National Association of Practising Psychiatrists

Submission to Senate Community Affairs Committee

Health Insurance Amendment (Safety Net) Bill 2015

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EXECUTIVE SUMMARY

- The National Association of Practising Psychiatrists (NAPP) sees the proposed Health Insurance Amendment (Safety Net) Bill 2015 as highly problematic

- NAPP asserts that the rationale for proposed changes, as they affect Psychiatry, is flawed and urgently requires careful reconsideration

- There is a failure to recognise that much psychiatric treatment is *not* available in the public sector, highlighting the importance of EMSN arrangements in psychiatry

- NAPP is concerned about *serious misunderstanding* of the legislative facts that underpin the workings of the Medicare Schedule, and its Item numbers, which therefore lead to errors of fact in relation to the impact of rebate reduction

- NAPP is concerned that the removal of the Extended Medicare Safety Net will disadvantage a significant number of ill patients, who otherwise represent high use of hospital services if untreated (NHMRC)

- NAPP is concerned about unintended consequences for families, and victims of abuse or domestic violence if access to treatment is threatened

- NAPP s concerned about seeming contradictions in Reports used as the basis for proposed changes to the Health Insurance Amendment (Safety Net) Bill 2015

- NAPP contends that the proposed Bill is not in accord with The Mental Health Statement of Rights and Responsibilities, 2012

- NAPP asserts that patients will pay more, for longer, with proposed reductions

- NAPP suggests that patients will limit their own treatment

- NAPP foresees expenses will occur in rising PBS costs and hospital / legal costs if the Bill is not amended

- The proposed changes will raise inequity and increase inequality

- The way forward is suggested

The National Association of Practising Psychiatrists (NAPP) is grateful for this chance to expand and clarify our position regarding the proposed Health Insurance Amendment (Safety Net) Bill 2015. NAPP also acknowledges the opportunity we were given to present, in person, our views to the Senate Community Affairs Legislation Committee, at its public hearing on 16 November 2015.

In her Explanatory Memorandum, Minister Sussan Ley explains the Bill thus:

*"This Bill introduces a new medicare safety net to replace the Extended Medicare Safety Net (**EMSN**), the Original Medicare Safety Net (OMSN) and the Greatest Permissible Gap (GPG). The purpose of this Bill is to consolidate the complex medicare safety net arrangements and to introduce a new medicare safety net that will continue to provide assistance to singles and families with out-of-pocket costs for out-of-hospital medicare services. To protect medicare for the long term it is important to consider whether elements of the medicare programme are having their desired consequences. Expenditure under the medicare safety nets continues to increase significantly, with expenditure continued to be directed in areas where doctors charge the highest fees."*

NAPP has grave concerns regarding the potential impact of this legislation, and we respectfully ask the Committee to consider these. We cannot see how the proposal above "will continue to provide assistance" when the Minister's own Memorandum shows a significant reduction in benefits that accrue to the new EMSN threshold (p5).

NAPP especially asks the Committee to note that long term intensive psychiatric treatment is *NOT* available in the public sector. Any notions that removing the EMSN will benefit patients are completely misguided, as out-of-pocket costs can only increase, and the burden of a lesser (150%) cap will disadvantage an already marginalized group, by virtue of the reduced rebates for Item 316.

We expand on our concerns under the headings below.

Contentious Assumptions

NAPP sees the following as false assumptions underlying proposed changes in the Bill:

- NAPP maintains that one of the assumptions underlying changes to the Medicare Safety Net is that if the Safety Net is reduced, '**the market'** will adjust with downward pressure on medical fees and hence no adverse impacts on patients.
- NAPP rejects this assumption as being a complete **misunderstanding** as to how private psychiatry is delivered.
- Patients with psychiatric illness often present with **limited income** because of the illness and their inability to achieve full function in their employment. Hence the fees they are charged are already adjusted to meet as close as possible their financial capacity.

- Psychiatrists have an obligation to ensure that they maintain a viable medical practice. There is a **limit** to how much they can cross-subsidise patients before closing their books.
- Sadly, the services and expertise of practising psychiatrists are in growing demand. Hence changes to the Safety Net which threaten the ability of practising psychiatrists to continue to offer subsidised and no-gap services, will be a catalyst for many highly trained clinicians **to move** to other forms of work where there is considerable demand and less face-to-face work pressure. These include medico-legal, expert witness, private consulting and paid employment.
- NAPP rejects the misapplication of market theory and **managerial theory** where it is assumed that patients who are in need of treatment for psychiatric illness are simply consumers in an retail wonderland and their treating psychiatrists are shopkeepers with the ability to discount their services to attract greater demand.
- Australian psychiatrists are under considerable **pressure** with a growing burden of mental illness and new concerns over the radicalisation of young people and all the challenges that presents to mental health professionals.
- Psychiatry is having difficulty attracting medical graduates. Misapplied changes to the Safety Net which weaken the ability of this specialty to offer a full range of treatment modalities, will further **undermine** the efficacy of treatment for mental illness in Australia and create a situation where a very few psychiatrists will deliver fewer services to fewer patients leaving others to seek less effective and far more costly forms of treatment.

Medicare Schedule Item Numbers

NAPP strongly recommends that psychiatry item numbers be exempted from proposed changes of the Safety Net Bill 2015, given that we already have caps where there have been concerns about excessive billings. We contend that the problem has already been solved by the existing caps. Another cap is going to be detrimental or have serious unintended consequences.

NAPP is concerned to correct the **misunderstandings** we heard at the Public Hearing, which we see as being based on the complex operation of the relevant psychiatric item numbers, viz Items 300 – 319, and 342.

NAPP is especially concerned about the misunderstanding that “Item 316” represents a lower fee for milder disorders. This is completely wrong. Item 316 represents *the only* rebate possible after the caps on Item 306 and 319 have been attained; ie 316 is a 50% reduced rebate, leaving a 50% *increased gap* payment for affected patients.

316: Under current arrangements (due to possibly change as of Jan 1, 2016), any patient requiring ongoing psychiatric treatment after exceeding MBS limits (*ie after 50 sessions for Item 306, and after 160 sessions pa for Item 319*) must be billed using Item 316.

The latter item brings with it a **marked (50%) reduction** in MBS rebate, and hence a financial impost in raised out of pocket expense for patients. Currently, this is addressed by the Extended Medicare Safety Net (EMSN), also due for review.

Should the Govt succeed in changing current MBS arrangements, in line with its proposals to abolish the EMSN and cap rebates, then NAPP sees inequity of access and poor clinical outcomes as the only result. This will be due to the increased financial burden placed on vulnerable patients who will be increasingly unable to meet gap-payment requirements, in part because of their illness, and in part because of an increasingly uncertain economy that jeopardises employment.

NAPP's recommendation is for elimination of the restriction on the number of consultations permitted for MBS rebate under MBS Item Number 306; then Item 316 will no longer be required.

If it is not approved then NAPP would recommend retention of MBS Item No 316 together with the current Safety Net arrangements.

319: The detailed working of Item 319, in particular, needs to be understood; this will be of significant concern to affected patients, present and future, if EMSN is removed.

Medicare Item 319 refers to an item number in the MBS which is described as follows:

> *"Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner - an attendance of more than 45 minutes duration at consulting rooms, where the patient has: (a) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance related disorder, somatoform disorder or a pervasive development disorder; and (b) for persons 18 years and over, been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale - where that attendance and any other attendance to which items 300 to 308* ***apply do not exceed 160*** *attendances in a calendar year."*[1]

The fee indicated for this Item is $183.65.

Furthermore, explanatory Notes to this Item, in part, read as follows:

> *"A.15.2 It is not sufficient for the patient's illness to fall within the diagnostic criteria. It must be evident that a* ***significant level of impairment*** *exists which interferes with the patient's quality of life. For persons 18 years and over, the level of impairment must be within the range 1 to 50 of the Global Assessment*

[1] Commonwealth Department of Health and Aged Care. Medicare Benefits Schedule.

> *of Functioning (GAF) Scale contained in the DSM-IV (ie the patient is displaying at least "serious" symptoms). The GAF score, incorporating the parameters which have led to the score, should* ***be recorded at the time of commencement of the current course of treatment****. Once a patient is identified as meeting the criteria of Item 319, he/she continues to be eligible under that item for the duration of the current course of treatment (provided that attendances under 300 to 308 and 319 do not exceed 160 in a calendar year). Where a patient commences a new course of treatment, the GAF score in relation to Item 319 is the patient's score as assessed during the new course of treatment.*
>
> *A.15.3 In addition to the above diagnostic criteria and level of functional impairment, it is also expected that other appropriate psychiatric treatment has been used for a suitable period and the patient has shown little or no response to such treatment. It is expected that such treatment would include, but not be limited to: shorter term psychotherapy; less frequent but long term psychotherapy; pharmacological therapy; cognitive behaviour therapy.*
>
> *A.15.4 It is the responsibility of the psychiatrist to ensure that the patient meets these criteria. The Health Insurance Commission will be closely monitoring the use of Item 319.*
>
> *A.15.5* ***When a patient who meets the criteria defined in Item 319 attends a psychiatrist on more than 160 occasions in 12 months such attendances would be covered by Items 310 to 318."***[2]

It was indicated at that time that if the results of the Budget decision of 1996 could be seen to be ineffective or damaging and a viable alternative was available the Minister was willing to reconsider the Budget decision. This has not happened.

NAPP asks the Committee to note that:

- Not all severely ill patients qualify for this Item
- If they do not, and need long term treatment, removing the Safety Net is problematic
- If they do qualify, but need even more intensive treatment, the above applies too
- Rebates fall by 50% after session 160
- Financial stress, as it applies to already ill patients, is modified by the EMSN now
- This item is of particular use in many relapsing psychiatric conditions

NAPP made submissions regarding the detrimental effects of Item 319 legislation to the Senate Select Committee on Mental Health, 2005. In there, we stated this:

The NSW Legislative Council Final Report entitled, "Inquiry into Mental Health Services, December 2002" made the key point that the non-psychotic illnesses are chronically debilitating and need more treatment options available for them. **The dichotomy between "serious and (presumably) non-serious" mental illness is completely false**. In the words of the Final Report,

The New South Wales mental health system seems to be geared towards people with recognised psychotic illnesses which respond to medication. We do not suggest it is inappropriate that these people be given high priority, but we suggest that there are other people with non-psychotic illnesses who also need help. For people…who are depressed, suicidal and in need of long-term psychotherapy, it seems that the mental health system has little to offer apart from 'band aid' measures such as a dose of medication.
(Page 218 Final Report - December 2002)

NAPP strongly contends this is still the case today. NAPP asserts that the proposed removal of the EMSN will severely affect the access to treatment, and treatment itself, for severely unwell patients, since these patients can only be treated intensively in the private sector.

NAPP argues that the distinction made in the Public Hearing of 16 November 2015, viz that there are severely ill patients who use Item 319, and there are those with mild or moderate issues who use 316, is misguided and not in keeping with clinical reality. It is also a complete misunderstanding of the legislative facts. The removal of the EMSN can only exacerbate inequity of access to treatment.

306: MBS Item 306 identifies general psychiatric consultations and/or treatment.

It is important to recognise the variety of approaches this item encompasses; anywhere from assessment, ongoing medical review up to and including long term intensive psychiatric treatment.

NAPP wishes to emphasise the following:

1. Psychiatric attendances have been *declining* for reasons that are unclear. Therefore NAPP asserts that while reviewing all psychiatric Items may lead to increased efficiency, access and equity while lessening the cost burden on the general medical system this will only eventuate if the complexity of the bio-psycho-social model is kept at the forefront of considerations in the Review process.

2. Many severely ill patients do not qualify for Item 319 benefits, and so are penalised if they require intensive, high volume treatment

3. The above applies to many diagnostic issues, including psychotic illness such as Bipolar Disorder or Schizophrenia in young adults

4. NAPP is concerned about families where **multiple members** need psychiatric treatment, and where this treatment may be provided by different psychiatrists. We have situations with five members of families, often with complex histories of abuse and sexual disorder—family violence and all sorts of other problems—so the out-of-pocket **expenses will multiply** for the one family.

5. NAPP remains very concerned about patients needing long-term intensive psychiatric treatment. We are concerned about patients who need **hospital in the home** and who need to be seen **daily**. We are concerned about patients with multiple illness, for example: patients who have both psychiatric disorder and who also suffer from cancer, or from other **medical disorders**.

6. When we look at patients receiving intensive psychiatric treatment, we are concerned that they will not be able to access treatment if this bill becomes law

In other words, many differing psychiatric patients will have treatment severely curtailed if the Legislation proceeds unamended. This will be due to the removal of the EMSN, and hence the loss of support for costs, as well as the reduction in rebates allowed (150%) to accrue towards the new threshold.

291 & 296: These Items were introduced into the Medicare Schedule to try to redresss issues of access; these were accompanied by the Better Access arrangements for psychologists.

The intent of these Items was to provide GPs with timely access to expert opinion.

In reality, the perhaps unintended consequence of these arrangements has been that more psychiatrists use these Items for one-off assessments. This then :

- Increases turnover of consultations
- Increases costs because of higher fees involved
- Reduces capacity for expert long term intensive treatment
- Exacerbates the declining use of Item 306 & 319
- Exacerbates loss of expertise in the bio-psycho-social model of care

NAPP contends that the reduction proposed in the Medicare cap, of 150%, can only produce a vicious circle of inequity of access, lack of treatment, and increasing costs by way of rising PBS costs, rising hospital admission rates and rising morbidity.

Reports of 2009 and 2011

NAPP understands that Health Minister Ley, on advice from the Dept of Health, relied very heavily on two Reports from 2009 and 2011. These concern the operations of the EMSN, and are the ***2009 Review into the Extended Medicare Safety Net***, and ***2011 Review into the Extended Medicare Safety Net.***

It is with some concern that NAPP notes that these Reports are being used to justify changes proposed in the Safety Net Bill 2015. In particular, we are concerned about apparent contradictory statements and assertions.

For example, in 2009 it is asserted that *"This government policy (EMSN) was designed to provide additional financial relief for those patients with high out-of-pocket costs, particularly those with complex and high health care needs." (pVI)* and

"High out-of-pocket costs are widely regarded as a barrier to health care, especially amongst poorer sections of the community, and are likely to lead to greater health inequities." (pV)

NAPP's modelling indicates rises in costs after reductions in rebate caps, in the order of $107 per consultation; that will be multiplied in intensive long term treatment, or families with several patients seeing several providers. NAPP cannot see how the proposed changes are in keeping with the notions expressed in the above Report quotes.

Further, the 2009 Report states: *"A fall in OOP costs would be expected to lead to some additional demand for services. Again, we examined pre- and post-EMSN trends for per capita service use for each of the professional groups identified…..**The post-EMSN trends for specialist attendances and psychiatry, as well as operations, were not significantly different from zero—meaning that they were no different to the prevailing pre-EMSN trends in the number of services used per capita.*** (p62).

NAPP contends that, if demand is consistent, then concerns about rising costs are exacerbated by the Government's own policies under the Better Access Scheme that encourages rapid turnover, less treatment, and higher professional fees. Attempts to redress this will fall on patients, who can ill-afford to carry the financial consequences of ill-informed health policy.

The argument by the Health Dept, regarding unequal access in "affluent areas" rests on this: *"To investigate the socioeconomic pattern of OOP costs over the period, we examine the distribution of OOP costs for individuals separately by quintile of the Australian Bureau of Statistics "SEIFA" score of advantage and disadvantage. The SEIFA score estimates relative socioeconomic status of **geographic areas (not individuals)** using information such as income and education from the Census. This analysis was based on **the postcode** of the person as recorded by Medicare Australia**, not on the individual characteristics of the person**. Therefore, the results of this analysis should be interpreted at the group level, not the individual level."*

NAPP makes the following observations:

- Assumptions about individuals, based on SEIFA, seem highly dubious
- Mental illness does not respect geography; ethical practice respects patients
- If it is true that "well off" patients are high users of services, surely the conclusion is that *much more* needs to be done for less affluent suburbs and patients
- The above should not occur at the expense of those patients who just happen to reside in particular locations; all need access

Human Rights

This Bill is said to be compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

Further on page 10 of the Minister's Explanatory Memorandum, it states"… *the right to health is not to be understood as a right to be healthy, but rather entails a right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health"*

NAPP cannot reconcile these statements with The Mental Health Statement of Rights and Responsibilities, 2012. This statement was prepared under the auspices of the Safety and Quality Partnership Subcommittee of the Mental Health Standing Committee of the Standing Council on Health and endorsed by Australian Health Ministers. The proposed Safety Net Bill of 2015, in NAPP's view, completely runs counter to the objectives of The Mental Health Statement of Rights and Responsibilities.

EVIDENCE BASE

Establishing the efficacy of long-term intensive psychiatric treatment has resulted in a growing body of evidence from studies meeting appropriate quality standards that indicate that it is effective, and that initial post-treatment effects tend to improve during follow-up (Sandell, 2012). For example, in the Stockholm Outcome Project (Sandell, 1999), patients receiving long term intensive psychiatric treatment not only demonstrated positive change at the conclusion of treatment, but continued to show improvement at three-year follow-up.

A randomized controlled trial (Bateman & Fonagy, 2001) of individuals with a diagnosis of borderline personality disorder randomly assigned to an intensive day-hospital treatment vs general psychiatric treatment showed that patients in the intensive group made greater gains, relative to controls.

The Sheffield Project (Shapiro et al, 1995) also found evidence for the effectiveness of intensive psychiatric treatment of major depression. There is also impressive outcome data for similarly treating panic disorder (Milrod, Busch & Cooper, 1997; Leichsenring & Rabung 2008).

A study by Leuzinger-Bohleber et al (2002) which involved a large-scale follow-up at 6.5 years after the completion of long term intensive treatment found that 80% patients showed good outcomes in relation to depression and anxiety. Savings were also demonstrated in relation to the use of hospital and outpatient medical treatment of physical symptoms.

Meta-analytic studies, which pool single studies into larger groups of patients, also support the contention that intensive treatment demonstrates significant change at treatment completion, with continued improvements evident at follow-up: deMaat (2009, 2013), Lamb (2004), Leichsenring & Rabung (2008, 2011), and Smit (2012).

The specific domains of personality function that improve with treatment include global psychiatric symptom reduction, target complaints, interpersonal relationships, social and work adjustment, and life satisfaction, with attendant reductions in health care utilization and costs (deMaat, de Jonghe, Schoevers, & Dekker, 2009, 2012; Leichsenring & Rabung, 2008, 2011).

Results drawn from pooling all outcome effectiveness studies indicate that between 60%-90% achieve clinically significant positive change (Bachrach, Galatzer-Lev, Skolnikoff, & Waldron, 1991; deMaat, de Jonghe, Schoevers, & Dekker, 2009; Doidge, 1997, 2001; Fonagy, 2002; Galatzer-Levy, Bachrach, Skolnikoff, & Waldon, 2000). Long term intensive psychiatric treatment is therefore comparable in its effectiveness with a range of commonly used medical treatments (e.g., the 5-year survival for colon cancer varies between 6% -74%; for breast cancer, 22% - 100%).

Recent Finnish studies (Lehtonen 2011) have delineated the interplay between biology and the mind, highlighting the important place of neurotransmitters (serotonin) in mediating states of mind; these are therefore seen to be amenable to long term intensive psychiatric treatment in this study.

Lastly, studies of the effectiveness of cognitive behavioural therapy (CBT) found that CBT was more effective when CBT therapists recruited psychodynamic processes into their treatment (Ablon & Jones, 1998, 1999, 2002), suggesting the specific effectiveness of intensive interventions.

CONCLUSION

NAPP reiterates the following important points, detailed above:

- Many patients need frequent, protracted treatment & consultations
- There are no such persons as “the worried well”
- Reductions in EMSN arrangements can only burden patients
- Burdens accrue from removing the EMSN and reducing existing caps
- Patients will pay more, for longer
- Patients will limit their own treatment
- Expenses will occur in rising PBS costs and hospital / legal costs
- The proposed changes will raise inequity by limiting access to treatment.

RECOMMENDATIONS:

- ***existing arrangements remain,or***
- ***psychiatry Items be exempt from proposed changes, or***
- ***that changes be deferred until the MBS Review Taskforce presents its final Report.***

References

Ablon, J. S., & Jones, E. E. (1998). How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive-behavioral therapy. *Psychotherapy Research*, 8, 71-83.

Ablon, J. S., & Jones, E. E. (1999). Psychotherapy process in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 67:64–75.

Ablon, J. S., & Jones, E. E. (2002). Validity of controlled clinical trials of psychotherapy: Findings from the NIMH Treatment of Depression Collaborative Research Program. *American Journal of Psychiatry*, 159: 775-783.

Anderson, E. M., & Lambert, M. J. (1995). Short-term dynamically oriented psychotherapy: a review and meta-analysis. *Clinical Psychology Review*, 15:503–514.

Australia Institute for Health & Welfare: Australia's health 2014, http://www.aihw.gov.au/australias-health/2014

Bachrach, H., Galatzer-Levy, R., Skolnikoff, A., &Waldron, S. (1991). On the efficacy of psychoanalysis. *J Am Psychoanal Assoc*, 39:871–916.

Bateman, A., & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *American Journal of Psychiatry*, 158:36–42.

Berghout, C.C., & Zevalkink, J. (2009). Clinical significance of long-term psychoanalytic treatment. *Bull Menninger Clin*, 73:7–33.

Berghout, C.C., & Zevalkink, J. & Hakkaart-van Roijen, L. (2010). The effects of long-term psychoanalytic treatment on health care utilization and work productivity and their associated costs. *J Psychiatr Pract*, 16:209–16.

Boyce P. & Harris M. Psychiatric Caseload Project. Department of Human Services and Royal Australian & New Zealand College of Psychiatrists. 1996.

Clarkin, J. F., Foelsch, P. A., Levy, K. N., et al. (2001). The development of a psychodynamic treatment for patients with borderline personality disorder: a preliminary study of behavioral change. *Journal of Personal Disorders,* 15:487–495.

Crits-Christoph, P., & Cooper, A., & Luborsky L. (1988). The accuracy of therapists' interpretations and the outcome of dynamic psychotherapy. *Journal Consulting and Clinical Psychology*, 56:490–495.

de Jonghe, F., de Maat, S., Barber, J. P., Abbas, A., Luyten, P., Gomperts, W., & Dekker, J. (2012). Designs for studying the effectiveness of long-term psychoanalytic

treatments: balancing level of evidence and acceptability to patients. *Journal of the American Psychoanalytic Association, 60*(2): 361-387.

de Maat, S., de Jonghe, F., Schoevers, R., & Dekker, J. (2009). The effectiveness of long-term psychoanalytic therapy: a systematic review of empirical studies. *Harvard Review of Psychiatry, 17*(1), 1-23.

de Maat, S., de Jonghe, F., de Kraker, R., Leichsenring, F., Abbass, A., Luyten, P., & Dekker, J. (2013). The current state of the empirical evidence for psychoanalysis: a meta-analytic approach. *Harvard Review of Psychiatry, 21*(3): 107-137.

Doidge, N. Simon. B.et al. Characteristics of psychoanalytic patients under a nationalised health plan: DSM-111-RDiagnoses, Previous Treatment, and Childhood Trauma. *AmericanJournalofPsychiatry.* 151:586-590,1994.

Doidge N. (1997). Empirical evidence for the efficacy of psychoanalytic psychotherapies and psychoanalysis: an overview. *Psychoanalytical Inquiry*, suppl: 102–50.

Doidge, N. (2001). Is psychoanalysis effective? *Economic Neuroscience*, 2001; 3:41–7.

Fonagy, P. (1996). Target M. Predictors of outcome in child psychoanalysis: a retrospective study of 763 cases at the Anna Freud Centre. *Journal of the American Psychoanalytical Association*, 44:27–77.

Fonagy, P., Kachele, H., Krause. R., *et al*. (2002). *An Open Door Review of Outcome Studies in Psychoanalysis*, 2nd ed. London: International Psychoanalytical Association.

Gabbard, G. O., & Gunderson, J. G., & Fonagy, P. (2002). The place of psychoanalytic treatments within psychiatry. *Archives of General Psychiatry,* 59: 505–510.

Galatzer-Levy R, Bachrach H, Skolnikoff A,& Waldon S. (2000). *Does Psychoanalysis Work?* New Haven, CT: Yale University Press.

Hobson, R. F. (1985). *Forms of Feeling: The Heart of Psychotherapy*. New York: Basic Books.

Høglend, P. (1993). Personality disorders and long-term outcome after brief psychodynamic psychotherapy. *Journal of Personality Disorders*, 7:168–181.

Holmes, J. (2002). All you need is cognitive behaviour therapy? *British Medical*

Journal, 324:288–294.

Jones B & Bradshaw T: Surviving as a Personality disorder service: Psychoanalytic Psychotherapy, 2014, 1 – 21.

Joyce, A. S., & Piper, W. E. (1993). The immediate impact of transference interpretation in short-term individual psychotherapy. *American Journal of Psychotherapy*, 47:508–526.

Lamb, (2004). *A Meta-Analysis of Outcome Studies in Psychoanalysis*. Unpublished Dissertation.

Lehtonen J, Serotonin, vital affects and psychotherapy, University of Eastern

Finland, Lecture, Oct 2011

Leichsenring, F., Biskup J, Kreische R & Staats H (2005). The Gottingen Study of Psychoanalytic Therapy, in *Int J Psychoanal* 2005;**86**:433–55

Leichsenring, F., & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *JAMA,* 300(13): 1551-1565.

Leichsenring, F., & Rabung, S. (2011). Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis. *British Journal of Psychiatry, 199*(1): 15-22.

Leff, J., Vearnals, S., & Brewin, C.R., et al.(2000). The London Depression Intervention Trial. Randomised controlled trial of antidepressants v. couple therapy in the treatment and maintenance of people with depression living with a partner: clinical outcome and costs. *British Journal of Psychiatry*, 177:95–100.

Leuzinger-Bohleber, M., & Target, M. (eds.) (2002). *The Outcomes of Psychoanalytic Treatment.* London: Whurr.

Lonigan, C. J., Elbert, J. C., & Johnson, S. B. (1998). Empirically supported psychosocial interventions for children: an overview. *Journal of Clinical Child Psychology,* 27:138–345.

Milrod, B., Busch. F., & Cooper, A. (1997). *Manual for Panic-Focused Psychodynamic Psychotherapy.* Washington: American Psychiatric Press.

Monsen, J., Odland, T., & Faugli, A. et al. (1995). Personality disorders and psychosocial changes after intensive psychotherapy: a prospective follow-up study of an outpatient psychotherapy project, 5 years after the end of treatment. *Scandinavian Journal of Psychology,* 36: 256–268.

Monsen, J. Odland, T. Faugli, A, et al. (1995). Personality disorders: changes and stability after intensive psychotherapy focusing on affect consciousness. *Psychotherapy Research,* 5:33–48.

Long Term Intensive Psychiatric Treatment:The Impact of Medicare Item 319 and Associated Restrictions on Patients, Psychiatrists and the Community; NAPP Submission, 2003, at www.napp.org.au/

Marston G and Watts R; Tampering with the evidence: a critical appraisal of evidence-based policy making; School of Social Science and Planning, RMIT University, Aug 2002 http://www.rmit.edu.au/browse?SIMID=z6tvp2uchl83&STATUS=A&QRY=tampering%20with%20the%20evidence&STYPE=ENTIRE

NH & MRC. (2013). Clinical Practice Guideline for the Management Of Borderline Personality Disorder. *https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/mh25_borderline_personality_guideline.pdf*

Olfson, M. (1999). Emerging methods in mental health outcomes research. *Journal of Practice Psychiatry and Behavioral Health*. 5:20–24.

Roth, A. & Fonagy, P. (1996). What Works for Whom? A Critical Review of Psychotherapy Research. New York: Guilford Press.

Sandell, R. (1999). *Long-term findings of the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP).* Presented at the Meeting Psychoanalytic Long-Term Treatments: A Challenge for Clinical and Empirical Research in Psychoanalysis; October, Hamburg.

Sandell, R. (2012). Research on outcomes of psychoanalysis and psychoanalysis-derived psychotherapies. Chapter 26, in *Textbook of Psychoanalysis* (2nd ed.).

Shapiro, D. A., Rees, A. Barkham, M., et al. (1995). Effects of treatment duration and severity of depression on the maintenance of gains after cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal Consulting and Clinical Psychology*, 63:378–387.

Slade T, Johnston A, Teesson M, Whiteford H, Burgess P, Pirkis J et al. 2009. The mental health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Canberra: DoHA.

Smit, Y., Huibers, M. J. H., Ioannidis, J. P. A., van Dyck, R., van Tilburg, W., & Arntz, A. (2012). The effectiveness of long-term psychoanalytic psychotherapy--a

meta-analysis of randomized controlled trials. *Clinical Psychology Review, 32*(2): 81-92.

Stanton, A. H., Gunderson, J. G., Knapp, P. H., et al. (1984). Effects of psychotherapy in schizophrenia: I. Design and implementation of a controlled study. *Schizophrenia Bulletin*, 10:520–563.

Stevenson, J., & Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder, *American Journal of Psychiatry*, 149: 358–362.

Stevenson, J., & Meares, R. (1995). *Borderline patients at 5-year follow-up* Presented at the Congress of the Royal Australia-New Zealand College of Psychiatrists. May, Cairns.

Tambs, in Acta Psychiatr Scand 2012: 125: 187–188

Thompson, L. W., Gallagher, D., & Breckenridge, J. S. (1987). Comparative effectiveness of psychotherapies for depressed elders. *Journal of Consulting and Clinical Psychology*, 55: 385–390.

Westen, D., & Gabbard, G. O. (2002). Developments in cognitive neuroscience: I. Conflict, compromise, and connectionism. *Journal of the American Psychoanalytical Association,* 50: 53–98.

Westen, D., & Gabbard, G. O. (2002). Developments in cognitive neuroscience: II. Implications for theories of transference, *Journal of the American Psychoanalytical Association*, 50: 99–134.

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