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Psychotherapy in European Public Mental Health Services

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abstract

The delivery of psychotherapy has not yet become a routine part of Public Mental Health Services. It still is unevenly organized in Western European societies. The paper describes this diversity. The paper then points to the need of using a scientific definition of psychotherapy and delineates the diversity of options where evidence-based interventions should be part and parcel of professional and publicly funded. Finally the paper reviews aspects of cost-effectiveness of psychotherapy.

Europa, in Greek mythology, was the daughter either of Phoenix or of Agenor, king of Phoenicia. The beauty of Europa inspired the love of Zeus, who approached her in the form of a white bull and carried her away from Phoenicia to Crete, where she became a queen (Encyclopaedia Britannica). We wish we could end this paper by saying that Europe as a unified body of many countries has been carried away by the love to psychotherapy for all people in the European community. Alas, this is not the case. We are a far cry from being able to state that psychotherapy is available for everybody in all European countries. We cannot avoid reminding our readers to Freud´s famous statement from the lecture in Budapest 1918: „ that sometimes the conscience of a society will arise and decide.....

The role for psychotherapy, the subverse profession, in a changing and increasingly ruled bound Europe has been made a number of tome a key topic of conferences. Rules are made by rulers, by goverments which are increasingly ruled by economic constraints. The rising costs of the health sector are a constant topic in daily news. Recipes for cost containment are manifold most often they imply cutting of services. We want to raise the issue whether we are in a position to argue that psychotherapy can contribute to cost containment in a

significant degree. Therefore we shall raise the issue of cost-effectiveness that in our opinion has been neclected not only by the public, but the our profession itself.

German popular magazines regularly raise the issue: What can psychotherapy do? This is the more surprising as psychotherapy has been included into the contracts between doctors´association and insurance companies within the public health service since 1967. Based on informal work by many psychoanalysts of the post-war generation and by one major study demonstrating cost-effectiveness of analytic psychotherapy (Dührssen & Jorswieck 1965) the introduction of psychoanalytic and psychodynamic therapy into the operating schema of state-controlled but independent insurance companies fulfilled Freud´s hopes. Everybody who was insured was entitled to get psychotherapy in quite a generous way.
However such a degree of implementation of psychotherapy into the public health system is unevenly distributed across Europe. Even if psychotherapy is available for the educated people in all European societies for private money, it is not so as public health option. One finds a gradient of public health provision of psychotherapy from the North to the South somewhat patterned to the distribution of protestant to catholic fractions. The Scandinavian countries, Great Britain, the Netherlands, Germany, Switzerland may loosely looked at countries under the spell of Max Weber´s protestant work ethic. Austria as a predominant catholic country seems to contradict this hypothesis; alas they have a very liberal „protestant“ admission to the profession, but they are quite catholic in the amount of money insurance companies pay for the individual session. But in the other catholic countries like France, Italy, Spain, Greece to our knowledge the public health system does not generously invest in psychotherapy as a public task.

In the USA psychotherapy had its academic zenith in the sixties slowly reducing degree and intensity when the decade of the brain opened a new biological perspective. However recent trends show:

between 1987 and 1997: no statistical significant change in the overall rate of psychotherapy use (3.2 persons per 100 persons to 3.6)
significant increases in psychotherapy use by adults aged 55-64 years and by unemployed adults
psychotherapy patients show a marked increase in the use of antidepressant medications (14.4% to 48.6%)
a smaller proportion of patients made more than 20 psychotherapy visits in 1997 (10.3%) than in 1987 (15.7%)
in 1997, 9.7 million Americans spent $5.7 billion on out-patient psychotherapy

(Source: Olson et al. 2002)

It is more difficult to characterize the former East-European countries under the communist regimes. Looked at it from the western position one realized that a lively field of mainly group psychotherapy in the capitals had been established, however it was less clear how widespread these options have been available. At least in East-Germany, the former German Democratic Republic, low keyed psychotherapy was available in the major cities, but hardly in rural areas. After the great change of the political system one encounters an upsurge of interest in East Europe in manifold forms of psychotherapy without public funding.

@@The countries where islamic cultures dominate seem to be fairly free from typical westernized forms of psychotherapy. Asian countries as far as

> we know are a far cry from providing western forms of psychotherapy; let us hope for the people that they are providing something that helps them to stay alive and well. Sometimes they in fact do have their own versions like Morita therapy in Japan.

The idea at first seemed far fetched of why this confession based regional distribution should still be working in times where the societal role of religion is clearly diminishing, we would want to stipulate a discussion on the national budgets foer psychotherapy in the European countries.

Let us return to the situation in the European countries including the US. Why after more than thirty years of formalized psychotherapy research – taking the publication of the first Handbook of Psychotherapy and Behavior Change by Bergin and Garfield in 1971 as its starting point[1] - do we still have to demonstrate that psychotherapy works. Do we first have to demonstrate that it „really" alters brain mechanisms? Which, by the way, it does (see Roffman et al. 2005).

Looking back since its implementation the field of psychotherapy had the object of furious critiques. In the midst of this 20th century the famous British psychologist Eysenck - when the psychoanalytic form of psychotherapy were still dominating - launched a furious attack on all of psychotherapy. He claimed to demonstrate that sponteous recovery from minor mental illness would surpass the effects of the psychoanalytic therapies (1952). Although many discussants contradicted Eysenck´s verdict at that time (for a summary see Bergin 1971) his paper has been one of the most often quoted and still holds a position in most textbook of clinical psychology. One cannot but assume that it struck a chord in the public opinion.

[1] Since then this bible of psychotherapy research marks the position of the field. The fifth edition has recently been published (Lambert 2004).

McNeilly & Howard (Chicago) in 1991 re-analyzed Eysenck´s data set and compared it to a mega-analytic compiled large sample (more than 2000 patients). They demonstrated that once a week dynamic psychotherapy does work faster than the assumed spontaneous remission!
With the foundation of the international Society for Psychotherapy Research (SPR) in 1968 the field had at least reached a kind of academic maturity. Journals and book specially devoted to psychotherapy appeared; national and international congresses took place. But parallel to it psychotherapy developed in a wildly growing fashion. The numbers of diverse forms of psychotherapy reached phantastic dimensions (Corsini 1983). Year by year new forms of psychotherapy were advocated by a more or less well known guru without providing evidence for its efficacy and effectiveness. As long as this development did not impact on the medical system but remained para-medical one could only raise concerns about customers self-selected fate. However the more these „subverse" activities intruded the medical system the practice of psychotherapy was bound to become an object of policy makers (Vandenbos 1980). Finally the question „What works for whom" (Roth & Fonagy 1996) was no longer academic:
„Concerns regarding the financing of mental health services by goverment and insurance companies have led to increased scrutiny of what sorts of treatment are practiced. To contain spiraling costs of health care, those who pay for treatment are concerned about the effectiveness and efficiency of these services" (Kazdin 1996, p.V)

One might be tempted to draw a line between para-medical and medical forms of psychotherapy. Those forms of psychotherapy that are interested to operate inside the medical service system, have to fulfill certain standard, have to fulfull the criteria of a scientifically based psychotherapy**.** How could one define it?

A Famous German-Austrian Definition

"Psychotherapy is a deliberate and planned interactional process to influence behavioral disturbances and states of suffering, that in agreement among patient, therapist and society are looked at as in need for treatment with psychological means mostly verbal, also non-verbal, in direction of a defined, shared goal (like symptom reduction or personality change) for which teachable techniques are available based on a theory of normal and pathological behavior" (Strotzka 1975).

Using the Strotzka´s definition, the formidable task of psychotherapy besides being based on a widely accepted theory is to influence behavioral disturbances and states of suffering.

These objectives mark the weak and strong aspects of psychotherapy:

Weak - because one easily can say, people can overcome these states without the professional help of psychotherapists. Strong - because research has amply demonstrated that with psychotherapy people can overcome these states much quicker.

Our arguments for establishing psychotherapy in the field of Mental Health may be much strengthened by including not only the traditional mental disorders like anxiety disorder, depressive disorders, schizophrenia, but by taking into account the vast array of co-morbidity in medical disorders.

Fava & Sonino (2000) point out that a substantial amount of medical disorders have been shown to be associated with stressful life events in controlled studies:

Asthma / Diabetes / Graves´disease / Hypothalamic amenorrhea / Peptic Ulcer / Inflammatory bowel disease / Functional gastrointestinal disorders / Myocardial infarction / Functional cardiovascular disorders / Autoimmune disease / Cancer / Infectious disease / Psoriasis / Alopecia areata & urticaria / Headache / Cerebrovascular disease

What is the impact of these findings on our argument for public funding of psychotherapy.

Fava and Sonino go on to list the medical conditions in which short-term psychotherapies have been found to be effective in randomized controlled trials:

Chronic pain / Chronic fatigue syndrome / Coronary heart disease / Hypertension / Diabetes / Cancer / Asthma / Epilepsy / Obesity / Peptic ulcer / Cancer / Irritable bowel syndrome / Inflammatory bowel disease / Arthritis / Preparation to medical procedures

It may come as a surprise to some of us, but we am sure that many of us have met these patients where psychotherapy as an addendum to somatic therapy has been most helpful. To our knowledge there is one field where the medical service system widely has accepted that additional psychological service represents the state of the art. This is psycho-oncology (Grulke et al. 2004). For most of the other mentioned somatic conditions the application of psychological intervention seems to be arbitrary depending on local condition in terms of policy shaping people and institutions involved. (Patients usually have no words in such decisions).

So besides the traditional applications for psychotherapy f.e. people that do not like to take psychopharmacological drugs and people that suffer from disturbances that are not likely to be positively influenced by drugs (personality disorders, eating disorders, somatoform disorders etc) it could and should also be offered for people with more severe medical disturbances to ameliorate their psycho-social adaptation. Taking the shrinking medical budgets everywhere the immediate question arises: can we really demonstrate that psychotherapy does not only work in these conditions (would be nice) but is it cost-effective?

Cost-effectiveness

We mentioned earlier that the introduction of psychotherapy as a routine option for any insured patient in the German health system had been tremendously influenced by a single study that demonstrated impressive effects of medium range psychoanalytic oriented therapy on the working class people´s days off work. Leaving aside our preference for the alleviation of human suffering it should be obvious that the public prefers other less humanistic achievements, the public wants achievements that can be expressed in monetary form. Precipitously rising costs of medical activities led to the call for data providing a rational basis to build a health service system that guarantees affordable high quality treatment: "the most pervasive myth within the clinical community is that costs are the business of business and not a clinical concern" (Newmann & Howard 1986). Cost-benefit and cost-effectiveness analysis (CBA/CEA) are rare and usually receive attention merely from the angle of health policy. Therapists perceive all these approaches as a substantial threat to their freedom to practice therapy as they see fit "to do the best possible for their patients"; they are probably right from a micro-perspective focusing on individual patients. However, from the macro-perspective of the clinical institution or the health care system as a whole, their practice may well be sub-optimal.

Not only clinicians are reluctant to take this further step of uncovering myths about psychotherapy. Researchers too are afraid that they may jeopardize what they stand for if they do administratively directed research, particularly because the rationale for political decision-making is not always compatible with the scientific and methodological standards adhered to in empirical research.

There is no doubt that all people involved wish for maximally efficient psychotherapy, but clinicians as well as researchers hesitate to put this into

monetary terms. This is not at all necessary : the point of interest in CBA/CEA is not just decreasing costs, but discovering how to utilize scarce therapeutic resources to achieve a maximum of returns. An example of the latter would be a study designed to investigate how best to distribute sessions over treatments in order to support the processes of psychic development. In this respect CBA/CEA offers an opportunity to apply and validate theories of psychotherapy, and is complementary to the more familiar areas of psychotherapy research.

What are costs, what is benefit? It has proved helpful to distinguish direct and indirect costs:

1. Direct costs:
The most obvious costs of treatment obviously are direct costs. Each session has its price which seems easy to determine in outpatient therapy. Calculating the costs for supervision with more experienced colleagues presents some inherent difficulties. In the case of inpatient treatment, one has to decide whether to take the real costs for each patient or to work with an a priori averaged sum.

2. Indirect costs:
Besides paying the bills of their therapists, patients have to invest time for the treatment which often means time taken from the patient's working hours. During outpatient treatment this may not directly affect the costs; however, patients treated in psychotherapeutic hospitals, as quite often happens in Germany, cause considerable indirect costs to their firms. Furthermore, inpatient treatments (rarely outpatient treatments) also induce costs for the patients' families, even if some of the stresses are hard to quantify in monetary terms. Whether subsequent life events (e.g., divorce, loss of job, etc.) that may have some connections to the treatment should evaluated as costs is an open matter.

With regard to the benefits of treatments two distinctions are useful:

1. Saved costs:
The main momentum lies in the reduction of disease-related costs as psychological treatment may be cheaper than somatic treatments, and/or psychological treatment as well reduces other complaints not directly related to the identified disorder. Furthermore the reduction of days off work which was

one of the major results of the German outcome study (Dührssen 1962) and the further implications on the productivity index are major aspects of saved costs.

2. Gained benefits:
Psychotherapy may lead directly or indirectly to increased work productivity by enhancing creativity, assertiveness or just by more presence on the job; it also may increase the qualities of private life that are even more difficult to include in a financial evaluation procedure. Improvement of quality of life thus escapes the range of CBA, though most therapists would put it into the center of their goals for patients.

Thus in CBA/CEA different interests of different groups (patients and their relatives, insurance companies, employers) are to be distinguished, but do not have to be reconciled. One of the most esteemed studies in this field is the "EAP Financial Impact Study" implemented by the well know air technology plant, McDonnell Douglas Corporation (The Almacan 1989). This study was started in 1985 to evaluate the McDonnell Douglas Employee Assistance Program (EAP) by a longitudinal analysis of costs associated with health care claims and absenteeism for a multi-year period before and after EAP-intervention. Included were persons who had undergone treatment under ICD classifications related to psychiatric disorders, substance abuse or alcoholism and their families.

"We did not try to measure the financial impact of factors which cannot be objectively and concretely measured. 'Soft-dollar' items such as productivity, job-performance level, replacement labor costs and other subjective data were ignored. We wanted the most conservative possible study outcome. Therefore, the only two variables that were measured were actual health claims costs for the employee and absenteeism. Absenteeism costs were determined by the individual's daily income, extrapolated from either hourly base rates or annual salaried base compensation, then multiplied by the number of days lost." (The Almacan, 1989).

The study demonstrated a tremendous gain:

"A final cost-offset ratio (investment-to-savings) 4:1; a four-year dollar savings

for the EAP population of $5.1 million. The $5.1 million savings include the value of working days saved by the employee, which is $ 762,526. This, too, is a conservative figure because it does not include replacement labor costs, hiring, training, etc., and losses due to normal attribution were factored in." (The Almacan, 1989). Of special importance is that not only the medical claim costs for the EAP decreased, but also the per-case family medical claim costs.

To be fair, the majority of studies evaluated the offset effect in inpatient medical settings mainly for short psychological interventions (Chiles et al 1999). Our late Swiss colleague Klaus Grawe has summarized the findings on cost-effectiveness of out-patient psychotherapy (Grawe et al. 1994). Gabbard and colleagues (1997) reported similar findings for the US. A recent German psychoanalytic follow-up study again demonstrated a significant reduction of days off work compared to the data of the general population (Beutel et al. 2004). However the Swedish STOPP study could not identify impact of long intensive treatment on objective aspect (Lazar et al. 2006). The following findings from a prospective study from the Center for Psychotherapy Research in Stuttgart (since 2005 in Heidelberg) are relevant here:
In the frame of a naturalistic longitudinal study on 402 patients in psychodynamic and 236 patients in cognitive-behavioral therapy Kraft et al. analyzed the costs before and during the course of treatment. The main results on the random responders sample of 176 participants were:

- Increase of health care costs prior to first inquiry & subsequent reduction
- Clinical & socioeconomic variables show – if so – only minor relationships with health care costs before 1st inquiry (age, physical impairment, somatization)
- Best predictor of subsequent reduction: health care costs before first inquiry.

The message we could take home from this study is clear. The more expensive for the medical system patients are, the more patients are likely to profit from psychotherapy in cost-effective dimensions. However confronted with economists´ stiff attitudes – as a symposium at NIHM in 1999 demonstrated (Miller & Magruder 1999) – is is still a long way to go. We would wish that this message travel across Europe and moves policy makers to make good policy for the good of our patients.

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