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The Cost of Therapy Services Provided by a Day Psychotherapy Unit

Natassa Karapostoli,Nikolaos Polyzos and Ioannis K. Tsegos

The sole clinical evaluation of a therapeutic approach is not enough anymore; cost-effectiveness studies are also necessary. The findings of several studies agree that community-based care services and psychotherapy reduce the cost of mental health consumers. However, much of the 'psychiatric reform' process throughout Europe is not based on knowledge of cost and effectiveness of various interventions. On the contrary, it seems that several myths concerning the cost of psychotherapy still have an impact on the choices of clinicians.

The aim of the present study is to measure psychotherapy's financial cost both for the patient and for the providing organization; in our case the latter is the Open Psychotherapy Centre: an autonomous, self-sufficient and non-profit psychotherapy day centre, which is not financially supported by any other organization inside or outside of Greece. The results confirm the operational viability of such unit and the observance of the constitution's principles (i.e. good working conditions, practicing psychotherapy on a daily basis especially for the seriously disturbed patients and the fact that psychotherapy may be accessible to all patients regardless of their diagnosis or economic status), the low cost of psychotherapy for the patient and the providing organization, especially that of group psychotherapy (group analysis and therapeutic community) compared to dyadic psychotherapy.

Key words: cost of psychotherapy, cost-effectiveness, out-patient psychotherapy

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Myths and Realities Concerning the Cost of Psychotherapy

The financial dimension of health services may function as an external pressure or interference in the clinical work of health practitioners and influence in different ways both therapists and patients. It is rather difficult to assess the efficacy of psychotherapy and even more difficult to value it in monetary terms. Krupnick and Pincus (1992) observe that the lack and difficulty in conducting relevant studies at that time, is due to various factors: *in addition to practical problems that occur in any research, there are two potential problems particularly within the psychiatric area: first, who and why is conducting a study, and second, whether there are the appropriate tools and data in order to be conducted effectively.* The authors suggest the creation of an interdisciplinary team (comprising of psychiatrists, psychologists and health economists)[1] or a post-graduate training program for professionals in health economics.

According to Gabbard (1998), a particular stigma, that appears to derive from several myths, has been attached to psychotherapy: for many years its effect as a real treatment has been challenged; also, it has been labeled as simply a hand-holding process that can be performed by any not-trained professional; moreover, that there is no evidence supporting the efficacy of psychotherapy; and finally, that if psychotherapy were to be available to the public as a component of a standard benefits package, then 'everyone' would use it and it would thus 'break the bank'.

The myth of expensive psychotherapy originates from various factors, and to this day still exists, despite several current studies that prove the opposite. The origin of this myth is possibly related to the practice of classical psychoanalysis. During the initial period of its establishment it was indeed addressing few wealthy individuals who had the financial means to pay for their analysis on an almost daily basis and for an indeterminable period (usually a long-term one). An additional factor that feeds to this myth is that, even today, psychotherapy is considered by some to be extending only to *dyadic psychotherapy*. In reality, the cost of *dyadic psychotherapy* is huge in comparison to *group psychotherapy*, as the data of the present study indicate[2].

Another factor which has contributed to this myth, is the hesitation of the insurance companies to cover not only psychotherapy's cost for their clients, but also any kind of health services provided by day care units. Generally, insurance companies demonstrate a peculiar preference to services that are provided by the residential

departments of hospitals (public or private) and they thus seldom refuse to pay for their clients' medication. This selective attitude, which is not supported by evidence, gives rise to questions about the motives, or rather, the profit lures concerning the insurance companies.

Although the type of therapy conducted within the hospital environment or through drug treatment is more expensive[3] and less effective, people 'are entitled', according to the insurance companies, to such therapy; the argument for this is that such services are widely recognized, while psychotherapy cannot exhibit any tangible results of effectiveness. This factor has been decisive in motivating psychotherapists to plan and carry out cost-effectiveness studies.

MacKenzie (1998) observes that cost-effectiveness of treatment approaches is a preoccupation of clinical practice today. A skeptic would say that in practice this translates to a preoccupation with cost and to a passing curtsey to effectiveness. Psychotherapy finds itself somewhat at risk in this environment due to the popular notion that most people who seek and receive psychotherapy are not critically ill and, even if they are, they probably receive too much treatment. The extended duration of psychotherapy is another strong argument against it. As a result, a fruitless discussion talk was initiated regarding the evaluation of psychotherapy's effectiveness in relation to the number of sessions, to brief psychotherapy etc. to such a degree that the insurance companies determine the course and the duration of therapy regardless of the treatment's outcome[4].

As a counterbalance, specific studies were carried out in order to investigate the effectiveness of extended psychotherapy. More specifically, they investigate the decrease of the long-term cost for insurances, which is a consequence of the decreased use of medical services, especially that of hospital treatment[5]. The culmination of that in the United States was the explicit conflict between psychiatrists–psychotherapists and the administration of health services. Indicative of this inflicting climate was the question of an administrative health executive to a psychiatrist–psychotherapist: 'Can't you listen faster?' (Clemens et al., 2001 **[AQ: 1]**). Hence psychotherapy by psychiatrists in the field of managed care appears to be an oxymoron, since psychiatry is dedicated to helping people, whereas managed care was spawned by and focuses on profit line alone.

Health professionals (who are responsible for the selection of the appropriate therapy for a specific patient), are often undecided and in suspense between ethics (i.e. the patient's well being) and reduction

of expenses (as these are expressed by the administration's wishes or orders)[6].

The cooperation between medical staff and health administrative executives seems to be in crisis globally, particularly so in western societies due to the threatening economic climate. Unfortunately, it is known that when conflict occurs between administrative and medical personnel, the patients are usually the ones being affected. Serious issues of ethics are at stake, and this should not be acceptable under any circumstances. Professionals involved in the area of mental health (amongst other areas), need to also notice the political dimensions of their actions, as well as of the expediencies of any choice. It is impossible to be unaware of the financial dimension of psychiatry;

> the latter is extended from the self-evident necessity of its vehicles for survival and its necessarily connections for vote-hunting and position-seeking with the machineries of the state and the political parties to the unacceptable pawn bondages (slavery) to the multinational drug-industry and other colossus. (Tsegos, in Polyzos et al., 2004: 164–5)

In recent decades, the interest in health economic issues has increased due to the explosion of the cost of health care worldwide; this has led to what has been described as a 'global epidemic' of health care reforms. Mental health care has a significant share in both the cost and the attempts for reform (Rice et al., 1992). Until 1992, there was no evidence to support that communal or other day care mental health services are preferable to institutional ones. It therefore seems paradoxical that a major policy change was implemented with no systematic evaluation of its cost or its benefits to patients and their environment (O' Donnell et al., 1992).

As a result of the above survey inadequacy, there is a growing body of evidence that psychotherapy is cost-effective and that it is reducing disability, morbidity and mortality; also, in particular instances, causes a reduction of medical and surgical services (Lazar and Gabbard, 1997). Among other suggestions for health care reforming in the United States, Hu and Hausman (1994) observe that community health care programmes for mental patients are an applicable alternative solution. At the same, time Grove (1994) describes the progressions and changes in mental health in Europe and notes that there is a certain tendency in community care programmes, although there was very little evidence concerning the cost-effectiveness of these methods. A meta-analysis study of 58 controlled studies by

Mumford et al. (1998) concludes that a retrospective analysis of health insurance claims shows the following: data and meta-analyses of time-series studies and prospective controlled experimental studies converge to provide evidence of a general cost-offset effect following outpatient psychotherapy. Gabbard et al., (1997), Eells (1999) and Carr (2009) reach a similar conclusion in their studies: despite methodological difficulties, psychotherapy appears to have a beneficial impact on a variety of costs when used in the treatment of the most severe psychiatric disorders. Studies 'confirm that for many conditions, psychotherapy works, it is cost-effective, it can, at times, provide a significant cost-offset in other medical and hospital expenses, and it is not overused or abused by those not truly in need' (Lazar, 2010: 22).

Greece has submitted to the international reforming 'fashion', despite the fact that economic evidence for such submission was largely inadequate. The 'psychiatric reform', which was initiated in 1984 and was concluded in 1995, is recapitulated in an effort to lessen hospitalization and to propagate alternatives. Although significant progress (decentralization of mental health and rehabilitation services) has been observed in some areas, the only research referring to the cost of psychotherapy within mental health services was conducted by Moiropoulou et al. (2000)[7]. The latter concerns the outcome of practised group psychotherapy within one of the largest public health insurances in the country. According to these findings, the participation in the group resulted in: a) avoidance of hospitalization, thus a considerable profit was made for the insurance; b) minor pharmacotherapy that was profitable for health insurances along with improved functionality for the patients; c) improvement of patients' functionality and productivity, i.e. less absences from their jobs, better professional relations and higher sense of self-respect; and d) better quality of life for both patients and their families.

Concluding our brief review we note that the findings of several studies indicate that community based care services and psychotherapy reduce the cost of mental health consumers. Nevertheless, when researchers are referring to the cost of psychotherapy, specific points are frequently unclear:

- The type of psychotherapy they refer to: the term *psychotherapy* can be used to define a diverse spectrum that includes a wide range of treatments, from psychoanalysis and intensive psychoanalytic psychotherapy to weekly meetings (individual or group).

Only a small number of studies clarify the type of therapy and there is no evidence for the different costs in each approach;

- the context in which psychotherapy is provided: either by large hospital units or medium day units (public or otherwise) or by private practice. The majority of the studies were conducted in large public hospitals or/and in collaboration with insurance companies;
- the population: a) clients: psychotherapy services could be addressing mixed psychiatric population or specific diagnostic categories, chronic severe psychiatric disorders and hospitalized patients or neurotic functional patients etc. There is increasing number of studies referring to specific diagnostic categories; b) therapists: each research should clarify the status of the therapist (training, experience, payment etc), however it seems that, strangely, such information is considered a taboo.

The above points have a great effect on efficacy and costs. Currently, although there are a considerable number of studies, we were not able to locate any data concerning the cost per hour of psychotherapy for the patient or for the providing organization, the different costs for the different types of psychotherapy (dyadic, group analysis, therapeutic community, family therapy etc) or the significance of the setting.

Framework and Aim of the Study

The aim of the present study is to measure psychotherapy's financial cost both for the patient and the providing organization, in relation to the outcome of psychotherapy. To our knowledge, it is the first study realized in Greece that estimates the cost-effectiveness of psychiatric services and it is part of a wider functional and economic evaluation of the OPC's services[8], accomplished by the collaboration with a group of health economists and colleagues at the administration department. The study was carried out during multiple stages:

- The first stage, concerning the cost of psychotherapy for the providing organization (OPC), was estimated for a period of three years (1999, 2000, 2001). The findings of the first year led to several decisions concerning policy matters and the results were re-evaluated (years 2000 and 2001) (Kostopoulos et al., 2003; Polyzos et al., 2004).

- The second stage, concerning the monetary cost for the patient was estimated by the data collected from the archives of the therapy and administration units for 1999 (Kostopoulos, 2001).
- The third stage concerned the evaluation of the effectiveness of the group therapeutic activities of OPC, studying the cases of 1999 (Villiotou, 2004).
- Additionally, we exported the findings to the centre's current financial data of. A data reduction was conducted in present monetary costs (2010). It should be noted that Greece (as well as several European countries) is currently experiencing a major economic crisis; thus, similar studies are all the more necessary.

Since the institutional background (structure and philosophy) is strongly influencing the cost of the provided services and, most importantly, the effectiveness of the method, it is necessary to provide some basic information about the Open Psychotherapy Centre (OPC). It is an autonomous, self-sufficient, non-profit day care unit, which is not, as previously mentioned, financially supported by the state or any private or public organization in or outside of Greece. In addition to the therapeutic and training activities, theoretical and structural innovations regarding the organizational structure (administrative and financial function) have been applied since the very beginning. The basic characteristics of the organization are: the administration is group-centred, the operation is based on the open systems, where the small and large group meetings are utilized, and role interchange is frequent (the conductor's position in each department is renewed every two years). In the communal approach (the approach is labelled as such) there are no gaps in communication. On the contrary, small and large group meetings are functioning officially in order to provide the appropriate space for the personnel to discuss thoughts, emotions and disagreements, face-to-face while at the same time everyone is aware of the organization's function as a whole (Tsegos, 1985, 2002, 2007).

Methodology

A. Cost of Psychotherapy for the Patient

Estimation of the total amount of the therapeutic hours per therapeutic activity, separately for each unit and for the amount of money received for each activity for a year.

Record and coding of the combination of therapies for each patient, in order to estimate the number of therapeutic hours, of money spent per hour and the total amount of money spent on therapy.

B. Cost of Psychotherapy for the Organization
In our case, the final product is the 'therapeutic hour'. Thus we followed the equation: = M : N

(Cost) = M (Monetary Cost) : N (Number of Therapeutic Hours)

Assignation of cost centres for each department:

a. Therapy Department: 500–20 patients per month / 55–60 therapists[9], 11.500–12.500 therapeutic hours per year.
b. Training-Research Department: 200 trainees per month / 25 trainers (we will not be referring to this data in the present article).
c. Administration Department: four full-time secretaries and six part- time collaborators.

C. Cost-Effectiveness Analysis
Every case of the year 1999 was recorded: N=495. Diagnosis and treatment outcome in relation to the duration of therapy was estimated for those participating in group psychotherapy activities. The categorization of diagnosis was realized according to DSM-IV (American Psychiatric Association, 1994), based on data obtained from the archives of the Therapeutic Department. The evaluation of the outcome was realized through the clinical observation of the therapist, the patient's opinion[10] and the findings of the psychological tests (M.M.P.I., Rorschach, Symptom Check List etc.) before and after therapy. The outcomes were divided into four categories: (I) the patients who had accomplished their goals showing improvement in functioning and returned to their life without symptoms; (II) those who were improved, but had some symptoms; (III) those who had no significant change; and (IV) the patients who had relapsed or were recommended to another therapy. In conducting the CEA outcome, data were divided by the costs in order to form cost-effectiveness rations.

Results
Financial Data of the OPC Participation in therapeutic communities' groups as well as in other group activities (group analysis, group analytic psychodrama, children's and adolescents groups) has a very low cost (6,15 and 21,6 euro per hour respectively), both for the

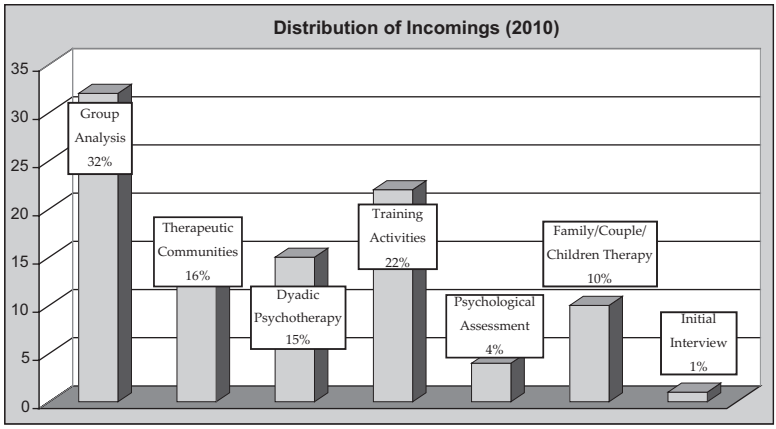

Figure 1 **Distribution of Incomings:** the two therapeutic poles of OPC, i.e. Group Analysis and Therapeutic Community, account for almost half of the total incomings (48%).

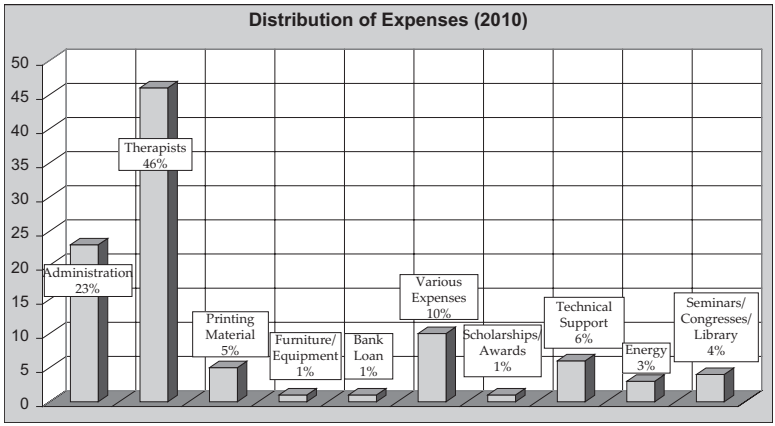

Figure 2 **Distribution of Expenses:** the personnel fee (therapists and administration) is the most significant factor in the formation of the total cost, since it accounts for 69% of the expenses.

patient and the organization. Additionally:

- All group therapies have a positive balance.
- Dyadic therapies have either marginal balance or losses (e.g. the psychological assessment).

Therapeutic Activity	Cost for the OPC		Cost for the Patient		Balance	
	1999	*2010*	*1999*	*2010*	*1999*	*2010*
Dyadic Psychotherapy	*27,10*	38	*35*	40	*7,90*	2
Psychological Assessment	*34,50*	48	*30*	45	*–4,50*	–3
Group Analysis*	*33*	46,2	*(120 euro for 6 hours (4x1,5) per month = 18,33 for each patient)* 4* x 18,33 = 73,32	(130 euro for 6 hours (4x1,5) per month = 21,6 for each patient) 4 x 21,6 = 86,4	*40,32*	40,2
Group Analytic Psychodrama*	*33*	46,2	*(120 euro for 6 hours (4x1,5) per month = 18,33 euro for each patient) 4* x 18,33 = 73,32*	(130 euro for 6 hours (4x1,5) per month = 21,6 for each patient) 4 x 21,6 = 86,4	*40,32*	40,2
Therapeutic Communities Groups*	*30,06*	42,08	*(130 euro for 26 hours per month = 5 euro per hour) 4 members x 5 = 20 per group; 4 groups per patient: 4x20 = 80*	(160 euro for 26 hours per month = 6,15 euro per hour) 4 members x 6,15 = 24,6 per group; 4 groups per patient: 4x26,4 = 98,4	*49,94*	56,32
Family/ Couples Therapy	*33*	46,2	*30*	60	*–3*	13,8
Children's and Adolescent's Groups*	*30,06*	42,08	*(120 euro for 6 hours (4x1,5) per month = 18,33 euro for each patient) 4 x 18,33 = 73,32*	(130 euro for 6 hours (4x1,5) per month = 21,6 for each patient) 4 x 21,6 = 86,4	*43,26*	40,2

Figure 3 Mean Cost of Therapeutic Hour per Therapeutic Activity: Comparison between the years 1999 and 2010 (for the OPC and for the Patient)
*By calculating the costs for group psychotherapy we take that every group has at least four members.

- OPC's pricing policy favors treatment in groups. As we proceed from individual to group psychotherapy (group analysis and therapeutic community), prices are lowering**.**
- Policy decisions over a 10-year period (1999–2010) had two main targets:

1. Preservation of the cost for the patients: 15%–20% rise over 10 years.
2. Rise of the therapists' payment (from six euro in 1999 to 15 euro in 2008, i.e. 150%).
3. The balance remains marginally positive.

The organization retains a significantly low pricing policy for the acute disturbed patients who need combined therapies (multifactorial approach). Cost of a therapeutic hour for such patients may be more than half compared to a patient in less need for therapy. The same financial policy is adopted by the therapeutic communities. As the number of the groups increases, the cost per hour decreases. This proves in practice the theoretical basis of marginal cost and economies of scale.

Cost-Effectiveness Analysis

Evidently the cost of a single service does not offer reliable information on its efficacy, therefore a cost-effectiveness analysis is necessary in order to evaluate, beyond cost, the treatment outcome and the duration of therapy. For this purpose a retrospective study has been conducted in order to evaluate the effectiveness of the group therapeutic activities of the OPC (group analysis, therapeutic communities and group-analytic psychodrama). The study included 495 patients who had attended one or more of the therapeutic activities during 1999[11] (Villiotou, 2004). The results of the study are the following:

The distribution of diagnosis (%) for the patients of the therapeutic unit reveals a large portion with disturbances on Axon I, II or on both. Most of them were suffering from emotional disorders, psychosis and mood disorders. On the other hand, the majority of the disturbances on Axon II were severe personality disorders.

Analysing the obtained data for the duration of the therapy, we observed that a large portion (16.4%) terminated their therapy, or they did not start, during the first month, *the assessment period* (as it is referred to). The scope during this month is focused on the clinical

Treatment Profile	Duration	Total Cost per Month	Cost per Hour
A. Dyadic Psychotherapy + Therapeutic Community *(Participation in at least 10 TC Groups, i.e. 10x1,5x4 = 60 hours per month + 2 hours dyadic meetings for the TC = 62)*	4 hours + 62 hours 66	140 euro* + 200 euro 340 euro	(340/66 =) **5,15**
B. Group Analysis + Therapeutic Community *(Participation in at least 4 TC Groups, i.e. 4x1,5x4 = 24 hours per month + 2 hours dyadic meetings for the TC =* 26	6 hours + 26 hours 32	130 euro + 160 euro 290 euro	(290/32 =) **9,06**

Figure 4 Examples of Cost in Various Therapeutic Combinations for each Patient Treated (2010)

*When a patient participates in the Therapeutic Community, the cost of individual psychotherapy is automatically reduced to 35 euro per session.

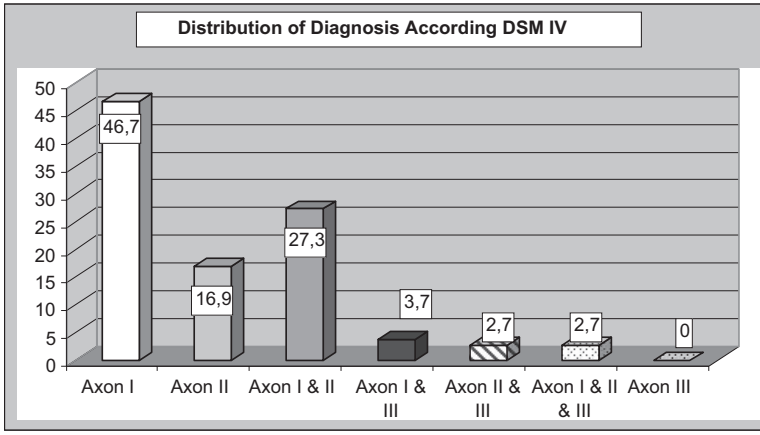

Figure 5

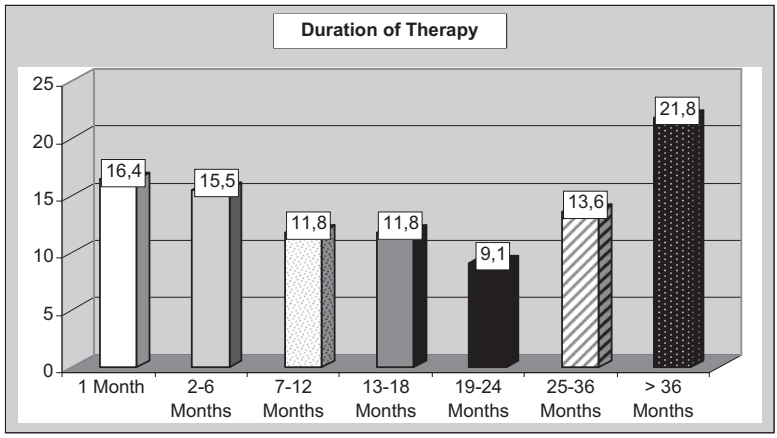

Figure 6

assessment of the patient and his/her adjustment to therapy as well as the clarification of his/her motives and needs.

The analysis of the outcome of the therapy at the moment of the release shows a large portion of completion of the settled aims for the patients, with improvement in functioning without symptoms 46.7%. This portion was excluded after the substation of the persons who interrupted their therapy during the first month. A remarkable portion 20.7% is observed with improvement in functioning but with symptoms as well as a portion of 27.2% with no results, when 5.4% of patients deteriorated or another therapy was recommended.

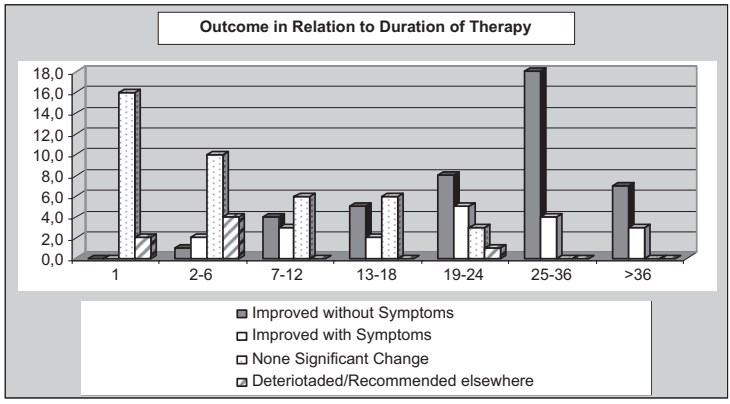

Figure 7

	Mean Value of Therapy Duration (Months)	Mean Value of The Cost (€)
Improved without Symptoms	26±4.5	3,052±540
Improved with Symptoms	22.6±3.8	2,653±450
No Significant Change	6.4±1.1	754±13
Deteriorated / Other Therapy Recommended	5.6±1	660±11

Figure 8 Mean Value of Therapy Duration and Therapy Cost in Relation to Outcome

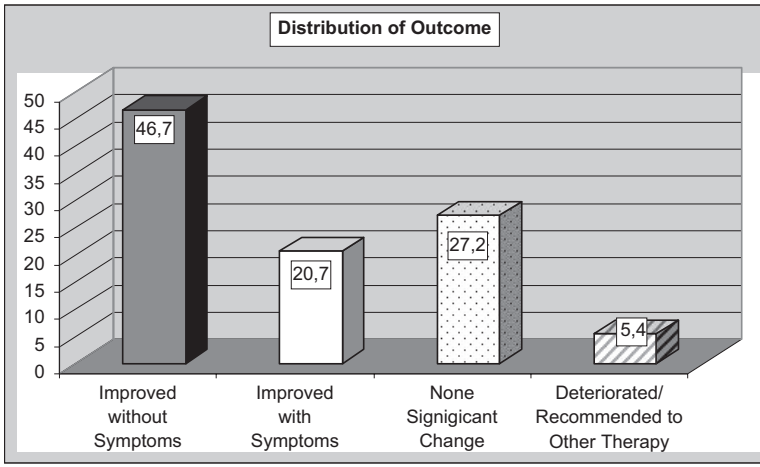

Figure 9

The above study concludes that group activities are indeed cost-effective. The findings of Villiotou (2004) are in accordance with other relevant studies regarding the effectiveness and the mean duration of psychotherapy (Capelluto, 2003; Terlidou et al., 2004; Tziotziou et al., 2005).

V. Discussion

Summarizing the results of the present study, we note the following:

The economic viability of an autonomous, self-sufficient, medium size organization, which adopts a communal approach for all its activities, is confirmed. The administration board, which surveys the

financial function, consists of individuals who are not economic professionals (they are, in their majority, professionals of psychotherapy), but have a personal interest in the work and goals of the organization. Often in health care organizations, there is a mutual suspicion between the administration and the medical staff (Clemens et al., 2001). In our case, health economists were invited by the organization; therefore they were not considered an intruding body. Their suggestions, which derived from the findings of the economical and functional evaluation of the OPC, were either adopted or rejected, not due to the financial profit, but depending on their adjustment to the philosophy and culture of the organization.

The results of the study concerning the marginally positive balance, resonate with the original goals of the organization (non-profit), but also generate considerations regarding the aspiration of a more efficient function. Still, the organization functions and 'survives' without any grants, leaning entirely on those using its services (patients and trainees).

The confirmation of the constitutional principles of functioning:

The creation of good working conditions for the staff and the patients' fees comprise 69% of the expenses (year 2010), divided between therapists and administrative personnel. At this point, it should be clarified that the salary of the administration was, and still is, in accordance with regulations, while the fees of the therapists were considerably low in 1999, i.e. six euro/hour. Following the proposals of the health economists conducting the first study, the organization was able to achieve a better financial management: expenses in several categories were more sufficiently controlled and thus therapists' fees could gradually increase to 15 euro/hour (for the therapists' benefit), i.e. 150% —which is currently the standard ministration fee in Greece. The motives of the therapists are not financial; they are working at the organization part-time, and they have to compensate by being employed in public or private health services or by maintaining private practices.

The proportion of fees and expenses is almost identical to relevant studies in health care organizations. Office of Technology Assessment (1980: 53), underlines that *the cost of personnel is usually the largest therapy cost (between 60 and 80%)*. Regarding the therapists other significant parameters should be taken into account, such as the quantitative (proportion between staff and patients) and qualitative criteria (training, experience, productivity, effectiveness). At the OPC the proportion between staff and patients is 1:8; *in other EU countries (1989–90) it is 4,6 while in Greece it is 3,5* (Polyzos,

Yfantopoulos, 2000). The most significant difference lies in the proportion between administration and medical staff. According to Polyzos and Yfantopoulos (2000), 43,25% of the employees in the public hospitals are administrative staff, while at the OPC only 18,8% works in administration and supportive services (such as secretariat, maintenance, accounts etc).

The contribution to abolishing the myth that mental patients are dangerous (social stigma etc.) is conceptualized mainly through psychotherapy on a daily basis. The findings of the present study confirm that psychotherapy is proposed as the most appropriate therapy for the seriously disturbed patients; most importantly, it is less expensive, compared to over-prescribing treatment and particularly to custodial or in-patient care. The two therapeutic poles of the OPC, i.e. group analysis and therapeutic community, account for almost half of the incomings, a fact that shows that these are the therapies of choice, not only literally but also clinically. Half of the patients at the OPC are treated with conjoined approaches (multifactorial approach). The OPC's financial policy favours treatment in groups. As we proceed from individual (40 euro) to group psychotherapy (group analysis: 21,6 and therapeutic community: 6,15), prices reduce significantly.

The demystification of the notion that psychotherapy is only for minorities (those who are well-off or the 'neurotic' ones). This study shows that, on the contrary, psychotherapy may be accessible to everyone. The organization retains an exceptionally low financial policy for the acute disturbed patients that need combined therapies. The cost of a therapeutic hour for such patient may be more than half compared to a patient with less need of therapy. The same financial policy is adopted by the TCs. As the number of groups increases, the cost per hour decreases. As mentioned previously, the cost of a single service does not prove its effectiveness and clients are largely entitled to the evaluation of the latter. Several authors declare that the patients' *willingness to pay* constitutes a strong argument for the significance of psychotherapy in their lives (Schelling, 1968; Donaldson 1990). Indeed, the quite large number of patients (approximately 520 persons per month) and trainees (200 persons per month, in other words, 720 clients per month) indicates that the organization is widely trusted. Additionally, the evaluation of provided services constitutes a critical priority for the organization; for this reason, numerous research studies have been conducted since the beginning (Tsegos et al., 1995; Capelluto 2003; Villiotou 2004; Terlidou et al., 2004; Tziotziou et al., 2005).

The detailed economic evaluation indicates that the OPC preserves its principles throughout the years; also, it undervalues the financial side of psychotherapy and the various choices are always made in the interest of the patient and the personnel. The therapeutic approach and the financial policy reduces the total cost of psychotherapy; moreover, patients are not deprived of their therapeutic needs due to financial problems according to institutional principles[12].

It is therefore proven that there is a necessity for mental health services that are based on communal approaches provided by medium size institutions. The OPC is characterized as an intermediate institution (along with family and large hospitals) due to its size, administrative structure and financial cost. Such institutions are the result of recent considerations and attempts in order to address the pathological phenomena that occur from psychopathology, the patient's role and the consequences of institutionalization. The purpose of an intermediate institution is to diminish the social dimensions of a disturbing incident, which are usually magnified by the family environment or, in a large institution, by the therapeutic process itself (Tsegos, 1985).

In general, it appears that psychotherapy today in monetary terms can be much more affordable for the patient. We are aware that the cost of psychotherapy involves more than determining the price of treatment. We should also estimate the: a) the benefits of psychotherapy on a daily basis (the patients' quick return to their activities: no exclusion from their family, work and social environment, reducing of stigmatization and institutionalization consequences); and b) the efficacy of therapy, also confirmed by other studies, but mainly evaluated by the patients themselves.

Notes

1. The present study was conducted by an interdisciplinary team, consisting of specialists in health economics (N. Polyzos, V. Bardis, D. Bartsokas, G. Pierrakos, K. Pantelaki, Ch. Kostopoulos) and psychotherapists (N. Karapostoli, I.K. Tsegos) and the results were first published by Kostopoulos et al. (2003) and Polyzos et al. (2004).
2. The same results derive from the study of Heinzel et al. (2000): the proportionate cost-efficiency of group therapy is about 13 times that of individual therapy.
3. Sharfstein et al. (1993) note that the insurance companies appear to be discriminatory towards the treatment of mental illness, paying the minimum for a non-psychiatric treatment in a day psychotherapy unit. Additionally,

De Hert et al. (1998) conclude that the mean price per day for the insurance system in a day-hospital was $52 and $138 for a bed in a psychiatric hospital.

4. Selingman (1995) makes an immediate correlation between the outcome of psychotherapy and the existence of selection potentiality. That is, patients who are limited from their insurances regarding the selection of the therapist or the duration of therapy presented negative results in relation to the outcome.
5. See further details in Stevenson and Meares 1992; Bateman et al. 1999; Gabbard 2000.
6. While studying the physicians' attitudes and practices concerning cost-effectiveness in patient care, Ginsburg et al. (2000) summarize that physicians appear ambivalent as to whether they have a duty to offer all treatment options when the chance of success is small and the cost is great.
7. Psychiatrist and group analyst.
8. More specifically, the aim of this extended study was: a detailed analysis of the therapeutic and training activities, financial results per year, an estimation of cost of each therapeutic activity for the organization and for the client, SWOT analysis, planning and proposals, financial management.
9. More specifically, in 2010 the personnel of the organization consisted of: 11 psychiatrists, 30 psychologists, five social workers, two occupational therapists, two nurses, two sociologists); all have been trained either in psychotherapy (25 in group analysis, 18 in psychodrama/sociotherapy, 17 in family therapy) or in psychological assessment (20 persons) in four or five years post graduate trainings, provided by the corresponding institutes. The clinical experience of the personnel varies between 30 (maximum) and five (minimum) years.
10. Since 1980, it is a common practice for the OPC to immediately record the clinical evaluation of the therapist and the patient's opinion after the termination of therapy, in a protocol kept in the archives of the therapy department. This protocol consists of several categories such as outcome of therapy, way of termination, reasons the patient submits for the termination etc.
11. The choice of the specific year was purposeful, since it is the initial year of the extensive financial evaluation and there were evidence about the cost of the therapeutic hour per activity.
12. According to OPC policy, no one is deprived of therapy due to financial difficulties. When a client struggles with their financial obligations, they are granted a discount (which can be up to 100%)· in return, they offer their services to the OPC by doing administrative work, or coordinating the therapeutic community groups, etc.

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