic hospital care are nowhere near sufficient. In the development of future reimbursement systems this needs to be corrected.

Barufka, S., Heller, M., Prayon, V. et Fegert, J. M. (2015). "[Nonnative guidelines for allocating human resources in child and adolescent psychiatry using average values under convergence conditions instead of price determination - analysis of the data of university hospitals in Germany concerning the costs of calculating day and minute values according to Psych-PV and PEPP-System]." Z Kinder Jugendpsychiatr Psychother **43**(6): 397-409.

> OBJECTIVE: Despite substantial opposition in the practical field, based on an amendment to the Hospital Financing Act (KHG). the so-called PEPP-System was introduced in child and adolescent psychiatry as a new calculation model. The 2-year moratorium, combined with the rescheduling of the repeal of the psychiatry personnel regulation (Psych-PV) and a convergence phase, provided the German Federal Ministry of Health with additional time to enter a structured dialogue with professional associations. Especially the perspective concerning the regulatory framework is presently unclear. METHOD: In light of this debate, this article provides calculations to illustrate the transformation of the previous personnel regulation into the PEPP-System by means of the data of section sign21 KHEntgG stemming from the 22 university hospitals of child and adolescent psychiatry and psychotherapy in Germany. In 2013 there was a total of 7,712 cases and 263,694 calculation days. In order to identify a necessary basic reimbursement value th1\t would guarantee a constant quality

of patient care, the authors utilize outcomes, cost structures, calculation days, and minute values for individual professional groups according to both systems (Psych-PV and PEPP) based on data from 2013 and the InEK' s analysis of the calculation datasets. CONCLUSIONS: The authors propose a normative agreement on the basic reimbursement value between 270 and 285 EUR. This takes into account the concentration phenomenon and the expansion of services that has occurred since the introduction of the Psych-PV system. Such a normative agreement on structural quality could provide a verifiable framework for the allocation of human resources corresponding to the previous regulations of Psych-PV.

Bousen, M., Laasman, J. M. et Pirson, A. F. (2018/09). Remboursement des soins psychologiques de première ligne : quel modèle pour répondre aux besoins ? . Bruxelles : Solidaris**:** 82p.
http://www.cresam.be/wp-content/uploads/2018/10/Etude-Solidaris_Organisation-des-soins-psychologiques-de-premi%C3%A8re-ligne.pdf

Bradley, S., Doucet, R., Kohler, E. et Drapeau, M. (2015). "[Access to government-funded psychotherapy: Comparing the point of view of psychologists and psychotherapists]." Sante Ment Que **40**(4): 175-200.

Objectives Within the Quebec context, as well as the larger Canadian and International context, increasing access to mental health care treatment has become a major health care priority (see Peachey, Hicks, & Adams, 2013). Initiatives to increase access through government-funded psychotherapy have been successfully implemented in Australia and the United Kingdom. The current study sought to document how licensed psychologists and psychotherapists in Quebec differ in their attitudes about the components of these government-funded psychotherapy programs and increasing access to psychotherapy treatment. Methods The target population for the study included both psychologists and psychotherapists whom were licensed to practice psychotherapy with the Ordre of Psychologists of Quebec. Participants (N = 1 275) were recruited by email to participate in an online questionnaire focusing on components such as the services that should be offered in a new government-funded psychotherapy model (eg., individual therapy, family therapy; including employment and debt counselling), the choice and autonomy clinicians have in their treatment interventions, the role of the referring General Practitioner (GP), the fees per psychotherapy hour, the hiring structure (e.g., in the public sector versus reimbursing private psychotherapy services), among others.Results The results indicated that psychotherapists were more in favour of including family and couple therapy, and employment/vocational counselling than psychologists. Psychologists were more in favour of using evidence-based practices as well as tracking treatment outcomes using validated measures, and publishing treatment satisfaction ratings to the public. Psychotherapists were more in favour of being paid on a session-to-session basis as opposed to be being hired on a salaried basis to offer government-funded psychotherapy. Conclusions Given that psychologists and psychotherapists differ in their training background and have historically played different roles in the health care system, it is important to understand how they differ in their perspectives on accessibility to psychotherapy. The implications for implementing government-funded psychotherapy initiatives in Quebec given the different professional perspectives of the two groups are discussed.

Bradley, S. et Drapeau, M. (2014). "Increasing access to mental health care through government-funded psychotherapy : The perspectives of clinicians." Canadian Psychology **55**(2): 80-89.

The lack of accessibility to mental health care in Canada has been described as a silent crisis with the Canadian Psychological Association proposing possible actions that could be taken to achieve increased accessibility (Peachey, Hicks, & Adams, 2013). Efforts to make psychotherapy more accessible have been implemented in both the United Kingdom (U.K.) and Australian health care systems through government-funded services (Clark et al., 2009; Hickie & Groom, 2002). The aim of the present study was to document the attitudes of psychologists and psychotherapists licensed to practice in Quebec toward accessibility to psychotherapy and government-funded psychotherapy programs. Participants (N = 1,275) completed an online questionnaire; results indicated that 77% of the sample strongly agreed that accessibility to psychotherapy should be increased. Participants indicated that priority for government-funded psychotherapy should be given to those with diagnosable mental health disorders, particularly mood disorders, anxiety disorders, and schizophrenia and other psychotic disorders, and psychological functioning related to health, injury and illness, and family difficulties. Participants indicated that treatment priority should be based on severity of illness. There was stronger agreement that clinicians working within a government-funded psychotherapy program should be paid on a session-to-session basis as opposed to receiving a yearly salary; to be able to set their own fee; and to have freedom to choose the appropriate psychotherapeutic approach (e.g., cognitive behavioural therapy [CBT], emotion-focused therapy [EFT]) and appropriate treatment materials (e.g., psychoeducational handouts) to be used in treatment. Other results concerning the structure of a government-funded psychotherapy program and the implications for increasing accessibility in a Canadian context are discussed. (PsycINFO Database Record (c) 2016 APA, all rights reserved).

Bramesfeld, A., Grobe, T. et Schwartz, F. W. (2007). "Who is treated, and how, for depression? An analysis of statutory health insurance data in Germany." Soc Psychiatry Psychiatr Epidemiol **42**(9): 740-746.

BACKGROUND: Studies on the treatment of depression using epidemiological survey methods suggest a high level of under-treatment. Little is known about the characteristics of those people receiving treatment and indeed what kind of treatment they are likely to receive. METHOD: Analysis of the data of a statutory health insurance company in Germany. RESULTS: In middle-aged groups, about 50% of those diagnosed as being depressed in outpatient care are prescribed antidepressants and/or psychotherapy in the course of a year. There is more pharmacologic treatment provided in rural areas and more psychotherapy in cities, suggesting that treatment is dependent upon service availability rather than evidence-based treatment decisions. Treatment rates are considerably lower in the very young and the very old and show gender bias. Young females receive less pharmacologic treatment than young males, and elderly men are, in general, treated less than women, suggesting under-treatment at least for these groups. CONCLUSIONS: The low treatment rates following the diagnosis of depression in the young and the old require attention, in particular with respect to gender aspect.

Briand, C., Reinharz, D., Lesage, A., Nicole, L., Stip, E., Lalonde, P., Villeneuve, K. et Planet-Sultan, S. (2010). "[Implementation in Quebec of the Integrated Psychological Treatment (IPT) for people with schizophrenia: five years later]." Sante Ment Que **35**(2): 145-162.

This article examines the adoption in Quebec of the evidence-based practice, Integrated Psychological Treatment (IPT) of people with schizophrenia and the longevity of this practice within nine clinical milieus in a context of transformation of services. A team of researchers of the Centre de recherche Fernand Seguin has closely followed the implementation and the maintenance of the IPT in nine clinical milieus. More specifically, this article presents the factors that have contributed, on a five year period, to the maintenance (or not) of the IPT in these settings. It raises the important question of longevity of an approach that is specialized and specific to a clientele in contexts of transformation of services.

Brocheler, A., Bergmann, F. et Schneider, F. (2009). "Models of mental health care in psychiatry across sectoral borders." Eur Arch Psychiatry Clin Neurosci **259 Suppl 2**: S227-232.

Since 2004, article 140 of the fifth German Social Code Book (SGB V) provides the opportunity for developing and implementing models of Integrated Care (IC). The main aim of integrated care projects is to improve the quality and efficiency of health care in Germany by ameliorating the cooperation between the different sectors hospitals, ambulatory and rehabilitative care. As an example of implementing an integrated care network in the psychiatric sector, the first local network for integrated care in psychiatry in Aachen is described. It was founded in 2006 by the department of Psychiatry and Psychotherapy of the University Hospital Aachen, the DGPPN (German Association of Psychiatry and Psychotherapy) and the BVDN (Professional Association of German Neuropsychiatrists). The present interface problem between the separated sectors of medical care in Germany is being

solved by evidence-based therapy, coordinated treatment between the different sectors, a standardised documentation and advanced training for all clinical participants. Early diagnosis and treatment of depression are improved by integrating clinical diagnostics, acute therapy, maintenance therapy, prophylaxis of relapse and after-care within one network. By the end of 2008, 1,081 patients have been treated within the integrated care network in Aachen by 56 ambulant general practitioners and psychiatrists and by 3 local psychiatric hospitals. Currently the network is going to be enlarged by integrating the diagnosis of schizophrenia. Following this, other mental illnesses should be integrated. The aim is to create a nationwide integrated care network across all diagnostic borders of mental illnesses.

Chiappelli, M., Grigoletti, L., Albanese, P., Taras, M. A., Tulli, P. et Grassi, A. (2007). "[The cost and utilization of psychotherapy in community-based mental health services. A multicentre study in five Italian areas]." Epidemiol Psichiatr Soc **16**(2): 152-162.

AIMS: To investigate the prevalence of psychotherapy intervention in five Italian Centres for Mental Health. Analysing sociodemographic characteristics, geographical differences, frequencies of psychotherapy interventions, and the costs of these interventions. METHODS: Five Italian Community-based Psychiatric Services collected data from 1250 patients during October 2002. Socio-demographic and clinical characteristics and GAF scores were collected at baseline. All psychiatric contacts during the following six months were recorded and categorised into 24 service contact categories. A comparison between patients who received or did not receive psychotherapy was made. RESULTS: The socio-demographic characteristics of patients are very similar to those found in previous studies; there is a great difference in the number of psychotherapy treatments between the five areas. Psychotherapy patients use different services compared to the other patients, and their care cost less. CONCLUSIONS: This study provides a description of the provision of psychotherapy by Italian Mental Health Services. Further research is required into this topic.

Denman, C. (2007). "The organization and delivery of psychological treatments." Int Rev Psychiatry **19**(1): 81-92.

This article reviews the major issues which face health providers when they seek to organise the delivery of psychological treatments to best effect. A lack of consensus on efficacy, efficiency and acceptability makes policy decisions difficult. Streamlined focused services offering evidence based interventions for a limited target group are compared with broader enterprises offering comprehensive provision of a range of therapies. The dilemmas that the relative strengths and weaknesses of these two models pose are compared in relation to setting, cost efficiency, patient acceptability, equitable access and the pragmatics of staff training, service delivery and clinical governance. It is suggested that changes in the structure of health service provision more generally and the potential inherent in new technology and innovative ways of working may provide new solutions to some of these difficulties and the successive restructurings of a department of psychological treatments are adduced as an example.

Deutsch Gesell, P. (2015). "Concept of budget-based remuneration system for the fields of psychiatry and psychotherapy, psychosomatic medicine and psychotherapy, child and adolescent psychiatry and psychotherapy." Nervenarzt **86**(11): 1400-1402.

A new remuneration system is currently being developed for the hospital care of people with mental disorders. Last year, because of sharp criticism the option phase of the planned Flat-rate Charges in Psychiatry and Psychosomatics (Pauschalierende Entgelte Psychiatrie und Psychosomatik, PEPP) was extended by 2 years. During this time the Federal Ministry of Health wants to look for alternatives and possible starting points for the further development of care. Now, 16 scientific professional associations and organisations have presented a joint concept for a sustainable solution: the budget-based remuneration system. The system is suitable for ensuring that people with mental disorders are treated according to their particular needs and for promoting the appropriate further development of regional care in all treatment settings. It corresponds with the objectives as formulated in Section 17d of the Hospital Finance Act (Krankenhausfinanzierungsgesetz, KHG) and translates the PEPP system, which is currently being developed and focusses on average prices, into a performance-oriented, transparent budgetary system. The fundamental principle is the separation of the individual hospitals' budgeting on the basis of evidence-based, feature-and performance-related modules and billing in the form of advance payments from the agreed budget.

Diminic, S. et Bartram, M. (2019). "Does Introducing Public Funding for Allied Health Psychotherapy Lead to Reductions in Private Insurance Claims? Lessons for Canada from the Australian Experience." Can J Psychiatry **64**(1): 68-76.

OBJECTIVE:: Provincial and territorial governments are considering how best to improve access to psychotherapy from the current patchwork of programmes. To achieve the best value for money, new funding needs to reach a wider population rather than simply replacing services funded through insurance benefits. We considered lessons for Canada from the relative uptake of private insurance and public funding for allied health psychotherapy in Australia. METHOD:: We analysed published administrative claims data from 2003-2004 to 2014-2015 on Australian privately insured psychologist services, publicly insured psychotherapy under the 'Better Access' initiative, and public grant funding for psychotherapy through the 'Access to Allied Psychological Services' programme. Utilisation was compared to the prevalence of mental disorders and treatment rates in the 2007 National Survey of Mental Health and Wellbeing. RESULTS:: The introduction of public funding for psychotherapy led to a 52.1% reduction in private insurance claims. Costs per session were more than double under private insurance and likely contributed to individuals with private coverage choosing to instead access public programmes. However, despite substantial community unmet need, we estimate just 0.4% of the population made private insurance claims in the 2006-2007 period. By contrast, from its introduction, growth in the utilisation of Better Access quickly dwarfed other programmes and led to significantly increased community access to treatment. CONCLUSIONS:: Although insurance in Canada is sponsored by employers, psychology claims also appear surprisingly low, and unmet need similarly high. Careful consideration will be needed in designing publicly funded psychotherapy programmes to prepare for the high demand while minimizing reductions in private insurance claims.

Dlouhy, M. et Bartak, M. (2013). "Mental Health Financing in Six Eastern European Countries." Ekonomie a Management **16**(4): 4-13.
http://search.ebscohost.com/login.aspx?direct=true&db=ecn&AN=1421473&lang=fr&site=ehost-live
http://www.ekonomie-management.cz/en/archiv/

We describe and compare the current status of mental health financing in Bulgaria, the Czech Republic, the Republic of Moldova, Poland, Romania, and Slovakia. In all six Eastern European countries, the state financed and state organized health system was transformed into a public health insurance scheme, though the implementation thereof differs from country to country. The country-specific information was obtained from a health policy questionnaire that includes both qualitative and quantitative information and covers health financing, purchasing, and provision of services. The compulsory health insurance secures that population has access to mental health services irrespective of their ability to pay. It seems that there is a problem to achieve such universal access in Bulgaria and the Republic of Moldova. The countries spend lower shares of GDP on total health expenditure and from this amount they spent lower shares of total health expenditure on mental health services than Western European countries. The political, social and economic transition in the 1990s initiated the process of mental health policy formulation, adoption of mental health legislation stressing human rights of patients, and a call for a pragmatic balance of community and hospital services. However, not all of this has been successfully realized. Mental health services are underfinanced. Insufficient financing of mental health services leads to absence of financial resources for mental health system development. There were poor investments in mental health services in the past, which led to the situation with a need of renovation of inpatient facilities, and need of improvement of the living conditions in the existing institutions. On the other hand, the national mental health systems need resources for strengthening weak community services. But such additional resources are not available.

Egede, L. E., Gebregziabher, M., Walker, R. J., Payne, E. H., Acierno, R. et Frueh, B. C. (2017). "Trajectory of cost overtime after psychotherapy for depression in older Veterans via telemedicine." J Affect Disord **207**: 157-162.

BACKGROUND: Little evidence exists regarding the costs of telemedicine, especially considering changes over time. This analysis aimed to analyze trajectory of healthcare cost before, during, and after a behavioral activation intervention delivered via telepsychology and same-room delivery to elderly Veterans with depression. METHODS: 241 participants were randomly assigned into one of two study groups: behavioral activation for depression via telemedicine or via same-room treatment. Patients received 8 weeks of weekly 60-min individual sessions of behavioral activation for depression. Primary outcomes were collected at 12-months. Inpatient, outpatient, pharmacy, and total costs were collected from VA Health Economics Resource Center (HERC) datasets for FY 1998-2014 and compared between the two treatment groups. Generalized mixed models were used to investigate the trajectories over time. RESULTS: Overall cost, as well as, outpatient and pharmacy cost show increasing trend over time. Unadjusted and adjusted trajectories over time for any cost were not different between the two treatment groups. There was a significant overall increasing trend over time for outpatient (p<0.001) and total cost (p<0.001) but not for inpatient (p=0.543) or pharmacy cost (p=0.084). LIMITATIONS: Generalizability to younger, healthier populations may be limited due to inclusion criteria for study participants. CONCLUSION: Healthcare costs before, during, and after intervention did not differ between the telemedicine and in-person delivery methods. Outpatient costs accounted for most of the increasing trend of cost over time. These results support policies to use both telehealth and in-person treatment modalities to effectively and efficiently provide high quality care.

Fansi, A. et Jehanno, C. (2015). Avis sur l'accès équitable aux services de psychothérapie, Volet II : Analyse des modalités et des conditions d'accès aux services de psychothérapie pour le traitement des adultes atteints de troubles dépressifs et anxieux. Volet II – Analyse des modalités et des conditions d'accès aux services de psychothérapie pour le traitement des adultes atteints de troubles dépressifs et anxieux. Institut national d'excellence en santé et en services sociaux**:** 47p.
http://capqc.ca/sites/capqc.ca/files/uploads/pages/2015/inesss_psychotherapie_voletii_modalites_conditions_acces.pdf

L'accessibilité physique et financière à la psychothérapie reste limitée. Au Québec, seulement le tiers des professionnels habilités à offrir de la psychothérapie pratiquent dans le secteur public et la politique de couverture et de remboursement de ce service est très restreinte. Cela fait en sorte que ce sont majoritairement les personnes qui ont les moyens financiers de débourser le coût des séances ou qui ont une assurance privée qui profitent de ce service, lequel est largement disponible dans le secteur privé. En 2012, le Commissaire à la santé et au bien-être a recommandé au gouvernement du Québec de diversifier le panier de services assurés dans le secteur de la santé mentale et d'offrir un accès équitable aux services de psychothérapie. La Direction de la santé mentale du Ministère de la Santé et des Services sociaux (MSSS) a donc confié à l'Institut national d'excellence en santé et en services sociaux (INESSS) le mandat d'effectuer une analyse descriptive des modalités et des conditions d'accès aux services de psychothérapie dans différents pays, tant sur le plan international (principalement au Royaume-Uni et en Australie) que sur le plan national (au Canada) et provincial (au Québec). Cette analyse servira de base à l'élaboration d'un modèle ou des modèles adéquats d'introduction de la psychothérapie dans l'arsenal thérapeutique du Québec en vue d'augmenter l'accessibilité à la psychothérapie. Cette publication présente une revue de littérature.

Fenger, M., Mortensen, E. L., Poulsen, S. et Lau, M. (2014). "A register-based study of long-term healthcare use before and after psychotherapy." Nord J Psychiatry **68**(7): 450-459.

BACKGROUND: Psychotherapeutic treatment for non-psychotic disorders is associated with significant reduction in patients' symptoms, and therefore it is believed that treatment improves health and decreases the need for additional healthcare. However, little is known about long-term changes in utilization of healthcare services. AIM: To investigate long-term changes in utilization of public healthcare services for patients referred to psychotherapeutic treatment. METHODS: A pre-post study with 761 consecutive patients and 15,220 matched individuals in a matched population reference group. Data from a comprehensive set of healthcare services were collected from central registries for 4 years prior to intake and for 4 years after completion of treatment. RESULTS: Of the 761 patients, 216 did not show up for treatment and 545 completed treatment. Completer patients achieved a substantial reduction in symptoms (effect size, ES = 0.99). However, completer patients increased their use of all healthcare services by 296% (ES = 0.58) in the 4th year pre-post comparison, while the reference group increased usage by 99% (ES = 0.23). Completer patients had significantly higher increase in contacts with psychiatric hospitals (P < 0.008), contacts with primary care psychologists (P < 0.001), psychotropic medication (P < 0.001) and contacts with primary care physicians (P < 0.001) than the reference group at the 4th year pre-post comparison. CONCLUSION: Over a long-term period, patients who completed psychotherapeutic treatment increased utilization of healthcare services. Studies are needed to clarify how and why psychotherapeutic treatment does not necessarily lead to a reduction in the utilization of healthcare services for the average patient and to evaluate other potential interventions for patients with mental problems and include efficiency studies in this evaluation.

Finley, E. P., Noel, P. H., Lee, S., Haro, E., Garcia, H., Rosen, C., Bernardy, N., Pugh, M. J. et Pugh, J. A. (2018). "Psychotherapy practices for veterans with PTSD among community-based providers in Texas." Psychol Serv **15**(4): 442-452.

Significant changes in national health policy, like the Veterans Choice Act, have created growing opportunities for veterans to receive care outside of the Veterans Administration (VA), yet little is known about the attitudes and practices in PTSD care of community providers, particularly their use of evidence-based psychotherapies (EBPs). The authors assessed psychotherapy practices of community providers serving veterans with PTSD in Texas. They surveyed Texas mental health providers regarding their patient population, practice setting, and posttraumatic stress disorder (PTSD)-related screening, assessment, and treatment practices. They identified providers from state licensing board rosters and included a stratified sample of social workers, marriage and family therapists, and professional counselors (500 each), all psychologists with available email addresses (n = 3,986), and 106 providers known to have completed state-sponsored training for 1 of the EBPs for PTSD, cognitive processing therapy. Four hundred sixty-three eligible respondents returned surveys (15% response rate). Providers reported treating a mean of 7.9 veterans with PTSD in the past year (range = 0-200; SD = 20.5), using a variety of therapeutic approaches for PTSD. Only 15.0% of providers reported regularly conducting psychotherapy for PTSD following a treatment manual, and fewer than half reported any use of EBPs for PTSD with patients. Although many veterans are receiving treatment for PTSD in the community, many community-based mental health providers in Texas do not consistently use recommended treatments for PTSD. These findings may suggest an important opportunity for VA to engage and partner with community providers to achieve high-quality care for veterans. (PsycINFO Database Record (c) 2018 APA, all rights reserved).

Finning, K., Richards, D. A., Moore, L., Ekers, D., McMillan, D., Farrand, P. A., O'Mahen, H. A., Watkins, E. R., Wright, K. A., Fletcher, E., Rhodes, S., Woodhouse, R. et Wray, F. (2017). "Cost and outcome of behavioural activation versus cognitive behavioural therapy for depression (COBRA): a qualitative process evaluation." BMJ Open **7**(4): e014161.

OBJECTIVE: To explore participant views on acceptability, mechanisms of change and impact of behavioural activation (BA) delivered by junior mental health workers (MHWs) versus cognitive behavioural therapy (CBT) delivered by professional psychotherapists. DESIGN: Semistructured qualitative interviews analysed using a framework approach. PARTICIPANTS: 36 participants with

major depressive disorder purposively sampled from a randomised controlled trial of BA versus CBT (the COBRA trial). SETTING: Primary care psychological therapies services in Devon, Durham and Leeds, UK. RESULTS: Elements of therapy considered to be beneficial included its length and regularity, the opportunity to learn and not dwelling on the past. Homework was an important, although challenging aspect of treatment. Therapists were perceived as experts who played an important role in treatment. For some participants the most important element of therapy was having someone to talk to, but for others the specific factors associated with BA and CBT were crucial, with behavioural change considered important for participants in both treatments, and cognitive change unsurprisingly discussed more by those receiving CBT. Both therapies were considered to have a positive impact on symptoms of depression and other areas of life including feelings about themselves, self-care, work and relationships. Barriers to therapy included work, family life and emotional challenges. A subset (n=2) of BA participants commented that therapy felt too simple, and MHWs could be perceived as inexperienced. Many participants saw therapy as a learning experience, providing them with tools to take away, with work on relapse prevention essential. CONCLUSIONS: Despite barriers for some participants, BA and CBT were perceived to have many benefits, to have brought about cognitive and behavioural change and to produce improvements in many domains of participants' lives. To optimise the delivery of BA, inexperienced junior MHWs should be supported through good quality training and ongoing supervision. TRIAL REGISTRATION NUMBER: ISRCTN27473954, 09/12/2011.

Fiori, W., Bohnenkamp, B., Schneider, G., Heuft, G., Roeder, N. et Burgmer, M. (2014). "[The significance of the principal diagnosis in Germany's new payment system for inpatient treatment of mental disorders]." Z Psychosom Med Psychother **60**(1): 25-38.

In 2013 Germany implemented a new payment system for the inpatient treatment of mental disorders. Besides perpetuating a per-diem payment, the payment system sets up a classification system that groups cases with comparable costs per diem. The first release of the system reveals the principal diagnosis to be the main grouping variable. Especially in psychosomatic and psychotherapy this approach seems to be at least questionable. Because of the insufficiently precise definition of the assignment of the principal diagnosis in the coding standards - and therefore the expected conflicts between clinics and health insurance funds - this paper discusses the difficulties involved in defining the principal diagnosis. It also formulates recommendations of how the principal diagnosis should be assigned.

Friedman, R. C. (2014). "Introduction to the special issue on psychotherapy, the affordable care act, and mental health parity: obstacles to implementation." Psychodyn Psychiatry **42**(3): 339-342.

Fussinger, C. (2006). La psychoathérapie comme pratique professionnelle réglementée. Lausanne : Institut universitaire d'Histoire de la médecine et de la santé publique**:** 18p.
https://serval.unil.ch/resource/serval:BIB_7EEB53DCD90B.P001/REF.pdf

Gallas, C., Puschner, B., Kuhn, A. et Kordy, H. (2010). "[Utilization of outpatient psychotherapy and its implications for service provision]." Psychother Psychosom Med Psychol **60**(1): 5-13.

Time structure of outpatient psychotherapy is important for clinical practice, as well as for theoretical and cost-effectiveness reasons. In this paper, important time variables (session number and frequency, therapy duration, utilization of the allocated session contingent, extension of therapy) are studied in a sample of n=714 German insurees in outpatient psychotherapy over a four-year period. Session number and duration of therapy were modelled with survival analysis, Cox regression was used to study the influence of covariates assessed at the beginning of therapy. Results are reported separately for the three therapy approaches financed by the German health insurance system: psychoanalytic psychotherapy (AP), psychodynamically-oriented therapy (TP) and cognitive-behavioral therapy (VT). Results show median session numbers of 25 (VT), 42 (TP) and 101 (AP) and a therapy duration of 12.8 (VT), 16.7 (TP) and 23.5 (AP) months. Initial therapeutic alliance was negatively associated with therapy duration and session number in AP. In TP and VT, a negative association

between age and treatment duration was observed. 72.5% of the total session contingent was utilized and 38.4% of the participants applied for additional therapy sessions. An extension of psychotherapy happened more frequently 1) in psychoanalytic treatments and 2) in participants with higher initial psychological distress. Results show that the utilization of therapeutic resources differs from both theoretical concepts and fixed contingents allocated by health insurances. Potential implications for the allocation of psychotherapeutic resources are discussed.

Godemann, F., Hauth, I., Richert, A. et Berton, R. (2015). "Features of regional mandatory psychiatric care in Germany." Nervenarzt **86**(3): 367-372.

> The regional mandatory care is a central element of psychiatric treatment in Germany. Therefore, it is possible to realize care near to the place of residence of psychiatric patients and good contact to the outpatient health system. Up to now the new payment system in psychiatry in Germany does not explicitly include this central factor. The article investigates which criteria possibly describe psychiatric mandatory care and whether they can be ascertained from routine data. The results are based on the so-called A A 21 records of 47 psychiatric and psychosomatic clinics all of which participated in the German VIPP (healthcare indicators in psychiatry and psychosomatics) project. It is obligatory to send the standardized A A 21 record to the Institute for the Hospital Remuneration System (InEK) annually. The study identified two factors which could describe clinics with regional mandatory care. Many patients attend these hospitals outside the core time of Monday to Friday, 8 am to 5 pm and the distance to their place of residence is shorter. This is associated with a higher day-related valuation, the so-called day mix index (DMI). Routine data contain information describing regional mandatory psychiatric care. Patients treated in this system show a higher DMI. This means higher proceeds for the hospitals but it is not clear if these proceeds are able to cover the higher costs in clinics with regional mandatory care. Therefore, it is necessary for the InEK to set up a new cost center for all clinics which participate as a so-called calculation site. By posting all structural costs of mandatory care in this cost center it will be possible to compare them with the income of psychiatric clinics in the future.

Hadlaczky, G., Stefenson, A. et Wasserman, D. (2012). "The state of psychiatry in Sweden." Int Rev Psychiatry **24**(4): 356-362.

> The number of practising psychiatrists in Sweden has increased by nearly 30% between the years 1995-2009; however, the profession has suffered serious recruitment difficulties. The Swedish National Board of Health and Welfare estimated that about 5-10% of the population is in need of psychiatric treatment, but only 3-4% seek psychiatric care. Among patients who receive psychiatric care, approximately 47% are treated with psychopharmacology, 13% are treated with psychotherapy and 40% receive both treatments. There are still challenges facing Swedish psychiatry: reduction in waiting times for psychiatric care, broader accessibility of evidence-based treatment methods for all groups of psychiatric patients both in rural and urban areas, and targeting the needs of immigrants and refugees. The allocation of resources to psychiatric research, and development of novel treatment methods are crucially needed. The Swedish government is strongly committed to decreasing the number of suicides, as there are approximately 1,400 individuals lost to suicide every year in a country with a population of around 10 million. Given that nearly 20% of all suicides are amongst psychiatric inpatients, a regulation has been passed regarding the analysis of all completed suicides in the healthcare system. Results from these analyses can be used for increasing quality of treatment.

Heuft, G., Hildenbrand, G. et Cuntz, U. (2010). "[The hospital financing frame regulation, psychiatric OPS figures and new reimbursement ordinance for psychosomatic medicine and psychotherapy as well as psychiatry and psychotherapy]." Z Psychosom Med Psychother **56**(1): 86-105.

> In March 2009 the "Krankenhausfinanzierungsrahmengesetz (KHRG)" (Hospital Finance Law) came into force. For this reason, new procedures covering psychosomatic-psychotherapeutic und

psychiatric-psychotherapeutic inpatient treatment had to be developed. This paper presents the new Psych-Procedures (Psych-OPS) together with first instructions on coding procedures.

Holtfort, M. G., Kramer, U. et Dauwalde, J. P. (2015). "La psychothérapie psychologique en Suisse vers la transparence et la qualité. ." Sante Ment Que **40**(4). https://www.erudit.org/en/journals/smq/2015-v40-n4-smq02456/1036093ar.pdf

The article gives an overview of psychological psychotherapy in Switzerland. We describe the legal status of psychological psychotherapists, their position and role within the Swiss health-care system, the professional context they practice in, the format of psychotherapy training, various employment models of psychological psychotherapists, as well as the currently insufficient reimbursement situation of psychological psychotherapy. Reimbursement by mandatory health insurance is highlighted as the most important current challenge psychological psychotherapists face in Switzerland, on their way to be fully acknowledged as independent providers of psychotherapy.

Hulliger, B. et Sterchi, M. (2018). "A survey-based design of a pricing system for psychotherapy." Health Economics Review **8**.

For admission to statutory health insurance, it is common in Switzerland that health care providers negotiate prices for health care services directly with health insurers. Once they agree upon a price, they must submit the resulting price to the Federal Office of Public Health (FOPH), which can then authorize it. Swiss law requires the prices in health care to be based on empirical data. There has been little research on how to derive such a price for health care from empirical data and which data should be used. Based on a collaboration with psychological psychotherapists in Switzerland, we have designed a pricing system. The empirical basis were two representative surveys: a survey about costs and earnings of psychotherapists, as well as a time-use survey for psychotherapy. This paper shows the methodology followed to establish an empirically based pricing system. The paper may serve as a practical guide for health service providers who want to develop a pricing system. Our approach offers a high degree of freedom because it involves the collection of the data and an explicit modelling phase. At the same time, it might be more resource intensive than other approaches that are based on existing data sources.

Jacke, C. O. et Salize, H.-J. (2014). "Cost effectiveness of a health insurance based case management programme for patients with affective disorders." Neuropsychiatrie : Klinik, Diagnostik, Therapie und Rehabilitation : Organ der Gesellschaft Osterreichischer Nervenarzte und Psychiater **28**(3): 130-141.

OBJECTIVE: Health economic evaluation of a health insurance based case management intervention for persons with mood to severe depressive disorders from payers' perspective. Intervention intended to raise utilization rates of outpatient health services. METHODS: Comparison of patients of one German health insurance company in two different regions/states. Cohort study consists of a control region offering treatment as usual. Patients in the experimental region were exposed to a case management programme guided by health insurance account manager who received trainings, quality circles and supervisions prior to intervention. Utilization rates of ambulatory psychiatrist and/or psychotherapist should be increased. Estimation of incremental cost effectiveness ratio (ICER) was intended. RESULTS: Intervention yielded benefits for patients at comparable costs. A conservative estimation of the ICER was 44,16 euro. Maximum willingness to pay was 378,82 euro per year. Sensitivity analyses showed that this amount of maximum willingness to pay can be reduced to 34,34 euro per year or 2,86 euro per month due to cost degression effects. CONCLUSIONS: The intervention gains increasing cost effectiveness by the number of included patients and case managers. Cooperation between health insurances is suggested in order to minimize intervention cost and to maximize patient benefits. Results should be confirmed by individual longitudinal data (bottom-up approach) first.

Kennedy, P. J. (2014). "Preface to psychotherapy, the affordable care act, and mental health parity: obstacles to implementation." Psychodyn Psychiatry **42**(3): 343-344.

Kleiboer, A., Smit, J., Bosmans, J., Ruwaard, J., Andersson, G., Topooco, N., Berger, T., Krieger, T., Botella, C., Banos, R., Chevreul, K., Araya, R., Cerga-Pashoja, A., Cieslak, R., Rogala, A., Vis, C., Draisma, S., van Schaik, A., Kemmeren, L., Ebert, D., Berking, M., Funk, B., Cuijpers, P. et Riper, H. (2016). "European COMPARative Effectiveness research on blended Depression treatment versus treatment-as-usual (E-COMPARED): study protocol for a randomized controlled, non-inferiority trial in eight European countries." Trials **17**(1): 387.

> BACKGROUND: Effective, accessible, and affordable depression treatment is of high importance considering the large personal and economic burden of depression. Internet-based treatment is considered a promising clinical and cost-effective alternative to current routine depression treatment strategies such as face-to-face psychotherapy. However, it is not clear whether research findings translate to routine clinical practice such as primary or specialized mental health care. The E-COMPARED project aims to gain knowledge on the clinical and cost-effectiveness of blended depression treatment compared to treatment-as-usual in routine care. METHODS/DESIGN: E-COMPARED will employ a pragmatic, multinational, randomized controlled, non-inferiority trial in eight European countries. Adults diagnosed with major depressive disorder (MDD) will be recruited in primary care (Germany, Poland, Spain, Sweden, and the United Kingdom) or specialized mental health care (France, The Netherlands, and Switzerland). Regular care for depression is compared to "blended" service delivery combining mobile and Internet technologies with face-to-face treatment in one treatment protocol. Participants will be followed up at 3, 6, and 12 months after baseline to determine clinical improvements in symptoms of depression (primary outcome: Patient Health Questionnaire-9), remission of depression, and cost-effectiveness. Main analyses will be conducted on the pooled data from the eight countries (n = 1200 in total, 150 participants in each country). DISCUSSION: The E-COMPARED project will provide mental health care stakeholders with evidence-based information and recommendations on the clinical and cost-effectiveness of blended depression treatment. TRIAL REGISTRATION: France: ClinicalTrials.gov NCT02542891 . Registered on 4 September 2015; Germany: German Clinical Trials Register DRKS00006866 . Registered on 2 December 2014; The Netherlands: Netherlands Trials Register NTR4962 . Registered on 5 January 2015; Poland: ClinicalTrials.Gov NCT02389660 . Registered on 18 February 2015; Spain: ClinicalTrials.gov NCT02361684 . Registered on 8 January 2015; Sweden: ClinicalTrials.gov NCT02449447 . Registered on 30 March 2015; Switzerland: ClinicalTrials.gov NCT02410616 . Registered on 2 April 2015; United Kingdom: ISRCTN registry, ISRCTN12388725 . Registered on 20 March 2015.

Klimke, A., Godemann, F., Hauth, I. et Deister, A. (2015). "[Structural quality in psychiatric and psychotherapeutic hospitals]." Nervenarzt **86**(5): 525-533.

> BACKGROUND: The new German flat rate reimbursement system for psychiatry and psychosomatics (PEPP) is primarily based on the diagnostic classification and the costs of therapeutic processes. In 2019 the current normative standard for calculating the therapeutic staff in psychiatric clinics (Psych-PV) will be substituted by a stepwise adaptation process over 5 years. Using regionally calculated remuneration factors, all clinic budgets should eventually converge to comparable values. AIM: Major factors influencing the structural quality of therapy in psychiatric clinics are identified and recommendations are given to support the work of the Federal Joint Committee (G-BA) which has been appointed to develop new recommendations for the minimum setting of personnel requirements. RESULTS: The full reimbursement of the necessary staff and of the costs resulting from outsourcing of day clinics and outpatient departments in the community, including the obligation to treat psychiatric emergency patients is mandatory and currently not sufficiently guaranteed in the new PEPP system. A workflow which opens the possibility to finance therapeutic innovations (e.g. psychotherapy) and helps to overcome the financial sectorial boundaries between inpatient and outpatient treatment is also missing. DISCUSSION: A mandatory recommendation for minimum staff settings needs a guaranteed full financing from the political side. Additionally, important would be an option for financing of therapeutic innovations and increased costs because of changed patient

structures with respect to diagnosis and severity. Moreover, a sufficient remuneration for regional treatment responsibilities and for additional financial outlay resulting from structural costs for regionally outsourced departments is needed to avoid supplementary financing by reducing the budget for the therapeutic staff.

Knapstad, M., Nordgreen, T. et Smith, O. R. F. (2018). "Prompt mental health care, the Norwegian version of IAPT: clinical outcomes and predictors of change in a multicenter cohort study." BMC Psychiatry **18**(1): 260.

BACKGROUND: Prompt mental health care (PMHC) is a Norwegian initiative, inspired by the English 'Improving Access to Psychological Therapy' (IAPT), aimed to provide low-threshold access to primary care treatment for persons with symptoms of anxiety and depression. The objectives of the present study are to describe the PMHC service, to examine changes in symptoms of anxiety and depression following treatment and to identify predictors of change, using data from the 12 first pilot sites. METHODS: A prospective cohort design was used. All participants were asked to complete questionnaires at baseline, before each treatment session and at the end of treatment. Effect sizes (ES) for pre-post changes and recovery rates were calculated based on the Patient Health Questionnaire and the Generalized Anxiety Disorder scale. Multiple imputation (MI) was used in order to handle missing data. We examined predictors through latent difference score models and reported the contribution of each predictor level in terms of ES. RESULTS: In total, N = 2512 clients received treatment at PMHC between October 2014 and December 2016, whereof 61% consented to participate. The changes from pre- to post-treatment were large for symptoms of both depression (ES = 1.1) and anxiety (ES = 1.0), with an MI-based reliable recovery rate of 58%. The reliable recovery rate comparable to IAPT based on last-observation-carried-forward was 48%. The strongest predictors for less improvement were having immigrant background (ES change depression - 0.27, ES change anxiety - 0.26), being out of work at baseline (ES change depression - 0.18, ES change anxiety - 0.35), taking antidepressants (ES change anxiety - 0.36) and reporting bullying as cause of problems (ES change depression - 0.29). Taking sleep medication did on the other hand predict more improvement (ES change depression 0.23, ES change anxiety 0.45). CONCLUSIONS: Results in terms of clinical outcomes were promising, compared to both the IAPT pilots and other benchmark samples. Though all groups of clients showed substantial improvements, having immigrant background, being out of work, taking antidepressant medication and reporting bullying as cause stood out as predictors of poorer treatment response. Altogether, PMHC was successfully implemented in Norway. Areas for improvement of the service are discussed.

Korkeila, J. (2009). "Current trends in psychiatry care in Finland with special focus on private practice psychiatry and psychotherapy." Nord J Psychiatry **63**(1): 87-90; discussion 90-81.

Several previous reforms decentralized Finnish psychiatric services to a great extent. The Ministry of Social Affairs and Health is outlining a proposal for Health Care Law, which makes an effort to centralize and reorganize healthcare. It is not yet possible to see what this will mean for the psychiatric services. In general, the health status of the Finnish population has improved. Although rates of suicides have declined considerably, rates of alcohol-related deaths have risen. Moreover, disability related to major depression has increased drastically, which has lead to a nationwide project called MASTO, which has the aim to improve early detection and treatment of depression. The Ministry of Social Affairs and Health set up a work group, MIND 2009, to draft local working models for mental health and addiction services. To study the significance of psychotherapy in a private practice psychiatric context, the Finnish Psychiatric Association conducted a survey amongst its members. Most psychiatrists in private practice conduct psychotherapy.

Kramer, U., Ambresin, G., de Roten, Y., Fassassi, S., Hedjal, A., Herrera, F., Kolly, S., Pomini, V., Preisig, M. et Despland, J. N. (2010). "[What place is there for psychotherapy in public psychiatry?]." Rev Med Suisse **6**(263): 1760-1762, 1764.

> The question of the place of psychotherapy in psychiatric public care is posed in this article. We will address this question first by presenting two clinical and research programmes which were implemented in a clinical psychiatric unit, section Karl Jaspers (Service of General Psychiatry) of the Department of Psychiatry CHUV, in Lausanne with the collaboration of the University Institute of Psychotherapy. The first one puts forward psychodynamic psychotherapy of depressed inpatients; the clinical programme and the research questions on efficacy of this treatment are discussed. The second focuses on the early treatment of patients with Borderline Personality Disorder, in particular in its research question on the effect of the motive-oriented therapeutic relationship in this process. We conclude by underlining the convergences of the two programmes.

Kruse, J., Larisch, A., Hofmann, M. et Herzog, W. (2013). "[Psychosomatic and psychotherapeutic outpatient care in Germany - Capacity profile based on data from the National Association of Statutory Health Insurance Physicians]." Z Psychosom Med Psychother **59**(3): 254-272.

> OBJECTIVES: At the centre of the study lay a representation of outpatient psychosomatic and psychotherapeutic care with a focus on different groups of medical and psychological therapists. METHODS: The routine data of the National Association of Statutory Health Insurance Physicians (KBV) from the year 2008 were analyzed based on a systematic literature review (Medline, ISI, to November 2010). RESULTS: Neurologists and psychiatrists see the most patients (n = 3,172 vs n = 1,347 cases per practice), but they rarely provide services according to the directives for psychotherapy (4,4 %). However, specialists for psychosomatic medicine and psychotherapy (65 %), physicians providing only psychotherapy (66 %) and psychological psychotherapists (73 %) provide care mainly according to the directives for psychotherapy and therefore see fewer patients (170-190 cases per practice).Medical psychotherapists work more often on a psychodynamic basis, while psychological psychotherapists perform more often behavioral therapy. CONCLUSIONS: The treatment of patients with mental and psychosomatic disorders is based on three columns of care, which differ in their supply profile and each make a specific contribution to the treatment.

Lorentzen, S., Wilberg, T. et Martinsen, E. W. (2015). "Group Psychotherapy in Norway." Int J Group Psychother **65**(4): 543-551.

> This paper gives an overview of group psychotherapy in Norway: the history, approaches in use, programs for systematic training, how group services are financed, and finally how practice and research are integrated in the public mental health system.

McDaid, D., Hewlett, E. et Park, A. L. (2017). Understanding effective approaches to promoting mental health and preventing mental illness. OECD Health Working Papers; 97. Paris OCDE**:** 46 , tabl., fig.

> The health, social and economic consequences of poor mental health are substantial. More attention is focusing now on the development of actions to promote better mental health and wellbeing and prevent mental ill-health. If effective and well-implemented, such actions may potentially help avoid some of these substantial adverse individual, social and economic impacts of poor mental health. This paper provides an overview of the development of approaches to promoting mental wellbeing and preventing mental ill-health in OECD countries, together with an assessment of what is known on their effectiveness and cost effectiveness. The paper finds that there is a sound and quite extensive evidence base for effective and cost effective actions which can promote mental wellbeing and prevent mental ill-health. However, the existence of actions and programmes in mental health promotion and prevention is uneven both between countries, and across different points of the life course. Many countries could stand to scale-up their promotion and prevention efforts in the mental health field, and further efforts are particularly needed to introduce interventions targeted at unemployed and older populations.

Mehl, S., Falkai, P., Berger, M., Lohr, M., Rujescu, D., Wolff, J. et Kircher, T. (2016). "[Guideline-conform psychiatric psychotherapeutic treatment for patients with schizophrenia : A normative evaluation of necessary personnel requirements]." Nervenarzt **87**(3): 286-294.

> BACKGROUND: Although national treatment guidelines and current publications of the German Federal Joint Committee (Gemeinsamer Bundesausschuss) recommend cognitive behavior therapy for all patients with schizophrenia, the implementation of these recommendations in current inpatient and outpatient treatment is only rudimentary. OBJECTIVES: The aim of this study was to systematically search randomized controlled studies (RCTs), meta-analyses and the guidelines of the German Association for Psychiatry and Psychotherapy, Psychosomatics and Neurology (DGPPN) and the British National Institute for Health and Clinical Excellence (NICE) in order to assess the number of personnel necessary for psychiatric and therapeutic inpatient treatment in line with present guidelines. Moreover, the number of staff required was compared with the personnel resources designated by the German psychiatry personnel regulations (Psych-PV). METHODS: The German and NICE guidelines, RCTs and meta-analyses were analyzed and an adequate weekly treatment plan for an inpatient unit was developed. Moreover, the number of personnel necessary to realize the treatment plan was calculated. RESULTS: In order to realize adequate inpatient treatment approximately 107 min extra for medical psychotherapeutic personnel per patient and week (of which 72 min for psychotherapy) and another 60 min for nursing staff per patient and week are required in addition to the current Psych-PV regulations. Thus, implementation in an open ward with 20 inpatients would require 3.62 positions for physicians, 0.7 positions in psychology and 12.85 positions for nursing staff (including management positions and night shifts). DISCUSSION: These evidence-based recommendations for precise specifications of inpatient treatment should lead to improved inpatient treatment in line with present guidelines. Moreover, outpatients and day patients could be included in this treatment model. The results should be considered in the construction of the future prospective payment system for inpatient psychiatric healthcare in Germany.

Moscarelli, M. et Rupp, A. (2008). "Costs of psychological treatment." J Ment Health Policy Econ **11**(1): 1-2.

Normann, C., Wolff, J., Hochlehnert, A., Klein, J. P., Hohagen, F., Lieb, K., Deckert, J., Falkai, P., Berger, M. et Herpertz, S. C. (2015). "[Resource use and financing of guideline-adherent psychotherapeutic inpatient care]." Nervenarzt **86**(5): 534-541.

> BACKGROUND: The financing of psychiatric psychotherapeutic care in Germany is determined by the German psychiatric staffing regulations which are unchanged since 1991. Psychotherapy was established after 1991 as an effective and indispensable treatment of mental and behavioral disorders. AIMS AND OBJECTIVES: The aim of this study was to empirically investigate the use of psychiatrists' and psychologists' working time for psychotherapy in guideline-adherent hospital care. A further aim was to compare these results to the resources defined by the German psychiatric staffing regulations and in the new prospective payment system for psychiatry and psychosomatics in Germany. MATERIAL AND METHODS: University hospitals for psychiatry and psychotherapy were asked to retrospectively provide data of patients for which guideline-adherent care was possible. Participating institutions provided both data describing the staff time utilization of psychotherapeutic services provided by psychiatrists and psychologists and patient classifications according to the German psychiatric staffing regulations and the new prospective payment system for psychiatry and psychosomatics. RESULTS: Resources defined by the German psychiatric staffing regulations covered a mean of only 71 min of psychotherapy per patient and week while the actual mean intensity of psychotherapeutic care provided by the participating hospitals was 194 min per patient and week. The associated use of staff time was 102 min per patient and week. Both figures increased during an inpatient episode. The resources defined by the German psychiatric staffing regulations covered only 70 % of medical and psychological personnel. The current configuration of the new prospective payment system for psychiatry and psychosomatics covered only 59 % of staff time. CONCLUSION: The results of this study provide another unambiguous recommendation to adjust the out-dated German psychiatric staffing regulations to the current evidence and S3 guidelines for psychiatric

psychotherapeutic hospital care. In particular, more resources are required for the provision of psychotherapeutic care.

OCDE (2014). Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care. Paris OCDE**:** 244 , tabl.
https://www.oecd.org/publications/making-mental-health-count-9789264208445-en.htm

> Despite the enormous burden that mental ill-health imposes on individuals, their families, society, health systems and the economy, mental health care remains a neglected area of health policy in too many countries. Mental disorders represent a considerable disease burden, and have a significant impact on the lives of the OECD population, and account for considerable direct and indirect costs. This report argues that even in those OECD countries with a long history of deinstitutionalisation, there is still a long way to go to make community-based mental health care that achieves good outcomes for people with severe mental illness a reality. The disproportionate focus on severe mental illness has meant that mild-to-moderate mental illnesses, which makes up the largest burden of disease, have remained overwhelmingly neglected. This book addresses the high cost of mental illness, weaknesses and innovative developments in the organisation of care, changes and future directions for the mental health workforce, the need to develop better indicators for mental health care and quality, and tools for better governance of the mental health system. The high burden of mental ill health and the accompanying costs in terms of reduced quality of life, loss of productivity, and premature mortality, mean that making mental health count for all OECD countries is a priority.

Poirier, M. (2003/09). "La psyhcothérapie est rentable." Psychologie Québec: 23-25.

Richards, D. A. (2012). "Stepped care: a method to deliver increased access to psychological therapies." Can J Psychiatry **57**(4): 210-215.

> OBJECTIVE: To introduce stepped care as a method of organizing the delivery of treatments, and to consider the factors necessary for implementation. METHOD: Stepped care is described within the context of strategies such as collaborative care that aim to increase access to mental health care through the improved coordination of care between primary and specialist mental health services. Results from the implementation of stepped care in the United Kingdom and elsewhere are used to highlight the factors required for introducing stepped care into routine services. Issues to address when implementing high-volume services for common mental health problems are derived from this experience. RESULTS: Stepped care sits within the continuum of organizational systems, from situations where responsibility rests almost entirely with primary care clinicians to systems where all patients are managed by specialists for the entire duration of their treatment. Its core principles of delivering low-burden treatments first, followed by careful patient progress monitoring to step patients up to more intensive treatment, are easy to articulate but lead to considerable implementation diversity when services attempt to work in this manner. Services need to ensure they have specific staff competency training, including skills in delivering evidence-based treatments, access to telephony, and smart patient management informatics systems. CONCLUSIONS: Stepped care can provide the delivery system for supported self-management. To be successful, health systems need high levels of clinical outcome data and appropriately trained workers. Further attention is required to ensure equity of access and to reduce patient attrition in these systems.

Ronis, S. T., Slaunwhite, A. K. et Malcom, K. E. (2017). "Comparing Strategies for Providing Child and Youth Mental Health Care Services in Canada, the United States, and The Netherlands." Administration and Policy in Mental Health and Mental Health Services Research **44**(6): 955-966.
<Go to ISI>://WOS:000412947700012

> This paper reviews how child and youth mental health care services in Canada, the United States, and the Netherlands are organized and financed in order to identify systems and individual-level factors that may inhibit or discourage access to treatment for youth with mental health problems, such as

public or private health insurance coverage, out-of-pocket expenses, and referral requirements for specialized mental health care services. Pathways to care for treatment of mental health problems among children and youth are conceptualized and discussed in reference to health insurance coverage and access to specialty services. We outline reforms to the organization of health care that have been introduced in recent years, and the basket of services covered by public and private insurance schemes. We conclude with a discussion of country-level opportunities to enhance access to child and youth mental health services using existing health policy levers in Canada, the United States and the Netherlands.

Saxena, S., Sharan, P. et Saraceno, B. (2003). "Budget and Financing of Mental Health Services: Baseline Information on 89 Countries from WHO's Project Atlas." Journal of Mental Health Policy and Economics **6**(3): 135-143.
http://search.ebscohost.com/login.aspx?direct=true&db=ecn&AN=0674259&lang=fr&site=ehost-live
http://www.icmpe.org/test1/journal/journal.htm

WHO's Project Atlas collected information on policies, programmes, budget and financing, and resource indicators related to mental health care from all countries. Of the 89 countries that provided the requisite information, 36% spent less than 1% of their total health budget on mental health. Out-of-pocket expenditure was the primary method of financing mental health care in many (16.4%) countries. Counties categorized based on the proportion of mental health budget to health budget, differed significantly in terms of income-levels (World Bank classification), policy on disability benefits and mental health resource indicators (beds, personnel, services for special populations and availability of drugs). To meet the substantial burden of neuropsychiatric disorders, most countries need to increase their mental health budgets and use resources more efficiently and judiciously, by supporting equitable ways of financing mental health care, integration of services, and provision of appropriate training.

Schussler, G. (2010). "[Psychotherapy as public health insurance covered benefit]." Z Psychosom Med Psychother **56**(3): 229-230.

Skapinakis, P., Caldwell, D., Hollingworth, W., Bryden, P., Fineberg, N., Salkovskis, P., Welton, N., Baxter, H., Kessler, D., Churchill, R. et Lewis, G. (2016). "A systematic review of the clinical effectiveness and cost-effectiveness of pharmacological and psychological interventions for the management of obsessive-compulsive disorder in children/adolescents and adults." Health Technol Assess **20**(43): 1-392.

BACKGROUND: Obsessive-compulsive disorder (OCD) is a relatively common and disabling condition. OBJECTIVES: To determine the clinical effectiveness, acceptability and cost-effectiveness of pharmacological and psychological interventions for the treatment of OCD in children, adolescents and adults. DATA SOURCES: We searched the Cochrane Collaboration Depression, Anxiety and Neurosis Trials Registers, which includes trials from routine searches of all the major databases. Searches were conducted from inception to 31 December 2014. REVIEW METHODS: We undertook a systematic review and network meta-analysis (NMA) of the clinical effectiveness and acceptability of available treatments. Outcomes for effectiveness included mean differences in the total scores of the Yale-Brown Obsessive-Compulsive Scale or its children's version and total dropouts for acceptability. For the cost-effectiveness analysis, we developed a probabilistic model informed by the results of the NMA. All analyses were performed using OpenBUGS version 3.2.3 (members of OpenBUGS Project Management Group; see www.openbugs.net). RESULTS: We included 86 randomised controlled trials (RCTs) in our systematic review. In the NMA we included 71 RCTs (54 in adults and 17 in children and adolescents) for effectiveness and 71 for acceptability (53 in adults and 18 in children and adolescents), comprising 7643 and 7942 randomised patients available for analysis, respectively. In general, the studies were of medium quality. The results of the NMA showed that in adults all selective serotonin reuptake inhibitors (SSRIs) and clomipramine had greater effects than drug placebo. There were no differences between SSRIs, and a trend for clomipramine to be more effective did not reach statistical significance. All active psychological therapies had greater effects than drug

placebo. Behavioural therapy (BT) and cognitive therapy (CT) had greater effects than psychological placebo, but cognitive-behavioural therapy (CBT) did not. BT and CT, but not CBT, had greater effects than medications, but there are considerable uncertainty and methodological limitations that should be taken into account. In children and adolescents, CBT and BT had greater effects than drug placebo, but differences compared with psychological placebo did not reach statistical significance. SSRIs as a class showed a trend for superiority over drug placebo, but the difference did not reach statistical significance. However, the superiority of some individual drugs (fluoxetine, sertraline) was marginally statistically significant. Regarding acceptability, all interventions except clomipramine had good tolerability. In adults, CT and BT had the highest probability of being most cost-effective at conventional National Institute for Health and Care Excellence thresholds. In children and adolescents, CBT or CBT combined with a SSRI were more likely to be cost-effective. The results are uncertain and sensitive to assumptions about treatment effect and the exclusion of trials at high risk of bias. LIMITATIONS: The majority of psychological trials included patients who were taking medications. There were few studies in children and adolescents. CONCLUSIONS: In adults, psychological interventions, clomipramine, SSRIs or combinations of these are all effective, whereas in children and adolescents, psychological interventions, either as monotherapy or combined with specific SSRIs, were more likely to be effective. Future RCTs should improve their design, in particular for psychotherapy or combined interventions. STUDY REGISTRATION: The study is registered as PROSPERO CRD42012002441. FUNDING DETAILS: The National Institute for Health Research Health Technology Assessment programme.

Snowden, L. R., Wallace, N., Cordell, K. et Graaf, G. (2017). "Increased Mental Health Treatment Financing, Community-Based Organization's Treatment Programs, and Latino-White Children's Financing Disparities." Journal of Mental Health Policy and Economics **20**(3): 137-145.
http://search.ebscohost.com/login.aspx?direct=true&db=ecn&AN=1675629&lang=fr&site=ehost-live
http://www.icmpe.org/test1/journal/journal.htm

Settlement of California Medicaid's EPSDT lawsuit provided county mental health treatment systems state funding for children's services without the usual requirement for matching county funds. Using expenditures as an indicator of mental health treatment and participation in services, the study evaluates whether expanded EPSDT funding disproportionately benefited Latinos and, accordingly, achieved Latino-White inequality reduction, especially where county mental health plan administrators made use of CBOs with culturally sensitive mental health programs. The infusion of funds disproportionately affected Latino children immediately but did not translate into a long-term trend. For addressing Latino-Whites expenditure disparities, counties in the study were shown to be better equipped if they collaborated with organizations offering culturally and linguistically sensitive programming. This study demonstrates that increases in funding and reductions in local cost-sharing, and the leveraging of local linguistically and culturally sensitive programs, hold potential for reducing mental health access and utilization inequities for this population.

Soeteman, D. I., Busschbach, J. J., Verheul, R., Hoomans, T. et Kim, J. J. (2011). "Cost-effective psychotherapy for personality disorders in the Netherlands: the value of further research and active implementation." Value Health **14**(2): 229-239.

OBJECTIVE: In a budget-constrained health care system, decisions regarding resource allocation towards research and implementation are critical and can be informed by cost-effectiveness analysis. The objective of this study was to assess the societal value of conducting further research to inform reimbursement decisions and implementation of cost-effective psychotherapy for clusters B and C personality disorders (PDs). METHODS: Value of information and value of implementation analyses were conducted using previously developed cost-effectiveness models for clusters B and C PDs to evaluate the parameters that contribute to most of the decision uncertainty, and to calculate the population expected values of perfect information (pEVPI) and perfect implementation (pEVPIM). RESULTS: The pEVPI was estimated to be euro425 million for cluster B PDs and euro315 million for cluster C PDs, indicating that gathering additional evidence is expected to be cost-effective. The

> categories of parameters for which reduction of uncertainty would be most valuable were transition probabilities and health state costs. The pEVPIM was estimated to be euro595 million for cluster B PDs and euro1,372 million for cluster C PDs, suggesting that investing in implementation of cost-effective psychotherapy is likely to be worthwhile. CONCLUSIONS: The societal value of additional research on psychotherapy for clusters B and C PDs is substantial, especially when prioritizing information on transition probabilities and health state costs. Active implementation of cost-effective treatment strategies into clinical practice is likely to improve the efficiency of health care provision in The Netherlands.

Soeteman, D. I., Verheul, R., Delimon, J., Meerman, A. M., van den Eijnden, E., Rossum, B. V., Ziegler, U., Thunnissen, M., Busschbach, J. J. et Kim, J. J. (2010). "Cost-effectiveness of psychotherapy for cluster B personality disorders." Br J Psychiatry **196**(5): 396-403.

> BACKGROUND: Recommendations on current clinical guidelines are informed by limited economic evidence. AIMS: A formal economic evaluation of three modalities of psychotherapy for patients with cluster B personality disorders. METHOD: A probabilistic decision-analytic model to assess the cost-effectiveness of out-patient, day hospital and in-patient psychotherapy over 5 years in terms of cost per recovered patient-year and cost per quality-adjusted life-year (QALY). Analyses were conducted from both societal and payer perspectives. RESULTS: From the societal perspective, the most cost-effective choice switched from out-patient to day hospital psychotherapy at a threshold of 12,274 euros per recovered patient-year; and from day hospital to in-patient psychotherapy at 113,298 euros. In terms of cost per QALY, the optimal strategy changed at 56,325 euros and 286,493 euros per QALY respectively. From the payer perspective, the switch points were at 9895 euros and 155,797 euros per recovered patient-year, and 43,427 euros and 561,188 euros per QALY. CONCLUSIONS: Out-patient psychotherapy and day hospital psychotherapy are the optimal treatments for patients with cluster B personality disorders in terms of cost per recovered patient-year and cost per QALY.

Soeteman, D. I., Verheul, R., Meerman, A. M., Ziegler, U., Rossum, B. V., Delimon, J., Rijnierse, P., Thunnissen, M., Busschbach, J. J. et Kim, J. J. (2011). "Cost-effectiveness of psychotherapy for cluster C personality disorders: a decision-analytic model in the Netherlands." J Clin Psychiatry **72**(1): 51-59.

> OBJECTIVE: To conduct a formal economic evaluation of various dosages of psychotherapy for patients with avoidant, dependent, and obsessive-compulsive (ie, cluster C) personality disorders (Structured Interview for DSM-IV Personality criteria). METHOD: We developed a decision-analytic model to assess the cost-effectiveness of 5 dosages of psychotherapy (ie, long-term outpatient psychotherapy, short-term and long-term day hospital psychotherapy, and short-term and long-term inpatient psychotherapy) over a 5-year time horizon in terms of cost per recovered patient-year and cost per quality-adjusted life-year (QALY). Model parameters were estimated using data from 466 patients with cluster C personality disorders who were admitted to 6 specialist centers of psychotherapy in The Netherlands and assigned to 1 of the 5 treatment groups. Probabilistic analysis was conducted to explore the stability of results over uncertain data ranges. Analyses were conducted from both societal and payer perspectives. RESULTS: From the societal perspective and below a threshold of euro 2,637 (US $3,351.92) per recovered patient-year, short-term day hospital psychotherapy resulted in the highest level of benefit for its cost; above the threshold, short-term inpatient psychotherapy was the most cost-effective choice. In terms of cost per QALY, this switch point was at a threshold value of euro 16,570 (US $21,062.29) per QALY. From the payer perspective, the optimal strategy changed from short-term day hospital psychotherapy to short-term inpatient psychotherapy at threshold values of euro 9,874 (US $12,550.94) per recovered patient-year and euro 66,302 (US $84,277.13) per QALY. CONCLUSIONS: This study indicates that short-term day hospital psychotherapy and short-term inpatient psychotherapy are the most cost-effective treatment strategies for patients with cluster C personality disorders. The ultimate selection depends on what cost-effectiveness threshold is considered acceptable and what perspective is adopted.

Spengler, E. (2013). "Des psychothérapeutes indépendants dans la LAMal." A jour(3): 1 p.

https://www.a-jour-sviluppi-professionali-in-psicoterapia.ch/index.php/psyber/article/view/1360/1715

Stip, E. (2015). "Maintenant qu'elle est bien découverte, la psychothérapie devrait être couverte !" Sante Ment Que **40**(4): 7-14.
https://psychiatrie.umontreal.ca/wp-content/uploads/sites/5/2016/03/SMQ-40.4%C3%89ditorial.pdf

Sudak, D. M. (2015). "Advancing the accessibility of psychotherapy: learning from our international colleagues." J Psychiatr Pract **21**(2): 150-153.

> Although the Affordable Care Act has theoretically made access to mental health care possible for all patients, the United States continues to lag behind other countries with respect to the provision of psychotherapeutic treatments. In the United Kingdom, for example, substantial resources have been committed to increase the availability of effective psychotherapies, particularly for depression and anxiety disorders. This development required a significant deployment of resources, with more than one billion dollars committed over the course of 7 years (2008-2015). Over 6,000 therapists have been trained and are currently being deployed in specialized local services to treat patients with depression and anxiety. A second phase of the initiative aims to bring psychotherapeutic treatment to patients with schizophrenia, bipolar disorder, and borderline personality disorder. Psychotherapy advocates in the United States may be more successful in advocating for such treatments by using similar methods to influence legislators and insurers.

Tasca, G. A., Town, J. M., Abbass, A. et Clarke, J. (2018). "Will Publicly Funded Psychotherapy in Canada Be Evidence Based? A Review of What Makes Psychotherapy Work and a Proposal." Canadian Psychology-Psychologie Canadienne **59**(4): 293-300.

> Jurisdictions in Canada, notably in Ontario and Quebec, are proposing a laudable goal of increasing publicly funded access to psychotherapy. Ontario and Quebec will likely follow the lead of the Increasing Access to Psychotherapy (IAPT) program in the United Kingdom and train psychotherapists to provide cognitive-behavioural therapy. Results from IAPT provide some important lessons about taking an approach that prefers one brand of psychotherapy. We argue that such policy decisions are based on a medical model approach to psychotherapy that makes erroneous assumptions about what psychotherapy is, what is the nature of the evidence, and how training and services should be delivered. In this article, we review critically these assumptions and the state of the art of the research about what makes psychotherapy work. Psychotherapy is effective and preferable to antidepressant medication. Differences between psychotherapies account for a small proportion of variance in patient outcomes. The largest known predictors of patient outcomes are patient factors (coping style, resistance/reactance, interpersonal problems, culture) and therapeutic relationship factors (therapeutic alliance). Also notable are therapist factors (facilitative interpersonal skills, empathy, and managing countertransference), and practices like progress monitoring. Canadian jurisdictions should note that training therapists to adapt treatment and interpersonal stances to patient characteristics, to develop and maintain the therapeutic relationship, to enhance therapist facilitative interpersonal skills, and to engage in progress monitoring has a greater chance of achieving a reduction in the burden caused by depression and anxiety among their citizens than focusing on delivering a particular brand of psychotherapy.

Tress, W. (2008). "[Target dimensions of psychosomatic-psychotherapeutic care]." Z Evid Fortbild Qual Gesundhwes **102**(6): 367-372.

> In 1965, the effectiveness of psychoanalytic therapy was demonstrated, which was then included in the reimbursement schemes of the statutory health insurance. In 1987, epidemiologic evidence was provided for the high prevalence of psychosomatic diseases, often associated with a high risk load. Later a phase model described the effects of psychotherapy by the successive levels of remoralisation, symptom and functional improvement. On the basis of health insurance data Felliti (2002) provided plausible evidence for the psychosocial aetiology of most chronic somatic diseases. These data

correspond to a dramatically reduced life expectancy. Thus, a causal bio-psycho-social chain exists between adverse childhood events (ACE), unspecific bodily tensions, dysfunctional health-related coping behavioural strategies (risk load), serious chronic diseases and premature death. In summary, psychosomatic medicine and psychotherapy is a field of health care with a variety of target dimensions which can be brought together in an appropriate model.

Vasiliadis, H. M., Dezetter, A., Latimer, E., Drapeau, M. et Lesage, A. (2017). "Assessing the Costs and Benefits of Insuring Psychological Services as Part of Medicare for Depression in Canada." Psychiatr Serv **68**(9): 899-906.

OBJECTIVE: The study estimated costs and effects associated with increasing access to publicly funded psychological services for depression in a public health care system. METHODS: Discrete event simulation modeled clinical events (relapse, recovery, hospitalizations, suicide attempts, and suicide), health service use, and cost outcomes over 40 years in a population with incident depression. Parameters included epidemiologic and economic data from the literature and data from a secondary analysis of the 2012 Canadian Community Health Survey on mental health. Societal costs were measured with the human capital approach. Analyses estimated the incremental cost-effectiveness ratio associated with improved access to psychological services among individuals not receiving adequate mental health care and reporting an unmet need for such care compared with present use of health services for mental health reasons. RESULTS: Over 40 years, increased access to mental health services in a simulated population of adults with incident depression would lead to significantly lower lifetime prevalence of hospitalizations (27.9% versus 30.2% base case) and suicide attempts (14.1% versus 14.6%); fewer suicides (184 versus 250); a per-person gain of .17 quality-adjusted life years; and average societal cost savings of $2,590 CAD per person (range $1,266-$6,320). Publicly funding psychological services would translate to additional costs of $123,212,872 CAD ($67,709,860-$190,922,732) over 40 years. Savings to society would reach, on average, $246,997,940 CAD ($120,733,356-$602,713,120). CONCLUSIONS: In Canada, every $1 invested in covering psychological services would yield $2.00 ($1.78 to $3.15) in savings to society. Covering psychological services as part of Medicare for individuals with an unmet need for mental health care would pay for itself.

Vasiliadis, H. M., Dezetter, A. et Lesage, A. (2015). "Améliorer l'accès aux psychothérapies au Québec et au Canada : Expériences de pays francophones." Sante Ment Que **40**(4): 245p.
https://www.researchgate.net/profile/Martin_Grosse_Holtforth/publication/301905621_La_psychotherapie_psychologique_en_Suisse_vers_la_transparence_et_la_qualite/links/57fb7cda08ae8da3ce60fa2d/La-psychotherapie-psychologique-en-Suisse-vers-la-transparence-et-la-qualite.pdf#page=17

von Heymann-Horan, A. B., Bidstrup, P. E., Kristiansen, L. C., Olsen, A., Andersen, K. K., Elsass, P., Johansen, C. et Dalton, S. O. (2013). "Equity in the use of publicly subsidized psychotherapy among elderly Danish cancer patients--a register-based cohort study." Acta Oncol **52**(2): 355-363.

UNLABELLED: Approximately 30% of cancer patients suffer from psychological distress, and psychotherapy has been shown to be effective in alleviating it. Based on the 'Behavioral Model of Health Service Use', we investigated equity in the use of publicly subsidized psychotherapy in a cohort of Danish cancer patients. We present descriptive data on patients' use of psychotherapy and examine characteristics of those who used this service. MATERIAL AND METHODS: The study population comprised 3646 participants in the prospective Diet, Cancer and Health cohort, diagnosed with a first cancer between 2003 and 2009, aged 56-80 years. Data on cancer diagnosis, psychotherapy use and comorbid conditions were obtained from registers, whereas data on demographics, social support and health status were obtained from questionnaires. Cox proportional hazards regression was used to identify factors related to use, which were subsequently evaluated with regard to equity. RESULTS: Subsidized psychotherapy was used by 2.3% of the cancer patients. Longer education (> 10 years compared to < 8) was associated with greater likelihood of initiating psychotherapy [hazard ratio (HR), 1.97; 95% confidence interval (CI), 1.06-3.65], as was previous psychotherapy use compared to no previous use (2.86; 1.32-6.20). Patients with partners who did not reliably provide emotional support were significantly more likely to use psychotherapy than those without a partner (2.36; 1.05-5.30), a difference not found for those with partners who did provide support. Further, a higher SF-36 mental component score (0.96; 0.94-0.98, per point increase), and older age were associated with less use (65-69 years: 0.43; 0.21-0.89, 70-74 years: 0.17, 0.07-0.41; > 74 years: 0.07, 0.01-0.57, compared to < 60 years). CONCLUSIONS: The results allow several possible interpretations. We found that mental health plays a role for accessing subsidized psychotherapy, suggesting that use of psychotherapy is predicted by need and thus characterized by equity. However, education and previous psychotherapy use also play a role, suggesting elements of inequity.

Walendzik, A., Rabe-Menssen, C., Lux, G., Wasem, J. et Jahn, R. (2014). "[The health-care situation in outpatient psychiatry--results of a survey among members of the Germany Association of Psychotherapists (DPtV)]." Gesundheitswesen **76**(3): 135-146.

BACKGROUND: Mental-health problems are of increasing importance in the German population. Nonetheless there is a lack of data concerning outpatient psychotherapeutic care, especially with a focus on psychotherapy sessions approved by social health insurances and performed by psychological psychotherapists and paediatric psychotherapists. METHODS: The study presents the results of a survey among all members of the German Association of Psychotherapists (DPtV) and is based on questionnaires filled in by 2,497 psychotherapists (return rate 33.3%). The assessment is based on the therapists' data without an external validation. Main topics of the survey were characteristics of the supply of psychotherapeutic care, therapeutic time contingents per patient and their utilisation and demographic and socio-economic features of patients. Evaluating the survey, the results were analysed overall and by groups of therapists varying in demographic features, professional qualifications and regional criteria, using bivariate as well as multivariate methods. RESULTS: The study provides evidence indicating an underprovision of outpatient psychotherapeutic care. Psychotherapists who use a waiting list reported average waiting times of more than 2.5 months. Additionally there are differences in psychotherapeutic care between various patient groups. In regions with lower population density we found less provision of psychotherapeutic care compared to regions with higher population density. Taking into account epidemiological data, the study indicates that the participation of men, persons of older age and patients with lower levels of education in psychotherapeutic care is below average. CONCLUSION: The results suggest a considerable degree of underprovision and inadequate provision of outpatient psychotherapeutic care. With regard to special population groups, further research is necessary to identify utilisation barriers towards psychotherapy.

Werbart, A., Levin, L., Andersson, H. et Sandell, R. (2013). "Everyday evidence: Outcomes of psychotherapies in Swedish public health services." Psychotherapy (Chic) **50**(1): 119-130.

This naturalistic study presents outcomes for three therapy types practiced in psychiatric public health care in Sweden. Data were collected over a 3-year period at 13 outpatient psychiatric care services participating in the online Quality Assurance of Psychotherapy in Sweden (QAPS) system. Of the 1,498 registered patients, 14% never started psychotherapy, 17% dropped out from treatment, and 36% dropped out from data collection. Outcome measures included symptom severity, quality of life, and self-rated health. Outcomes were studied for 180 patients who received cognitive-behavioral, psychodynamic, or integrative/eclectic therapy after control for dropout representativity. Among treatment completers, patients with different pretreatment characteristics seem to have received different treatments. Patients showed significant improvements, and all therapy types had generally good outcomes in terms of symptom reduction and clinical recovery. Overall, the psychotherapy delivered by the Swedish public health services included in this study is beneficial for the majority of patients who complete treatment. Multilevel regression modeling revealed no significant effect for therapy type for three different outcome measures. Neither did treatment duration have any significant effect. The analysis did not demonstrate any significant therapist effects on the three outcome measures. The results must be interpreted with caution, as there was large attrition and incomplete data, nonrandom assignment to treatment, no treatment integrity control, and lack of long-term follow-up.

Wetzelaer, P., Lokkerbo, J., Arntz, A., van Aselt, T., Smit, F. et Evers, S. (2017). "Cost-effectiveness and Budget Impact of Specialized Psychotherapy for Borderline Personality Disorder: A Synthesis of the Evidence." J Ment Health Policy Econ **20**(4): 177-190.

> BACKGROUND: Specialized outpatient psychotherapy for patients with borderline personality disorder (BPD) is expected to reduce their use of other health care resources. It is currently unknown to what extent the costs of providing these interventions can be expected to be offset by a reduction in other health care costs in the Netherlands. To establish the cost-effectiveness and budget impact of specialized outpatient psychotherapy, the estimated incremental costs are synthesized with the estimated incremental effects. We have developed a method for the synthesis of all relevant evidence on clinical effectiveness as well as health care resource use. AIM OF THE STUDY: The aim of this article is to present a method for the synthesis of evidence for cost-effectiveness and budget impact analysis with a specific application to specialized outpatient psychotherapy for borderline personality disorder in the Netherlands. METHODS: A systematic search of the English-language literature is performed to retrieve evidence on the clinical effectiveness and the health care resource use following 12 months of specialized outpatient psychotherapy for borderline personality disorder. The available evidence is used as an input for a model-based economic evaluation. Simulated patient-level data are used to provide overall estimates of the incremental costs and incremental effects, which serve to assess the cost-effectiveness and budget impact of specialized outpatient psychotherapy for borderline personality disorder in the Netherlands. RESULTS: The results indicate that specialized outpatient psychotherapy for BPD can be considered cost-effective and that its scaling up to Dutch national level would require an investment of 2.367 million (95% C.I.: 1,717,000 - 3,272,000) per 1,000 additional patients with BPD. Sensitivity analyses demonstrated the robustness of our findings in light of several uncertain components and assumptions in our calculations, but also their sensitivity to the choice of included studies based on the comparator condition and the assumption of high intervention costs. DISCUSSION: We present a method for the synthesis of evidence from different types of studies in a way that respects the uncertainty surrounding those findings. Limitations of the study pertain to the inclusion of findings from studies with suboptimal designs, the transferability of research findings, and uncertainty regarding the time horizon considered. More research is needed on the sensitivity of our findings to the choice of included studies based on the comparator condition. IMPLICATIONS FOR HEALTH CARE PROVISION AND USE: THE results suggest that the provision of specialized outpatient psychotherapy for BPD leads to a reduction in other health care resource use. Overall, the results are promising and encourage future studies on aspects that are currently still uncertain. IMPLICATIONS FOR HEALTH POLICIES: The results may support policy makers in deciding whether or not to allocate health care budget for the provision of specialized outpatient psychotherapy for patients with BPD in the Netherlands. IMPLICATIONS FOR FURTHER RESEARCH: The results provide important directions for future research. This includes the need for future studies to make a comparison between specialized outpatient psychotherapy and treatment as usual and to have longer follow-up time.

Pour aller plus loin : quelques quelques publications de référence sur les psychothérapies

Beutler, L. E. et Mark Harwood, T. (1995). "Prescriptive psychotherapies." Applied and Preventive Psychology **4**(2): 89-100.
http://www.sciencedirect.com/science/article/pii/S0962184905800824

> This article reviews the history and foundations of the evolving prescriptive psychotherapy movement. These models share the premises that therapy procedures are most effective if tailored to the individual needs and characteristics of patients and that empirical research should form the basis for selecting and implementing treatments. A description of various prescriptive approaches is provided and directions for future research and practice are advanced.

Briffault, X. (2016). Santé mentale, santé publique : un pavé dans la mare des bonnes intentions, Grenoble : Presses Universitaires de Grenoble
http://www.pug.fr/produit/1291/9782706125669/Sante%20mentale%20sante%20publique

Jamais notre santé mentale n'a été l'objet d'autant d'attention par les pouvoirs publics. Qu'il s'agisse de nous éviter d'être déprimés, anxieux, en burn-out, agressifs envers nous-mêmes ou autrui, de trop manger, trop boire, trop fumer, etc., le dispositif de santé publique multiplie les programmes de prise en charge de notre mal-être.

Coyer, G. (2017). "Vingt ans de débats législatifs sur la réglementation du titre de psychothérapeute en France." Annales Médico-psychologiques, revue psychiatrique **175**(3): 234-240.
http://www.sciencedirect.com/science/article/pii/S0003448715002668

Résumé Les débats législatifs qui ont eu lieu en France entre 1993 et 2014 sur la formation et l'exercice des psychothérapeutes montrent la difficulté de légiférer dans un champ lié par nature à l'engagement dans la pratique et se développant dans un paysage très diversifié. Les questions débattues à l'Assemblée nationale et au Sénat se sont orientées autour de cinq pôles : l'encadrement de la formation aux psychothérapies ; le contrôle de leur exercice ; l'habilitation ou non des universités à encadrer ces formations ; la reconnaissance de compétences de professionnels non-psychologues, non-psychiatres, non-psychanalystes, se formant en dehors des universités ; le contrôle des abus de faiblesse et des mouvances sectaires. Aujourd'hui, l'encadrement légal auquel ils ont abouti n'a pas empêché que se perpétuent des pratiques des psychothérapies hors réglementation, que celles-ci soient sectaires ou non sectaires, faites d'abus ou non. Mais une réflexion à distance sur ces débats intégralement publiés dans les comptes rendus des séances de l'Assemblée nationale et du Sénat, sur les différentes propositions de loi, ses amendements, les différentes versions de ses décrets d'application et sur les rapports des commissions gouvernementales ou expertises collectives sur lesquels ils se sont appuyés – rapport de la mission interministérielle de lutte contre les sectes (MILS) 2001 ; expertise collective de l'Institut national de la santé et de la recherche médicale (Inserm) 2004 « psychothérapie : trois approches évaluées » ; commission d'enquête 2013 « dérives thérapeutiques et dérives sectaires : la santé en danger » : mission gouvernementale sur la santé mentale et l'avenir de la psychiatrie 2013 – montre qu'à l'intérieur des problématiques statutaires, institutionnelles et de politique de santé publique qui ont été soulevées, la question est aussi celle des oppositions structurelles entre les recherches d'objectivation des troubles et leur subjectivation, les conduites de traitement et les rencontres intersubjectives. Ces oppositions sont vécues comme des contradictions particulièrement sensibles en psychiatrie, mais elles la dépassent aussi dans celles plus larges, entre objectivation et subjectivation, intersubjectivité et soin, construction clinique et rapport de pouvoir/savoir. Elles appellent, pour pouvoir être non plus clivées et opposées, mais réfléchies et articulées dans leurs rapports complexes, un questionnement éthique. À défaut, elles pourraient bien soutenir dans l'évolution actuelle de la psychiatrie, d'une part, des attitudes prescriptives normées et désubjectivées et, d'autre part, des positions empathiques empiriques qui, réunies à elles deux – non pas mises en débat à partir de leur opposition, mais additionnées – caractérisent justement les dynamiques des dérives sectaires dont il a été question lors des premiers débats législatifs. The legislative debates that took place in France between 1993 and 2014 on the training and exercise of psychotherapists show the difficulty of legislating in a field linked by its very nature to engagement in practice; a field which is currently developing in France in a highly varied landscape. The questions discussed at the National Assembly and in the Senate were oriented around five poles: supervision of the training of psychotherapists; control of their exercise; recognition of the skills of those professionals who are neither psychologist, psychiatrist, or psychoanalyst, and who train outside universities; control of abuse of weakness; and sect movements. Today, the legal framework that these poles have given rise to has failed to prevent the continuation of psychotherapeutic practices that fall outside the zone of regulation, whether they are sectarian or otherwise, abusive or otherwise. However, when one takes a step back to look at the debates that have been published in their entirety in the collected proceedings of the National Assembly and the Senate, at the various Bills and their amendments, at the different versions of the implementing decrees, and at the reports from the government commissions or collective expert teams that they drew on (the report on the inter-ministerial mission for combating sects from 2001; the collective expert assessment Psychotherapy: Three Approaches Evaluated, by the Institut National de la Santé et de la Recherche Médicale, INSERM, from 2004; the 2013 inquiry Therapeutic Excesses and Sectarian Excesses: healthcare in danger; and the 2013 government mission on mental health and the future of psychiatry), we can see how, at the heart of the problematics concerning statutes, institutions and public healthcare policy which have been brought to the fore, the question is also that of the structural points of opposition between, on the one hand, research that objectifies disturbances, and, on the other, their subjectification, the treatment that is carried out, and inter-subjective encounters. These oppositions are being experienced in psychiatry as especially sensitive contradictions, but they also exceed these oppositions by encompassing the wider contradictions between objectification and subjectification, between inter-subjectivity and care, and between clinical construction and the knowledge/power relationship. In order no longer to be divided and opposed, but rather thought through and articulated in all their complexity, these oppositions call upon an ethical mode of questioning. In the direction that psychiatry is currently taking, these oppositions run the risk of supporting normative and prescriptive attitudes that are devoid of subjectification and, on the other hand, empirical empathic positions which, when matched together (rather than being debated on the basis of their opposition) characterise precisely those dynamics of sectarian excess that were in question during the first legislative debates.

Delahousse, J. (1997). "Ou en sommes-nous des psychothérapies ?" Gestions Hospitalieres(370): 750-753.

[BDSP. Notice produite par ENSP RffR0xXu. Diffusion soumise à autorisation]. Au sens le plus large du terme, on peut considérer comme psychothérapique tout ce que repose sur l'influence psychique du soignant et entraîne un effet thérapeutique chez le patient. Dans une telle perspective, on peut considérer que cette influence est constituée d'éléments très divers utilisés volontairement par le soignant ou véhiculés à son insu. Cette diversité peut aller de l'influence magique, à la suggestion, à l'utilisation raisonnée du transfert ; elle est toujours étroitement liée au contexte historique et social. (R.A.).

Doron, C. O. (2009). "Evaluation de l'efficacité des psychothérapies entre science et société." Information Psychiatrique (L') **85**(2): 131-141.

Cet article revient sur certains principes et problème de l?évaluation de l?efficacité des psychothérapies. Dans un premier temps, il étudie les principes constitutifs de l?épistémiologie de la recherche en psychiatrie, en montrant en quoi ils définissent une approche spécifique de l?efficacité et s?opposent à certains principes de la clinique, produisant une tension significative dans la recherche clinique. Dans un second temps, il analyse dans la confrontation de ces épistémiologies, des tentatives, qui comme les études naturalistes, visent à la dépasser, et montre comment elles risquent de reconduire à un autre niveau la même opposition. Enfin, en prenant acte des limites d?une approche uniquement épistémiologique, l?analyse se déplace du côté des techniques du gouvernement, montrant comment l?évaluation de l?efficacité, loin d?être un principe interne à la science, s?inscrit dans une rationalité de gouvernement à laquelle il est au moins légitime de résister.

Dumesnil, H., Cortaredona, S., Cavillon, M., et al. (2012). "La prise en charge de la dépression en médecine générale de ville." Etudes Et Resultats (Drees)(810): 8.
http://www.drees.sante.gouv.fr/etudes-et-resultats,678.html

[BDSP. Notice produite par MIN-SANTE 8BR0xjr7. Diffusion soumise à autorisation]. Les deux tiers des médecins déclarent être confrontés fréquemment à des états dépressifs de leurs patients. Neuf sur dix s'estiment efficaces dans la prise en charge de la dépression et les trois quarts ont suivi une formation sur cette prise en charge. Les stratégies de prise en charge de la dépression et leurs déterminants ont fait l'objet d'une enquête réalisée fin 2011 dans le cadre du panel de médecins généralistes de ville. La majorité des participants perçoivent les psychothérapies comme un traitement à part entière de la dépression et les jugent efficaces. Mais ils soulignent plusieurs freins à leur accès : coût, délais de rendez-vous, réticence des patients. Dans la prise en charge de la dépression, les médecins prescrivent rarement une psychothérapie seule, même dans les cas d'intensité légère, lors desquels elle est particulièrement recommandée. Deux tiers d'entre eux proposent des antidépresseurs, associés par près de la moitié des prescripteurs à une psychothérapie. Les choix de traitement semblent être influencés par les caractéristiques démographiques et personnelles des médecins et les caractéristiques sociodémographiques des patients, plus particulièrement lors de dépressions d'intensité légère.

Epping, J., de Zwaan, M. et Geyer, S. (2018). "Healthier after Psychotherapy? Analysis of Claims Data (Lower Saxony, Germany) on Sickness Absence Duration before and after Outpatient Psychotherapy." Psychotherapie Psychosomatik Medizinische Psychologie **68**(8): 337-345.
<Go to ISI>://WOS:000441453400003

Introduction In employed populations sickness absence can be used as a good indicator of health status. In the present study, it was examined how periods of sickness absence are developing within one year before and after psychotherapy under comparison of three types of psychotherapy (behavior therapy, psychodynamic psychotherapy, and psychoanalysis), all fully covered by statutory health insurance. Methods and data The analyses were performed with pseudonymized claims data from the AOK Niedersachsen, a statutory health insurance (N = 2,900,065 insured). Certified sickness absences before and after psychotherapy were examined for 9,916 patients. Parallelized controls were used to build a comparison of the length of sickness absences. Analyses were performed separately for women and for men. Results Within one year before starting psychotherapy, patients had longer sickness absences than controls on average. There was a reduction in the length of sickness absence of 20 days (median) within one year before to 12 days (median) within one year after the psychotherapy. The obtained differences between types of psychotherapy were considerable. Discussion Differences in terms of sickness absences may in part be explained by socio-demographic differences. Patients who underwent psychoanalysis were younger and had higher educational levels. However, it remains unclear why the differences of sickness absence periods were that high. It has to be discussed whether self-selection of patients with better health into psychoanalysis had occurred. Conclusions Patients undergoing psychoanalysis differ from patients who underwent other types of psychotherapy in terms of their duration of sickness absence as well as socio-demographic profile. Thus, due to differences in the composition of patients future research in psychotherapy will have to differentiate by type of psychotherapy.

Falissard, B. (2010). "Comment penser l'évaluation des psychothérapies dans le contexte général de l'évaluation des thérapeutiques ?" Annales Médico-psychologiques, revue psychiatrique **168**(2): 156-158.
http://www.sciencedirect.com/science/article/pii/S0003448709003655

Résumé La méthodologie d'évaluation des thérapeutiques médicamenteuses est bien établie. Est-ce aussi le cas en ce qui concerne les psychothérapies ? Les avis sont partagés. Quatre points méthodologiques clés relatifs à l'évaluation de toute thérapeutique seront abordés dans un premier temps : quelles sont les thérapeutiques à comparer ? Quels sont les patients inclus ? Comment évaluer l'efficacité des thérapeutiques ? Comment assurer la comparabilité des groupes de traitement ? Nous verrons ainsi que l'évaluation des thérapeutiques médicamenteuses ou psychothérapeutiques relève fondamentalement de la même méthodologie. Nous verrons enfin que l'évaluation des thérapeutiques médicamenteuses vit actuellement les débuts d'une révolution avec un possible déclin du poids des essais randomisés. Cette révolution a curieusement été anticipée par certaines méthodologies d'évaluation des psychothérapies. The methodology of evaluation of medicinal products is well established. Is this also the case with psychotherapies? The opinions are divided. Four key methodological points related to the evaluation of therapeutics will be successively approached in a first time: what are the therapeutics that will be compared? Who are the patients included? How to evaluate the effectiveness of the treatments? How to ensure the comparability of the treatments groups? We will see that the evaluation of medicinal products or psychotherapies remain basically on the same methodology. We will see in a conclusion that the evaluation of medical treatments is presently in a kind of revolution, with a decline of the role of randomized controlled trials. Curiously, this revolution has been anticipated by certain methodologies used in the evaluation of psychotherapies.

Falissard, B., Gasquet, I. et Simondon, F. (2001). "Evaluation de l'efficacité et du coût de trois stratégies de prise en charge de sujets adultes déprimés." Revue D'epidemiologie Et De Sante Publique **49**(2): 204-206.

[BDSP. Notice produite par INIST sQ4kR0xH. Diffusion soumise à autorisation].

Fischman, G. (2009). "Modèles épistémologiques de l'évaluation des psychothérapies et méthodologies de la recherche en psychanalyse." L'information psychiatrique **85**(2): 143-151.
https://www.cairn.info/revue-l-information-psychiatrique-2009-2-page-143.htm

RésuméL'auteur aborde les objections soulevées par les recherches psychothérapiques selon le modèle de la « Psychothérapie empiriquement fondée ». Cette méthodologie ne paraît pas adaptée pour évaluer de manière spécifique la thérapeutique psychanalytique. Des remarques épistémologiques et méthodologiques se proposent de signaler les différentes voies de validation des résultats à partir des modèles herméneutiques et idiographiques. Quant à la recherche empirique sur le processus psychanalytique, une attention particulière est prêtée aux protocoles de cas singuliers.

Fischman, G. d. (2009). L'évaluation des psychothérapies et de la psychanalyse : fondements et enjeux, Paris : Elsevier-Masson

Depuis la parution du rapport Inserm sur l'évaluation des psychothérapies, la polémique initiale a laissé place à un débat de grand intérêt clinique et épistémologique dont ce livre se fait l'écho. L'objectif est d'enrichir ce débat en proposant au lecteur une analyse approfondie des logiques et des méthodologies à l'oeuvre dans l'évaluation des psychothérapies et de la psychanalyse. Les auteurs interrogent les postulats et les méthodes: comment la subjectivité pourra-t-elle être mesurée afin de déterminer quantitativement les effets d'une psychothérapie? Quelles sont les recherches réalisées en psychanalyse et l'évolution actuelle des investigations sur les psychothérapies? La recherche prônée par l'evidence based medicine peut-elle établir la norme d'une psychothérapie fondée sur la science? Le livre s'intéresse également aux enjeux politiques et culturels qui sous-tendent ce débat : les résultats issus du calcul de l'efficacité deviendront-ils le seul standard pour faire face à la singularité des individus? L'idéal de l'expertise biomédicale servira-t-il une politique visant à réduire la complexité de l'humain à des considérations gestionnaire? Georges Fischman a ainsi réuni dans ce livre polyphonique cliniciens et des chercheurs qui dépassent leurs diverge] théoriques Ils proposent de nouveaux axes de réflexion sur un sujet dont les enjeux sont fondamentaux pour notre société

Gajic-Veljanoski, O., Sanyal, C., McMartin, K., et al. (2018). "Economic Evaluations of Commonly Used Structured Psychotherapies for Major Depressive Disorder and Generalized Anxiety Disorder: A Systematic Review." Canadian Psychology-Psychologie Canadienne **59**(4): 301-314.
<Go to ISI>://WOS:000448792300002

Face-to-face cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) are time-limited, structured psychotherapies recommended for the management of adult major depressive disorder (MDD) and generalized anxiety disorder (GAD). We conducted a systematic review to evaluate the reporting and methodological quality, and cost-effectiveness of economic evaluations that examined these two thoroughly researched psychotherapies. Economic studies were retrieved through systematic searches of bibliographic databases (e.g., Ovid MEDLINE, Embase, PsycINFO: January 2000 to February 2018) and grey literature. The reporting and methodological quality of the studies was independently evaluated by two reviewers using the Consolidated Health Economic Evaluation Reporting Standards (CHEERS) checklist and Quality of Health Economic Studies (QHES) tool. The cost-effectiveness results were qualitatively synthesized. Fifteen out of 161 identified economic evaluations

> were included: 14 examined CBT and one IPT. None was conducted in Canada. Based on the CHEERS criteria, overall reporting quality of the included studies was good. Eighty-seven percent of the included studies were of high quality based on the QHES criteria. Most of these studies examined the cost-effectiveness of individually delivered CBT (alone or with pharmacotherapy) over a short time horizon. CBT represented good value for money at different country-specific willingness-to-pay thresholds. The cost-effectiveness of IPT was uncertain. In conclusion, the quality of economic analyses examining structured psychotherapies is good. Face-to-face CBT represents good value for money in the management of adult MDD and GAD though no study was done in Canada. The long-term cost-effectiveness of the group versus individual format remains unclear and warrants further research.

Guery, O., Vanneste, P. et Dezetter, A. (2019). "Perception by family physician regarding the management of psychosomatic factors. Towards a professional collaboration in Belgium?" Annales Medico-Psychologiques **177**(2): 157-162.
<Go to ISI>://WOS:000460366900006

> Objectives. - The biopsychosocial model became a reference of quality in healthcare. This model insists on all psychosocial healthcare factors and invites healthcare professionals to consider all of them. When considering all the psychosomatics and psychosocial factors, the question of the participation of family physicians and psychologist is important. In Belgium, the Ministry of Health just recognized the psychologist as health care professionals to ease their integration in the healthcare system. This study is about what family physicians think about their professional practices and their perception of psychosomatics factors. Methods. - A qualitative survey by semi-structured interviews was conducted with 13 physicians in the Brussels and Hainaut area, they were asked about their daily practices, on how they work with psychologists on the management of chronic diseases and their training. Results. - It emerged that the personality and the affinities of doctors impact the management of patients. In addition, doctors want unanimously the establishment of a system of reimbursement by health insurance for psychological counseling and psychotherapy in the perspective of a better consideration of psychosomatic factors. However, adaptations of the health system must remain flexible and adaptable to the individuality of each patient. Conclusion. - Family physicians want to collaborate with psychologists and would like to incorporate Psychology into healthcare system. (C) 2018 Elsevier Masson SAS. All rights reserved.

HCSP (2016). Évaluation du plan psychiatrie et santé mentale 2011-2015. Paris HCSP**:** 226.
http://www.hcsp.fr/explore.cgi/avisrapportsdomaine?clefr=555

> Le Plan psychiatrie et santé mentale 2011-2015 a été construit autour d'objectifs stratégiques avec un rôle central des agences régionales de santé pour sa mise en œuvre. Il est décliné autour de quatre axes pour prévenir et réduire les ruptures: 1) au cours de la vie ; 2) selon les publics et les territoires ; 3) entre la psychiatrie et son environnement sociétal ; 4) entre les savoirs. Le HCSP dresse les constats suivants : ce plan est consensuel et pertinent. On constate des progrès dans la reconnaissance du rôle des personnes vivant avec des troubles psychiques et de leur entourage. Les études et les recommandations sur le handicap psychique se sont développées. On a assisté à un rôle accru des secteurs médico-social et social, et à un début de rééquilibrage de l'offre de soins. La santé somatique est mieux prise en compte et une attention a été apportée à la prise en charge en urgence et à l'accès aux soins des populations défavorisées. Il persiste cependant des difficultés : notamment une hétérogénéité des pratiques de soins et des moyens. Le HCSP regrette l'absence de remboursement des soins de psychothérapie. Le HCSP recommande d'inscrire la politique de santé mentale et de psychiatrie de façon pérenne et pilotée à long terme, avec une dimension interministérielle, plutôt que de mettre en place des plans successifs. Une enquête qualitative dans 5 régions a permis d'enrichir cette évaluation. Le rapport comporte 64 recommandations déclinées autour de cinq thèmes principaux : organisation des actions, prévention, développement des formations et soutien de la recherche, amélioration de l'accès aux soins, et amélioration des conditions de vie des personnes vivant avec un trouble psychique.

Hochmann, J. F (1996). "La place de la psychothérapie dans la prise en charge des enfants autistes." Cahiers Du Ctnerhi : Handicap Et Inadaptation(69-70): 3-16.

> [BDSP. Notice produite par CTNERHI 8CHR0x3x. Diffusion soumise à autorisation]. La psychanalyse n'est pas une entreprise de culpabilisation des parents. Les autistes relèvent, pour la plupart, plus de psychothérapies que de cures analytiques. La psychothérapie doit s'articuler avec une démarche éducative. Ce n'est que dans certaines conditions et souvent après un long traitement psychothérapique préalable qu'une analyse peut s'engager. L'article, après avoir levé quelques préalables idéologiques, décrit une expérience de psychothérapie des autistes articulée avec un travail institutionnel.

Inserm (2004). Psychothérapies : trois approches évaluées. Expertise collective. Paris INSERM**:** 553.
http://www.inserm.fr/fr/questionsdesante/mediatheque/ouvrages/expertisecollectivepsychotherapie.html

> Cette expertise collective est réalisée sous l'égide de l'Inserm à la demande de la Direction Générale de la Santé et de deux associations de patients, l'Unafam et la Fnap-psy. Elle dresse un état des lieux de la littérature internationale sur l'évaluation de l'efficacité de trois approches psychothérapiques : psychodynamique (psychanalytique), cognito-comportementale, familiale et de couple. Les principaux résultats des études d'évaluation sont présentés pour les troubles anxieux, les troubles de l'humeur, la schizophrénie, les troubles de comportements alimentaires, les troubles de la personnalité, et l'alcoolodépendance chez l'adulte. Les travaux spécifiques chez l'enfant et l'adolescent ont été également analysés.

Kalogeropoulos, C., Roquet, C., Sztopa, V., et al. (2018). "Psychologists and Psychotherapists' Practices of Psychotherapy in Quebec: What Differences Exist?" Canadian Psychology-Psychologie Canadienne **59**(4): 332-346.
<Go to ISI>://WOS:000448792300005

> The landscape of psychotherapy continues to change with the accreditation of other mental health professionals-like social workers and clinical counsellors-as psychotherapy practitioners. Data about potential similarities and differences between psychologists and psychotherapists may provide the field with a more thorough understanding of diverse aspects of psychotherapeutic practices, practitioner characteristics, and clinical training backgrounds. We employed an online survey to obtain information on the psychotherapy practices of psychologists and psychotherapists working in the private sector in Quebec as nearly half of Canadian licensed psychologists practice in Quebec. All 664 participants were licensed by the Ordre des Psychologues du Quebec (OPQ). There were significant differences between psychologists and psychotherapists. Although they both provide psychotherapy services they present with differences in: education levels, presenting problems of their clients, referrals sources, theoretical orientation, assessment and diagnostic procedures, duration of their interventions, collaboration with other health professionals, as well as fees charged for their services. These differences may relate to variances in training and/or professional development requirements for each group. Overall, the results suggest that psychologists and psychotherapists in the private sector take different approaches to the practice of psychotherapy in Quebec.

Korkeila, J. (2009). "Current trends in psychiatry care in Finland with special focus on private practice psychiatry and psychotherapy." Nord J Psychiatry **63**(1): 87-90; discussion 90-81.

> Several previous reforms decentralized Finnish psychiatric services to a great extent. The Ministry of Social Affairs and Health is outlining a proposal for Health Care Law, which makes an effort to centralize and reorganize healthcare. It is not yet possible to see what this will mean for the psychiatric services. In general, the health status of the Finnish population has improved. Although rates of suicides have declined considerably, rates of alcohol-related deaths have risen. Moreover, disability related to major depression has increased drastically, which has lead to a nationwide project

called MASTO, which has the aim to improve early detection and treatment of depression. The Ministry of Social Affairs and Health set up a work group, MIND 2009, to draft local working models for mental health and addiction services. To study the significance of psychotherapy in a private practice psychiatric context, the Finnish Psychiatric Association conducted a survey amongst its members. Most psychiatrists in private practice conduct psychotherapy.

Kovess, V., Sapinho, D., Briffault, X., et al. (2007). "Usage des psychothérapies en France : résultats d'une enquête auprès des mutualistes de la MGEN." Encephale **33**(1): 65-74.
http://www.sciencedirect.com/science/article/pii/S0013700607915602

Résumé Il n'existe quasiment aucune donnée empirique sur l'usage des psychothérapies en France. Cet article présente une étude concernant les pratiques psychothérapiques à partir de données déclarées par les patients : fréquence des psychothérapies, caractéristiques des personnes qui les suivent, modalités de suivi, association avec différents traitements, lieux de traitement, motifs invoqués et pathologies déclarées. Les données sont issues d'une enquête santé conduite par la fondation MGEN auprès de 6 500 adhérents de la mutuelle, comparées aux données existantes dans d'autres enquêtes. La fréquence de recours à la psychothérapie au moins une fois dans la vie est relativement élevée, puisque suivant les études de 5 à 11,5 % des répondants y ont eu recours. Les femmes, nées au début des années 1960, sont celles qui, au moment de l'enquête, avaient le plus souvent consulté. Pour les hommes, ce sont ceux nés à la fin des années 1950 qui avaient, au moment de l'enquête, le plus souvent consulté. La très grande majorité de ces psychothérapies sont faites en individuel, dans des cabinets privés ; elles durent souvent plus d'une année et ont lieu une fois par semaine ou plus ; 30 % des personnes déclarent avoir entrepris plusieurs thérapies. Les motifs tels que déclarés par les patients sont essentiellement les troubles dépressifs et anxieux. La satisfaction est importante, puisque plus de 90 % des personnes se déclarent satisfaites des résultats, et 60 % estiment qu'elles ont été améliorées beaucoup et durablement ; 77,5 % des personnes qui déclarent suivre une psychothérapie ont consommé au moins un traitement médicamenteux et 70,8 % un psychotrope. L'ensemble de nos résultats montre l'importance jouée par les pratiques psychothérapiques dans le paysage français, et la nécessité d'étudier ces techniques et de réfléchir à la place qui doit leur être faite dans une politique de santé mentale. Summary Introduction Today in France, little empirical data on the use of psychotherapy is available. This paper presents an empirical study of psychotherapeutic practices, from the patient's point of view. We will present results regarding frequency of psychotherapies, patients characteristics, associations between different kinds of therapy, where they take place, and the reasons given for beginning psychotherapy. Methodology Data is based on a general and mental health survey conducted by MGEN1 is a professional-based health insurance (school and university teachers) and their relatives : 60 % are teaching. It has nation-wide coverage, with around 3 million people (mainly women, between 40-60 years). The basic coverage (SS) plus complement a 95 % coverage provides a comprehensive insurance system (drugs, medical care, hospitalization) foundation among 6 500 persons, as well as on general population data collected by the BVA survey institute. Results Depending on the population studied, between 5 to 11.5 % of people have had psychotherapy sessions at least once in their lifetime. Women born at the beginning of the sixties and men born at the beginning of the fifties are those who consulted the most. The vast majority of these psychotherapies are individual, in private practice. They often last more than one year, with a frequency of once per week or more. Thirty percent declare that they have undergone several psychotherapies. The reasons for consultation reported by users are mainly depression or anxiety. There are significant differences between genders for the reasons for consultation, women being concerned by depression, problems with sleep and food, and men being concerned by obsessive thoughts and addiction (alcohol, tobacco). People undergoing psychotherapy give an average of 2.5 reasons for this psychotherapy, and only 28 % gave only one reason. A relationship exists between the number of consecutive treatments and the number of reasons given for undergoing psychotherapy. More than 25 % of the psychotherapies last less than 6 months. « Intensive psychotherapy » (at least 6 months and a frequency of 2 to 3 times per month) concern 5.9 % of the whole population studied, and represent 51.4 % of all psychotherapies. People are quite satisfied by their psychotherapy ; 90 % are satisfied with the results and 60 % believe that their

> condition has been much improved in a durable manner. 16.6 % were unsatisfied with the results. There is (in women only) an association between satisfaction and intensity of treatment ; satisfaction is lower in those women undergoing intensive psychotherapy ; 77. 7 % of users have also used some sort of drugs for the problem (80.6 % of women and 69.9 % of men) with psychotropic drugs most frequently used : 70.8 % of the psychotherapy users had taken such drugs for their problem (women 72.9 %, men 65.4 %). Conclusion In France, psychotherapies are playing an important role and it is necessary to study these techniques better in order to give them the place they deserve in the French mental health policy.

Kovess-Masfety, V. et Husky, M. (2016). "Recours à la psychothérapie en France : résultats d'une enquête épidémiologique dans quatre régions." Actualite Et Dossier En Sante Publique(97): 10-15.

> [BDSP. Notice produite par EHESP Jnk8R0xA. Diffusion soumise à autorisation]. A l'heure actuelle, seules les enquêtes épidémiologiques peuvent nous renseigner sur le suivi de psychothérapies au sein de la société française. Une enquête menée dans quatre régions nous révèle que 7% de la population suivent une psychothérapie. Pour plus de la moitié, elle a été réalisée auprès d'un psychiatre et pour 30% auprès d'un psychologue. Des travaux supplémentaires sont néanmoins nécessaires pour comprendre le type de psychothérapies dispensées et établir des recommandations de bonnes pratiques.

Lang, J. P., Jurado, N., Herdt, C., et al. (2019). "L'éducation thérapeutique pour les patients souffrant de troubles psychiatriques en France : psychoéducation ou éducation thérapeutique du patient ?" Revue D'epidemiologie Et De Sante Publique **67**(1): 59-64.
http://www.sciencedirect.com/science/article/pii/S0398762018313634

> Résumé Position du problème La psychoéducation ou l'éducation thérapeutique du patient pourraient s'intégrer efficacement aux traitements des patients souffrant de troubles psychiatriques. Ces deux thérapies éducatives ont démontré leur efficience et ont des objectifs communs pour améliorer la morbidité de la maladie, l'observance du traitement et la qualité de vie du patient en le formant à devenir un acteur privilégié de son soin. Elles ont des modalités d'application et des exigences différentes. Leur intégration aux soins psychiatriques ne semble pas à la hauteur des enjeux cliniques ou institutionnels. Il convient de préciser leurs spécificités et de s'interroger sur les facteurs qui influencent l'investissement et le développement de ces deux thérapies en psychiatrie. Méthode Nous avons effectué une recherche bibliographique et analysé les programmes d'éducation thérapeutique du patient validés avec la collaboration de l'Agence régionale de santé. Nous avons ensuite discuté la littérature à partir de nos expériences de cliniciens psychiatres formés à ces thérapies. Résultats Malgré un cahier des charges peu contraignant et de nombreuses expérimentations, la psychoéducation semble s'être peu développée en psychiatrie. Les programmes d'éducation thérapeutique du patient en psychiatrie ont été multipliés par deux en quatre ans mais ne représentent que moins de 4 % des programmes validés en France et 154 programmes pour 1175 secteurs publics de psychiatrie en 2016. L'éducation thérapeutique du patient dispose d'une légitimité législative et de recommandations cliniques qui rendent propice son intégration aux soins et à la formation des intervenants en psychiatrie. Sa rigueur d'élaboration, son obligation de formation et son financement potentiel pourraient sécuriser le développement de l'éducation thérapeutique dans l'institution et aider à la modification des pratiques professionnelles et de la culture de soins des soignants en santé mentale vis-à-vis de cette pratique. Conclusion L'éducation thérapeutique a une place conséquente à prendre en psychiatrie avec un réel bénéfice pour les usagers et leurs familles mais aussi pour les pratiques de soins et leurs coûts. L'éducation thérapeutique du patient, adaptée au handicap psychique, peut faciliter plus efficacement cette prise en soin en aidant les malades à se prendre en charge et à réaliser leurs projets de vie.

Lapalme, M., Moreault, B., Fansi, A., et al. (2018). Accès équitable aux services de psychothérapie au Québec. Québec : Iness**:** 124p.

https://www.inesss.qc.ca/fileadmin/doc/INESSS/Rapports/ServicesSociaux/INESSS_Acces-equitable-psychotherapie.pdf

L'ampleur des problèmes de santé mentale et des troubles mentaux incite les autorités responsables de la santé de nombreux pays à se pencher sur l'accessibilité aux soins et aux services psychologiques. Plus d'une personne sur cinq sera aux prises avec un trouble mental au cours de sa vie. Les troubles anxieux et les troubles dépressifs représentent près des deux tiers de l'ensemble des troubles mentaux. On sait que lorsqu'ils ne sont pas traités, les problèmes de santé mentale et les troubles mentaux ont tendance à devenir de plus en plus sévères, récurrents et chroniques. Pourtant, moins de la moitié des personnes consultent pour ces problèmes. La crainte de la stigmatisation et les enjeux qui limitent l'accès aux interventions psychologiques dans le réseau public figurent parmi les obstacles observés. Les préoccupations soulevées par cette réalité ont conduit le ministère de la Santé et des Services sociaux (MSSS) à confier à l'INESSS le mandat d'éclairer les décideurs sur les enjeux organisationnels et économiques qui permettrait d'améliorer l'accès aux services de psychothérapie pour la population québécoise. Cet état de connaissances répond aux quatre questions d'évaluation formulées par l'INESSS dans le but d'éclairer le MSSS soit : Qui devrait avoir accès à la psychothérapie ? Lorsque la psychothérapie est indiquée, quelles sont les modalités à privilégier ? À quelle étape du traitement, la psychothérapie doit-elle être envisagée ? Quels sont les coûts et les bénéfices associés à la psychothérapie ?

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[BDSP. Notice produite par ORSMIP Cm8R0xIm. Diffusion soumise à autorisation]. Commentaire de l'article "" Pour eux c'est seulement à propos de la mortalité ". La production des données et ses conséquences dans le déroulement d'un essai clinique." (Charlotte Brives) de ce même numéro.

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Recent publications (i.e., Chodos, 2017; Peachy, Hicks, & Adams, 2013) have made many recommendations for improving access to psychological services for all Canadians but lack a focus on rural and northern (R&N) populations. Limited access to psychologists' expertise is demonstrable in R&N regions, where resources are particularly strained. This article examines the recommendations through the lens of the R&N psychologist, including those that aim to change existing service delivery models and increase funding. The authors highlight the unique challenges (e.g., recruitment and retention of professionals) and opportunities (e.g., a history of maximizing limited resources) inherent to R&N psychological practice in Canada. We also suggest strategic maximization of current resources (e.g., use of technology to reach remote locations, increased use of stepped care models) alongside a much needed increase of overall support for psychological service provision in R&N areas, particularly among Indigenous communities; we strongly encourage cultural sensitivity and local consultation prior to implementation of psychological services within Indigenous communities.

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Principes de base d'une psychotherapie analytique et application chez la personne agee dans le but d'une consolidation du moi

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Résumé Objectifs Le rétablissement, ou recovery, décrit un processus qui permet aux personnes souffrant de troubles psychiques de vivre dignement avec leur maladie, sans égard à la sévérité ou persistence éventuelle des symptômes de celle-ci, et de retrouver une place de citoyen à part entière dans la société. Dans le droit de fil de ce concept, le soutien par les pairs s'est développé rapidement dans le monde, au départ dans un contexte de bénévolat. Depuis quelques années, ce phénomène tend vers une plus grande formalisation, et des expérimentations en faveur de l'intégration de pairs aidants professionnels rémunérés dans des équipes de soins traditionnelles ouvertes à cette approche ont eu lieu dans de nombreux pays. Dans ce contexte, l'objectif de notre étude est de faire une synthèse des programmes de pairs aidants professionnels et rémunérés en France, et de tenter d'identifier les difficultés que rencontrent ces projets. Méthodes Notre travail est une revue de littérature nationale et internationale en français et anglais, effectuée à partir de bases de données médicales et psychologiques, sur une période récente : 2005–2016. Résultats En France, l'émergence de telles politiques est récente mais réelle, à travers des projets expérimentaux pour la plupart toujours en cours. Ces programmes ont suscité un vif intérêt de la part des associations d'usagers et de familles, mais également de vives tensions au sein du système de soins. Conclusions Nous terminerons notre article par des recommandations issues de l'expérience internationale mais également du contexte français. Objectives Recovery is a process through which people experiencing mental illness learn to live with their disorder and reach social insertion and citizenship. This positive approach focuses on a person's competencies and strengths rather than on the symptoms. Within this philosophy, peer support has been unevenly developing in mental health services worldwide with roots in the South-American social programs for homeless people and in the American recovery circles in the field of addiction. Therapeutic efficiency of peer support has been proven by several studies including a control group, as being at least as good as traditional services and even better in some specific areas such as reduction of need for emergency services and ability to reach "difficult" patients. The integration of former psychiatric services users in mental health services can take several forms, from the participation to scientific research studies to the direct involvement in a professional team at mental health facilities. In this context, our research aims to sum up the situation in France in comparison with other countries. Methods We conducted a worldwide literature review in English and in French on peer support experiences and policies in mental health services, using medical and psychological databases (PsycInfo, PsycArticles, SantéPsy, Cairn, Medline, Wiley Interscience and PubPsych) on a recent period: 2005–2016. In total, 32 relevant scientific papers have been included in our research. In some cases, we have also used official reports, blogs, Internet sites, and mass media articles when they were relevant. Results Our results show that this movement has been long to develop in France, with controversies having been raised since the beginning on the role that peers should play and confusion with existing social integration programs in the associative sector. Drawing inspiration from the Canadian model, a recent "peer mentor" initiative has been analyzed after 2 years of existence: many benefits for services users such as the optional aspect of this care process, a more authentic therapeutic relationship, a less normative frame, an active partnership, and a more optimistic philosophy aiming to make "small steps" towards improvement have been reported. Health professionals and peer mentors themselves have found benefits during the process. However, several limits such as difficulties to find a place with regards to the psychiatric team and difficulties to take advantage of the peer specificity, resulting in a significant attrition of the number of peer mentors, could be observed. A few other important initiatives focused on social insertion and using the help of professional peer support have been developed in recent years, but they seem to have encountered the same issues about positioning themselves both in terms of day-to-day integration in the professional environment and in the job title given by institutions which rarely corresponds to their experience and specificity. In addition, it remains difficult to obtain reliable information, as only a few papers have been published on this matter. Also, while some evaluation studies are currently being carried out, independent quantitative studies of the few running programs seem to lack in this field. Conclusions In our presentation, taking into account the difficulties that were raised in French programs and the lessons of practical experiences at work in other countries, we propose recommendations for larger and more effective implementations of peer support programs in France. As this new kind of care is emerging and seems promising in terms of benefits for not only the users but also the peer supporters and the teams of health professionals, we also insist on the need for a systematic scientific and objective evaluation of the programs.