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Psychotherapy Regulations in Europe

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Abstract

Aim: This paper explores the evolving regulatory landscape of psychotherapy across European countries to identify structural, legal, and ethical patterns that shape the profession. The primary objective is to assess whether psychotherapy should be defined and regulated as an independent profession or as a specialisation within established health disciplines such as psychology or psychiatry. A comparative analysis was conducted, based on case (country regulations') studies and data from the ACSTEC/SWPS (2023) and EABCT (2025) projects, which document a significant diversity in qualification and training requirements.

Theses: The main theses are as follows: (1) regulatory systems based on the "lowest common denominator" and overly inclusive educational pathways pose a risk to patients because:

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(a) they carry a risk of consensus that undermines standards of evidence-based treatment, (b) they legitimize practices with undocumented efficacy and cost-effectiveness; (2) legal frameworks for psychotherapy in Europe are highly diverse in terms of access to qualifications, the role of university education, and oversight.

Conclusion: Europe requires a balanced model that protects patient safety, upholds evidence-based practice, and allows for the assimilation of knowledge stemming from the scientific development of psychotherapy. The article proposes a hybrid, competency-based regulatory model emphasizing transparent standards for evidence-based practice, clear educational pathways, and guarantees of access to effective care.

Keywords: psychotherapy regulation, evidence-based practice, Europe, professional standards, legal frameworks, competency-based training, ethics, hybrid model

While psychotherapy has gained increasing recognition as a scientifically grounded treatment modality, national systems differ in their approaches to licensing, education, and recognition of psychotherapeutic modalities across Europe. This variation raises critical questions about whether regulation enhances safety and quality, or inadvertently stifles scientific progress and flexibility. These inequalities also pose a challenge to both mobility and harmonization, as well as to the quality assurance of psychological services across the European Union (EU).This paper examines the current state of psychotherapy regulations, with a focus on training standards, institutional roles, and the integration of evidence-based treatments.

Essential Empirical Groundwork. The 2023/2025 Survey on Psychotherapy Regulation in Europe

There are Europe-wide scientific organizations with established traditions that possess the substantive expertise necessary to justify their influence on regulations and training standards. By taking clear positions on the role of evidence-based practice in psychotherapy, these organizations can support greater consistency and assist countries in aligning with psychological best practices.

European Association for Behavioural and Cognitive Therapies (EABCT), one of the largest European psychotherapy organisations with over 50 years of history and a mission to promote evidence-based psychological therapies across countries, In 2023, ACSTEC at SWPS University surveyed across more than 25 European countries representatives at EABCT. The survey assessed legislative regulation, professional recognition, and the inclusion of psychotherapy in formal training and guidelines. Results were first presented at an SWPS conference and subsequently discussed at the EABCT General Assembly (May 2023). In 2025, the EABCT Working Group on Regulations reviewed these findings, consulting national member associations to produce an updated synthesis, forming the basis of this paper.

The survey assessed:

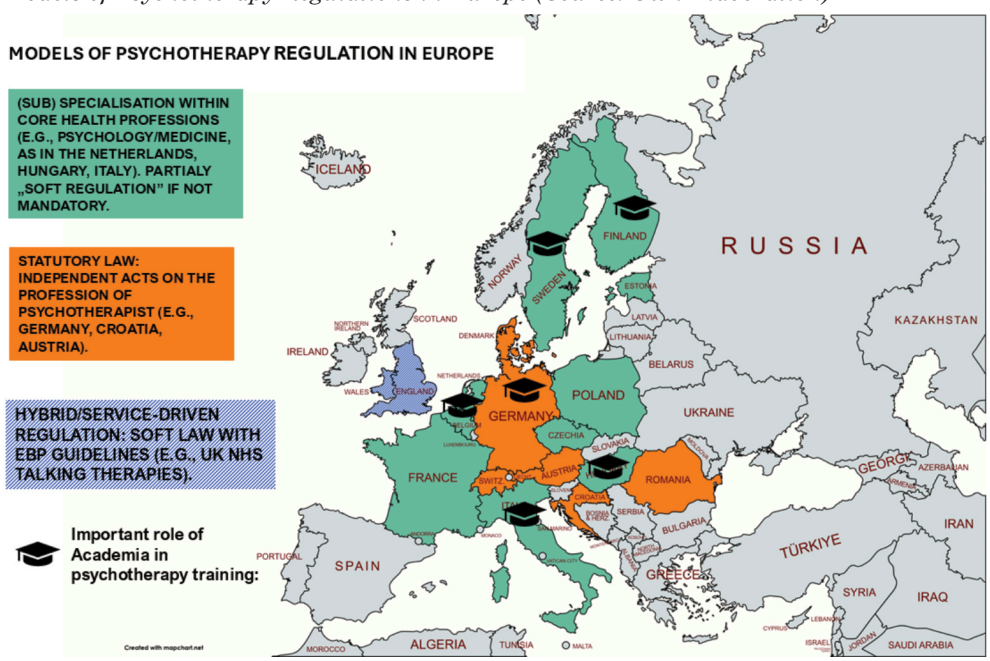
– whether psychotherapy is legally regulated;
– who can legally practice psychotherapy;
– what are the regulated professions in the country;
– which modalities/theoretical approaches are recognized (if any) in official registries;
– the role of treatment guidelines;
– the role of universities and state funding in training programs;
– the role of psychotherapy associations .

The initial survey conducted by ACSTEC/SWPS and the subsequent EABCT discussions revealed a significant finding: a widespread discrepancy in the understanding of what "regulation" actually means in the context of psychotherapy across different European legal systems. This inconsistency largely reflects the broader difficulties encountered in harmonizing professional education and qualifications in other sectors across Europe. Findings confirmed significant variation across Europe. Some countries implement psychotherapy under strict legal statutes; others rely primarily on professional or voluntary frameworks. Given the ongoing debates and documented changes in regulations across the continent, Figure 1 presents an indicative map illustrating the observed regulatory diversity across Europe.

Despite methods derived from the CBT tradition being empirically supported and recommended in many national clinical guidelines, their place in formal regulatory structures remains inconsistent, as is the distinction between approaches

Figure 1

Models of Psychotherapy Regulations in Europe (Source: Own Elaboration)



that create a theoretical foundation for empirically supported treatments (e.g., psychodynamic, interpersonal) and modalities that are theoretically and historically interesting but lack methods supported by reliable data indicating treatment efficacy. Following the detailed analysis of the survey responses and a check of the source legal acts (national laws and executive decrees), it became clear that the diversity was not random. Instead, four distinct regulatory archetypes—or models—emerged, which we discuss in detail below.

What Does It Mean for Psychotherapy to Be "Regulated by Law"? Regulations and Models

The phrase "regulated by law" may appear straightforward, but in practice, it encompasses a spectrum of legal arrangements that differ significantly across European countries. Broadly, four primary models can be identified:

1. Statutory law (national legislation).
2. Specialisation within psychiatry or psychology.
3. Professional licensing and certification acts (Soft Law Model).
4. Hybrid Regulation Model.

Statutory Law (National Legislation)

In some countries, such as Germany and Austria, psychotherapy is formally regulated by national legislation. Psychotherapy is recognized as a legally defined health profession with clear legal stipulations about who can practice, how they are trained, and under what conditions they can be reimbursed. These laws are enacted at the federal or national level and integrated into the broader healthcare and educational systems. In some cases, regulations also cover the conditions for accreditation and the financing of education. These laws provide a high level of legal protection and public trust but can be slow to adapt to scientific developments.

Specialisation Within Psychiatry or Psychology

In many countries**,** psychotherapy exists legally only as a recognised activity within a broader profession (e.g., psychology or psychiatry), and associations provide the infrastructure for training, supervision, and continuing education. These organisations also shape national debates around the legitimacy of specific modalities and lobby for inclusion in health system reimbursement structures.

Professional Licensing and Certification Acts (Soft Law Model)

Such regulation is guided by professional bodies, such as psychological, psychiatric and psychotherapy associations. These entities maintain registers, issue

certifications, and enforce ethical codes. While often rigorous, this model depends on voluntary adherence and may lack enforceability under national law. Access to public funding or reimbursement may also be more restricted.

Other countries operate through sector-specific professional laws or licensing bodies that may grant rights to practice psychotherapy to psychologists, psychiatrists, or specially trained professionals. These laws often coexist with university or postgraduate programs and vary in their strictness and transparency. Regulation may come from professional associations or health ministries through guidelines, ethical codes, or informal practice standards. These may lack legal enforceability but still guide professional behaviour and influence public funding decisions.

Hybrid Regulation Model

A growing number of European countries operate under a hybrid model, where elements of legal and professional governance coexist. For instance, a ministry of health may define general criteria for psychotherapy practice but delegate certification and accreditation processes to national associations. In such systems, associations play a central role in upholding standards of care, running training programs, managing professional registers, and engaging in public health policy discussions. This hybrid approach offers flexibility and can integrate the latest research and clinical insights into practice more dynamically than rigid legal frameworks. However, its effectiveness depends on transparent cooperation between state institutions and associations. Where coordination is weak or fragmented—e.g., multiple associations promoting different standards—patients and professionals alike may suffer from unclear guidance or unequal treatment access. The presence and influence of professional associations are therefore essential components of the regulatory ecosystem.

Examples of Legal Frameworks

Statutory Regulation

Germany: Under the Psychotherapeutengesetz (PsychThG) reform, effective September 2020, psychotherapy education has been standardised at the university level: a three-year bachelor's in psychology followed by a two-year master's in clinical psychology and psychotherapy. Universities play a central role as exclusive providers of basic professional training. Graduates obtain state licensure (Approbation) to practice under supervision, with a subsequent five-year specialisation required for full independent practice reimbursable by statutory health insurance (Gesetz über den Beruf der Psychotherapeutin und des Psychotherapeuten…, 2020).

Belgium: Psychotherapy is recognized within the legal framework of mental health care but has faced political contention (Gecoördineerde wet betreffende de uitoefening van de gezondheidszorgberoepen, consolidated act No. 2015A24141,

2015). The law introduced in 2016 restricted psychotherapy to clinical psychologists and psychiatrists with additional training. Universities are key providers of psychological education, but psychotherapy-specific training is also conducted in recognized private institutions. The compromise law allows both routes but with differentiated recognition.

Croatia: In 2006 a formal legal regulation of psychotherapy, marked a shift from its previous association-led training model. However, the statutory framework in its most recent version of a law of 2022 (Zakon o djelatnosti psihoterapije NN 18/22 na snazi od 17.02.2022) presents an unusual and problematic feature: it refers explicitly and exclusively to one association – the European Association for Psychotherapy (EAP) as the basis for training and professional recognition. While referencing a pan-European organisation may seem like a step toward harmonisation, this choice is controversial for several reasons: The EAP represents a broad and eclectic range of psychotherapeutic modalities, many of which are not supported by contemporary empirical research or clinical guidelines.

Psychiatry or Psychology (Sub)Specialisation

Italy: Psychotherapy is a licensed health profession restricted to psychologists and physicians who complete a four-year postgraduate specialisation in an accredited school of psychotherapy. Although universities are involved in some training, most psychotherapy schools operate independently of the university system and vary in academic and clinical rigour. The Italian model recognizes the profession of psychotherapy while granting equal status to diverse theoretical orientations**.** While this supports academic freedom and professional choice, it lacks prioritization of evidence-based methods and makes no differential funding based on treatment efficacy. Critics argue that this creates a regulatory façade without empirical safeguards (Regulation of the profession of the psychologist. Presidential acts, decrees and ordinances – ACT No. 56 18/2/1989).

The Netherlands: Psychotherapy is recognised as a clinical specialisation under the Individual Health Care Professions Act [Wet van 11 november 1993, houdende regelen inzake beroepen op het gebied van de individuele gezond-heidszorg (Wet op de beroepen in de individuele gezondheidszorg), 2023]. It is primarily accessible to clinical psychologists, psychiatrists, and healthcare psychologists who undergo advanced training in psychotherapy. University education in psychology is a prerequisite, and further training is typically provided by post-academic institutions closely aligned with research standards and professional oversight.

Romania: Psychotherapy is recognised as a professional activity and is legally regulated, primarily through the Romanian College of Psychologists. Training is based on university psychology degrees, followed by approved postgraduate training programs in various approaches. Medical doctors, particularly psychiatrists, may also specialise in psychotherapy, often as an extension of their medical specialisation, though psychotherapy is not a separate medical speciality (Legea nr. 213 din 27 mai 2004 privind exercitarea profesiei de psiholog cu drept de liberă practică, înființarea, organizarea şi funcționarea Colegiului Psihologilor din România, 2004).

Hungary: Psychotherapy is regulated as a medical speciality. A state exam contains a part unified for all candidates and a part specific for the approach in which the training takes place) it belongs to the group of medical specializations under Ministry of Health. A state license of psychotherapy is required for independent psychotherapy practice and for working for the National Health Insurance Fund of Hungary. Professionals allowed to start their psychotherapy training which leads to specialist state examination are: clinical psychologists, psychiatrists, and medical doctors with any clinical specialist state license, health psychologists, and neuropsychologists. Psychotherapy also partially belongs to regulations under Ministry of Health, under Ministry of Higher Education, and other regulations, psychotherapy appears in many legal acts concerning mental health, education or insurance, but no specific law about psychotherapy (1997. évi CLIV. törvény az egészségügyről).

Hybrid Regulation Model

United Kingdom: The UK adopts a service- and evidence-driven model, with psychotherapy embedded in public mental health services**,** especially through the NHS Talking Therapies (formerly IAPT) program. Titles like "psychotherapist" or "CBT therapist" are not legally protected, but regulated through professional registration (e.g., BABCP, 2024). Training is modular, based on NICE guidelines, and aligned with specific disorders (e.g., low-intensity and high-intensity CBT for depression/anxiety). Practice is embedded in multidisciplinary teams, often within the NHS. Emphasis is on outcomes, access, and EBP, rather than allegiance to any specific modality. This system prioritizes clinical effectiveness, flexibility, and cost-efficiency. Psychology graduates may follow this pathway, as may nurses and social workers, provided they complete accredited training in methods specified by HTA standards. It allows diverse entry routes, including psychology graduates, nurses, and social workers, provided they complete accredited EBP training. However, lack of legal protection for the title "psychotherapist" raises concerns about public transparency and quality assurance in private practice. Psychotherapy roles are embedded within NHS services through the Improving Access to Psychological Therapies (IAPT)—or NHS Talking Therapies—program. The IAPT program was originally developed to expand access to evidence-based treatment for common mental health disorders, especially depression and anxiety. It led to the training of thousands of CBT therapists to meet NICE recommendations for first-line treatment and to reduce waiting times for psychological services. While universities provide many training modules, non-university accredited organisations also play a major role in delivering practice-based training. Beyond NHS there is no legal protection of the title. Anyone can set themselves up as a 'Psychotherapist' or 'CBT' therapist, however they will not be recognised by certain private health insurance companies without registration/accreditation by one of the recognised psychotherapy professional associations. All the professional associations are encouraged to be a member of the Professional Standards Authority for Health and Social Care (n.d.).

Poland: The profession of psychotherapist is not currently regulated by a separate legislative act. Within the healthcare system, psychotherapy functions under a hybrid model. Psychotherapy is defined in the Mental Health Protection Act and the so-called "basket" regulations (ordinances on guaranteed benefits), which outline general minimum training requirements. The certification of psychotherapy, issued by various scientific associations representing five arbitrarily distinguished approaches, is recognized as confirmation of professional competence. Furthermore, pursuant to the statutory delegation regarding the attainment of specialist titles in health-related fields, specialized training in child and adolescent psychotherapy is available (the specialization program has been in effect since September 2019). There is also a regulation by the Minister of Health from June 2023 introducing a specialization in psychotherapy; however, as of December 2025, the specialization program has not been implemented. Outside the healthcare system, psychotherapy may be practiced within the education and social assistance systems, among others.

Universities play a role in offering academic programs in psychology and psychotherapy, but the vast majority of psychotherapeutic training takes place in private institutions accredited by professional associations. Medical specialisations in psychotherapy exist with a minor role in training psychotherapists. The debate surrounding the psychotherapy legislation in Poland has become highly polarised, with sharp divisions between different professional groups (Wykowski, 2024a, 2024b). The controversy centres on a paradox of choosing between a softer, hybrid model of regulation, focused on evidence-based practice within the healthcare system (similar to England), and frameworks that are more legally rigid (governed by a separate professional act) yet fully eclectic regarding psychotherapy methods and the so-called 'base education,' similar to the systems in place in Germany or Croatia.

The Role of Universities in Psychotherapy Training

In many European countries, university education plays a strong role not only in foundational psychological or medical training, but also in psychotherapy training or specialization (see "university icon" on Figure 1, p. 153) In Germany, universities have a central and exclusive role in initial psychotherapy education under the reformed PsychThG system. In The Netherlands, psychology degrees from universities are required, and further training is provided by academically affiliated post-university institutions. In Belgium, universities provide foundational education in psychology, while psychotherapy training is split between universities and private institutions. In Italy, psychotherapy training predominantly occurs in private accredited schools, many of which are not formally integrated with university structures. In United Kingdom, universities offer many training modules, but large portions of psychotherapy training are delivered by independent accredited providers, especially within NHS-linked pathways. In Croatia, universities provide basic psychological education, but most psychotherapy training occurs in private associations, outside of formal university programs. In Poland, public universities offer psychological education

and some postgraduate training, but there is an active movement against recognising psychotherapy training at the postgraduate academic level in favour of non-university providers.

Discussion

These results provide a vital empirical basis for future advocacy and policy alignment across Europe, underscoring the need for pan-European quality standards, clearer definitions of the psychotherapist profession, and stronger integration of evidence-based practices in regulation.

This layered legal landscape leads to variability in training duration, quality assurance, and public protection. For example, in some systems, only psychiatrists can practice psychotherapy within the public system, while in others, accredited psychologists or even lay therapists may be permitted to do so. Furthermore, differing levels of legal oversight can impact the implementation of evidence-based practices and limit cross-national recognition of qualifications. The analysis of solutions focused on the structure of the regulations, but in this Discussion section, we will emphasize that the priority is whom the regulation should serve.

National Regulation of Psychotherapy – Necessity or Risk?

A key point of contention in the ongoing debate about psychotherapy in Europe is whether national legal regulation of the profession is not only beneficial, but necessary—particularly given the pluralism of psychotherapeutic approaches and the disparity in scientific support across modalities.

Advocates of regulation often argue that psychotherapy should be treated as a public trust profession, governed by national law, with a unified professional chamber and statutory protection of the title. This model—akin to that used in Germany or Austria—promises to ensure patient safety, training quality, and accountability. However, this approach raises significant concerns: homogenization of training standards often leads to dilution of core scientific principles. When legal frameworks attempt to accommodate all recognized modalities equally, training curricula can become bloated with content from methods not empirically supported, extending the duration and cost of training unnecessarily. In an effort to ensure inclusivity, national standards may sacrifice specificity and undermine evidence-based approaches, such as CBT, which are often more protocol-driven and outcomes-focused.[2] As emphasized by Popiel and Zawadzki

[2] Although an "evidence-based approach" is imprecise, as it risks confusion with broad theoretical orientations. We use it also to underline its presence in public debate, and to recognize that the English term 'approach' is ambiguous and can refer both to a broad theoretical orientation (e.g., the psychodynamic approach) and to a general stance toward scientific evidence. Writing about the 'evidence-based approach,' we intend

(2023), this type of "regulatory averaging" may paradoxically fail to protect patients from ineffective or even harmful practices, especially if all modalities are legally accepted under a broad definition of psychotherapy without empirical vetting.

Moreover, the continuum model of psychotherapy presented in their work—from general well-being interventions to structured clinical treatment of mental disorders—calls into question whether a single regulatory framework can effectively encompass such a diverse field. Does it make sense to regulate the same way both a clinical trauma-focused therapy and a personal growth-oriented modality with no demonstrated clinical effect?

In light of these tensions, the surveys and discussions found widespread ambivalence among psychotherapy associations and countries. While some seek full legal recognition, others value the flexibility and autonomy of association-based or hybrid models.

As a result, in 2025, the EABCT Working Group on Regulations undertook a comprehensive review. Their conclusion—reflected in this paper—is that uniform legal regulation is neither universally desirable nor automatically protective. Instead, countries should consider:

- flexible regulatory frameworks that differentiate between clinical and non-clinical applications of psychotherapy;
- clear legal recognition and privileging of evidence-based modalities in publicly funded systems;
- selective legal protection of psychotherapeutic titles, possibly limited to clinical settings, while allowing non-clinical practices under alternative labels;
- empowering professional associations to define training and accreditation standards, with state oversight limited to patient safety and public funding criteria.

The goal is to balance public protection with scientific integrity, without forcing a one-size-fits-all model. As emphasized in *Psychoterapia – quo vadis?*

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the latter meaning: the general attitude and commitment to considering the importance of scientific data in professional practice, rather than referring to a specific theoretical school.Instead, Evidence-Based Practice (EBP) is defined by its three integrated pillars: Best Available Research Evidence, Clinical Expertise, and Patient Values and Context. The Best Available Research Evidence component specifically concerns the demonstrated efficacy and effectiveness of specific interventions (methods, protocols) in treating particular disorders (e.g., CBT for PTSD, Interpersonal Therapy for depression). Clinical Expertise involves the therapist's ability to integrate this evidence with their experience and individual patient assessment, while Patient Values and Context requires considering the patient's preferences and life situation. True patient safety and ethical practice rely on the use of methods with robust empirical support, not on broad theoretical assumptions. Consequently, regulation must promote EBP by focusing on methods with documented efficacy—consistent with clinical guidelines (e.g., NICE)—rather than institutionalizing the lowest common denominator by granting equal status to broad theoretical approaches. This essential focus on evidence-based methods eliminates terminological confusion and directly links the legitimacy of professional regulation to scientific rigor and public protection.

(Popiel and Zawadzki, 2023), the danger of codifying pseudoscientific or unverified approaches under legal legitimacy must be avoided at all costs. Regulation, when poorly constructed, can institutionalise mediocrity or worse—offer false assurance of safety where none is warranted (see: Nowak Far, 2025)

Patient Safety as the Justification for Limiting Economic Freedom

The introduction of legal regulations for any profession, including psychotherapy, is an act that inherently restricts the economic freedom of practitioners. Under public law and economic principles, such a restriction must be clearly justified by a significant social benefit that is proportionate to the regulatory cost imposed. For the profession of psychotherapist, the primary justification is the protection of the public interest, namely patient safety and the quality of care. However, a fundamental question emerges: what defines patient safety in the context of psychological intervention? Is it sufficient to protect against obvious ethical or legal misconduct (which general civil and criminal law already addresses), or must it extend to protection against ineffective, suboptimal, or potentially harmful treatment? This paper contends that genuine patient safety is intrinsically linked to treatment efficacy confirmed by scientific research, and this aspect forms the foundation of conducting evidence-based practice (EBP).

If legal regulation, in its pursuit of inclusivity and unification (the "lowest common denominator" effect), places modalities with proven effectiveness on equal footing with those lacking robust empirical support, it effectively fails to protect the patient from the risk of lost time, money, and potential deterioration of their condition. In this scenario, regulation becomes a legal façade that legitimizes non-evidence-based practices and, paradoxically, undermines the very justification for restricting economic freedom.

Therefore, the argument for regulation must be tightly integrated with the argument for EBP. The true social benefit lies in ensuring that public resources (including reimbursement funds) are directed towards interventions that have the best chance of effectiveness and deliver measurable economic benefits (as demonstrated by programs like NHS Talking Therapies/IAPT). Failing this, regulation serves only professional interests (e.g., title protection) rather than the overarching social goals (patient protection and effective treatment).

The Problem of the Lowest Common Denominator in Defining Evidence and Training Standards: Ethical Considerations

A significant challenge in the regulation of psychotherapy across Europe lies in the tendency to define "evidence" and set educational standards at the level of the lowest common denominator. This approach attempts to reconcile the broad diversity of psychotherapeutic schools by establishing inclusive standards that often accommodate both well-validated and poorly supported methods.

Such an approach entails serious consequences for therapy quality and patient protection:

- dilution of scientific rigor: methods with strong empirical support (e.g., cognitive-behavioural therapy for anxiety disorders and PTSD; CBT and interpersonal therapy for depression, or CBT and psychodynamic therapy for personality disorders) are frequently placed on equal footing with therapies lacking robust scientific evidence;
- risk of ineffective treatment: patients may legally receive psychotherapeutic interventions that are not supported by current clinical guidelines, despite the availability of proven, effective alternatives;
- ethical dilemmas: from an ethical perspective, therapists are obligated to provide treatments grounded in the best available evidence. If legal regulations allow for a broad range of practices, including those not evidence-based, patients may unknowingly receive suboptimal care. This situation conflicts with the principles of beneficence and informed consent, as patients may not be adequately informed about the efficacy of their treatment options.

In terms of training standards, attempts to incorporate all therapeutic approaches lead to unnecessarily extended and diluted curricula. This results in increased training duration and costs without corresponding improvements in clinical competence, while effective methods risk being overshadowed by less effective ones.

Ethically, this raises the question of professional responsibility: therapists must balance respecting patient autonomy with the duty to offer scientifically supported care. Weak or ambiguous regulations undermine this balance, potentially eroding public trust.

To address these issues, there is a clear need for:

- reevaluation of evidence criteria: establishing rigorous and current definitions of evidence-based practice to guide curriculum development and clinical standards;
- core competency frameworks: defining a set of essential, empirically validated therapeutic skills required of all psychotherapists [See the UCL Competence Framework in the UK or the description of therapists' competencies in Poland described by Popiel and Pragłowska (2022)];
- transparency: ensuring patients are fully informed about the evidence supporting their treatment choices;
- regulatory flexibility: allowing innovation and pluralism in psychotherapy while safeguarding patients from ineffective or harmful interventions.

In conclusion, regulations based on the lowest common denominator risk compromising patient safety and the scientific integrity of psychotherapy. Thoughtful, evidence-centred regulation is essential to reconcile diversity with quality and ethical care

Thus, a fundamental question emerges: Should regulation aim to standardise identity (a unified profession), or competence (core, validated skills)?

The 2025 EABCT Working Group suggests a tiered model:

- Core clinical competencies (e.g., in CBT, interpersonal therapy, trauma-focused methods) recognized across countries.

– Flexible modality-based training, as long as it is aligned with clinical evidence.
– Legal regulation focused on patient safety and public funding eligibility, not theoretical pluralism.

Understanding and harmonising these regulatory levels is essential for achieving a coherent European psychotherapy space, one that ensures both high-quality care and professional mobility. Under Directive 2005/36/EC**,** as amended by Directive 2013/55/EU, the European Union allows for the creation of a Common Training Framework (CTF) to harmonise professional qualifications across member states (Directive 2013/55/EU of the European Parliament and of the Council of 20 November 2013 amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation (EU) No 1024/2012). For a CTF to be proposed, at least one-third of EU countries (currently 9 out of 27) must regulate the profession in question under comparable standards. If these criteria are met, a shared set of minimum training requirements and competencies can be established to facilitate the automatic recognition of qualifications across the EU and promote professional mobility. But is it possible at this stage of psychotherapy development?

Consequences of Regulation on Access, Equity, and Cost

Beyond the issues of scientific rigor and professional title protection, regulatory choices have profound and direct consequences for access, equity, and treatment costs within public health systems. Models characterized by high entry barriers, such as those requiring lengthy, post-graduate specialization after a Master's degree (e.g., Germany's pre-reform system or the extended Italian path), often result in a limited supply of licensed practitioners and contribute to high treatment costs. This scarcity disproportionately harms equity by restricting access, often confining effective psychotherapy to privileged socioeconomic groups who can afford long private training programs and private practice fees. Conversely, service-driven regulatory models—like the UK's NHS Talking Therapies (IAPT)—explicitly prioritize access and cost-effectiveness. By utilizing a tiered workforce trained intensively in high-volume, empirically supported methods (e.g., low-intensity CBT), these systems achieve massive scale, significantly reducing waiting times and improving equity across diverse populations. Thus, the choice of a regulatory model is not just an academic or legal one; it is a fundamental policy decision about who can receive effective care and at what cost to the public purse (See Table 1, p. 164 for comparison).

Challenges and Future Directions

Key challenges include:
– fragmentation: multiple regulatory bodies with differing standards;
– professional conflicts: divergences between psychological, psychiatric, and psychotherapeutic associations;

Table 1

Regulatory Models and Their Implications

Regulatory Model Type	Key Implication	Impact On Professionals (Training, Licensing)	Impact On Patients (Access, Quality, Cost)
Statutory (High barrier, e.g., Germany)	Legal protection of title and scope of practice.	Long, mandatory postgraduate specialization process. Limited supply of practitioners.	Restricted access; High individual cost/reimbursement burden. Quality is defined by legal pluralism, not evidence—no guarantee of access to the most effective EBP methods.
Specialisation (Eclectic, e.g., Italy, Netherlands)	Legal protection within a core profession (Psychologist/Psychiatrist).	Focus on adherence to a theoretical school; Wide variation in required clinical rigor.	Quality defined by school accreditation, not EBP. Risk of unequal efficacy; Access determined by modality preferences.
Soft Regulation (Self-Regulation, e.g., Scandinavia, parts of Poland)	Regulation via professional associations/registries; Title often not legally protected.	Flexibility in training routes; Standards enforced via ethical codes and membership requirements.	High access (unregulated market); Quality varies widely; No public oversight or guaranteed minimum EBP standard.
Hybrid/Service-Driven (EBP-Focused, e.g., UK-IAPT, Norway, in part also Finland)	Protection of service quality via EBP guidelines and outcome metrics.	Modular, competency-based training in specific methods; Increased supply and workforce tiers.	High equity and access (e.g., via stepped care). Quality defined by treatment outcome data and proven efficacy (EBP).

– resistance to evidence-based practice: cultural or theoretical allegiance to non-evidence-based methods sometimes expressed as “all psychotherapy modalities/approaches have evidence – all are equally effective”.

Recommended steps forward:

1. Support from European institutions for EBP-driven policy.
2. Unified definitions and competencies for psychotherapists.
3. Enhanced mobility of certified therapists across EU borders.
4. Greater research funding for psychotherapy effectiveness studies.

Conclusion

The regulation of psychotherapy in Europe stands at a crossroads. As the mental health burden grows, there is an urgent need for standardised, evidence-based, and transparent training and practice frameworks. Cognitive-behavioural therapy, given its empirical foundation, is well-positioned to lead this

transformation (Salkovskis et al., 2023). Through collaboration among professional associations, universities, and regulatory bodies, Europe can move toward a more cohesive and scientifically grounded psychotherapy landscape. The 2025 EABCT Working Group on Regulations emphasises that *overregulation under the banner of independence* may threaten quality and flexibility, especially if it leads to rigid inclusion of non-evidence-based modalities. Thus, the conversation must shift from whether psychotherapy should be regulated, to how it should be regulated to preserve specificity, protect patients, and promote science-based practice. The development of psychotherapy must be anchored in best scientific evidence, particularly as more countries move to regulate the profession. As Holmes et al. (2018) emphasize, innovation in psychological treatments must go hand in hand with methodological rigor to ensure effectiveness and safety. This is not only a national but a European challenge, requiring shared standards and oversight. The urgency is amplified today, as robust evidence demonstrates that psychological interventions are effective not only in treating mental disorders but also in prevention—and these outcomes translate into measurable economic benefits. Programs like the NHS Talking Therapies (formerly IAPT) have shown that timely access to evidence-based treatment improves recovery rates, reduces disability, and yields significant savings to public services (Clark 2018; Layard and Clark, 2014). Regulation and investment in psychotherapy must therefore be seen as both a public health and economic imperative.

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