Moving Forward While Standing Still: A Case of Mental Health Advocacy Evolving in the Time of COVID-19

Introduction Eric M. Plakun, MD

Guest Columnists:

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There have been shifts over time in the value placed on long-term psychotherapeutic modalities even though they can be life-saving. For example, the province of Ontario in Canada has been dealing with a government proposal put forward in 2019 to limit the length of psychotherapy treatment. In response, stakeholders from numerous groups came together to advocate for the importance of continuing unrestricted access to long-term psychotherapy. Approaches to this advocacy then had to unexpectedly adapt to the Coronavirus Disease 2019 (COVID-19) pandemic that came to the forefront in 2020 and will continue to develop in response to this changing landscape.
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Introduction to Guest Column
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Villela and Lazar offer us an update on the Ontario Ministry of Health's atavistic proposal to impose an arbitrary limit on the number of psychotherapy sessions a patient may receive annually (roughly 24) in that Canadian province through its Ontario Health Insurance Plan (OHIP). The initial proposal led to a counter-response described by the authors in a previous[1] and in this current psychotherapy column. They also describe how the pandemic derailed some of their efforts or shifted them—and the provision of psychotherapy—to a virtual realm.

There are a few underlying issues worth naming to understand this in context. One is that we are in an era when evidence in the form of empirical studies matters so much that we may be blind to the authentic limits of what we know about making a meaningful difference for suffering patients. An evidence-base showing minimal benefit may be reified as evidence-based practice despite what we know from practice-based evidence. As Shedler carefully documents, if one looks at the actual evidence for short-term psychotherapies, the inescapable conclusion is that, with cognitive-behavioral therapy (CBT) and other short-term therapies, most patients fail to get better most of the time.[2] Somewhere between 12 and 24 sessions of a manualized therapy tested in carefully selected "unicorn" patients with single disorders, though such patients are the exception and not the rule, just does not leave most of even these less complex patients significantly improved.

Studies of short-term therapies like CBT are more frequently funded than those of often longer term psychodynamic therapy. I know one CBT researcher who wanted to research psychodynamic therapies but found funding obstacles so significant that a reluctant shift to CBT research ensued. This is but one of a series of significant biases against psychodynamic therapy described in a previous column by Abbass et al.[3] Such bias is relevant in part because longer term psychodynamic therapies are the treatments that are generally recommended to target underlying issues in the majority of patients who present with comorbid and/or treatment-resistant disorders.

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The Ontario Ministry of Health appears to have gotten caught up in these issues in its unfortunate efforts to manage costs by limiting access to care. Ontario is at risk of following "alternate facts," as those of us who are Ontario's US neighbors have heard such misinformation called. Ironically, Ontario is doing this as the 2020 landmark verdict in a US federal class action known as Wit v United Behavioral Health (UBH) *finds that this nation's largest behavioral health insurer unlawfully limited care, including outpatient psychotherapy, to short-term crisis intervention, which appears to be what OHIP proposes. UBH was found to have failed to follow the generally accepted standards of care that do not limit outpatient psychotherapy or other treatment to crisis stabilization or to arbitrary time limits.[4] Indeed, UBH was found to have put profits over its fiduciary duty to patients.*

While a US federal district court judge calls out the nation's largest behavioral health insurer for embracing flawed standards limiting treatment to short-term crisis intervention, Ontario seems to be pursuing short-term crisis intervention as if it represented the generally accepted standard for treatment. What a puzzling shame that the Ontario Ministry of Health is proposing to limit access to psychotherapy in a way that has been found in the United States to be a breach of fiduciary duty to those in need! We owe it to our colleagues in Ontario, and their patients, to help publicize the flaws in this short-sighted proposal to limit access to psychotherapy.

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Prepandemic, it was already becoming increasingly disheartening as a psychiatrist providing intensive/long-term psychotherapy to attend the conference circuit in some parts of North America. More prestige seemed to be associated with presentations focusing on psychopharmacology. Some colleagues would ask where the evidence was for intensive and extended psychotherapeutic modalities, especially when the evidence base for the short-term approaches was seen as more robust. They would add that long-term psychotherapy was particularly wasteful in public health care systems where resource management was struggling to meet the demand for psychiatric services. Others opined that the so-called "worried well," with their seemingly interminable courses of psychotherapy, were clearly clogging access to much-needed consults and medication management. It was difficult to witness such a vital tool in the mental health armamentarium being vilified. It also seemed almost impossible that incoming generations of psychiatrists would be interested in learning the necessary long-term psychotherapy skills. It became clear that more education was needed about this important topic, both within the profession and with other stakeholders.

Cognitive-behavioral therapy (CBT) can be helpful to patients without severe and chronic disorders. The claim that short-term CBT is the most evidence-based psychotherapy for most patients is founded on a large body of randomized controlled trials yielding statistically significant improvement in symptoms. Brief, manualized CBT trials, however, are generally conducted with subjects with a sole diagnosis under investigation and are not typical of most psychiatric patients who have more complicated conditions and frequent comorbidity. Statistically significant improvement in symptom rating scales does not indicate clinical improvement or lasting change. Reviews of manualized brief treatments for depressive and anxiety disorders have found that there are only short-lived benefits (with more than half of patient cohorts seeking treatment again within 6 to 12 mo),[5] that most patients require more therapy to achieve remission (and a full 75% did not get well otherwise),[6] that "brief, "evidence-based" therapies are ineffective for most people most of the time,"[2] and that study design flaws and publication bias undermine claims of "findings of efficacy."[7,8] These types of studies also undermine the relevance of such therapies to most patients' clinical needs or appropriateness in shaping policy or insurance coverage protocols.

Long-term psychotherapy is not an elective treatment than can be equated with elective cosmetic surgery. In 1987 in the United States, before increasingly stringent restrictions of insurance benefits for psychotherapy, 3% of the population had been in outpatient therapy, with the poor and near-poor using long-term treatment in proportion to their numbers in the general population with the same percentage of out-of-pocket expenditures as short-term therapy users. Patients who were accessing long-term therapy were more complex; they had more distress, had poorer general health, had higher general medical costs, had

more functional impairment, and were more likely to need psychotropic medication and to have a psychiatric hospitalization than short-term therapy patients.[9,10]

In the past several decades, most insurance companies in the United States have slashed benefits for more than brief psychotherapy. A successful class action suit against United Behavioral Health/Optum that found a goal of cost-cutting had prevented the provision of generally accepted standards of patient care and inadequate support for psychotherapy and other mental health benefits may gradually reverse this now deeply entrenched lack of insurance support.[1] Patients in extended psychotherapy are not in treatment to take unnecessary advantage of an overly generous insurance benefit. The Rand Health Experiment found that, even when psychotherapy is free, 4% of an insured population access it and the average length of care is 11 sessions.[11] A higher cost burden for outpatient psychiatric care deters very ill patients who forego such treatment,[12,13] and such patients in poorer neighborhoods subsequently incur increased overall expenses in emergency care and hospitalization that are greater than what was saved in outpatient costs.[14]

The patients who need more extended psychotherapy are those with chronic severe anxiety and depression, personality disorders, and multiple chronic psychiatric disorders. Extremely costly to society in unemployment, high rates of drug problems, interpersonal problems, suicide attempts, child abuse, criminal behavior, and heavy use of health care, those with personality disorders have a lifetime prevalence in the United States between 10% and 13.5%.[15–19] Depression has a lifetime prevalence in the United States of 19.3%,[20] and it is the leading cause of worldwide disability according to the World Health Organization.[21] All of these chronic patients require more than brief treatment and can improve with extended psychotherapy in which longer duration and increased frequency have independent positive effects on outcome.[22–26] A lack of appropriate support for psychotherapy leads to insufficient treatment and is a hidden multiplier of morbidity, disability, and overall health care expenses compared with those of individuals without psychiatric illness.[27–29] Contrary to common assertions, a significant body of research has confirmed the equivalent efficacy of psychodynamic psychotherapy compared with cognitive-behavioral approaches and its superior usefulness for chronic patients with interpersonal difficulties.[30–35] There are also abundant data documenting the cost-effectiveness and frequent cost-offset (savings in medical and disability costs) provided by long-term psychodynamic psychotherapy compared with the costs of brief or insufficient treatment.[36–40]

Countries with centralized government-controlled single payer medical programs that have experimented with limitations on outpatient psychotherapy have found a resulting increase in their overall medical, emergency, and hospitalization budgets.[14,41,42] It is short-sighted in the extreme for a single payer centralized government insurance program to limit care in a way that results in greatly increased costs that it will itself have to meet, not to mention the increase in disability, lost lives, and patient suffering that ensues. Yet, in the Canadian province of Ontario, a government proposal was put forward in early 2019 aiming to restrict the number of hours per year available to patients for publicly-funded, physician-delivered psychotherapy with the limit to be based on a predetermined number rather than on clinical need.[1,43] As highlighted above, for challenging cases involving multiple medical/psychiatric comorbidities, the loss of access to intensive treatment resources could be devastating.

In response to the government's proposal, several professional organizations, as well as supportive individuals, mobilized to advocate against these potentially destabilizing changes. Starting with the traditional print media, Dr Norman Doidge wrote an article for *The Globe and Mail* newspaper arguing against the proposed cuts.[43] Dr Wei-Yi Song, then-President of the Canadian Psychiatric Association, subsequently wrote an editorial in *The Star* in support of avoiding preset limits.[44] Stakeholders connected with politicians and, by the summer of 2019, patients volunteered to share their stories on camera of how long-term/intensive psychotherapy had been a key ingredient in their recovery journey. The latter ultimately became part of the *Psychotherapy Saves* videos on YouTube.[45] Towards the end of 2019, the *Journal of Psychiatric Practice* published a succinct article summarizing the relevant data debunking the myths about long-term psychotherapy.[1]

To build on this momentum, Dr Villela looked to optimize psychotherapy content for the Ontario Psychiatric Association's March 2020 conference in her role as Psychotherapy Initiative Lead for the

group. Dr Lazar was scheduled to give a plenary presentation at that conference entitled "The Cost-Effectiveness of Psychodynamic Therapy, The Patients Who Need It, and Obstacles to Its Provision." Dr Villela also developed a new art exhibit for the conference called "In their Shoes: Sharing Psychotherapy Stories." It was to involve a curated collection of shoes donated for charitable purposes with the associated stories of how long-term/intensive psychotherapy had made a significant positive impact in the lives of the shoes' owners. Everything was in place until the global Coronavirus Disease 2019 (COVID-19) crisis completely changed the landscape in the late Winter/Spring of 2020. The conference and the associated art exhibit had to be postponed and are likely to be rescheduled for this year.[46] Other planned international presentations on the topic were tenuous depending on how the situation was to evolve. The potential loss for the advocacy momentum was deeply felt.

This unique situation of a pandemic resulted in a change of perspective. Everything had to adapt. Saving lives was still the priority; the approach just had to be different. So now the virtual world had to play a larger role than the in-person one. More telephone calls, video conferencing, and other electronic forms of communication had to be relied on while physical distancing measures relating to the COVID-19 pandemic were in effect.

Regardless of whether health care is taking place at a tertiary care center or at the heart of the community, it is the people that matter. Psychiatrists serving those with a complex diagnostic picture were helping to keep patients stable and out of the emergency department through remote long-term psychotherapy appointments, just one of many examples of offering help during the COVID-19 crisis.[47,48]

The stigma against mental illness and its treatment is already such that many suffer in silence. It can be demoralizing for patients to be repeatedly informed by the gatekeepers of health care systems that they need to "just get over" their issues quickly and move on with their lives so that the next person can be seen.[1] This attitude feels particularly outdated as researchers are exploring the role of specific genetic polymorphisms that potentially predict those who could benefit more from open-ended versus manualized psychotherapy.[49] Still, a patient with nerve damage postinjury would likely receive greater compassion and access to treatment because of the understanding that the nervous system takes time to heal and is deserving of patience. Putting forward a drive-through psychiatric care model is not going to meaningfully help; it will probably just make certain carefully curated statistics look more conforming to a standard inconsistent with actual patient need.

Psychiatrists practicing psychotherapy should ideally be operating at the top of their license. That means being able to offer a variety of treatments, including those with life-saving potential such as long-term psychodynamic psychotherapy that can be available for generations to come. While the virus can be relentless, so too should be the work done to keep people safe. Although the future of the proposed psychotherapy cuts in Ontario remains unknown, it is all the more important to not lose sight of the advocacy work by promoting the core message across various media.

REFERENCES

1. Plakun E, Villela R. Psychotherapy in psychiatry: fighting alternative facts. J Psychiatr Pract. 2019;25:466–469.
2. Shedler J. Where is the evidence for "evidence-based" therapy? Psychiatr Clin North Am. 2018;41:319–329.
3. Abbass AA, Luyten P, Steinert C, et al. Bias toward psychodynamic therapy: framing the problem and working toward a solution. J Psychiatr Pract. 2017;23:361–365.
4. Appelbaum PS, Parks J. Holding insurers accountable for parity in coverage of mental health treatment. Psychiatr Serv. 2020;71:202–204.
5. Westen D, Novotny C, Thompson-Brenner H. The empirical status of empirically supported psychotherapies: assumptions, findings, and reporting in controlled clinical trials. Psychol Bull. 2003;130:631–663.
6. Driessen E, Van H, Don F, et al. The efficacy of cognitive-behavioral therapy and psychodynamic therapy in the outpatient treatment of major depression: a randomized clinical trial. Am J Psychiatry. 2013;170:1041–1050.
7. Wampold B, Budge S, Laska K, et al. Evidence-based treatments for depression and anxiety versus treatment-as-usual: a meta-analysis of direct comparisons. Clin Psychol Rev. 2011;31:1304–1312.
8. Cuijpers P, Smit F, Bohlmeijer E, et al. Efficacy of cognitive–behavioural therapy and other psychological treatments for adult depression: meta-analytic study of publication bias. Br J Psychiatry. 2010;196:173–178.
9. Olfson M, Pincus H. Outpatient psychotherapy in the United States, I: volume, costs, and user characteristics. Am J Psychiatry. 1994;151:1281–1288.
10. Olfson M, Pincus H. Outpatient psychotherapy in the United States, II: patterns of utilization. Am J Psychiatry. 1994;151:1289–1294.
11. Manning W, Wells K, Duan N, et al. How cost sharing affects the use of ambulatory mental health services. JAMA. 1986;256:1930–1934.
12. Simon G, Grothaus L, Durham M, et al. Impact of visit copayments on outpatient mental health utilization by

members of a health maintenance organization. Am J Psychiatry. 1996;153:331–338.
13. Landerman L, Burns B, Swartz M, et al. The relationship between insurance coverage and psychiatric disorder in predicting use of mental health services. Am J Psychiatry. 1994;151:1785–1790.
14. Ravesteijn B, Schachar E, Beekman A, et al. Association of cost sharing with mental health care use, involuntary commitment, and acute care. JAMA Psychiatry. 2017;74:932–939.
15. Reich J, Yates W, Nduaguba M. Prevalence of DSM-III personality disorders in the community. Soc Psychiatry Psychiatr Epidemiol. 1989;24:12–16.
16. Casey P, Tyrer P. Personality, functioning and symptomatology. J Psychiatr Res. 1986;20:363–374.
17. Maier W, Lichtermann D, Klingler T, et al. Prevalences of personality disorders (DSM-III-R) in the community. J Personal Disord. 1992;6:187–196.
18. Zimmerman M, Coryell W. Diagnosing personality disorders in the community. Arch Gen Psychiatry. 1990;47:527–531.
19. Lenzenweger M. Epidemiology of personality disorders. Psychiatr Clin North Am. 2008;31:395–403.
20. Kessler R, Berglund P, Demler O, et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62:593–602.
21. World Health Organization. The Global Burden of Disease 2004. Geneva, Switzerland: World Health Organization; 2008.
22. Rudolf G, Manz R, Ori C. Ergebnisse psychoanalytischer therapie [Outcome of psychoanalytic therapy]. Z Psychosom Med Psychother. 1994;40:25–40.
23. Sandell R, Blomberg J, Lazar A, et al. Varieties of long-term outcome among patients in psychoanalysis and long-term psychotherapy: a review of findings in the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPP). Int J Psychoanal. 2000;81:921–942.
24. Grande T, Dilg R, Jakobsen T, et al. Differential effects of two forms of psychoanalytic therapy: results of the Heidelberg-Berlin Study. Psychother Res. 2006;16:470–485.
25. Leichsenring F. Effectiveness of long-term psychodynamic psychotherapy. JAMA. 2008;300:1551–1565.
26. Leichsenring F, Rabung S. Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis. Br J Psychiatry. 2011;199:15–22.
27. Melek S, Norris D. Chronic Conditions and Comorbid Psychological Disorders. Seattle, WA: Milliman; 2008.
28. Luber M, Hollenberg J, Williams-Russo P, et al. Diagnosis, treatment, comorbidity, and resource utilization of depressed patients in a general medical practice. Int J Psychiatry Med. 2000;30:1–14.
29. Deykin E, Keane T, Kaloupek D, et al. Posttraumatic stress disorder and the use of health services. Psychosom Med. 2001;63:835–841.
30. Levy K, Ehrenthal J, Yeomans F, et al. The efficacy of psychotherapy: focus on psychodynamic psychotherapy as an example. Psychodyn Psychiatry. 2014;42:377–421.
31. Steinert C, Munder T, Rabung S, et al. Psychodynamic therapy: as efficacious as other empirically supported treatments? A meta-analysis testing equivalence of outcomes. Am J Psychiatry. 2017;174:943–953.
32. Leichsenring F, Steinert C. Is cognitive behavioral therapy the gold standard for psychotherapy? The need for plurality in treatment and research. JAMA. 2017;318:1323–1324.
33. Huber D, Zimmermann J, Henrich G, et al. Comparison of cognitive-behaviour therapy with psychoanalytic and psychodynamic therapy for depressed patients: a three-year follow-up study. Z Psychosom Med Psychother. 2012;58:299–316.
34. Levy K, Meehan K, Kelly K, et al. Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. J Consult Clin Psychol. 2006;74:1027–1040.
35. Shedler J. The efficacy of psychodynamic psychotherapy. Am Psychol. 2010;65:98–109.
36. de Maat S, Philipszoon F, Schoevers R, et al. Costs and benefits of long-term psychoanalytic therapy: changes in health care use and work impairment. Harv Rev Psychiatry. 2007;15:289–300.
37. de Maat S, de Jonghe F, Schoevers R, et al. The effectiveness of long-term psychoanalytic therapy: a systematic review of empirical studies. Harv Rev Psychiatry. 2009;17:1–23.
38. Berghout C, Zevalkink J, Hakkaart-van Roijen L. A cost-utility analysis of psychoanalysis versus psychoanalytic psychotherapy. Int J Technol Assess Health Care. 2010;26:3–10.
39. Berghout C, Zevalkink J, Hakkaart-Van Roijen L. The effects of long-term psychoanalytic treatment on health-care utilization and work impairment and their associated costs. J Psychiatr Pract. 2010;16:209–216.
40. Beutel M, Rasting M, Stuhr U, et al. Assessing the impact of psychoanalyses and long-term psychoanalytic therapies on health care utilization and costs. Psychother Res. 2004;14:146–160.
41. Duehrssen A. Katamnestische Ergebnisse bei 1004 Patienten nach analytischer Psychotherapie [Catamnestic results with 1004 patients following analytic psychotherapy]. Z Psychosom Med. 1962;8:94–113.
42. Dossmann R, Kutter P, Heinzel R, et al. The long-term benefits of intensive psychotherapy: a view from Germany. Psychoanal Inq. 1997;17:74–86.
43. Doidge N. Opinion: In Ontario, a battle for the soul of psychiatry. *The Globe and Mail*; April 6, 2019. Available at: www.theglobeandmail.com/opinion/article-in-ontario-a-battle-for-the-soul-of-psychiatry. Accessed June 15 2020.
44. Song W. Don't penalize people with severe mental illness [Internet]. Toronto Star. July 8, 2019. Available at: https://www.thestar.com/opinion/contributors/2019/07/08/dont-penalize-people-with-severe-mental-illness.html. Accessed June 15, 2020.
45. YouTube. Psychotherapy saves; October 30, 2020. Available at: www.youtube.com/channel/UCQjLKWr8-7jOengYbm0Y7Xw. Accessed November 15, 2020.
46. Ontario Psychiatric Association (OPA). News & updates. Letter from OPA President, Dr Renata Villela; June 15, 2020. Available at: https://eopa.ca/news-updates. Accessed November 15, 2020.
47. Villela R. Coming together in the time of COVID-19. Royal College of Physicians and Surgeons of Canada Newsroom; April 16, 2020. Available at: https://newsroom.royalcollege.ca/perspectives-coming-together-in-the-time-of-covid-19. Accessed November 15, 2020.
48. Villela R. Staying Safe. Toronto, ON, Canada: Ontario Medical Association; 2020. Available at: www.protecthealthcare.ca/staying_safe. Accessed November 15, 2020.
49. Goldwaser EL, Miller CWT. The genetic and neural circuitry predictors of benefit from manualized or open-ended therapy. Am J Psychother. 2020;73:72–84.