Physician-delivered Psychotherapy for Psychiatric Disorders

In response to the Ontario Ministry of Health's recommendation to limit funding of physician-delivered psychotherapies to no more than 24 sessions (48 units per year) per patient, the following review of evidence and concerns was compiled for consideration in the negotiations. The proposed limits on funded psychotherapy represents <5% of the total $ amount of the 28 recommended cuts and comes with numerous serious concerns related to serving our citizens with mental health needs - savings that are disproportionate to the negative impacts of the measure. The Mental Health Commission of Canada and the World Health Organization have highlighted the critical societal importance of detecting, treating and preventing mental illnesses which are stigmatized, under-recognized, and under-addressed [1-3]. Evidence-supported mental health care with physicians who can deliver psychotherapy and/or pharmacotherapy is needed by Ontarians with problems related to mental illness.

Traumatized patients who have experienced adverse childhood experiences or life-threatening events with disabling psychiatric symptoms need more intensive and longer-term treatment, and therefore this cost-saving measure will disproportionately stigmatize and hurt the most vulnerable individuals who are suffering the most in the population.

Access to physician-delivered psychotherapy recommended in psychiatric consensus treatment guidelines for evidence-based and standardized, quality mental healthcare is critically important to preserve [3, 4]. Time-limited recommended structured psychotherapies are effective in treating individuals with mild to moderate symptoms of common mental disorders of depression or anxiety[5-7]; however p*atients with chronic or high levels of severity, a history of trauma, and multiple psychiatric illnesses require longer-term integrated psychiatric care with either or both medications and long-term psychotherapy[*8, 9].

Traumatic experiences in childhood or later life are extremely common among people who need mental health care [10]. Individuals with psychological trauma are among the most severe and persistently mentally ill patients and highest users of health care services. Although the consequences of exposure to profoundly aversive states of fear or terror can lead to typical PTSD symptoms, more often patients present with chronic and disabling symptoms of depression, anxiety, problems with regulating emotions, poor social supports, and frequent health care visits with medically unexplained symptoms [10]. For these patients, psychotherapies of longer duration are particularly needed, alone or in combination with medication, in order to foster recovery and restore functioning. Psychotherapy can be superior to pharmacology in long term follow up of some conditions, especially in anxiety disorders, and can decrease the risk of relapse [4, 7, 11-16]. Psychotherapy is the treatment of choice for: children with psychiatric disorders as there are no medications approved for children under 6 years old; and adults with personality disorders, or substance use disorders – all of which if left untreated will result in high costs to society in terms of both suffering to the patients and their families, disability and healthcare [17, 18]. In addition, early intervention, preventative treatment and attention to the social determinants of health for individuals at high risk of mental illness are critically important to promote resilience and health that will be cost-saving over time.

Limiting the number of psychotherapy sessions, or dose of treatment, without basing it on patient need or evidence poses multiple risks of under-treatment, worsening symptoms, disability, stigma, and ultimately greater healthcare costs. Severely ill patients are likely to be forced from outpatient clinics into hospital wards.

Although some psychotherapy treatments can be delivered by other kinds of providers, physicians must provide care for patients with higher levels of complexity, chronicity, risk, and severity of symptoms and disability. These patients need long-term continuity of care, beyond diagnostic consultations, that includes psychotherapy and pharmacotherapy. ***Such care not only saves lives and helps to keep patients out of hospital, but also significantly offsets costs and decreases overall healthcare utilization****[17-19]*.

An across-the-board limit on physician-delivered evidence-supported psychotherapies poses multiple hazards related to fragmented care and worsened outcomes. This is particularly true for the most vulnerable, high needs, and traumatized individuals with mental illness.

In addition, one must consider ***the worsening of stigma, by limiting necessary treatments to those with mental illness and not applying the same metric to other serious medical conditions***. Stigma affects both patients and their families, and can worsen symptoms, outcomes, and the disability associated with mental illness [20]. Why is it acceptable to offer sub-optimal care to fragile patients with mental disorders, when one would not consider such a decision for patients with HIV, COPD, recurring cancers, dialysis for renal failure, or other chronic medical conditions?

One needs evidence, beyond practice patterns to evaluate and measure the outcomes of interventions, and to inform the design of clinical services that improve access without compromising the quality, outcomes and costs of care for the most vulnerable in society. If the motivation for changing health care policies is for cost-savings, one must ask, at what future dollar cost, at what cost in terms of suffering of patients and families, and whether the cost is borne equally, or is it applied to a vulnerable high needs group with low capacity for advocacy. ***Psychotherapy alone or in combination with pharmacotherapy should be available as prescribed or delivered by physicians - without limits on the frequency or duration for patients with chronic, comorbid and recurrent mental illnesses. These vulnerable patients require access to the full treatment that they need in order to decrease morbidity and mortality.***

Although some publicly funded peer support and short-term psychotherapies are now available on-line (e.g. Bounce back, The Big White Wall), and the pilot program, "Increasing Access to Structured Psychotherapies" initiative has potential to scale up to improved access to mental health care, these target individuals with mild to moderate mental disorders or distress, and are limited to only one treatment approach at present, Cognitive Behavioral Therapy (CBT). CBT can be effective for mild to moderate depression and anxiety, however the empirical evidence is clear that *no one treatment approach works for all patients*. Other models of consensus guideline-recommended evidence-supported psychotherapies including Interpersonal Psychotherapy (IPT) [6], Group Psychotherapy [21], Dialectical Behaviour Therapy (DBT) [22], Mindfulness Interventions[15], Motivational Interviewing (MI) [23], and Psychodynamic Psychotherapy [24, 25] should be accessible to patients suffering from the symptoms of psychiatric disorders (see World Health Organization [3], American Psychiatric Association [26, 27], Canadian Association of Mood and Anxiety Treatments [4], and the U.K. National Institute of Clinical Excellence Guidelines [28]).

Psychotherapies alone or in combination with medication are essential, evidence-supported, effective treatments for patients across the life-span to address suffering and improve outcomes for common and disabling psychiatric conditions such as mood and anxiety disorders, post-traumatic stress disorder, substance use disorders, personality disorders, and unresolved psychological, developmental or physical trauma. Physicians provide these as either monotherapy, or sequenced or combined with medication in the provision of optimal psychiatric care.

What do patients want? Patients and families want and need psychotherapies as part of their mental health care. Evidence-based practice requires that treatment selection consider patient preference alongside effectiveness and clinical expertise [4, 29, 30]. A meta-analysis that analyzed treatment preferences found that patients, particularly younger patients and women, preferred psychotherapy over pharmacotherapy and preferences can moderate outcomes [30]. Counselling or psychotherapy was ranked the highest unmet mental health need by Canadians [31]. Furthermore, for children and adolescents, the evidence of efficacy for pharmacotherapy treatments has been mixed, with small effect sizes, and with concerns regarding side effects of medication [32]; and psychotherapies can prevent the onset of mental illness in at-risk adolescents [33].

A 2018 study of the determinants of access to health care for depression in 49 countries and 7870 individuals found, similar to Ontario, inequalities in access, with individuals with better education and more material assets having improved access [34, 35]; however rather than attributing the problem to individual psychiatric practice patterns they look further. Beyond the practice patterns of Ontario psychiatrists who see ~5% of patients on a more frequent basis, problems with access to psychiatric and mental health care are multi-determined by factors related to individuals in need of treatment, including barriers such as stigma. The authors of this international study conclude

that individuals with more education may be better able to recognize the need for depression treatment, and likely are able to navigate health systems. We in Ontario do need to improve access; however, without compromising the standards of needed best-practices of care.

The costs of under-treatment of mental illnesses include increased suffering, mortality, lost work productivity, high costs of acute care and hospitalization, and law enforcement costs for forensic populations. The costs of providing psychotherapy vary by provider type and dose of treatment. However, the cost of providing psychotherapy is estimated in some settings to be more than twice repaid through reduced healthcare costs, benefits savings, and increased taxes collected due to improved employment status [17, 18, 36], and can decrease healthcare utilization [37]

In closing, psychotherapy is an essential aspect of psychiatric care to foster mental health. Continued access to physician-delivered psychotherapy should be publically funded because of scientific evidence and public demand. It provides the citizens of Ontario with access to care that can reduce symptoms, and improve functioning and quality of life, decrease relapse rates, enhance resilience, mitigate the stigma of living with chronic forms of mental illness, and improve experiences and continuity of mental health care. Traumatized patients with chronic struggles with mental illness need more intensive and longer-term treatment, and therefore a limit on the number of sessions per year will disproportionately hurt these most vulnerable individuals who are suffering in the population

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1. Mental Health Commission of Canada. Available from: https://www.mentalhealthcommission.ca/English.
2. Prince, M., et al., *Global mental health 1 - No health without mental health.* Lancet, 2007. **370**(9590): p. 859-877.
3. W.H.O., *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings: Mental Health Gap Action Programme (mhGAP)*. 2010, Geneva: World Health Organization.
4. Parikh, S., et al., *CANMAT Guidelines for Major Depression: Psychotherapy Alone and in Combination Treatment.* Canadian Journal of Psychiatry, 2016. **61**(9): p. 15.
5. Cuijpers, P., et al., *A Meta-Analysis of Cognitive-Behavioural Therapy for Adult Depression, Alone and in Comparison With Other Treatments.* Canadian Journal of Psychiatry, 2013. **58**(7): p. 376-385.
6. Cuijpers, P., et al., *Interpersonal psychotherapy for mental health problems: A comprehensive meta-analysis.* The American Journal of Psychiatry, 2016. **173**(7): p. 680-687.
7. Katzman, M.A., et al., *Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders.* BMC Psychiatry, 2014. **14 Suppl 1**: p. S1.
8. Cuijpers, P., et al., *Psychotherapy for chronic major depression and dysthymia: A meta-analysis.* Clinical Psychology Review, 2010. **30**(1): p. 51-62.
9. Felitti, V.J., et al., *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults - The adverse childhood experiences (ACE) study.* American Journal of Preventive Medicine, 1998. **14**(4): p. 245-258.
10. Lanius, R.A., E. Vermetten, and C. Pain, eds. *The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic*. 2010, Cambridge University Press: Cambridge.
11. Pilling, S., et al., *Guidelines Depression in adults, including those with a chronic physical health problem: summary of NICE guidance.* British Medical Journal, 2009. **339**.
12. Cuijpers, P., et al., *The effects of psychotherapies for major depression in adults on remission, recovery and improvement: A meta-analysis.* Journal of Affective Disorders, 2014. **159**: p. 118-126.
13. Cuijpers, P., et al., *The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: a meta-analysis of direct comparisons.* World Psychiatry, 2013. **12**(2): p. 137-148.
14. Fonagy, P., *The effectiveness of psychodynamic psychotherapies.* World Psychiatry, 2015. **14**(2): p. 137-150.
15. Teasdale, J.D., et al., *Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy.* Journal of Consulting and Clinical Psychology, 2000. **68**(4): p. 615-623.
16. Frank, E., et al., *Randomized trial of weekly, twice-monthly, and monthly interpersonal psychotherapy as maintenance treatment for women with recurrent depression.* Am J of Psychiatry, 2007. **164**(5): p. 761-767.
17. Layard, R., Clark, D.M., *Thrive: The Power of Evidence-Based Psychological Therapies*. 2014: Penguin. 384.

18. Lazar, S.G., *The cost-effectiveness of psychotherapy for the major psychiatric diagnoses.* Psychodynamic Psychiatry, 2014. **42**(3): p. 423-57.
19. Lazar, S.G., et al., *Clinical Necessity Guidelines for Psychotherapy, Insurance Medical Necessity and Utilization Review Protocols, and Mental Health Parity.* Journal of Psychiatric Practice, 2018. **24**(3): p. 179-193.
20. Stuart, H., *Fighting Stigma and Discrimination Is Fighting for Mental Health*. Vol. 31. 2005. 21-28.
21. Yalom, I. and M. Leszcz, *The Theory and Practice of Group Psychotherapy*. 5th ed. 2005: Basic Books.
22. McMain, S.F., et al., *A Randomized Trial of Dialectical Behavior Therapy Versus General Psychiatric Management for Borderline Personality Disorder.* American Journal of Psychiatry, 2009. **166**(12): p. 1365-1374.
23. Hettema, J., J. Steele, and W.R. Miller, *Motivational interviewing*, in *Annual Review of Clinical Psychology*. 2005, Annual Reviews: Palo Alto. p. 91-111.
24. Driessen, E., et al., *The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis update.* Clinical Psychology Review, 2015. **42**: p. 1-15.
25. Leichsenring, F. and S. Rabung, *Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis.* British Journal of Psychiatry, 2011. **199**(1): p. 15-22.
26. Am. Psychiatric Association. *Practice Guideline for the Treatment of Patients With Major Depressive Disorder*. Psychiatryonline, 2010.
27. Connery, H. and H. Kleber *Guideline watch (April 2007): Practice guideline for the treatment of patients with substance use disorders, 2nd edition*. Focus: The Journal of Lifelong Learning in Psychiatry, 2007. **2**.
28. NICE. *Clinical Guideline - Depression in Adults: Recognition and Management*. 2016 2016; Available from: https://www.nice.org.uk/guidance/cg90.
29. Silverman, J.J., et al., *The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults.* Am J Psychiatry, 2015. **172**(8): p. 798-802.
30. McHugh, R.K., et al., *Patient Preference for Psychological vs Pharmacologic Treatment of Psychiatric Disorders: A Meta-Analytic Review.* Journal of Clinical Psychiatry, 2013. **74**(6): p. 595-602.
31. Sunderland, A. and L.C. Findlay, *Perceived need for mental health care in Canada: Results from the 2012 Canadian Community Health Survey-Mental Health.* Health Reports, 2013. **24**(9): p. 3-9.
32. Correll, C.U. and H.E. Carlson, *Endocrine and metabolic adverse effects of psychotropic medications in children and adolescents.* Journal of the American Academy of Child and Adolescent Psychiatry, 2006. **45**(7): p. 771-791.
33. Young, J.F., L. Mufson, and R. Gallop, *Preventing depression: A randomized trial of Interpersonal Psychotherapy-Adolescent Skills Training.* Depression and Anxiety, 2010. **27**(5): p. 426-433.
34. Araya, R., et al., *Determinants of access to health care for depression in 49 countries: A multilevel analysis.* Journal of Affective Disorders, 2018. **234**(20): p. 80-88.
35. Kurdyak, P., et al., *Universal coverage without universal access: a study of psychiatrist supply and practice patterns in Ontario.* Open Medicine, 2014. **8**((3)e88).
36. Clark, D.M., et al., *Improving access to psychological therapy: Initial evaluation of two UK demonstration sites.* Behaviour Research and Therapy, 2009. **47**(11): p. 910-920.
37. Kurdyak, P., A. Newman, and Z. Segal, *Impact of mindfulness-based cognitive therapy on health care utilization: A population-based controlled comparison.* Journal of Psychosomatic Research, 2014. **77**(2): p. 85-89.