Evaluatie van de eerstelijnspsychologische zorg : de meerwaarde vanuit een public-health perspectief

Prof. Ronny Bruffaerts

POPULATION STUDIES CENTER
INSTITUTE FOR SOCIAL RESEARCH

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18 december 2018…

EN FR NL

Andere informatie en diensten van de overheid www.belgium.be

Psychologencommissie
Commission des Psychologues

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Conventie terugbetaling klinisch psychologie

Deze legislatuur werd een budget vrijgemaakt van 22,5 miljoen voor de terugbetaling van bepaalde vormen van klinisch psychologische zorg. Maandag 17/12/2018 legde het Verzekeringscomité van het RIZIV de modaliteiten van deze financiering vast in een conventie. Indien u op deze conventie wenst in te tekenen, moet u hiervoor een aantal stappen zetten.

NIEUWS

Terugbetaling psychologen: stand van zaken

21 december 2018

Vanaf maart zou de terugbetaling van sessies bij een klinisch psycholoog eindelijk van start gaan. Maar pas op: niet iedereen kan hiervan genieten, je kunt niet bij eender welke psycholoog terecht, en het aantal sessies is beperkt.

Kader en situering terugbetaling klinisch psycholoog / orthopedagoog in België

Prof. Ronny Bruffaerts

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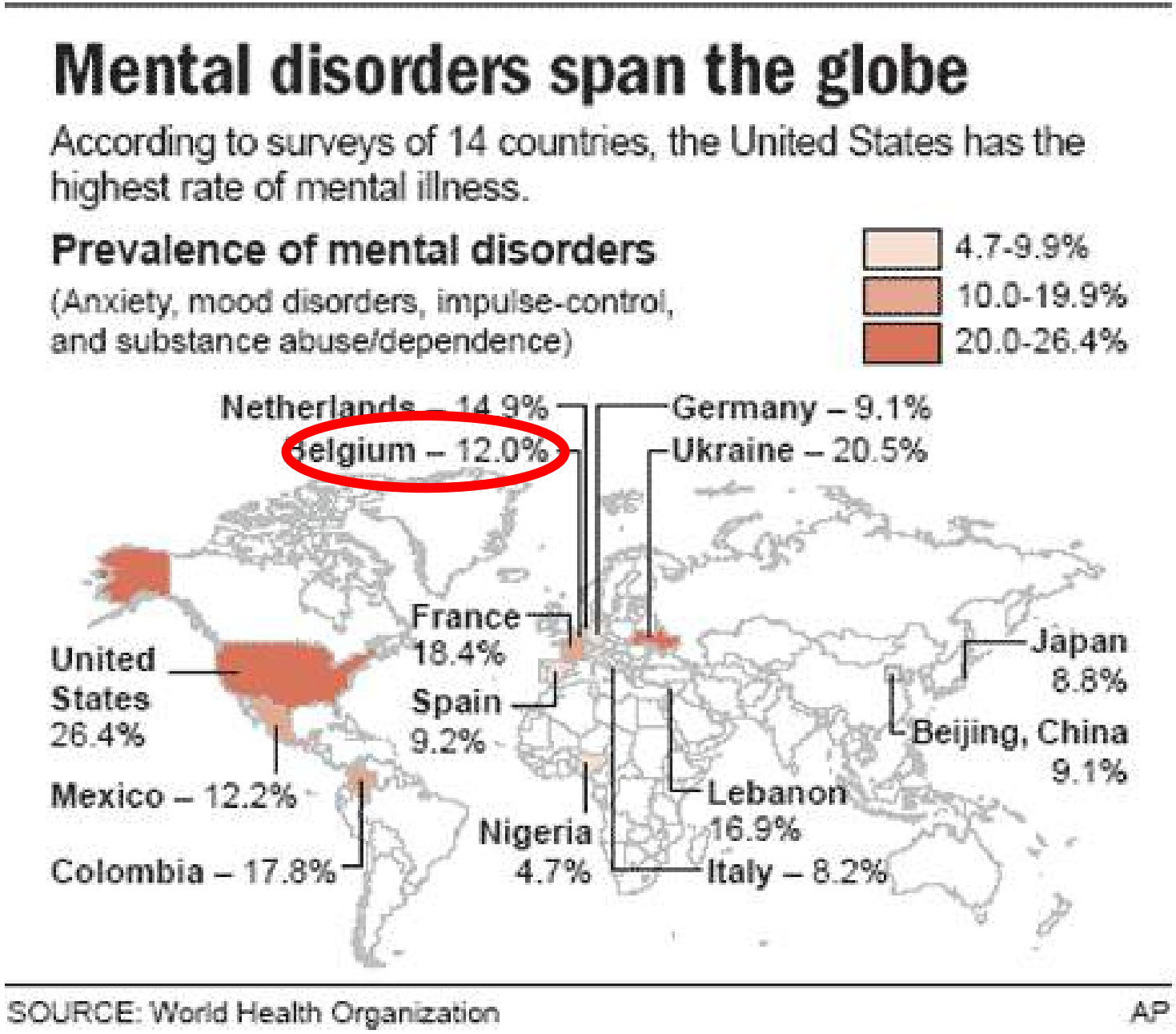
Public health perspectief op psychische gezondheid



12-14% laatste jaar; 1/3 *ooit* een stoornis;
50-70% van de stoornissen zijn mild

Demyttenaere, Bruffaerts, Possada-Villa, et al. JAMA, 2004

Psychische *stoornissen* in de Belgische maatschappij (18+)

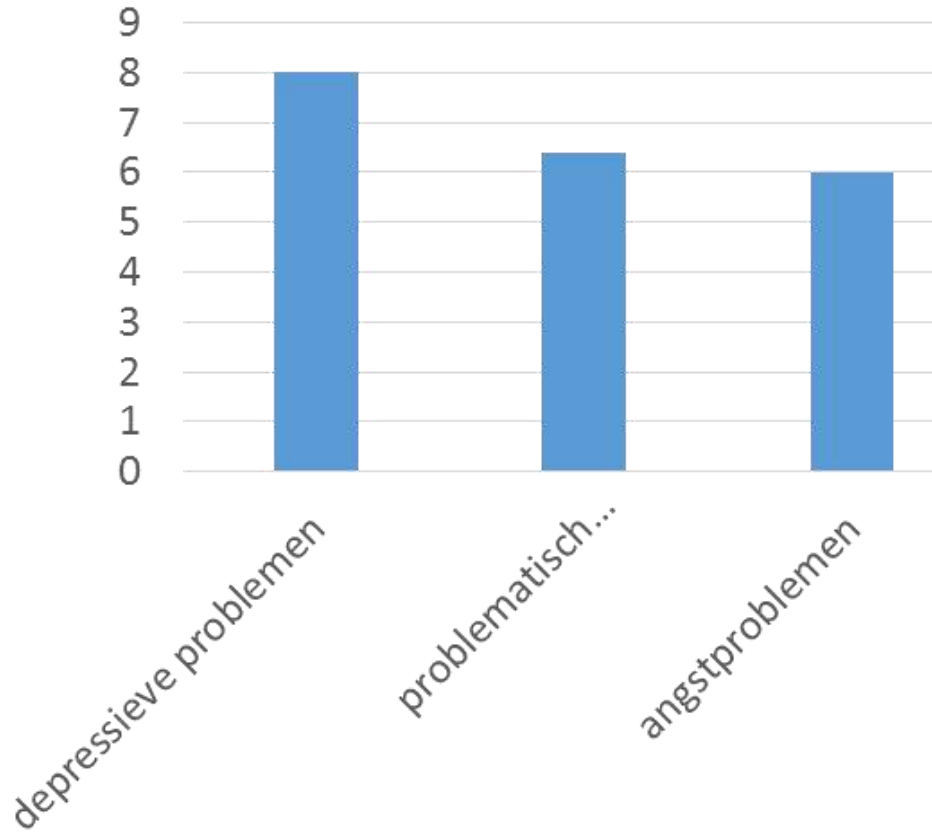
	12 m	aanvang	in behandeling	Uitstel zorg
Minstens één stoornis	12-13%	21-24j	40%	>10j
Depressie	6-8%	38j	51%	1
Angststoornis	6%	14j	38%	16
Alcoholgerelateerde stoornis	2%	23j	21%	18
Impulscontrolestoornis	2%	9j	22%	
Suïcidaliteit	**1%**	**30j**	**64%**	
Suïcidepoging	0.3%			

Baruffol & Thilmany, 1993; Ansseau et al., 1999; Bruffaerts et al., 2004; 2008; 2011; 2014; Demyttenaere et al., 2004; Kittel et al., 1997; Bietlot et al., 2000; Bonnewyn et al., 2007; Nock et al., 2008

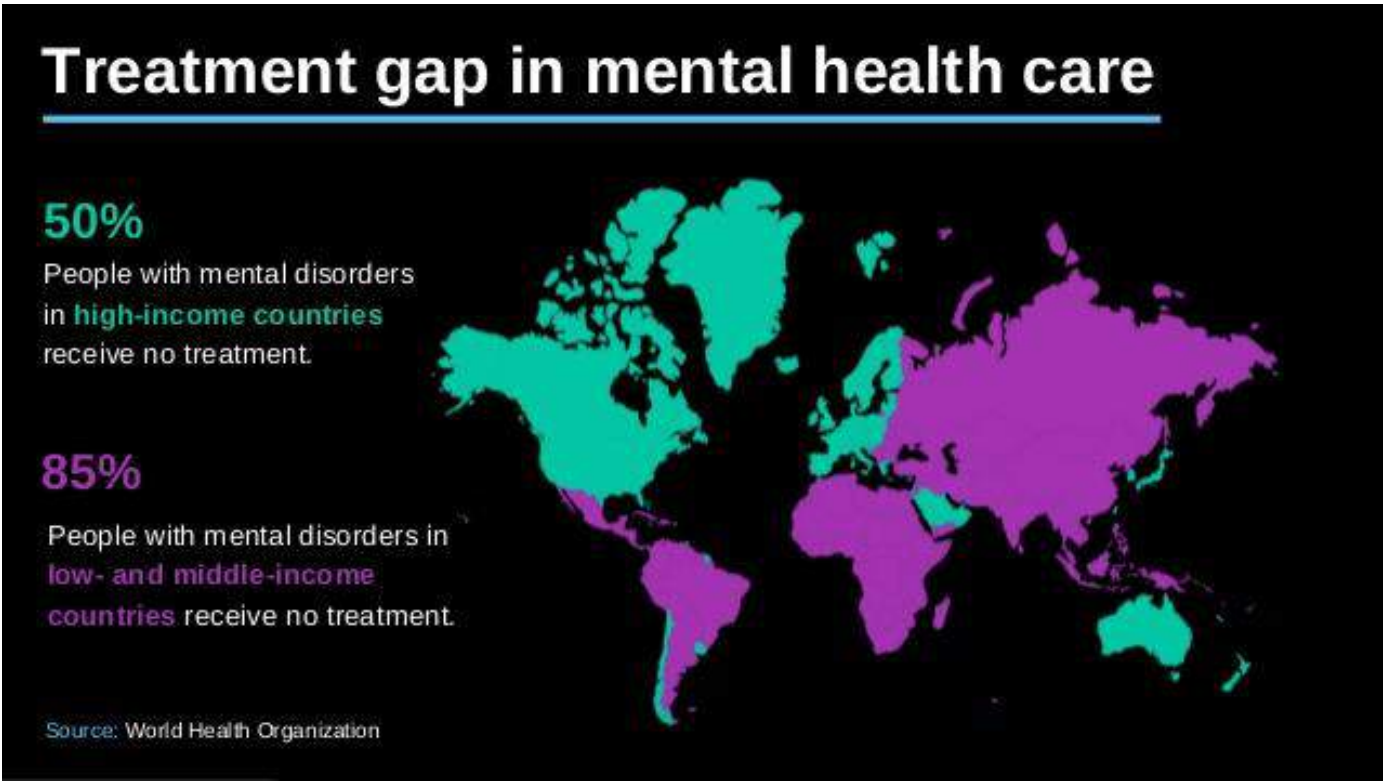
Psychische *problemen* in de maatschappij

- 12-maand prevalentie van *psychische problemen*
  - Internationaal ~13% (18+)
  - België (psychosociale problemen) ~11% (18+)
  - België (niet-ernstige psychische st.) ~14.5% (18-64)

- Meest prevalente psychische problemen
  - Depressieve problemen ~8%
  - Problematisch alcoholgebruik ~6%
  - Angstproblemen ~6%



Bruffaerts et al., 2015; 2009; Van der Heyden et al., 2010



- **4/10 zoekt hulp**
- **4/10 stelt hulp uit (~12 jaar)**
- **2/10 komt niet tot hulp**

Evoluties de laatste jaren:

- **Aantal personen dat effectief hulp zoekt stijgt aanzienlijk**
- **Vooral een toename bij de huisarts & spoeddiensten**

Thornicroft G, Chatterji S, Evans-Lacko , 2017 et al., Br J Psychiat; WHO, 2013

Behandeling psychische stoornissen in België

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Unmet need

Onbehandelde stoornissen
~6.2% van de algemene bevolking,
~60% van de personen met stoornissen,
Lange uitsteltijd tot behandeling

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Overmet need

Te gespecialiseerde ambulante behandeling voor
~11% van psychiatrische behandelingen,
(Te) snel naar (te) lange gespecialiseerde psychiatrische zorg

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Met need

Behandelde stoornissen
~40% van de personen met stoornissen,
Maar lage accuraatheid van behandeling (11-30%)

Hoe omgaan als maatschappij met *unmet* en *overmet* need?

		UNMET NEED	BEDDENCAPACITEIT	AANTAL_PSYCHIATERS	AANTAL_PSYCHOLOGEN	AANTAL_HUISARTSEN
UNMET NEED	Correlation Coefficient	1,000	,023	,006	,025	,025
	Sig. (2-tailed)	.	,340	,798	,311	,311
	N	1661	1661	1661	1661	1661
BEDDENCAPACITEIT	Correlation Coefficient	,023	1,000	,186(**)	,731(**)	,731(**)
	Sig. (2-tailed)	,340	.	,000	,000	,000
	N	1661	1661	1661	1661	1661
AANTAL PSYCHIATERS	Correlation Coefficient	,006	,186(**)	1,000	,584(**)	,584(**)
	Sig. (2-tailed)	,798	,000	.	,000	,000
	N	1661	1661	1661	1661	1661
AANTAL PSYCHOLOGEN	Correlation Coefficient	,025	,731(**)	,584(**)	1,000	1,000(**)
	Sig. (2-tailed)	,311	,000	,000	.	.
	N	1661	1661	1661	1661	1661
AANTAL_HUISARTSEN	Correlation Coefficient	,025	,731(**)	,584(**)	1,000(**)	1,000
	Sig. (2-tailed)	,311	,000	,000	.	.
	N	1661	1661	1661	1661	1661

- Behandeling onafhankelijk van **toegankelijkheid**
  - Onze ambulante ggz is toegankelijk en toch zoeken niet meer personen professionele hulp

- Behandeling onafhankelijkheid van **hoeveelheid** zorgverleners
  - Geen verband tussen # bedden, # psychiaters, #psychologen, # huisartsen

Van den Broeck, K et al 2017 Why Collaborative Care for Depressed Patients is so Difficult: A Belgian Qualitative Study. *International Journal of Integrated Care*, 17(2): 7, pp.1–9, DOI: https://doi.org/10.5334/ijic.2491

RESEARCH AND THEORY

Why Collaborative Care for Depressed Patients is so Difficult: A Belgian Qualitative Study

Kris Van den Broeck*, Frédéric Ketterer†, Roy Remmen‡, Marc Vanmeerbeek†, Marianne Destoop*,§ and Geert Dom*,§

Although current guidelines recommend collaborative care for severely depressed patients, few patients get adequate treatment. In this study we aimed to identify the thresholds for interdisciplinary collaboration amongst practitioners when treating severely depressed patients. In addition, we aimed to identify specific and feasible steps that may add to improved collaboration amongst first and second level Belgian health care providers when treating depressed patients. In two standard focus groups (n = 8; n = 12), general practitioners and psychiatrists first outlined current practice and its shortcomings. In a next phase, the same participants were gathered in nominal groups to identify and prioritise steps that could give rise to improved collaboration. Thematic analyses were performed. Though some barriers for interdisciplinary collaboration may seem easy to overcome, participants stressed the importance of certain boundary conditions on a macro- (e.g., financing of care, secure communication technology) and meso-level (e.g., support for first level practitioner). Findings are discussed against the background of frameworks on collaboration in healthcare and recent developments in mental health care.

frontiers in Psychiatry

ORIGINAL RESEARCH
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Designing easy access to care for first-episode psychosis in complex organizations

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[2]Division of Mental Health and Addiction, Oslo University Hospital, Oslo, Norway
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Email: k.l.romm@medisin.uio.no

Aims: Developing early intervention services (EIS) in healthcare organizations (HCOs) is difficult because it is necessary to integrate service approaches across units. To accommodate the needs of patients and relatives, Oslo University Hospital (OUH) chose to use service design (SD) to redesign their first-episode services with an emphasis on easy access to care. This paper discusses the results and how SD can help to overcome known barriers to change in complex organizations.
Method: SD is a method that relies on principles of participation, innovation and visualization to develop coherent services. The method emphasizes the exploration of a problem area from the perspective of multiple stakeholders to create a shared understanding of the complexity. Idea generation, visualization and early modelling of possible solutions are employed to test alternatives involving stakeholders.
Results: A low threshold EIS was developed. A helpline with a specialist managing the phone was established. High-quality assessment regarding possible psychosis development was thus made available to patients, relatives and professionals, eliminating the need for paper referral. This approach was supported by a communication strategy that includes web-based information. A dedicated cross-specialist team was established to increase collaboration in complex

Care Coordination Can Reduce Unmet Needs of Persons With Severe and Persistent Mental Illness

Anton Isaacs[1], Alison Beauchamp[2], Keith Sutton[2] and Nilay Kocaali[3]*

[1] School of Rural Health, Monash University, Traralgon, VIC, Australia, [2] Department of Rural Health, Monash University, Warragul, VIC, Australia, [3] Gippsland Primary Health Network, Traralgon, VIC, Australia

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Review

Addressing the treatment gap: A key challenge for extending evidence-based psychosocial interventions

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Models of intervention delivery

ABSTRACT

Remarkable progress has been made in developing psychosocial interventions for a broad range of psychiatric disorders for children, adolescents, and adults. In addition many efforts are well underway to address the research-practice gap, which refers to the dissemination evidence-based treatments from controlled settings to clinical care. The present article focuses on the treatment gap, which refers to the discrepancy in the proportion of the population in need of services and the proportion that actually receives them. Currently, in the United States (and worldwide), the vast majority of individuals in need of mental health services receive no treatment. Although there are many reasons, the dominant model of delivering psychosocial interventions in both research and clinical practice makes it difficult to scale treatment to reach the large swaths of individuals in need. That model includes one-to-one, in person treatment, with a trained mental health professional, and provided in clinical setting (e.g., clinic, private practice office, health-care facility). The article discusses the development of delivery models that would permit reaching more individuals in need, highlights criteria for developing such models, and illustrates novel models already available. The article proposes that our next challenge is to reach individuals in need with the many excellent interventions we have developed but through a diversified set of delivery models.

NORDIC JOURNAL OF PSYCHIATRY
2019, VOL. 73, NO. 1, 36–43
https://doi.org/10.1080/08039488.2018.1551929

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Addressing organizational barriers to continuity of care in the Danish mental health system – a comparative analysis of 14 national intervention projects

Mette Marie Kristensen, Ida Nielsen Sølvhøj, Amalie Oxholm Kusier and Anna Paldam Folker

National Institute of Public Health, University of Southern Denmark, Copenhagen, Denmark

ABSTRACT

Background: Continuity of mental health care is central to improve the conditions of people with enduring mental disorders. In Denmark, several government-funded projects on the improvement of continuity of mental health care have been initiated since 2009.
Aim: The aim of this study was to investigate how national intervention projects on continuity of mental health care have addressed major barriers for continuity of care and extract general learning points from the projects on the improvement of continuity of care.
Method: The study was designed as a thematic document analysis of external evaluations of 14 major national projects on the improvement of continuity of routine mental health care from 2009 to 2017. The data material was processed through thematic coding and comparative analysis.
Results: The analysis was organized around four main barriers for continuity: Lack of models for collaboration, different professional cultures and methods, lack of channels of communication, and intersectoral differences in management, economy, and legislation. The first three barriers were addressed in a predominant part of the projects through development of collaborative models, common tools and communication systems. The latter structural barrier was not addressed in any of the projects.
Conclusion: There is an ongoing need to address barriers for continuity of mental health care. So far, there has been a much larger focus on organizational, cultural and communicational aspects of continuity than on structural aspects. The study calls for an increased focus on how changes in existing managerial, economic and legislative structures can improve continuity of care.

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KEYWORDS
Continuity of care; psychiatry; mental health care; mental health rehabilitation; intersectoral collaboration

EDITORIAL

Nick Kates, M.B.
Hamilton, Ontario

Psychiatric Networks in Canada

The last 15 years have seen a rapid expansion in community mental health services across Canada. While this expansion has brought many benefits, it has also created some unanticipated problems. Foremost, among these has been poor coordination of services, exemplified by a lack of communication among programs, duplication of services, little collaborative planning and limited local accountability for individual services.

In response to this, coordinated planning initiatives aimed at more effective use of psychiatric resources are now underway in most provinces and communities (1,2). These have been accelerated by funding cutbacks and a recognition of the value of better coordinated local programs. Increasingly, communities are establishing integrated networks of mental health services, something that is fast becoming a rallying cry

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- Gecoördineerde zorg / getrapte zorg
- Samenwerking samenwerken samenwerken (huisarts, psycholoog, psychiater)
- Continuïteit van zorg
- Laagdrempeligheid
- Lage kost

Public health perspectief op wetenschappelijke evaluatie van de eerstelijnspsychologische zorg

3 evidente vragen …

- Is het goed voor de patiënt?
- Is het goed voor de psycholoog?
- Is het goed voor de maatschappij?

~~3~~6 evidente vragen …

- Is het goed voor de patiënt?

Mate van implementeerbaarheid interventie?

- Is het goed voor de psycholoog?

Mate van generaliseerbaarheid van effecten?

- Is het goed voor de maatschappij?

Mate van participatie van de actoren?

Niet enkel patiënt, ook context en actoren

~~36~~ 15 evidente vragen …

- Is het goed voor de patiënt?
- Is het goed voor de psycholoog?
- Is het goed voor de maatschappij?

Mate van implementeerbaarheid interventie?

Mate van generaliseerbaarheid van effecten?

Mate van participatie van de actoren?

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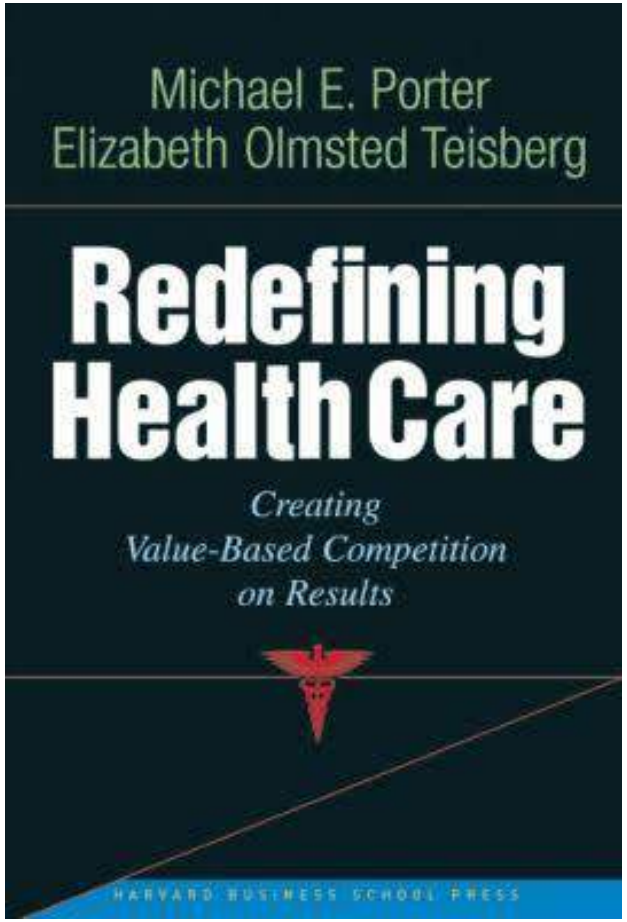

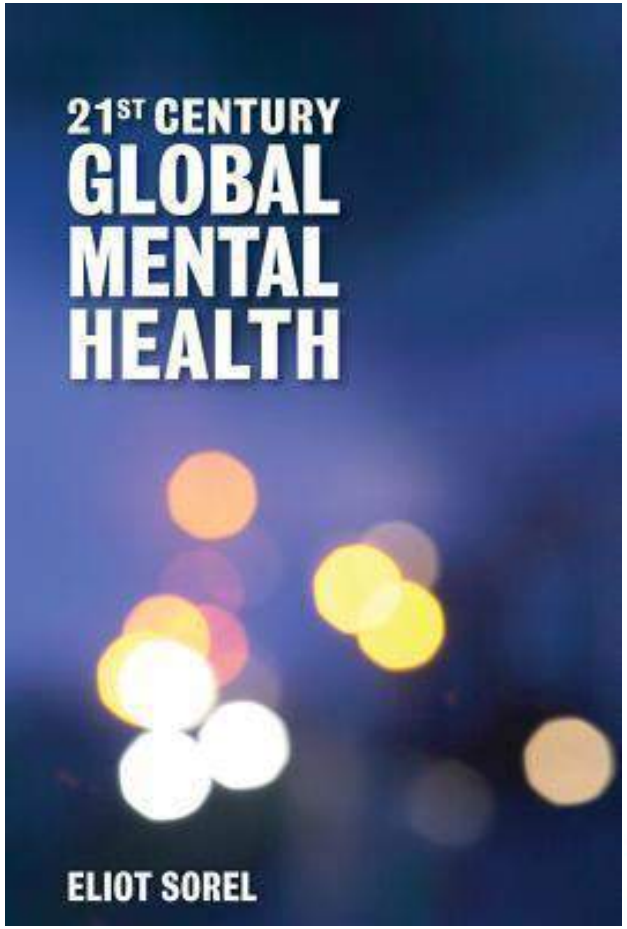

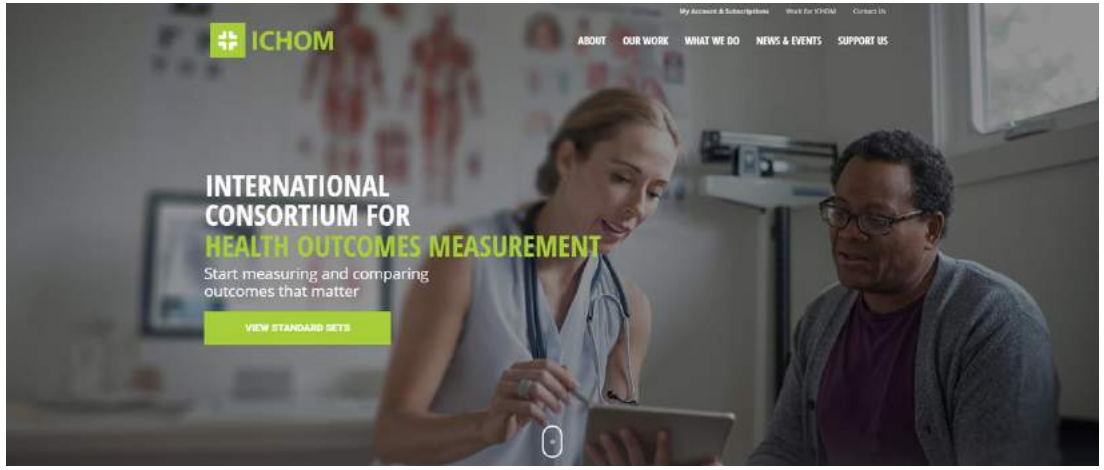

Transparency about the outcomes of mental health services (IAPT approach): an analysis of public data

David M Clark, Lauren Canvin, John Green, Richard Layard, Stephen Pilling, Magdalena Janecka

Summary

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 β 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.

Lancet 2018; 391: 679–86
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See Comment page 636

Department of Experimental Psychology, University of Oxford, Oxford, UK (Prof D M Clark DPhil, L Canvin BA Hons); The Oxford Academic Health Sciences Network, Oxford, UK (Prof D M Clark, L Canvin); Department of Clinical Health

Clark et al., 2018; Sorel, 2013; Porter & Teisberg, 2006

4 toetsstenen in een veranderend gezondheidsbeleid

- **Waarde van de ingestelde behandeling**
  - Effectiviteit van de interventie
  - Satisfactie van de patiënt
  - Mate van co-creatie
- **Expertise & innovatie**
  - Bij welke emotionele problemen is de interventie best?
  - In welke context en in welk samenwerkingsmodel?
- **Outcome data**
  - Bijhouden klinische data rond evolutie van pt
  - Maatschappelijk dividend – publieke data?
  - Met / unmet need?
- **Gezondheidseconomisch perspectief**
  - Kost / opbrengst voor de maatschappij
  - Kost / opbrengst voor de psycholoog
  - Kost / opbrengst voor de patiënt

Antwoord op de 3 basisvragen is afhankelijk van…

- Implementeerbaarheid
- Generaliseerbaarheid
- Participatie van actoren

Contextuele voorwaarden die leiden tot de beste implementatie

AUSTRALASIAN PSYCHIATRY

Building capacity

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2015, Vol 23(6) Supplement 35–37

DOI: 10.1177/1039856215609771
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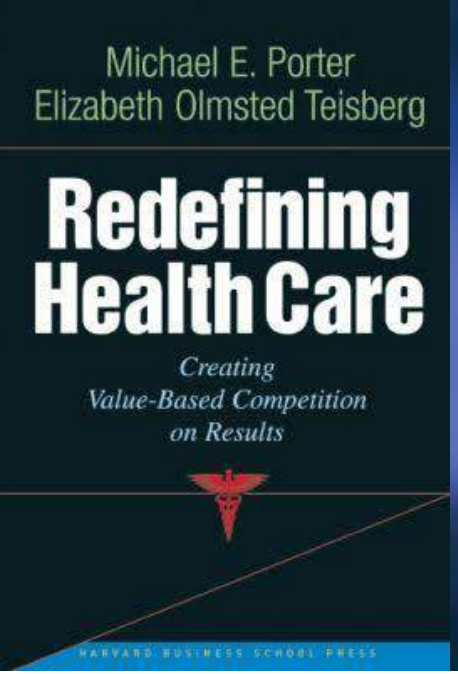
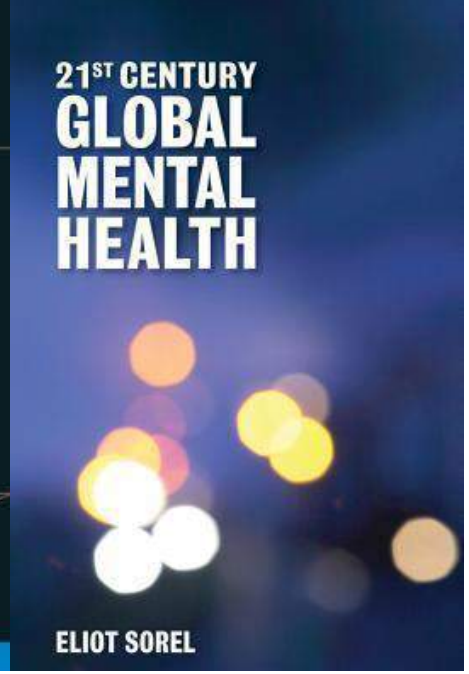
SAGE

Implementation Science for closing the treatment gap for mental disorders by translating evidence base into practice: experiences from the PRIME project

Rahul Shidhaye Mental Health Research Scientist and Assistant Professor, Public Health Foundation of India, New Delhi, India; Sangath, Goa, India; CAPHRI School for Public Health and Primary Care, Maastricht University, Maastricht, Netherlands





Building capacity

AUSTRALASIAN PSYCHIATRY

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Kwantitatieve benadering ⟺ **Kwalitatieve benadering**