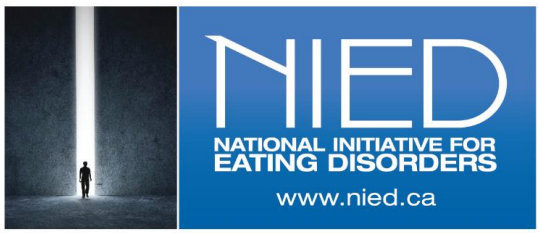


Awareness. Understanding. Action.

December 5, 2019

Hon. Michael A. Tibollo
Associate Minister of Mental Health and Addictions
Ministry of Health and Long-Term Care
99 Wellesley Street West
Toronto, ON M7A 1A2

Dear Minister Tibollo,

We are writing to express our deep concern over a proposal being considered by the Ministry of Health and Ontario Medical Association (OMA) Appropriateness Working Group (AWG) to limit full OHIP funding for outpatient psychotherapy to 24 hours per year.

For many patients, psychotherapy is medically necessary. Treatment decisions must be left up to a person's primary care provider and care team, particularly when providing medical care to a person diagnosed with a mental illness, whose recovery journey is not one-size-fit-all.

Reducing outpatient psychotherapy to 24 hours per year is at-best arbitrary and fails to recognize that people with serious mental illness, and particularly Eating Disorders, may have disease trajectories (we know from research) that are difficult to predict.

The decision to limit the availability of a medically necessary intervention that is shown to have considerable impact on people with certain mental illnesses must not fall to a policy advisory body, such as the Appropriateness Working Group (AWG), or the Minister of Health or the Ontario Medical Association, none of whom are accountable for implementing specialized clinical practice guidelines for patients they have never seen or assessed.

We strongly believe that all Ontarians who are affected by a diagnosed health problem, particularly serious illnesses and disorders, need and deserve access to an appropriate form of treatment (following assessment and diagnosis) that will help them. Limiting care for some patients has the potential to raise their hopes and, in the end, leave them stranded when they cannot receive appropriate medically necessary care.

To this end, and for the reasons we cite below, we believe that it would be appropriate for the Ministry of Health and OMA to not support any proposal that aims to limit full OHIP coverage for psychotherapy to 24 hours per year, particularly for people with a mental illness who may need more intensive forms of treatment at varying stages of their recovery journey.

As you know from our previous conversations, Eating Disorders are not a choice and that 1 person in 10 with an Eating Disorder will die. As a group, Eating Disorders have the highest mortality rates of all mental illnesses. Based on a recent systematic review[1] covering 1975 to 2016, we also know that relapse after treatment for anorexia nervosa (AN) remains a significant clinical problem and that relapse rates are positively associated with follow-up delays. The reality is that illness trajectories can differ markedly between patients who are affected by the same illness. In this way, recovery from any Eating Disorder is highly individualized, requires team-based, collaborative care that can benefit from psychotherapy.

Rather than believe that patterns of recovery can be predicted in all cases, we can and must acknowledge that recovery from some serious mental illnesses (or returning to one's usual self) is highly individual, which means that our health care system must remain flexible and adapt to people (not the other way around) who, through no fault of their own, are affected by a serious mental illness. Too often, it seems as though the medical system will be there for people when they experience a physical injury – even one they may have had a part in causing – but the same system will be inconsistently there for people affected by mental illness. For people and caregivers of those living with or recovered from a mental illness, this is extremely difficult to understand.

Equally difficult to comprehend is the already limited availability of psychotherapy in Canada. Intensive psychotherapy is unaffordable for most people given the perplexing and continuing approach to covering psychotherapy in Ontario and many Canadian provinces. We are, however, heartened to see the thoughtful analysis completed in 2018 by the Quebec National Institute of Excellence in Health and Social Services (INESSS), which shows certain psychotherapy interventions to have had a "considerable clinical impact" (« *un impact clinique considerable*[2] » ) notably in adults experiencing disordered eating or diagnosed with an Eating Disorder (ED). As you may know, the Mental Health Commission of Canada (MHCC) also provides an equally in-depth review[3] of models and evidence-based approaches from other jurisdictions, with the aim of seeing the adoption of more an equitable access to psychotherapy in Canada.

We would also call your attention to recommendation 12 of the *Canadian Eating Disorders Strategy: 2019 – 2029*[4] which, consistent with principles in the *Canada Health Act*, calls for all Canadians, including individuals living with an ED, to have equitable access to medically necessary services – no matter where they live and without discrimination. In line with the published literature, the *Strategy* also endorses evidence-based practices such as CBT-E and FBT.

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[1] Khalsa, S.S., Portnoff, L.C., McCurdy-McKinnon, D. *et al.* What happens after treatment? A systematic review of relapse, remission, and recovery in anorexia nervosa. *J Eat Disord* 5, 20 (2017) doi:10.1186/s40337-017-0145-3

[2] INESSS, *Equitable Access to the Psychotherapy Services in Quebec*, p. 25.

[3] MHCC, *Expanding Access to Psychotherapy: Mapping Lessons Learned from Australia and the United Kingdom to the Canadian Context*, https://www.mentalhealthcommission.ca/sites/default/files/2018-08/Expanding_Access_to_Psychotherapy_2018.pdf

[4] Canadian Eating Disorders Alliance (2019). *The Canadian Eating Disorders Strategy: 2019 - 2029*, p. 17.

We invite you to view a video[5] by Dr. Leora Pinhas regarding the treatment of patients with Eating Disorders, where she explains that some individuals do not respond adequately to short-term programs like CBT and are referred for more specialized, intensive treatment. In these cases, intensive psychotherapy can stabilize the person's health and rebuild their capacity to live a meaningful life. This is consistent with what we know about the use of intensive psychotherapy where short-term structured interventions have failed. Personalized healthcare demands that we, as recommended by the *Strategy* and health systems "[c]reate, fund and implement specialized services to address EDs across all levels of treatment intensity and for patients of all illness severities"[6] . This is especially true for comorbidities of mood, anxiety, substance use, post-traumatic stress and personality disorders, which are commonly seen in those with an ED[7].

Given these recent and highly relevant reviews of the evidence and experience with the treatment of Eating Disorders, we urge the OMA and Ontario Health to consider the potential unintended harms associated with any proposal that aims to limit OHIP covered psychotherapy for people diagnosed with a mental illness and who could benefit from psychotherapy in line with their primary care provider's and care team's treatment plan.

As you know, treating people early is a key factor in recovery and could also save millions of healthcare dollars. Certain settings of the healthcare system continue to address the needs of high-needs patients in urgent care and emergency room settings, rather than in out-patient, residential or other community-based settings. We believe that novel approaches to supporting recovery and smoother transitions to different levels of care can be implemented in Ontario, in a manner that is consistent with Health Quality Ontario quality standards, if only the proper evidence-based informational resources were available to support these transitions, team-based care and recovery outside of acute-care settings.

In closing, we know that publicly covered intensive psychotherapy can be appropriate for many patients. Ensuring such an approach is consistent with two pillars of the Government of Ontario's comprehensive plan to end hallway health care:

1. Keeping patients as healthy as possible in their communities and out of hospitals.
2. Providing the right care in the right place.

On the other hand, limiting OHIP covered psychotherapy in the manner being contemplated will not support the Government of Ontario and the OMA's goal of helping ensure better use of health care resources. Most importantly, limiting psychotherapy as proposed will prevent primary care providers and care teams from being able to provide affordable and appropriate care to those patients who could benefit from this intervention. It will also likely increase the already long wait times people experience in receiving appropriate medical care for their mental illness. This, in turn, will result in worsening symptoms and increase people's recourse

[5] https://www.youtube.com/watch?v=ej7MBji-zn0
[6] *Id.*
[7] *Id*. p. 16.

to emergency rooms and urgent care settings, as they will not be able to access affordable appropriate care in the community.

This is particularly true for complex mental illnesses, such as Eating Disorders, where it is difficult to predict disease trajectories for each patient at an early stage.

Allowing doctors to prescribe appropriate treatments to their patients in support of their recovery cannot possibly be predicted without first assessing the person in need of medical care. This is even more true for people affected by a serious mental illness, such as an Eating Disorder, and whose recovery may span years, not weeks or months, according to the published research literature.

To do otherwise would not improve care for people recovering from serious mental illnesses and would increase healthcare utilization of already strained resources.

As always, we welcome the opportunity to meet with you to review the evidence and share with you models and approaches from different settings and other jurisdictions that can make a meaningful difference in Ontarian's lives.

Sincerely,

Wendy Preskow,
President

Lynne Koss,
Executive Vice President

Mark Ferdinand,
Chairman and Executive Director

c.c. The Honourable Christine Elliot,
Deputy Premier and Minister of Health and Long-Term Care

Dr. Joshua Tepper,
Appropriateness Working Group Co-Chair

Dr. Paul Tenenbein,
Appropriateness Working Group Co-Chair