THE AUSTRALASIAN CONFEDERATION OF PSYCHOANALYTIC PSYCHOTHERAPIES

Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

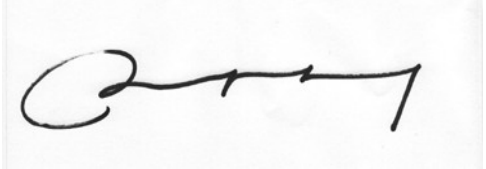
Dear Sir/Madam,

The Australasian Confederation of Psychoanalytic Psychotherapies is an umbrella organisation representing more than 450 psychoanalysts and psychoanalytic psychotherapists throughout Australasia. Member associations of the Confederation are:

- *The Australian Association of Group Psychotherapists,*
- *The Australian Centre for Psychoanalysis,*
- *The Australian and New Zealand Society of Jungian Analysts,*
- *The Australian Psychoanalytical Society,*
- *The Psychoanalytic Psychotherapy Association of Australasia.*

Our members treat patients for multiple or chronic mental disorders, personality disorders, psychotic disorders, anxiety, depression and those suffering long term abuse and trauma. We offer the following submission to assist the Committee with its review of proposed changes relating to mental health services in Australia.

Yours sincerely,



Paul McEvoy
On behalf of the Australasian Confederation of Psychoanalytic Psychotherapies.
1 August 2011

EXECUTIVE SUMMARY

The Australasian Confederation of Psychoanalytic Psychotherapies applauds the focus on mental health within the 2011 Federal Budget. Accordingly, we welcome the additional funding proposed for important initiatives such as the Early Psychosis Prevention and Intervention Centre (EPPIC) and Access to Allied Psychological Services (ATAPS) Programme. However we are concerned that the current raft of proposals does little to remedy an already serious flaw in current mental health services – the inadequate access for the seriously mentally ill, to long-term psychotherapy provided by appropriately qualified and experienced practitioners. Cuts to the Better Access Initiative (BAI) for psychologists, social workers and general practitioners have further disadvantaged this important group of consumers by widening the gap in funding for long-term mental health treatment. BAI appears to have served a very useful function in providing short-term interventions for mild to moderate mental disorders, but was not intended to provide services to the seriously mentally ill. Changes to the BAI identified within the Budget indicate that it is being further modified toward servicing short-term interventions for mild disorders. While it is proposed that ATAPS will facilitate provision of services to the more seriously mentally unwell, it is our concern that ATAPS funding is directed mostly toward providing pragmatic support for the mentally ill rather than access to high quality, and economically effective, long-term psychotherapy which research indicates to be beneficial to such people.

This submission presents arguments and research that support the expansion of access to psychoanalysis and longer-term psychoanalytic psychotherapy for treatment of severe psychological disorders. A substantial body of evidence (see Bibliography) demonstrates that the treatment of complex psychological problems requires more frequent, in-depth intervention than can be offered by brief, structured therapies. This research supports both the efficacy and lasting benefit of longer-term psychoanalytic and psychotherapeutic treatment for children, adolescents and adults. When employed, such treatment has led not only to reduced hospitalisations and hence, decreased loss of work and study time, but also to reduced need for costly pharmaceutical treatments.

It is our submission that, to be effective and inclusive, Australia's mental health services need to provide the seriously mentally ill with better access to highly-trained psychoanalysts and psychoanalytic psychotherapists. This is necessary to ensure equity and address ethical issues with regard to access to appropriate longer-term treatment for those with more complex psychological problems such as severe depression and personality disorders. It is also required to safeguard against those with serious mental health difficulties losing faith in psychological treatments as a result of short term treatment proving ineffective. The evidence also indicates this form of treatment will reduce costs for the health system for these patients.

Recent critics have suggested that psychoanalytic concepts and practice lack evidence-based research support. These criticisms are inaccurate and ignore recent evidenced-based research which supports the application of psychoanalysis and psychoanalytic psychotherapy as effective forms of treatment for patients in both long and short term therapy. This treatment modality has been shown to be particularly useful for the more severe forms of mental dysfunction.

Over the past 100 years psychoanalysis has continued to develop its clinical, theoretical and research base. And in recent years it has drawn on neurological insights and other developments in psychology and biology to extend its understanding of mental illness and its treatment

Thus, in suport of the government’s insistence on seeking evidence-based research for mental health interventions applied through the Medicare Benefits Schedule:

Our Confederation respectfully recommends that:

1. Given the substantial evidence for the efficacy of psychoanalytic psychotherapies, such approaches should be added to the list of approved interventions under the Better Access Initiative, or that an alternative support for access to such treatments should be provided, via both public and private mental health systems.

2. Given the evidence that patients with chronic or long standing mental health problems such as personality disorders or severe anxiety, as exhibited in obsessive compulsive disorder, require longer term, more intensive therapeutic interventions, we propose that the number of sessions available under the BAI (or alternative initiative) should be increased for these patients.

3. While services provided by the majority of our members attract some support via Medicare and Private Health insurance, some highly qualified psychoanalysts or psychoanalytic psychotherapists are currently not eligible for such rebates because they are not members of medical or allied health professions. We recommend that all practitioners who demonstrate eligibility for membership of our associations, be added to the list of health professionals recognized to deliver psychological therapies under the Better Access Initiative and any alternative programs that are introduced.

SUBMISSION TO THE SENATE STANDING COMMITTEE ON COMMUNITY AFFAIRS

We address specific aspects of the committee's Terms of Reference:

The government's 2011-12 Budget changes relating to mental health

(b) (ii) ***The rationalization of allied health treatment sessions***

The members of our five associations are principally engaged with providing psychoanalysis or long-term psychoanalytic psychotherapy to people who suffer from serious mental illnesses. The Budget initiatives offer little to redress the inadequate support, in current programs, for those members of the community requiring access to long-term psychotherapy provided by appropriately qualified and experienced practitioners. Severely mentally ill patients who require long term and intensive psychotherapy are generally not able to be accommodated by publicly funded mental health services, whose resources are already stretched. While current Medicare arrangements provide financial support for psychiatrists to provide ongoing, long-term contact, psychiatrists are in short supply, generally not affordable in particular for patients on disability pensions or low incomes (AMA recommended fee $305.00 per session) and furthermore, relatively few from among their ranks have sought specialised psychotherapy training to adequately provide intensive, long-term psychotherapy.

The Better Access Initiative (BAI) to psychologists and general practitioners through the Medicare Benefits Schedule was developed to address the increasing incidence of mental disorders, notably depression and anxiety, in specific communities. BAI has been proven to have served an important function in providing increased access to mental health services. Nevertheless, both in its design and implementation, the BAI has relied entirely on short-term therapies with an emphasis on cognitive behavioural treatments for their evidence-based research. The proposed reduction in the number of consultations supported under BAI indicates that this initiative is even further oriented toward the provision of short-term interventions. While such approaches have demonstrated their effectiveness for certain patients, they have not proven effective with more complex, chronic conditions which do not respond to specific symptom reduction. For such patients, longer-term therapy has demonstrated positive outcomes. It has been suggested that ATAPS will facilitate provision of services to the more seriously mentally ill, however the evidence available to our members to date indicates that ATAPS funding is directed mostly toward providing pragmatic support for the mentally ill rather than access to high quality, and economically effective, long-term psychotherapy which research described in the bibliography below indicates to be beneficial to such people.

(b) (iv) ***The impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule (*****MBS*****)***

The government has recommended that sessions under the BAI be reduced from 18 (12+6) to 10 (6+4) While we support the incentive to provide improved access to treatment services for high need and under-serviced populations, we believe there remains a problem for equitable access across all populations requiring psychological services. This is particularly the case for patients requiring longer-term psychotherapy. The reduced and time-limited nature of the rebate system means that longer-term psychotherapy is prematurely ceased, not because the treatment has been successfully completed but rather because of an arbitrary number dictated by the government.

Our members, not infrequently, offer treatment at reduced fees or bulk-billing rates to patients with serious mental illnesses who are unemployed, on low incomes or disability pensions, and who would otherwise be unable to afford the cost of psychotherapy.

However, there is a limit to the extent to which our members can offer subsidised treatment, and there are many patients who cannot afford even reduced fees. Short-term treatment cannot meet the needs of patients with long standing problems, and would ultimately prove costly in human and economic terms. Another important factor is that treatment prematurely curtailed may well be damaging to the mental health of the patient, thus undoing any of the benefits gained to that point in their psychotherapy.

This raises ethical dilemmas for our members as to whether it is justified to offer treatment to seriously ill patients if it cannot be provided beyond the mandated number of sessions. Patients are left with no therapeutic help or with the less trained and skilled practitioners offering short-term work, perhaps without the appropriate assessment skills to understand what is required. Clearly the reduction in the number of sessions available under BAI exacerbates these concerns. We would instead argue that the number of sessions be adapted according to the serious nature of individual patients' mental health needs.

(c) ***The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services (ATAPS) program***

It has been proposed that the needs of the seriously mentally ill may be addressed within the Access to Allied Psychological Services (ATAPS) program. The experience of our members is that the emphasis within ATAPS has been on providing pragmatic support such as employment and accommodation assistance. While such services are clearly of great importance to the seriously mentally ill, they do not replace the need for long-term, intensive psychotherapy. From the information currently available on ATAPS programs it seems that therapeutic interventions have primarily consisted of short-term, structured interventions, delivered often by the lesser trained practitioners. As indicated elsewhere in this submission, we are concerned that such interventions may be at best limited in their effectiveness, and at worst dangerous when applied to the severely mentally ill.

(d) ***Services available for people with severe mental illness and the coordination of those services***

There is a significant gap in the provision of mental health services for those suffering severe mental illness, particularly with respect to the availability of long-term, intensive psychotherapy provided by properly trained practitioners. Following is a brief summary of the evidence in support of the efficacy of such approaches.

Psychoanalysis and psychoanalytic psychotherapy have a distinguished international history of effective therapeutic work stretching back more than a century. Predominantly this work has been with cases of serious mental illness that have not responded to briefer therapies. These treatments have recognized and documented the importance of unconscious determinants in peoples' behaviour and thought patterns. Since then, psychoanalytically-informed therapy has grown and developed in clinical, theoretical and research areas.

Some critics of psychoanalytically-informed psychotherapies have claimed that psychoanalytic concepts and practice lack evidence-based research, and that the literature demonstrates that other forms of treatment are more effective. This belief is based on a selective sampling of available

research which ignores a vast amount of evidence.[1] The current emphasis on structured and time limited treatments has received strong support because it is well suited to the dominant research paradigm, basically the model of physical medicine. However, these unsubstantiated claims do not take into account the growing body of evidence for longer-term psychotherapy, demonstrating effective clinical practice, in both qualitative and quantitative studies, over several decades. In addition it has been argued that an evaluation of psychoanalytic psychotherapy requires methodologies appropriate to the nature of the treatment. The *European Federation for Psychoanalytic Psychotherapy* in the Public Sector (EFPP) has been developing and employing such methodologies for a decade.[2]

The evidence-based literature, reviewed below, shows unequivocal support for the efficacy of long-term psychoanalytic psychotherapy in treating a broad range of psychological conditions, particularly the more severe forms of mental dysfunction. The evidence strongly suggests that psychoanalytic models are much more appropriate to this client population than the shorter-term models endorsed by the BAI.

Research over the past 30 years has clearly demonstrated that the prime therapeutic factor in improvement in mental functioning is the relationship between patient and therapist. This can only be achieved through a framework which allows the relationship to develop, over a time-span appropriate to the nature of the work required. While there is evidence for the treatment modalities identified in the BAI, there are significant questions about the comprehensiveness of such evidence. This is generally based on studies which specifically exclude the type of complex cases that are suitably treated by longer term psychotherapy.[3]

An important development is the emergence of neurobiological studies that have established the efficacy of psychoanalytic psychotherapies. As Nobel prize-winning neuroscientist Eric Kandel[4] points out: "There is no longer any doubt … that psychotherapy can result in detectable changes in the brain." The brain restructures itself during psychotherapy and "the more successful the treatment the greater the change".[5] Solms and Turnbull also corroborate from functional imaging studies that 'the functional activity of the brain is indeed altered by psychotherapy".[6] Such studies emphasise the role of the therapeutic relationship and the need for a significant period of time to enable these changes to become expressed as physical changes in the brain.[7]

Specific populations

1) Working with children and adolescents: Evidence for longer-term psychoanalysis and psychoanalytic psychotherapy

Many members of our associations work with children and adolescents, individually and in groups, with parents and families, and in parent-infant psychotherapy. A review of 15 years of work on the outcomes of child psychoanalytic therapy concluded that:

> *"The follow-up study is consistent with the long-term good outcome of the early treatment of these relatively seriously disturbed children. We were again and again surprised to meet adults who, as children, manifested serious and in many instances "hopeless" conditions; yet who,*

[1] Shedler (2010), p.1
[2] Richardson, Kachele & Renlund (2004)
[3] Hardy, Barkham, Shapiro & Reynolds (1995), King, (1998).
[4] Quoted in Doidge (2007), p. 234.
[5] Doidge, (2007), p. 234
[6] Solms and Turnbull, (2002), p. 288.
[7] See research reviewed in Cozolino (2002), (2006)

following successful treatment, had become relatively high-achieving individuals with stable social circumstances and no history of further psychiatric problems."[8]

A number of other studies and reviews have shown the effectiveness of psychoanalytic therapies with children and adolescents.

- An extensive review[9] of research in child and adolescent psychotherapy found that psychoanalytic therapy is beneficial with a magnitude of effectiveness at least equivalent to that of psychotherapy with adults.
- The positive change continues after the termination of treatment. ie there is a positive, so-called, "sleeper effect". When tested, it emerges that this effect is maintained in adulthood.[10]
- Less disturbed children seem to have been able to be helped by therapy once a week.[11]
- More disturbed children need more intensive and longer treatment.[12]
- If the psychotherapy is too short or not sufficiently intensive, or if parallel work with parents is lacking, psychotherapy may in certain cases be damaging for seriously disturbed children.[13]

Psychotherapy has been found in formal studies to be effective for children with:

- Depression[14]
- Poorly controlled diabetes[15]
- Anxiety disorders[16]
- Personality disorder[17]
- Specific learning difficulties[18]
- Pervasive developmental disorders[19]
- Eating disorders[20]
- Infants exposed to violence[21]

Psychotherapy has had significant therapeutic benefits for severely deprived children, children in foster care and sexually-abused girls.[22] In the UK, studies have resulted in psychoanalytic psychotherapy (PDT) being included as a recommended form of treatment in public health care (NICE Guidelines).

We believe that it is necessary for Government to draw on evidence-based research from a broad range of therapeutic approaches. European evidence-based research in the effects of psychoanalysis and psychoanalytic psychotherapy show that our members belong to a group of mental health providers whose treatment outcomes are positive for their patients, and result in decreasing patient re-admissions to hospital.

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[8] Fonagy & Target (2002),p. 54
[9] Ellis Kennedy (2004)
[10] Schachter, (2004); Schachter and Target, (2009); Midgley and Target, (2005); Midgley et al., (2006).
[11] Muratori et al., (2002), (2003); Fonagy and Target, (1996).
[12] Lush et al., (1998); Schachter and Target (2009); Heinicke and Ramsay-Klee, (1986).
[13] Target and Fonagy, 2002; Szapocznik et al., (1989).
[14] Target and Fonagy, (1994b); Trowell et al., (2007); Horn et al., (2005).
[15] Fonagy and Moran, (1991).
[16] Kronmüller et al., 2005; Target and Fonagy, (1994b).
[17] Gerber, (2004).
[18] Heinicke and Ramsey-Klee, (1986).
[19] Reid et al., (2001)
[20] Robin et al., (1999)
[21] Lieberman et al., (2005)
[22] Lush et al., 1998, Trowell et al., (2002)

2) Working with adults: Evidence for longer-term psychoanalysis and psychoanalytic psychotherapy.

Recent studies indicate that psychoanalysis and psychoanalytic psychotherapy, both individual and group, are effective. These studies also show that patients continue to improve even after treatment has ended and for longer follow-up periods. Statistically significant and clinically meaningful improvements in panic, depression, anxiety, and functional impairment – both at treatment termination and at follow-up six months after completion – occur with psychoanalytic psychotherapy.[23]

A meta-analysis of the effectiveness of long-term psychoanalytic psychotherapy showed that it "was significantly superior to shorter-term" modalities and that long-term psychoanalytic psychotherapy yielded large and stable effect sizes in the treatment of patients with personality disorders, multiple mental disorders, and chronic mental disorders.[24] These patients are commonly regarded as "difficult", and it is particularly with respect to such patients who have "failed" or been excluded from other, briefer, therapies that psychoanalysis, or longer-term psychoanalytic psychotherapy have proven effective.

Doidge, in an earlier review of the efficacy of psychoanalytic approaches, makes the observation that with such patients, "therapeutic benefit is consistently and strongly associated with treatment length" (p123). It should be noted that he also points out that significant health care cost savings arise from the reduction of demand for other services.[25]

Patients diagnosed with a Borderline Personality Disorder who completed a program of longer-term psychoanalytic psychotherapy not only maintained their substantial gains at the end of treatment but also showed a statistically-significant, continued improvement on outcome measures.[26] A similar outcome, with a similar population, has been demonstrated in Australia.[27] This long-term follow up of patients treated intensively using psychoanalytic psychotherapy not only revealed positive clinical outcomes but positive economic outcomes in terms of increased productivity, and reduced demand on other health services.[28]

A Swedish study of more than 400 people during and after, subsidised psychoanalysis or longer-term psychotherapy showed continued improvement following the completion of treatment.[29] This observation suggests psychoanalytic treatment initiates a process that continues in the patient after the formal termination of treatment. The implication is that an advantage exists for extended, in-depth psychotherapy or psychoanalysis over short-term therapy and/or medication for a group of complex problems. For many people, psychoanalytic forms of psychotherapy may foster inner resources and capacities that allow richer, freer, more productive and fulfilling lives.[30]

Economic cost-benefits of psychoanalysis and psychoanalytic psychotherapy

A 1999 Australian study of the cost benefit of one year of twice weekly psychotherapy for patients with Borderline Personality Disorder showed an average cost reduction of hospital admissions of $21,431 per patient in the year following treatment compared to the year prior

[23] Milrod et al, (2000)
[24] Leichsenring and Rabung, (2008)
[25] Doidge (1997)
[26] Bateman and Fonagy, (2001)
[27] Meares, Stevenson & Comerford , (1999)
[28] Stevenson & Meares 1999; Hall, Caleo, Stevenson & Meares, (2001).
[29] Sandell R, Lazar A, Grant J, Carlsson J, Schubert J, & Falkenström F, (2004).
[30] Shedler, (2010), p. 18

to treatment.[31] With current session costs, this would fund a year and a half of twice weekly therapy sessions. Taking the current BAI recommended fee of $138 for a psychotherapy consultation, each day of hospital treatment may be the equivalent to several months of weekly psychotherapy sessions. Hence the cost of a year's psychotherapy treatment may be more than offset by reduced hospital stays, physician visits and other health system costs.

Since the continuity of the relationship between therapist and patient is central to the practice of psychoanalytic psychotherapy, patients experiencing crises between sessions are likely to contact their therapist for support before presenting to a hospital emergency department. The relationship is a significant asset which often helps in managing crises without more intensive medical intervention. The ongoing psychotherapeutic relationship is a resource to help manage patients outside the medical system and reduce other forms of intervention, which does not exist in shorter term, more goal-oriented treatments. There is now clear evidence that this reduces the need for additional intervention.[32]

Significance of the research findings

The above findings are of crucial importance to Government as it restructures the Australian mental health system. For optimum economic and preventative impact, longer-term psychoanalytic psychotherapy cannot be overlooked. It has been shown to result in markedly reduced medical utilization (sick days, hospital days, number of physician visits, drug intake) in the majority of patients studied in a review of health insurance.[33] This research indicates that patients reduced sick days by two thirds in the year after therapy, and by a further 50 per cent after five years. Hospital days were reduced by 87.5 per cent in the year after therapy and 50 per cent after five years. The research concludes:

> *"Even after 5 years, the improvement in the patients' state of health and attitude toward the disease resulted in a measurable reduction of health insurance claims (work days lost due to sickness, hospitalisation days, doctor's visits and psychotropic drug intake) in a significant number of the patients treated. This suggests that psychoanalysis is related to a reduction of health care and related costs. Cost effectiveness aspects increasingly play an important role as outcome criteria for health care purchasers and providers. This retrospective study demonstrated that psychoanalysis also has long-lasting effects on the patients' psychological wellbeing. The data here provide some convincing arguments for the effectiveness of psychoanalysis."* [34]

(e) (ii) ***Workforce qualifications and training of psychologists / clinical practitioners***

Our associations place a high emphasis on thorough and careful training. The minimum training required for membership of our professional associations is:

1. A tertiary degree and relevant clinical experience as a pre-requisite

2. Participation in a comprehensive professional training in psychoanalytic theory and clinical practice of between four to five years.

3. Weekly one-on-one clinical supervision of at least two clinical cases of psychoanalysis or psychoanalytic psychotherapy and/or group psychotherapy in which the patient or patients are

[31] Stevenson and Meares, (1999).
[32] Doidge, (1997); Stevenson & Meares, (1999); Hall, Caleo, Stevenson & Meares, (2001).
[33] Keller et al (2006a), p. 33
[34] Keller et al (2006 b) p.9

seen a minimum of twice a week. One of these cases must be of at least 24 months duration, and one at least 12 months. Most practitioners would have far in excess of these clinical hours.

4. Personal psychoanalysis or psychoanalytic psychotherapy and/or group psychotherapy, at least twice weekly, with an approved psychoanalyst or psychoanalytic psychotherapist for the duration of training. This is a unique component as it provides an actual experience of the process and ensures analysts and therapists are aware of how their own personal characteristics may influence the treatment. This is essential for effective psychoanalytic work. Not uncommonly a personal psychoanalysis would continue beyond the training period.

Trainees undertake the main elements of training- personal psychoanalysis/ psychotherapy, supervised clinical practice, and theoretical and clinical seminars, at the same time. In addition they have ongoing professional development and clinical supervision. There is no government funding for this and all costs are born by trainees. This is a substantial saving to Government and the community.

We consider the members of our associations to be the highest qualified professionals to deliver longer-term therapy. Our training in psychoanalysis/psychoanalytic psychotherapy is specific to serious mental problems and occurs at post-graduate level. Such preparation is central, providing our members with the sound theoretical and practical basis for assessment and treatment of complex cases. It is our view that without such rigorous training, practitioners may be ill-prepared to identify and manage severe mental illnesses, and thereby risk exacerbating such conditions.

(e) (iii) ***Workforce shortages***

The majority of members of our associations that provide psychoanalysis and psychoanalytic psychotherapy are university qualified in the medical and allied health professions such as psychology and social work. They are thus eligible for registration as Mental Health providers. However, we also have highly trained and experienced practitioners who came to their psychoanalytic training via other professional pathways, which currently make them ineligible for registration as Mental Health practitioners. They undertake the same post-graduate, theoretical and clinical psychoanalytical training, as all other members of our associations. Their theoretical understanding and clinical expertise for undertaking psychotherapeutic treatment of severe, complex and long standing mental health problems are equivalent in all respects to members from the medical and allied health sector.

Their non-recognition under the BAI has meant that their case-loads have fallen, and their skills are under-utilised while patients are encouraged to seek the help of practitioners who may not have had the training required to treat complex problems. As a consequence, their ability to contribute to the treatment of serious mental health problems in the community has been diminished. Their patients receive no rebates and are required to pay GST for their services. This is an inequitable oversight that has implications for optimum treatment, but also has implications for mental health workforce shortages. These practitioners constitute a highly trained, highly experienced, but underutilised resource.

(h) ***The impact of online services for people with mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups***

Members of our associations have been actively exploring options of remote therapy via telephone or Skype. Anecdotal evidence suggests that electronic media may be able to play a part in a long term psychoanalytic psychotherapy.

(j) ***Any other related matters***

The BAI has been predicated on a limited range of treatment modalities (CBT, Interpersonal Therapy, and Narrative Therapy with indigenous populations). An expanded range of therapeutic modalities would be more inclusive and would meet the needs of a broader range of target groups. Many of our members report working with patients who have tried brief, structured interventions and found them to be of limited effectiveness. This is not to suggest that such approaches are not helpful, but rather, their usefulness is greatest with certain patient populations.

In-depth, longer-term treatment is particularly required with the more serious disorders, including multiple or chronic mental disorders, personality disorders, severe obsessive-compulsive disorders, and chronic abuse and trauma victims. The National Mental Health Policy 2008 recognises the need to have a broad range of treatment modalities, stating that:

> *"Central to the population health framework is a range of high quality, effective interventions that target those at different levels of risk or with different levels of need. The interventions should be comprehensive, ranging from prevention and early intervention through treatment, to continuing care and prevention of relapse."(p.10)*

Our members draw on many models of mental dysfunction; the patient is not fitted into one mode of working but rather the treatment is guided by the specific character of the patient's experience and type of assistance most effective for them. We strongly support diversity in service providers to reflect the diversity in patients' needs. These needs are not necessarily obvious to the patient in treatment, but it is crucial that the treating clinician is aware of them. Clinicians (both treating and referring) need to have the training and experience to recognise and respond to the complex psychological treatment needs of their patients.

The BAI system as it currently functions may engender a false sense of security by implying that those professionals who have access to rebates automatically possess the training and experience to treat serious mental health disturbances when this is not necessarily the case. Psychoanalytic therapies have been specifically developed over more than a century to provide effective treatments for complex, chronic and resistant mental health conditions. The thoroughness of a training that includes theory, practice, supervision and personal analysis equips our members to be in the best position to treat patients with such disorders.

Unfortunately, those members of our associations who are not eligible to receive referrals under the BAI because of their primary qualifications outside of the health fields, but nevertheless undertake the same psychoanalytic trainings, are not being referred such patients. This means they can be under-utilised, while those who may not be adequately trained in these areas are being referred patients whose complex disorders are possibly beyond their training and experience. We are aware that there may be practitioners trained in other schools of psychotherapy including CBT, who are qualified to undertake longer term, relationship-oriented treatment of complex cases.

In promoting an increasingly limited treatment framework, the BAI appears to be fostering the idea that all problems can and should be able to be effectively addressed within the time-frame of short-term therapy – "one treatment fits all patients". There is a serious risk that patients may attend unsuitably trained practitioners who begin psychotherapy with them, but terminate prematurely because there is no further Medicare rebate available. This can have a negative effect in that the patient's expectation of the usefulness of therapy is not met. Indeed, the consequences of the BAI in this instance could do more harm to the patient in fostering a negative attitude to therapeutic work. Even more serious damage may occur when seriously disturbed and fragile patients are referred to practitioners who, not being trained to recognise

or deal with such complex cases, offer brief interventions, terminate prematurely, and leave the patient traumatised and damaged.

The broad range of psychological conditions which generate severe chronic distress require longer term psychotherapy as opposed to briefer interventions. The evidence derived from numerous recent studies strongly supports the appropriateness of psychoanalytic approaches in these complex cases.

RECOMMENDATIONS

1. Given the substantial evidence for the efficacy of psychoanalytic psychotherapies, we recommend that such approaches should be added to the list of approved interventions under the Better Access Initiative or an alternative support for access to such treatments be provided, via both public and private mental health systems.

2. Given the evidence that patients with chronic or long standing mental health problems such as personality disorders, severe depressive and anxiety disorders, require longer term, more intensive therapeutic interventions, we request that the number of sessions available under the BAI (or alternative initiative) should be extended for these patients.

3. While services provided by the majority of our members attract some support via Medicare and Private Health insurance, there are some highly trained and experienced psychoanalysts or psychoanalytic psychotherapists who are currently not eligible for such rebates because they are not members of medical or allied health professions. We recommend that all practitioners who demonstrate eligibility for membership of our own or equivalently trained associations, be added to the list of health professionals recognized to deliver psychological therapies under the Better Access Initiative (or alternative programme.)

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