RESPONSE FROM THE AUSTRALASIAN CONFEDERATION OF PSYCHOANALYTIC PSYCHOTHERAPIES TO THE RECOMMENDATIONS OF THE MENTAL HEALTH REFERENCE GROUP

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EXECUTIVE SUMMARY

The Australasian Confederation of Psychoanalytic Psychotherapies (ACPP) brings together the pre-eminent psychoanalytic professional associations in Australia, representing approximately 450 highly trained psychoanalysts and psychoanalytic psychotherapists.[1]

The Confederation strongly endorses the observation of the Mental Health Reference Group that *"patients with moderate to severe mental health disorders, a small cohort with the highest mental health burden, do not currently receive the treatment they need through the MBS."* (Report of the Mental Health Reference Group, 2018. p36.) While we question the assertion that it is a "small" cohort, we are able to advise that psychoanalytic practitioners are well equipped to assist this inadequately serviced group of patients. Psychoanalytic practitioners treat patients with multiple or chronic mental disorders, personality disorders, psychotic disorders, severe anxiety and depression and those suffering long term abuse and trauma. Evidence-based research indicates that the treatment of complex psychological problems requires longer-term , in-depth intervention than can be offered by brief, structured therapies, and demonstrates the efficacy and lasting benefit of longer-term psychoanalytic treatment for children, adolescents and adults. When employed, such treatment have been shown to reduce hospitalisations, decrease loss of work and study time, and reduced need for years of costly prescription pharmaceuticals.

To be effective and inclusive, access to mental health services in Australia needs to be broadened to provide access to more intensive therapies (referred to above) that are required by those suffering with severe mental health problems. This would ensure equity of access to appropriate treatment for those with more complex and co-morbid psychological problems, and provide them with hope that effective treatments for their suffering are available.

In light of these considerations, the Confederation particularly endorses the MHRG's recommendations to recognise:

1. the evidence that patients with chronic, long-standing and complex mental health problems such as personality disorders and severe anxiety and depression, require longer term, more intensive therapeutic interventions, and that the number of sessions available under the Medicare Benefits Schedule (MBS) should be extended to facilitate such treatments.
2. the substantial evidence for the efficacy of individual and group psychoanalytic psychotherapies, and support their inclusion in the list of MBS approved interventions.
3. the importance of specialised training in providing services to this particularly vulnerable and under-serviced group of patients, and increased access to practitioners who are trained and accredited to provide such specialised assessment and treatment. The Confederation submits that all practitioners who meet its training and accreditation standards should be included among the health professionals qualified to provide assessment and treatment under the MBS.

1 Foundation members of the Confederation are the Australian Association of Group Psychotherapists; the Australian and New Zealand Society of Jungian Analysts; the Australian Psychoanalytical Society and the Psychoanalytic Psychotherapy Association of Australasia.

Specific Response
The Australasian Confederation of Psychoanalytic Psychotherapies (ACPP) thanks the Mental Health Reference Group (MHRG) for its report. The ACPP endorses the spirit of the report and the majority of the recommendations embodied therein, and appreciates the opportunity to offer comment. We provide the following specific responses for your consideration.

Recommendation 1 – Expand the Better Access Program to at-risk patients
The ACPP welcomes the recommendation to extend Better Access to at-risk patients. We would however suggest that it is expanded such that services to patients with complex disorders are provided by those with appropriate qualifications and training (as accredited, for example, by the Confederation.) The MHRG identifies two categories of at-risk patients: i) those who present with no previous history and ii) those who are currently relatively symptom free but require professional service for relapse prevention. The ACPP particularly recognises the merit in ongoing access to services for the latter group of patients. While patients may, in the early stages of treatment, experience considerable symptom relief, if the underlying contributors to their mental distress have not been adequately addressed, risk of relapse is often high. It has been our observation that this is not uncommon in response to brief, structured treatments.

We note that this recommendation echoes the National Mental Health Policy 2008, which recognized the need to have a broad range of treatment modalities, as follows:
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)

Recommendation 2 – Increase the maximum number of sessions per referral
The ACPP supports this recommendation. Our support is linked with our response to Recommendation 3. The ACPP supports this recommendation with the proviso that increased services are provided by those best qualified to provide such services.

Recommendation 3 – Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness
The ACPP endorses the Reference Group's observation that *"patients with moderate to severe mental health disorders, a small cohort with the highest mental health illness burden, do not currently receive the treatment they need through the MBS"* and the associated recommendation for up to 40 sessions per year for Tier Three treatment for people in this under-serviced cohort. ACPP considers this recommendation to be the most potentially significant of the report in that it embodies the recognition that brief, structured interventions, while helpful for less severe disorders, are less likely to be helpful with more severe, complex and co-morbid presentations. In many cases attempts to treat people with such severe presentations via brief interventions have been counter-productive. In promoting a 10 session treatment framework, the BAI may have inadvertently fostered the idea that all problems can and should be able to be effectively addressed within the time-frame of short-term

therapy. There is a risk of significant negative impact on patients' expectation of the usefulness of therapy if consumers attend practitioners who begin treatment, but terminate prematurely when the MBS rebates are exhausted. 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 further traumatised and damaged.

The current emphasis on structured and time limited treatments has received strong support because such treatments are well suited to the dominant research paradigm. While there is evidence for the treatment modalities identified in the BAI, there are significant questions about the comprehensiveness of such evidence and the exclusion, from many of these studies, of the type of complex cases that are suitably treated by longer term psychotherapy. (Shedler, 2015; Hardy, Barkham, Shapiro & Reynolds 1995; King, 1998; Leuzinger-Bohleber et al, 2019)

In addition, evidence-based literature unequivocally demonstrates the efficacy of long-term individual and group psychodynamic psychotherapy in treating a broad range of psychological conditions, particularly the more severe forms of mental dysfunction. (Bradshaw et al, 2009; Kachele et al, 2000; Solms, 2018; Lorentzen et al. 2015) Meta-analyses demonstrate a mean effect size for psychodynamic psychotherapies in excess of 0.8 (compared, for example, with a mean effect size of 0.31 for antidepressant medications approved by the US FDA between 1987 and 2004). (Shedler, 2010) The evidence strongly suggests that psychodynamic models are much more appropriate to this client population than the shorter-term models which do not provide for the establishment of a patient-therapist relationship and time frame appropriate to the nature of the work. There is also research support for the application of short-term psyhcoanalytic therapies in certain circumestances. (Abbass et al, 2014) The depth of therapeutic work engaged in by psychoanalytic practitioners provides one of the most effective means of helping those presenting with the most entrenched and crippling mental health difficulties.

For example, a recent report of a British study of people with “treatment resistant” depression (defined by failure of two prior attempts at treatment using brief approaches) showed that, at two-year follow-up, 30% of participants who attended 18 months of weekly psychoanalytic psychotherapy showed sustained improvement, compared to only 4.4% of the “treatment as usual” control group. (Fonagy, Rost, Carlyle, McPherson, Thomas, Fearon, Goldberg & Taylor, 2015; Rost, Luyten, Fearon, & Fonagy, 2019) Interestingly, while both groups showed similar improvement at the end of treatment, the gains of the “treatment as usual” group declined steadily over the follow-up period, while the psychoanalytic treatment group sustained their gains. These data suggest that end-of-treatment evaluations or short follow-ups may miss the emergence of delayed therapeutic benefit of psychoanalytic treatments and therefore unfairly represents their outcomes. Other studies have also suggested that the longer term outcomes of other evidence-based treatments such as CBT reveal a fading treatment effect with longer term follow-up.

Other studies demonstrate the effectiveness of both individual and group psychoanalytic

psychotherapies. (Leuzinger-Bohleber & Kachele H, 2015; Burlingame, et al. 2016) 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 psychodynamic psychotherapy. (Milrod et al, 2000.) A meta-analysis of the effectiveness of long-term psychodynamic psychotherapy showed that it "was significantly superior to shorter-term" modalities and that long-term psychodynamic psychotherapy yielded large and stable effect sizes in the treatment of patients with personality disorders, multiple mental disorders, and chronic mental disorders. (Leichsenring & Rabung, 2008, 2011.) 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). He also points out that significant health care cost savings arise from the reduction of demand for other services. (Doidge,1997.)

Research also shows that patients diagnosed with Borderline Personality Disorder who completed a program of longer-term psychodynamic psychotherapy not only maintained their substantial gains at the end of treatment but also showed a statistically-significant, continued improvement on outcome measures. (Bateman and Fonagy, 2001.) A similar outcome, with a similar population, has been demonstrated in Australia. (Stevenson & Meares, 1992; Meares, Stevenson & Comerford, 1999; Meares, Stevenson & Comerford, 1999.) 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. (Stevenson & Meares 1999; Hall, Caleo, Stevenson & Meares, 2001)

A Swedish study, the Stockholm Outcome of Psychotherapy and Psychoanalysis (STOPP) Project, of more than 400 people during and after, subsidised psychoanalysis or longer-term psychotherapy showed continued improvement following the completion of treatment. (Sandell et al, 2000; Blomberg et al, 2001) 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. (Keller et al 2006.) 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 percent in the year after therapy and 50 per cent after five years. These observations lend support to the notion that 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, psychodynamic forms of psychotherapy may foster inner resources and capacities that allow richer, freer, more productive and fulfilling lives. (Shedler, 2009.) Recent studies have established the efficacy of psychodynamic psychotherapies at a neurobiological level (Cozolino, 2002, 2006; Buchheim et al, 2012). The brain restructures itself during psychotherapy and "the more successful the treatment the greater the change". (Doidge 2007,

p.234.) The evidence emerging in these studies emphasises the role of the relationship between therapist and patient and the need for a significant time to enable these changes to become expressed as physical changes in the brain.

A similar body of evidence is accruing for the effectiveness of longer term, more intensive treatments with children. 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, following successful treatment, had become relatively high-achieving individuals with stable social circumstances and no history of further psychiatric problems."* (Fonagy & Target, 2002, p 54)

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

- Extensive reviews (Kennedy & Midgley, 2007; Midgley & Kennedy, 2011) of research in child and adolescent psychotherapy found that psychodynamic therapy is beneficial. The magnitude of the effect is approximately 0.7, thus about the same effect as in other 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. (Schachter, 2004; Schachter & Target, 2009; Midgley and Target, 2005; Midgley et al., 2006; Midgley et al, 2009)
- Less disturbed children seem to have been able to be helped by therapy once a week. (Muratori et al., 2003; Fonagy and Target, 1996)
- More disturbed children need more intensive and longer treatment. (Lush et al., 1998; Schachter and Target, 2009; Heinicke and Ramsay-Klee, 1986)
- If the psychotherapy is too short or not sufficiently intensive, or if parallel work with parents is lacking (and this also supports recommendation 7), psychotherapy may in certain cases be damaging for seriously disturbed children, (Target and Fonagy, 2002; Szapocznik et al., 1989)

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

- Depression (Target and Fonagy, 1994b; Trowell et al., 2007; Horn et al., 2005)
- Poorly controlled diabetes (Fonagy and Moran,1991)
- Anxiety disorders (Kronmüller et al., 2005;Target and Fonagy, 1994b)
- Personality disorder (Gerber, 2004)
- Specific learning difficulties (Heinicke and Ramsey-Klee, 1986)
- Pervasive developmental disorders (Reid et al., 2001)
- Eating disorders (Robin et al., 1999)
- Infants exposed to violence (Lieberman et al., 2005)

Psychotherapy has had significant therapeutic benefits for severely deprived children, children in foster care and sexually-abused girls. (Lush et al., 1998 ; Trowell et al., 2002) In the UK, studies have resulted in psychodynamic psychotherapies (eg Dynamic Interpersonal Therapy) being included as a

form of treatment available in public health care (NICE Guidelines).

There is also evidence of the effectiveness of psychoanalytic psychotherapy for couples whose psychological difficulties could result in a costly divorce, and emotional turbulence for children of the relationship. (Hewison et al, 2014; Hewison et al, 2016)

Further evidence for the efficacy of psychoanalysis and psychoanalytic psychotherapies is available on our website at acpp.org.au.

Qualifications of service providers.

While the Reference Group does not align different levels of care with different qualifications, ACPP would make the point that it is crucial that, particularly with respect to the more severe clinical presentations, practitioners possess the specialist training required to properly assess and treat these patients. The research briefly outlined above reflects treatment provided by highly trained specialists such as those credentialled by the Confederation. These are not treatments which can be delivered by all health care providers. While AHPRA regulates the use of some designated professional titles, unlike other countries such as Germany and the UK, there is no regulation in Australia regarding the use of the terms “psychoanalyst” and “psychoanalytic psychotherapist”. Indeed, a primary motivation for the establishment of the Confederation has been to promote and ensure the highest standards of training and accreditation for psychoanalysts and psychoanalytic psychotherapists in Australasia. To this end, the Australasian Confederation of Psychoanalytic Psychotherapies is in the process of developing a formal Register of appropriately trained and accredited Psychoanalysts and Psychoanalytic Psychotherapists in Australia.

Training of Psychoanalysts and Psychoanalytic Psychotherapists

Practitioners who meet the Confederation's training and accreditation standards are extremely well qualified to deliver the specialised, intensive therapy required for the most severe patient presentations. This is because training in psychoanalysis/psychoanalytic psychotherapy prepares practitioners to work with serious mental problems and occurs at post-graduate level. Such preparation provides practitioners with a sound theoretical and practical basis for assessment and treatment of complex cases.

The minimum training required for membership of our professional associations is:

1. A tertiary degree and relevant clinical experience as a pre-requisite to training.
2. Participation in a comprehensive professional training in psychoanalytic theory and clinical practice of three or more.
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 seen a minimum of twice a week. 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 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 concurrently - theoretical and clinical seminars; personal psychoanalysis/psychotherapy; and supervised clinical practice. In addition they have ongoing professional development and clinical supervision. There is no government funding for this and all costs are borne by trainees.

The majority of the practitioners represented by the Confederation initially are qualified as medical or allied health professionals (eg. clinical psychologists and social workers) and are thus eligible for registration as Mental Health providers. However, a small number of highly trained and experienced psychoanalytic practitioners are currently ineligible for registration as Mental Health Practitioners as they would be for example in the UK. While these practitioners are not recognised under the MBS, 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 MBS has meant that their ability to contribute to the treatment of serious mental health problems in the community has been diminished.

In summary, the ACPP supports the principle underpinning Recommendation 3, that patient session allocation should be determined based on clinical need, rather than arbitrary session limits. While a three tiered system offers significant improvement on the current arrangement, we suggest that the research supports an even more complex structure. As a consequence, ACPP also strongly endorses Recommendation 4, the establishment of a new review body to consider (a) the most effective allocation of session limits, and (b) the most appropriate practitioners to deliver more intensive, longer term treatments.

Recommendation 4 – Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups

The ACPP endorses this recommendation and would welcome the opportunity to participate in such a review body, or to provide input to such a committee.

Recommendation 5 – Reduce minimum number of participants in group sessions

The ACPP endorses this recommendation. Psychoanalytic group practitioners report that for many very vulnerable patients, larger groups are daunting, and the option of smaller groups extends the availability of group treatments to more patients.

Recommendation 6 – Add a new group item for therapy in larger groups

As it appears that the purpose of this recommendation is primarily psycho-education, the ACPP has no comment.

Recommendation 7 – Enable family and carers to access therapy

The ACPP also strongly endorses this recommendation. Given the evidence of the effectiveness of couple and family psychoanalytic psychotherapy the ACPP also recommends that provision be made for couples and families to access such services which otherwise lead to costly consequences associated with marriage and family breakdown. Currently there are no Medicare item numbers available for couples and families. Psychoanalytic practitioners providing treatment to children and adolescents recognise the importance of engaging parents and family in the therapy process, and would welcome the introduction of a new item for the specific purpose of enabling consultation with family members, carers and/or support people. At times, following thorough assessment, it may be most helpful for therapeutic work to focus on the parents, and not the child themselves, despite the initial referral being for the child.

Recommendation 8 – Measure Better Access outcomes

ACPP strongly endorses the introduction of sophisticated, comprehensive and carefully implemented ongoing outcome measure. Elsewhere in the world it has been recognised that evaluation of complex service such as 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 these for a decade. (Richardson, Kachele & Renlund, 2004)

Recommendation 9 – Update treatment options

With reference to our summary above of the evidence base for psychoanalytic psychotherapies, the ACPP welcomes the recommendation that "Psychodynamic therapy" be included among the psychological therapies covered by the MBS, subject to the proviso that such evidence-based treatments are provided only by practitioners who are appropriately trained and accredited by the ACPP. We also strongly support the recommendation that MBS-rebated therapies are frequently reviewed and updated as evidence evolves.

Recommendation 10 – Unlink GP focused psychological strategy items from M6 and M7

No comment.

Recommendation 11 – Encourage coordinated support for patients with chronic illness and patients with mental illness

Given the acceptance of the role of epigenetic factors in the relapse and recurrence of chronic mental illness such as schizophrenia, bipolar disorder and major depressive disorder, the ACPP strongly supports this recommendation.

Recommendation 12 – Promote the use of digital mental health and other low-intensity treatment options

The ACPP is cautious with respect to indiscriminate application of digital mental health options. As indicated elsewhere in this submission, it has been the experience of many of our practitioners that people with complex and serious mental health disorders can become disillusioned, and dispirited

about seeking assistance if they are led to believe that their complex problems may be alleviated by simple programmes.

Recommendation 13 – Support access to mental health services in residential aged care
Strongly supported.

Recommendation 14 – Increase access to telehealth services
The ACPP strongly supports this recommendation which will facilitate more equitable access to mental health services for consumers in rural and remote locations.

Moreover, it is not uncommon that patients of psychoanalytic psychotherapists need to relocate for work or other reasons. Given that the development of a trusting relationship is a cornerstone of psychoanalytic approaches, it is increasingly the case that patients, rather than "starting again" with another therapist, in a new location, choose to continue therapy via electronic communications.

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