APPENDIX 1

Faculty of Psychotherapy (Victoria) Submission to the Royal Commission into Victoria's Mental Health System, 2019

APPENDIX 1

CONTENTS

Part 1.

Part 2. Prioritised recommendations for changes within the VPMHS, in order for patient, carer, family and workforce needs to be met, and to ensure the current system safeguards human rights.

APPENDIX 1

Introduction

The Faculty of Psychotherapy is a RANZCP speciality group that promotes the highest standards in academic and clinical aspects of psychiatric (medical) psychotherapy. Accredited members of the Faculty of Psychotherapy are psychiatrists who have completed additional specialist training in psychotherapeutic practice, either via the RANZCP Certificate of Advanced Training in Psychotherapy or an independent psychotherapy institution, or have equivalent experience in the field.

The RANZCP Binational Faculty of Psychotherapy, representing Australia and New Zealand, has 1586 members, comprising psychiatrists, affiliates and psychiatrists-in-training. The Victorian Faculty of Psychotherapy (V-FoP) comprises 17% of the Binational membership, with 266 members. The Faculty of Psychotherapy membership comprises 13% of the total membership represented by RANZCP. The Faculty of Psychotherapy has affiliations with the UK Faculty of Medical Psychotherapy, Royal College of Psychiatrists.

The aims of the Faculty of Psychotherapy are to:

- promote the psychotherapies
- advise on training for psychiatrists in the psychotherapies
- advance and disseminate research in the psychotherapies
- contribute to and promote the highest standards of clinical practice

A psychotherapeutic approach to best practice psychiatry involves the psychiatrist engaging with the patient, meeting them where they are emotionally and psychologically, in developing an understanding together of what has brought the patient to seek help. Psychotherapy is the healing of a patient by establishing a therapeutic relationship with a clinician who can guide them through understanding patterns of responding (thoughts, feelings, behaviours) in their lives leading to helpful changes in thoughts, feelings, attitudes, behaviours, relationships and / or personality (Harari, 2014).

This submission has drawn on the expertise and experiences of faculty members working across the mental health system, both public and private, who are engaged in the;

- specialist primary and secondary assessment of patients for psychotherapy treatments.
- provision of psychotherapy treatments to and for patients across the lifespan.
- delivery of psychotherapy training and provision of supervision to psychiatrists, psychiatrists-in-training and the multidisciplinary team (MDT).
- provision of reflective process groups for psychiatrists, psychiatrists-in-training and the MDT.
- practice of psychiatry in collaboration with other health professionals across multiple health settings, including emergency departments, and general medical and surgical wards.
- advocacy for patients, families and carers in relation to access to psychotherapy treatments, Trauma-Informed Care and Practice (TICP) and psychotherapeutically-informed best practice and holistic psychiatry able to meet patients personalised needs and human rights.

This submission was developed under the auspices of the Victorian Subcommittee of the RANZCP Faculty of Psychotherapy, with all members being invited to make submissions and participate in relevant meetings. This is intended to function both as a ‘stand alone’

document and also to assist with the development of the broader submission developed by the Victorian Branch of the RANZCP.

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APPENDIX 1

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APPENDIX 1

Executive Summary

It is well recognised that there exists a range of evidence-based psychotherapy treatments that support people to recover from mental illness, early in life, early in illness and early in episode, as well as in the context of more chronic and 'treatment-resistant' mental illnesses (Terms of Reference (TOR) #1). Psychotherapy treatments are best practice treatments for a number of mental illnesses (TOR # 2, 2.1). They are the first line treatment for patients[1] presenting with the complex sequelae of trauma, developmental neglect and abuse, often undiagnosed in the Victorian public mental health system (VPMHS) but which can present as "treatment resistance" to biomedical management. Psychotherapy treatments are the main treatments, which address the underlying impairments that result from trauma and neglect and which can complicate recovery from comorbid illness (mental and physical illnesses) and problematic alcohol and drug use (TOR # 1, 2, 2.1, 3, 4, 4.1, 4.2, 4.4, 5). Psychotherapy treatments are person-centred and trauma-informed and can support patients, their carers and families (TOR # 1, 2, 2.1, 3).

The Victorian Faculty of Psychotherapy (V-FoP), with the support of the Binational Faculty of Psychotherapy (FoP), representing the psychotherapies subspecialty of The Royal Australian and New Zealand College of Psychiatrists (RANZCP), submits its profound concerns regarding the lack of availability, accessibility and integration of evidence-based psychotherapeutic or psychotherapy treatments within the Victorian public psychiatric and mental health system (VPMHS).

The VPMHS has changed over time. Historically, psychiatrists worked across both the public and private mental health systems, providing holistic and psychotherapeutically-informed continuity of patient care. Within the last two decades, the VPMHS has become unsafe as a result of increasing pressures; limited resources for psychiatrist staffing, subsequent high psychiatrist caseloads of high acuity (unwell and at risk) patients, and with constant pressures to reduce lengths of patient stay. As a result, the VPMHS has become a system that provides a revolving door of brief, crisis-focused, often restrictive and generally biomedical (medication) interventions that fail to address patients' underlying conditions, which are often trauma-related.
These competing pressures have produced a loss of protected time that is required for psychiatrists to develop essential skills in psychological mindedness and reflective process, which underlie the capacity to be able to hear and respond compassionately and therapeutically to the emotional states and mental health needs of all patients, carers and families and which is a fundamental component of general psychiatric best practice and continuity of care (TOR # 1,2, 2,1, 2.3, 3, 4, 4.1, 4.2, 4.3, 4.4, 5).

[1] V-FoP recognises that there are a variety of preferred terms in use (e.g. "client", "consumer" etc) by different people(s) and organisations, with different backgrounds. We have used the term "patient" throughout this document for consistency and in recognising the historical definition of this term as "one who suffers". Fundamentally, V-FoP recognises that our patients' experiences and words are the most important, and when these can be heard by psychiatrists, can lead to the development of meaningful treatment relationships, recovery and healing.

Instead, the VPMHS is producing a psychiatric culture of diagnosis and medication management lacking in psychological and trauma-informed understandings. It is only when a mental health system (MHS) is psychotherapeutically- and trauma-informed, that it becomes safe for patients, carers, families and also for the workforce, who are otherwise placed at risk of secondary and vicarious traumatisation (TOR # 1, 2, 2.1, 2.3, 2.4, 3, 4, 4.1, 4.2, 4.3, 4.4, 5).

Psychiatrists are increasingly leaving the VPMHS workforce to work solely in the private MHS where psychologically-minded continuity of care and psychotherapy treatments are able to be provided (TOR # 1, 2, 2.1, 2.2, 2.3, 2.4, 2.5, 3). It is only when there is both adequate protected clinical time and the valuing of psychologically-informed continuity of care that a therapeutic relationship between patient and psychiatrist is able to develop, from which meaningful healing can emerge (TOR # 1, 2, 2,1, 2.2, 2.4, 2.5, 3, 4, 4.1, 4.2, 4.3, 4.4, 5) and which also underlies workforce satisfaction (TOR # 2.2).

Not all psychiatrists will become psychotherapists but all psychiatrists need to have adequate skills in psychological mindedness and reflective process, and adequate clinical experiences of multiple modalities of psychotherapy in order to develop expertise in the assessment, diagnosis and informed consideration of which form(s) of psychotherapy is indicated treatment(s) for patients with complex mental health presentations and needs (TOR # 1, 2, 2.1, 2.2, 2.3, 3, 4, 4.1, 4.2, 4.3, 4.4, 5). This benefits patients, carers and families as well as the entire medical system (equivalence of care for public patients, reductions in attendances of patients in crisis to emergency departments and inpatient admissions, reductions in stigma surrounding mental illness and personality disorder (TOR # 1, 2, 2.1, 2.2, 2.3, 2.5, 3, 4, 4.1, 4.2, 4.3, 4.4, 5).

V-FoP welcomes and seeks increasing communication and collaborative engagement between patient and consumer groups and the Victorian psychiatric public mental health system in order to develop and strengthen meaningful person-centred care within trauma-informed, safe, mental health care services (TOR # 1, 2, 2.1, 2.3, 2.4, 3, 4, 4.1, 4.2, 4.3, 4.4, 5).

V-FoP recognises and values the provision of psychotherapy treatments to patients by appropriately-trained psychologists, social workers, occupational therapists, mental health nurses, General Medical Practitioners, and other members of the multidisciplinary mental health team, just as psychiatrist psychotherapists, combining specialist medical, psychiatric and psychotherapeutic trainings, bring a unique skillset to the VPMHS. It is not a matter of psychotherapy being provided by one speciality group or another; there is a need to recognise that different speciality groups bring different expertise to the provision of psychotherapy and can meet different individual patient needs and presentations. Psychiatrist psychotherapists bring understanding and management of complex presentations at the body, mind and relational interface and can provide clinical, supervisory, teaching and management roles across a range of clinical and non-clinical settings (TOR # 1, 2, 2.1, 2.3, 3, 4, 4.1, 4.2, 4.3, 4.4, 5).

The VPMHS, lacking in consistent and equitable provisions for the development and protection of psychological mindedness and reflective process, and failing to provide effective, broadly accessible, trauma-informed psychotherapy treatments does not currently meet patients' human rights "to health" (UN Human Rights Council, 2017) and "to health care" that is "safe and high quality care" (Australian Charter of Healthcare Rights, 2008). There are possible legal implications when the government-provided VPMHS fails to provide internationally-accepted best practice psychiatric and mental health care. There is the

potential for a precedent legal case in the matter of human rights violations when the treatment of an individual patient's underlying condition, is not inclusive of evidence-based, at times first line, psychotherapeutic treatments.

V-FoP calls for the Royal Commission to make the following recommendations to the Victorian government, that it considers are required to bring the VPMHS up to contemporary best practice, able to meet the mental health and human rights' needs of patients, carers and families and in the provision of a safe and satisfying workplace for the workforce (TOR 1, 2, 2.1, 2.2, 2.3, 2.4, 2.5, 3, 4, 4.1, 4.2, 4.3, 4.4, 5).

Summary of Recommendations (TOR 1, 2, 2.1, 2.2, 2.3, 2.4, 2.5, 3, 4, 4.1, 4.2, 4.3, 4.4, 5)

The Victorian government is requested to support, establish and provide ongoing funding for:

Short Term:

1. Enhance and embed core skills of psychological mindedness and reflective process within the VPMHS (pages 39 - 43).
    i) Fund an additional 1.0 EFT Psychiatrist Psychotherapist position at each Victorian Area Mental Health Service to provide multiple roles and functions.
    ii) Fund the development of 2 x 0.5 EFT (1.0 EFT total) Psychiatrist-in-training Psychotherapy positions at each Victorian Area Mental Health Service embedded into areas of need.
    iii) Support the federal valuing and maintenance of MBS provisions that facilitate psychiatrists to provide continuity of care and psychiatric psychotherapy treatments to patients.

Medium Term:

2. Fund and establish specialist multidisciplinary psychotherapy community clinics, providing multiple modalities of best practice evidence-based psychotherapy treatments, with an individualised, whole of life, prevention and treatment focus (pages 44-48).
    i) Ringfence 0.1 EFT each week for psychiatrists-in-training to develop clinical experience in psychologically- and trauma-informed psychotherapy assessment and treatment(s). It is only with protected time in which core psychotherapeutically-informed skills and expertise in psychotherapy provision can be developed, that VPMHS will be able to meet contemporary health and human rights' needs.
    ii) Review funding models, such that training, supervision and research supporting psychotherapy are integrated within best practice rather than excluded from current Activity-Based Funding.

Long Term:

3. Develop a longer-term plan for the realignment and integration of VPMHS service and infrastructure to be a Trauma-informed Care and Practice state mental health system (pages 49 - 50).

APPENDIX 1

Vic. Faculty of Psychotherapy: Submission to the Royal Commission into Mental Health

Part 1:

1. Historical context: Psychotherapeutically-informed processes in the VPMHS

Historically, psychotherapy of different kinds was encouraged and practised within the public mental health system. Many psychiatrists who were consultants in the public MHS saw patients within an ongoing, supportive, psychotherapeutic and psychodynamically-informed framework. There was capacity for greater communication within the system, including between clinician and patient, within the multidisciplinary team and between internal and external parts of the system (inpatient and community services, acute and non-acute services, public and private MHS), and with carers and family members. In this way the patient was known as a person and not just by a diagnostic label; their psychosocial background became clear from the beginning of treatment (TOR # 2, 2.1, 2.2, 2.3, 2.4, 3, 4). This facilitated greater continuity and integration of patient care.

The legacy of deinstitutionalisation has seen the splintering of care across health, mental health, alcohol and other drug services, housing, disability, welfare, criminal justice, and correctional systems (Benjamin et al, 2019).

2. Current issues in the VPMHS: The loss of psychological mindedness & reflective process

Over the last two decades, the VPMHS has become progressively overloaded and under-resourced. The focus has shifted to episodic and acute, crisis-based interventions. Consequent issues include:

- Increasing focus on episodic, typically shorter-term, acute and crisis-based presentations and interventions
- Increasing rates of pharmacological (medication) management, including polypharmacy
- Increasing patient distress and consumer dissatisfaction with psychiatric services
- Increasing use of restrictive practices, including restraint and seclusion, which are (re)traumatising for patients and the workforce.
- Extremely high rates of abuse and trauma suffered by patients while inpatients within the VPMHS, which frequently go unrecognised (includes physical and sexual assaults, verbal intimidation, harassment)
- Devaluation and loss of psychotherapeutically-informed expertise and evidence-based psychotherapeutic treatment modalities from the VPMHS
- Increasing mental health staff distress, burnout and failures in workforce retention
- Failures to adequately understand and address trauma:
    - The complex trauma histories, presentations and needs of patients and their families

- Vicarious traumatisation of staff working with traumatised patients
- The impact of system pressures and under resourcing which transforms the VPMHS into a traumatogenic (leading to / causing trauma) and iatrogenically harmful (a medical system that causes harm) - *unsafe* - system.

These factors produce a range of negative sequelae, including having a detrimental impact on the capacity of patients, their families and carers to develop therapeutic relationships with their treating clinicians in the VPMHS. The relationship between patient and clinician is crucial to patient engagement with services and treatments. The therapeutic relationship positively benefits all aspects of best practice general psychiatric assessment and treatment, as well as underpinning and forming the core of the psychotherapeutic intervention (TOR # 1, 2, 2.1, 3, 4, 4.1, 4.2, 4.4, 5).

When the VPMHS is under pressure, psychologically-informed and reflective process practices within general psychiatric assessment and treatment are often the first components of care that are lost.

"With so many patients in need of care, they (psychiatrists) are pressured to see large numbers of patients for brief, symptom-focused evaluations, rapid initiation of medications, and brief follow-up visits without inquiry beyond the current symptomatic state. In addition, psychiatrists are often pressured into administrative and supervisory positions with much paperwork and minimal time with patients… There is little time for psychotherapy…" (Clemens et al, 2014). This can result in psychiatric assessments that are time pressured and focused on symptoms and diagnosis of disorders, which can miss underlying trauma that is often the central underlying dimension to the patient's presentation and condition. When psychiatrists and the VPMHS workforce are not trained, supported and supervised within models of care that contain and facilitate the understanding of trauma and of overwhelming stress, there is a negative impact on the capacity to think and maintain cohesive team functioning. Assessments that become pressured or focused on a diagnostic agenda, can be experienced by patients as, or become, unempathic.

3. The roles of psychiatrists

Practice standards for mental health practitioners from the National Mental Health Strategy guidelines include:

- Mental health practitioners need to learn about and value the lived experience of consumers, family members and/or carers

- Mental health practitioners should recognise and value the healing potential in the relationship between the consumer and service provider (Department of Health, 2013). (TOR # 1, 2, 2.1, 2.3, 3, 4, 4.1, 4.2, 4.3, 4.4, 5)

Psychological mindedness, reflective process or mentalization (including empathy and understanding of the transference-countertransference) is a core component of the psychiatrist-patient relationship (Holmes, 2007). Mentalization refers to the capacity to 'hold

mind in mind', or to 'see ourselves from the outside and others from the inside' (Holmes, 2006), which is a core capacity that all psychiatrists need to develop to be able to hear and understand the lived experience of patients, family members and / or carers. A capacity for mentalization underlies a psychiatrist's (or other clinician's) ability "to establish a good working alliance with their patients, to cope with the inevitable emotional storms integral to the practice of psychiatry and to be able to examine their own emotional reactions in an inquiring yet non-judgemental way (Allen & Fonagy, 2006). These core qualities of psychological mindedness underpin the capacities for empathy, respect and compassion for others (TOR # 1, 2, 2.1, 2.2, 3, 4, 4.1, 4.2, 4.3, 4.4, 5).

The high pressure, overloaded nature of the current VPMHS is eroding the capacity of psychiatrists and psychiatrists-in-training to develop these capacities and expertise. Training within a VPMHS under pressure produces psychiatrists steeped in repeated exposure to and the prioritising of a biomedical and authoritarian / patriarchal model of care. The rapid increase in short time duration consultations at the expense of longer sessions impairs the patient's capacity to communicate to the psychiatrist their difficulties and concerns, and impairs the capacity of the psychiatrist to listen and develop an understanding of the patient. Furthermore, patients are frequently frightened of others in the VPMHS, and can often feel disturbed by witnessing experiences of direct and/or indirect aggression and/or violence. There are deficits in workplace safety for both patients and the VPMHS workforce.

The role of psychiatrists is initially one of assessment and "the capacity to develop a psychological formulation is central to this task" (Denman, 2010). "If a diagnosis is a label, a formulation is more like a story (and) … gathers up all the biological, psychological and social factors that have led to a person becoming unwell and considers how these factors interconnect. In doing so, it provides clues to the pathway out of suffering…. If a diagnosis is a stamp, a formulation is more like a fingerprint, unique to each individual" (Pryor, 2019) (TOR # 1, 2, 2.1, 4, 4.1, 4.2, 4.4, 5). A formulation is an understanding that is arrived at between psychiatrist and patient; it fosters and underlies development of the therapeutic relationship, which will underpin the duration of treatment.

A comprehensive medical, psychiatric and psychotherapeutically-informed training, in which core skills in psychological mindedness, reflective process and mentalization are facilitated to develop, enables a psychiatrist to develop biopsychosocial formulations (collaborative and complex understandings of each individual patient's presentation), which can guide to appropriate treatments for that person at this point in time. These can include, depending on the formulation, the concurrent, integrated treatment of medication and psychosocial interventions; these include the psychotherapies, lifestyle and self-regulation practices such as exercise, social connection, meditation and mindfulness practices. This is commonly required for patients that are severely ill and / or presenting with complex comorbid needs and reduces costs (TOR # 1, 2, 2.1, 3, 4, 4.1, 4.2, 4.4, 5).

Best general psychiatric practice includes skills and developed capacities in psychological mindedness and reflective process, which emerge from psychotherapeutic models of understanding and care. These core psychological skills inform and underpin multiple

aspects of psychiatrists' roles, including learning; to combine psychotherapeutic and pharmacological interventions; to understand specific theories and techniques of supportive therapy for people with major mental illness looked after over extended time periods; the acquiring of skills needed to work with people suffering from severe personality disorders (Bateman & Fonagy, 2004, Meares et al, 2012); to understand and learn to work with, often in a leadership role, the group dynamics of multidisciplinary teams; and being able to model and teach reflective psychotherapeutic psychiatric practice to a wide range of medical and non-medical trainees and members of the MDT. There is some experience in other Australian jurisdictions that support for a trauma-informed psychodynamic model in acute care teams supports staff to support patients (Moloney et al, 2018). Implicit within this is the need for psychiatrists who have had adequate training and clinical experience in the provision of psychotherapeutic treatments to take the lead in developing and providing psychotherapy training for psychiatrists (Holmes et al, 2007, Haliburn et al, 2017) (TOR # 1, 2, 2.1, 2.2, 2.3, 2.4, 3, 4, 4.1, 4.2, 4.3, 4.4, 5).

The chronically pressured state of the VPMHS is negatively impacting the capacity of psychiatrists to develop holistic, psychologically-minded and psychotherapeutically-informed best psychiatric practice and expertise.

Responses from patient, consumer and carer groups suggest a shared experience of feeling that psychiatrists are not listening to their concerns or needs. The current state of burden and inadequate resourcing within the VPMHS requires that psychiatrists treat a large, rapidly changing number of acutely and severely ill patients, often with pharmacological and restrictive measures. There is little time for assessment and treatment beyond risk assessment, basic diagnosis and commencement and monitoring of psychotropic medications. This, in conjunction with the progressive devaluation and loss over time of psychotherapist psychiatrists from the VPMHS, is negatively affecting the capacity of psychiatrists to develop clinical expertise in attuned listening, psychologically-minded and psychotherapeutically-informed reflective process. Without significant VPMHS reform (as per the recommendations made in this document), there will be further diminution of this skill set with flow-on negative effects for patient, carers, families and the mental health workforce, both public and over time, in the Victorian private mental health system also.

This may be because reflective and psychotherapeutically-informed skills and processes are regarded as time-consuming when the focus in public psychiatry is on rapid discharge and patient turnover. However, this is false economy when research evidence shows that psychotherapeutic treatments reduce the number of hospital admissions, attendance at hospital emergency departments, use of psychotropic medication, readmission rates, suicidal and self-harming behaviours (see Contents, Part 1, sections 7, 8, 9 & 10). A psychotherapeutic approach involves the clinician engaging with the patient, meeting them where they are emotionally and psychologically, in developing an understanding together of what has brought the patient to seek help. This is very different to approaching the patient with clinician-led screening questions and assessment tools designed to elicit symptoms and risk. Time is required however for clinicians to develop skills and expertise in a psychotherapeutic approach.

Psychotherapy conducted by psychiatrists centres on a holistic approach to mental illness based on medical training, psychological insight and clinical experience. Psychiatrists are uniquely versed in the clinical conditions that present as mental illness because they are trained in the biological sciences as well as in the social, cultural and interpersonal dimensions of mental illness. Having both medical and psychiatric training provides a breadth and depth of exposure to severe, complex and comorbid (medical and psychiatric) conditions, particularly in patients with personality disorders, co-occurring problematic alcohol and drug use and histories of trauma, which is not provided by any other training (TOR # 1, 2, 2.1, 2.2, 4, 4.1, 4.2, 4.4, 5).

4. Trauma-Informed Care and Practice (TICP)

Patients accessing mental health services have higher rates of experiencing trauma in life in general. It is especially pronounced in the year prior to their contact with services (Kessler et al 2010; Mauritz et al 2013). Assessment and care planning in the VPMHS must include awareness of the profound ways trauma can affect us all. Trauma needs to be taken into account as a broad subjective experience, understood within a wider social, political and generational context. Its affects are cumulative and cross-generational (Shevlin et al, 2008), often obscuring the link between current psychiatric presentations and the experience of traumatic events. The effects of early childhood trauma, often experienced through parental attachments, can shape the neurobiology of generations to come (Siegel 1999, 2012; Yehuda et al 2016). This makes the care of children, pregnant woman and young families a major priority (TOR # 1, 2, 2.1, 3).

Without an awareness of the complexities in psychiatric presentations, overpowering and controlling practices can lead to higher risk of retraumatizing patients as well as negatively affecting the mental health of professionals via vicarious trauma from compassion fatigue, countertransference and burn-out (Jackson, 2003; Schauben and Frazier,1995; Rotstein et al, 2019). Trauma is costly in both human and economic terms. Economic costs can include lost employment, presenteeism (being at work but not functioning well), reduced productivity and the necessary provision of mental health and other services (McCrone et al, 2008) The real impact, however, is on people and society.

Addressing these issues within our VPMHS requires a shift in paradigm. Providing time, space and resources to protect and foster the development of the therapeutic relationship, psychotherapeutic alliance and continuity of trauma-informed care and practice in the VPMHS, along with strong psychotherapy training within psychiatric training programs, can “transform service users experience from (re)traumatisation and iatrogenic harm to building trust, connection and hope” (Sweeney et al, 2018) (TOR # 1, 2, 2.1, 2.2, 2.4, 3, 4, 4.1, 4.2, 4.4, 5).

Research emerging from the neuroscience of relational trauma and dissociation indicates that clinicians need to consider the safety of their patients, and also themselves, in the provision of all trauma-related care. Under-recognition of the potential for ‘vicarious traumatization’ of psychiatrists and psychotherapists working with traumatised patients can

lead to risks for both staff and patients within the VPMHS (McCann and Pearlman, 1990, Isobel and Angus-Leppan, 2018). Evidence suggests that staff who are exposed to numerous critical incidents (violence of patients towards self and others etc) without sufficient emotionally-attuned support have high rates of job dissatisfaction, burnout, vicarious trauma and possible mental health disturbance. This also contributes to issues in workforce retention. Historically, there was a greater provision for psychotherapeutic reflective process within the VPMHS, available to psychiatrists-in-training individually in supervision and for staff / multidisciplinary groups, which facilitated the containment of patient, staff and system anxieties and (dis)stress (TOR # 2.1, 2.2). The absence of protected time and space for reflective practice and adequate emotional containment, in conjunction with a high pressure, overburdened, and trauma-uninformed system produces a VPMHS that is unsafe for patients, carers and the workforce. In contrast, psychodynamic approaches to acute psychiatric team management have led to better supported staff and better patient outcomes (Moloney et al, 2018). In NSW and in some Victorian centres, psychotherapy educator positions for psychiatry training have been developed, in recognising the centrality of psychotherapy training but also its diminution within the VPMHS.

With developed understanding of psychodynamics and clinical expertise in reflective process and psychological and emotional containment, psychiatrists trained in psychotherapy are in a key position to supervise and teach junior doctors and trainees, facilitate understanding of complex cases, and build multidisciplinary team cohesion, thereby helping to prevent vicarious trauma in the team (Cammell et al, 2016) (TOR # 1, 2, 2.1, 2.2, 2.4, 3, 4, 4.1, 4.2, 4.3, 4.4, 5).

“Trauma-informed care is an emergent paradigm in mental health and human service delivery… (stemming from) the recognition that trauma is highly prevalent, that most clients who access the public mental health system have trauma histories and that the current organisation of health and human services does not reflect this reality and is inadequate to cope with it” (Jennings, 2004). Trauma-Informed Care and Practice (TICP) has not yet been integrated within current psychiatric and mental health practice and will need to be a part of contemporary mental health system reform (TOR # 1, 2, 2.1, 2.2, 2.3, 2.4, 3, 4, 4.1, 4.4, 5).

TICP can be defined as “an approach which recognises and acknowledges trauma and its prevalence, alongside awareness and sensitivity to its dynamics, in all aspects of service delivery” (Mental Health Coordinating Council, 2017). Grounded in a comprehensive understanding of the biological, neurological, psychological, and social effects of trauma and interpersonal violence, it involves “not only changing assumptions about how we organise and provide services, but creates organisational cultures that are personal, holistic, creative, open and therapeutic” (Mental Health Coordinating Council, 2017).

TICP rests on a foundational understanding of the impacts of trauma. This contrasts with the biomedical model of psychiatry and mental health, which emphasises symptoms and deficits and is therefore inherently pathologising. The strengths-based approach of TICP

emphasises the adaptive function of behaviours which may otherwise be regarded as signs of pathology and treated with medication. This leads to a paradigm shift from asking the patient '*what is wrong with you?*' to asking '*what has happened to you?*' (Sweeney et al 2018) (TOR 1, 2, 2.1, 2.4, 3, 4, 4.1, 4.2, 4.4, 5).

APPENDIX 1

Five Key Principles of Trauma-Informed Care & Practice (TICP)(TOR # 1, 2, 2.1, 2.3, 2.4, 3, 4, 4.1, 4.2, 4.4, 5).

Safety	Emotional, Relational, Physical, Environmental (in service settings)
Trustworthiness	Interpersonal trauma impairs the development of capacity for trust. The principle of trustworthiness requires service sensitivity to client needs at all levels of contact, and attentiveness to ways in which the reliability of the service is consistently conveyed to clients, so that genuineness and predictability can be expected (fundamental for the development of trust).
Choice	Services should provide options to clients at all the levels at which it is possible to do so, while taking care not to overwhelm the client. These includes choices regarding biological / pharmacological, psychological / psychotherapeutic, social and culturally-appropriate treatments.
Collaboration	The principle of collaboration requires consistent imparting to clients of a sense of “doing with” rather than “to” or “for”.
Empowerment	The capacity for the client to be able to exert influence over their immediate surroundings and to be part of the treatment planning process.

TICP perceives the worlds of the patient and the health system through a trauma-informed lens; this allows attunement to how institutions may re-enact trauma dynamics inadvertently, producing secondary traumatisation of patients and aims to minimise this risk. The physical, psychological and emotional safety of (trauma) survivors / patients and of care providers / the workforce are emphasised and prioritised (TOR # 1, 2, 2.1, 2.2, 3, 4, 4.1, 4.2, 4.4, 5).

The core dimension central to TICP and psychotherapeutic work is the creation and strengthening of relational attachments intentionally aiming to repair the past in the day-to-day experience of relationships in the present. “Time is required to allow the power of attuned, sensitive, and secure therapeutic relationships to heal the hurt that traumatised children and adults - overrepresented in consumers of the public MHS - carry with them” (Benjamin et al, 2019). Neural networks within the human brain change in a use-dependent manner in response to external stimuli, where repeated experience is required to underpin such change (Perry and Szalavitz, 2006) (TOR #1, 2, 2.1, 3).

RANZCP and the Binational Faculty of Psychotherapy is currently in the process of developing a Position Statement in regards to TICP. Psychiatrist psychotherapists in the RANZCP Binational and State Faculties of Psychotherapy are increasingly seeking the production of a RANZCP Clinical Practice Guidelines on the Assessment and Treatment of Trauma-Related Syndromes (including Complex-PTSD and other sequelae of childhood sexual abuse, as well as cumulative trauma (whereby other incidences of trauma, such as assault, physical abuse, emotional abuse, bullying etc occur for a person who has already experienced developmental trauma)).

APPENDIX 1

The Victorian Royal Commission into Mental Health will need to consider the recommendations emerging from the recent Royal Commission into Institutional Responses to Child Sexual Abuse and with particular reference to the National Redress Scheme and how the VPMHS is able to meet the psychological and psychotherapeutic needs of Victorian survivors and within a complex trauma-informed paradigm. “As was made plain by the work of the Royal Commission, unless the origin of a patient’s psychiatric condition is established, it may not be possible to provide an effective clinical response to the patient’s problems… the Royal Commission was convinced that a better understanding of the role of trauma in psychiatric illness and the development of trauma-informed responses are essential” (Benjamin R, 2019).

5. Consequences of the loss of core psychiatric psychotherapeutic expertise from the VPMHS

- Impairment in the capacity to understand the patient through a developmental, systems and psychologically and psychotherapeutically-informed, emotional and relational lens. When patients speak of not feeling heard, it is often this deeper psychologically-minded understanding of their difficulties which is absent.

- Acute and community-based public mental health and psychiatric care in which psychiatrists train and develop their core professional skill set is becoming disjointed, episodic and increasingly biomedically and medication-focused. Psychiatrists in both the public and private MHS are increasingly seeing patients for single or short-term assessments with little or no ongoing support and management. This results in the production of a generation of psychiatrists, in the public and private MHS, that have not developed capacity for the provision of continuity of holistic psychiatric care.

- Psychiatry is progressively becoming synonymous with diagnosis and medication management. While this is a fundamental part of the psychiatric role and expertise, “...the limitations of diagnosis must be recognised. Diagnosis can at times lead to unhelpful labelling, diminishing the agency of the affected person, promoting a reductionist perspective, and over-simplifying and under-valuing complexities of personal circumstances” (Patel et al 2018). There is an emerging body of literature that psychiatry needs to move beyond diagnostic classification systems, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) used in Victoria, towards a staging approach to the classification and treatment of mental disorders and that there should be further research into how to recognise diversity within a system of classification (Patel et al, 2018).

- Societally, patients are increasingly reluctant to consult a psychiatrist because of their expectation that they will primarily be provided with a potentially reductionistic and stigmatising diagnosis, and / or medication. This often results in delayed diagnosis and treatment that can result in the worsening of the person’s condition. The current VPMHS is limited in its capacity to value and provide psychologically- and trauma-informed

assessment, formulation and patient diagnosis from which sophisticated psychiatric understandings of which biopsychosocial treatments might be suited to each individual patient can develop. There can be significant pressures to have psychiatrists excluded from the psychosocial aspects of patient assessment and care to the detriment of both psychiatrists and their patients, carers and families. There can be pressure for psychiatrists to spend time only on assessment of symptoms, diagnosis and medication prescription and management. There is pressure for psychiatrists to see as many patients as possible for diagnostic assessment and medication prescription with no recourse for follow-up or role in ongoing care. Not only are there profound implications for patient care in these situations, which would become compromised, but movement in this direction would lead to escalating workforce dissatisfaction, increasing vicarious traumatisation of the workforce and burnout. When the 'person' of the patient and the therapeutic treatment relationship are lost from the system, it becomes a dehumanised and dehumanising system, both for patient and clinician.

- The loss of valuable psychiatrist psychotherapist leadership, supervision, emotional support and containment of other psychiatrists, psychiatrists-in-training, the multidisciplinary team, staff within the broader medical system (emergency departments, medical and surgical wards), patients, carers and families. (RANZCP Victorian Psychiatry Workforce Report, 2017)

- Not only is it consumer, patient and carer groups that are increasingly dissatisfied with the VPMHS, but psychiatrists also, who are dissatisfied with the constraints of the VPMHS, which impairs or prevents psychiatric capacity to provide evidence-based psychotherapeutically-informed psychiatric assessment and management. Psychiatrists are leaving the VPMHS workforce in order to be able to provide psychotherapeutically-informed assessment and treatment to patients in the private mental health system. Psychiatrists who are trained and able to practice psychotherapeutic modalities of treatment express high work satisfaction, which is often reflected in the responses of their patients. "Investment in psychotherapy in the public sector may contribute to retention of psychiatrists in the public sector" (RANZCP Victorian Psychiatry Workforce Report, 2017) (TOR # 1, 2, 2.1, 2.2)

- The current VPMHS is producing psychiatrists with little exposure and training in psychological mindedness, trauma-informed care and practice, reflective process, as well as assessment for and / or the provision of the psychotherapies as part of general holistic / comprehensive best psychiatric practice. The current VPMHS, in which psychiatrists are trained, is failing psychiatrists as well as patient and carer groups.

The current situation, which has developed over time, is one in which there is extremely limited or no access to psychotherapeutic treatments within the Victorian public mental health system.

- Access to the structured brief and shorter-term psychotherapies is possible but access is extremely limited despite a substantial evidence base.

- RANZCP psychiatric training requires that psychiatrists-in-training are facilitated to provide a single course of 40 sessions of psychodynamic psychotherapy to one patient within their five year (minimum) training in the public MHS. Typically, the patients accessing the public MHS have severe mental illnesses, often with multiple comorbidities. Often the level of severity and comorbidity prevents these patients from accessing this training psychotherapy despite it being an evidence-based treatment for their presenting illness(es) or difficulties. Patients can also at times require durations of psychodynamic psychotherapeutic treatment longer than 40 sessions. Constraints within the over-burdened public MHS do not generally allow for this limited access, limited number of treatment sessions to be extended. Premature discharge from psychological treatment, without the capacity to adjust treatment to meet the patient's individual needs, can be damaging for patients.

- There is currently no access to longer term non-structured psychodynamic and psychoanalytic psychotherapies, able to be individually tailored to meet patient's needs, despite a substantial positive evidence base (both clinically and in economic analyses, see Sections 7, 8, 9), within the VPMHS.

This is in stark contrast to the availability of a diversity of psychotherapy treatments in the urban regions of the Victorian private MHS, including psychotherapy treatments for individuals, mother-baby / parent-child, couples, families and in group settings, across multiple modalities, structured and unstructured, brief, short, medium and longer term.

There is a failure of equivalence of care between the Victorian public and the private MHS within Victoria. Patients who are unable to financially access the private Victorian mental health system are unable to access, often first-line evidence based psychotherapeutic treatments. The current public VPMHS does not facilitate patients with economic strain, often a consequence of mental illness, to access potentially healing psychotherapeutic treatments. Typically, these patients require more sessions than are currently accessible via the Better Access Scheme, and some patients will require both the specialist expertise that psychiatric training brings to psychotherapeutic treatment provision, as well as the psychotherapy treatment being fully or mostly funded by the public system.

6. What is psychotherapy?

Psychotherapy is the healing of a patient by establishing a therapeutic relationship with a clinician who can guide them through understanding patterns of responding in their lives leading to helpful changes in thoughts, feelings, attitudes, behaviours, relationships, or personality (Harari, 2014) (TOR # 1, 2, 2.1, 3, 4, 4.1, 4.2, 4.4, 5).

Psychotherapy can be provided by appropriately credentialed practitioners from various disciplines, including psychologists, social workers, occupational therapists, mental health nurses (MHN) as well as specialist general practitioners (GPs). Psychiatrists who have specialised in psychotherapeutic practice bring together their expertise as medical doctors,

psychiatrists and specialist psychotherapists, enabling psychotherapeutic treatments to be provided to patients who typically present with complex needs. A large proportion of the patients who see psychiatrists have experienced trauma (Dunne et al, 2005).

Psychiatrist psychotherapists typically see patients with significant biopsychosocial complexity, including but not limited to complex trauma, personality disorders, 'treatment-resistance', eating disorders, and comorbid medical health issues, which benefit from these multiple areas of professional expertise (TOR # 4.2, 5). The patients who see psychiatrist psychotherapists for specialist psychotherapeutic intervention tend to be more unwell, more chronically affected by their difficulties and with higher levels of risk than patients who attend non-medical, non-psychiatrist psychotherapists. Training in the public MHS, in which psychiatrists develop significant experience working with and holding the primary care and medicolegal responsibilities for very unwell and high-risk patients, underlies the expertise brought to psychiatric psychotherapeutic assessment and treatment provision.

Psychotherapy should form a key component of every psychiatric treatment. For some patients, it will be appropriate for their psychotherapeutic treatment to be provided by an appropriately credentialed psychologist, social worker, occupational therapist, mental health nurse (MHN) or GP, however many patients will require the additional expertise that a psychiatrist psychotherapist has developed. "Research has consistently demonstrated that, even in the most disordered of our patients, the addition of psychotherapy to the treatment regimen provides more successful treatment outcomes" (Kay & Myers, 2014) (TOR 1, 2, 2.1, 4, 4.1, 4.2, 4.4, 5).

7. What are the psychotherapies?

Psychotherapies are psychological treatments that can be conducted with individual patients, couples, families, and groups. Psychotherapy treatments can be brief / short term, medium and at times, for specific patients and needs, longer-term although V-FoP recognises there is a reality to treatments in the VPMHS needing to have a time-limit.

There are a diverse range of psychotherapeutic treatment modalities, both structured and unstructured, that have different symptom and patient foci. These include:

CBT: Cognitive Behavioural Therapy	*DBT: Dialectical Behavioural Therapy*
SFT: Schema Focussed Therapy	*TFP: Transference Focused Psychotherapy*
MBT: Mentalization Based Therapy	*CAT: Cognitive Analytic Therapy*
ERP: Exposure Response Prevention	*EMDR: Eye Movement Desensitization & Reprocessing*
Psychoeducation	*ACT: Acceptance & Commitment Therapy*
Supportive Psychotherapy	*Family Therapy, Parent-Infant / Child Psychotherapy*

APPENDIX 1

Conversational Model Psychotherapy	*Relational Psychotherapy*
Art Therapy	*Music Therapy*
Somatosensory / Sensorimotor Psychotherapy	*Psychodrama*
Social and life skills group therapies	*Motivational Interviewing*
STDP: Short Term Dynamic Psychotherapy	*LTPP: Long Term Psychodynamic Psychotherapy*
PIT (Psychodynamic Interpersonal Therapy)	*PAP: Psychoanalytic Psychotherapy*
Group therapy (structured / psychodynamic / psychoanalytic)	*Psychoanalysis*

All psychotherapeutic treatments are based upon and underpinned by the development of a safe and trusting therapist-patient relationship, which is vital to psychological growth and recovery from mental illness. There is a significant evidence base for the role of this secure attachment in facilitating and underlying healthy emotional and physical development across the lifespan. Psychotherapies have whole-of-life foci and have been developed and can be tailored to meet specific needs from infancy (infant and mother / parent-dyad therapies) and with benefit into older age. Longer term psychotherapies can help to repair attachment and foster recovery and wellbeing (TOR # 1, 2, 2.1, 3, 4, 4.1, 4.4, 5).

Supportive psychotherapy is fundamental to psychiatric treatment for patients with severe mental illnesses, including psychotic disorders and can not only prevent deterioration in mental health but can lead to improvement in quality of life and development of trust in the treating team and MHS. Psychiatrists are the members of the workforce who predominantly provide long-term treatment for these patients. They need specialist medical, psychiatric and psychotherapeutic experience and training to do so (TOR # 1, 2, 2.1, 3, 4.2).

Patients with developmental histories of trauma and abuse by ‘care-givers’, superimposed by other later traumatic experiences, usually require longer-term, more intensive psychotherapeutic treatments to become able to form secure attachment relationships. This is increasingly recognised within public MHS internationally with 1 - 2 years of longer-term psychotherapy treatments being made available and being demonstrated to be cost-effective with compared to costs from hospital attendances and psychiatric admissions (see Part 1, section 8). This cohort of patients may require and benefit from engagement with multiple different modalities of psychotherapeutic treatment (both structured and non-structured psychodynamic psychotherapies) across the course of their illness. The different modalities of psychotherapy target different symptoms and can offer differing outcomes (TOR # 1, 2, 2.1, 4, 4.2, 4.4, 5).

Psychodynamic and psychoanalytic psychotherapies are therapeutic processes that aim for deep seated change in personality and emotional development. They aim to help people with serious psychological disorders to understand and change complex, deep-seated emotional and relationship problems thereby reducing symptoms and alleviating distress.

This process helps patients gradually to identify these patterns and to develop the capacity to understand and change them (British Psychoanalytic Council, 2004). Patients with complex and longstanding difficulties, especially those firmly entrenched in their personality and often with their origins in childhood trauma, will probably require longer term psychoanalytic psychotherapy to make significant gain (Gabbard, 2005, Stevenson and Meares, 1992). This cohort of patients can often be labelled 'treatment-resistant'. They comprise a significant proportion of the multiple attendees and utilisers of emergency and VPMHS (crisis teams, outreach, inpatient admission), with significant economic costs.

It is problematic to apply the label of "treatment-resistant" when patients have not been offered nor adequately trialled the evidence-based psychotherapeutic treatments. A proportion of these patients can go on to make significant gains in the psychodynamic psychotherapies not currently available in the VPMHS (Haliburn J, 2016; Fonagy et al, 2015). The current system is failing this cohort of patients and their families (TOR 1, 2, 2.1, 3, 4.4, 5).

The prevailing biomedical model takes at face value the manifest behaviours of an individual; there is little regard for underlying psychodynamic explanations that can develop an understanding of the meaning of patients' behaviours and the context in which they have developed. As such, the biomedical model is unable to explain the crises generated by trauma, leaving the vacuum to be filled by reactive, often coercive psychiatric practices. In this culture, a distressed person with a trauma history is often misdiagnosed, as behaviours conditioned by trauma arise in reaction to environmental stressors and present in ways that can be pathologized as psychiatric symptoms (Herman, 1992; Harrison and Fowler, 2004; Lysaker and LaRocco, 2008, Benjamin et al, 2019). Psychiatric misdiagnosis can set a person on the wrong treatment pathway for life, with personal but also family and potentially transgenerational consequences.

Cost-benefit economic analyses demonstrate financial savings resulting from the provision of longer-term psychotherapies, which can reduce patient emergency department presentations (often for treatment of deliberate self-harm and suicidality) and acute mental health services inpatient admissions (Lazar, 2014) (See Part 1, section 8) (TOR # 1, 2, 2.1, 2.4, 3, 4, 4.1, 4.2, 4.4, 5).

The means by which psychotherapeutically-informed treatments may help to reduce emergency department presentations and acute inpatient admissions include better "containment" for the patient and family, and improved capacity to manage risk by the VPMHS service (TOR # 1, 2, 2.1, 2.3, 3). "Containment" is a technical term which refers to the complex ways in which a patient and their family may be able to feel supported, valued and understood by their professional care-givers, in such a way that they can feel safe between appointments and can know how to seek and find help and safety. The capacity for containment depends on deep understanding of the patient and their family context, and an ability for the professional care-givers to manage their own feelings of fear or anxiety about the patient (Hinshelwood RD, 1999) (TOR # 1, 2, 2.1, 3). This understanding in turn affects the capacity of the professional care-givers to feel confident that they can cope with and

influence ongoing risks, especially chronic suicidal risks. In the absence of these understandings service providers too often resort to referral to emergency departments, crisis teams or for acute admission, as a short-term way of managing risk defensively. These reactions can be counterproductive for the patient and family, as they can undermine confidence in the care-givers, especially when acute hospital admission may in itself be traumatic (TOR # 2.3, 3).

8. Funding of the psychotherapies: Evidence from economic analyses (TOR # 2.4)

Not only clinically effective, psychotherapy is an often highly cost-effective intervention for many serious psychiatric conditions. Additionally, "patients with chronic, complex, and/or recurrent psychiatric illness have more medical conditions and higher medical costs… These patients can often be treated with psychotherapy that yields better mental health and overall health outcomes" and psychotherapy can lead to savings not only in mental health but in other medical and societal costs (Lazar SG, 2014).

Cost effectiveness is the financial cost of a treatment as it relates to specific outcome measures of effectiveness; impact per dollar spent. It does not include the cost of treatment but includes what society is willing to pay for an outcome. "While 'cost-effective' treatments can yield savings in healthcare costs, disability claims, and other societal costs, 'cost-effective' by no means translates to 'cheap' but instead describes treatments that are clinically effective and provided at a cost that is considered reasonable given the benefit they provide, even if the treatments increase direct expenses" (Lazar SG, 2014).

The Bigger Picture: Costs

The costs of mental health disorders and associated childhood trauma in terms of mental health, physical health and to society are immense. The ACE study showed dramatic links between adverse childhood experiences (ACE) and unhealthy behaviours and impairments in physical and mental health leading to increased risk of disability, premature mortality and lasting effects on brain structure and function, with intergenerational transmission of risk (Anda R 2019; Brown DW et al 2009). The economic burden of ACE includes health care costs, productivity losses, child welfare costs, violence, crime and forensic costs, special education costs, suicide deaths and Quality Adjusted Life Years lost.

In the USA, "The estimated average lifetime cost per victim of nonfatal child maltreatment is $210,012 in 2010 dollars, including $32,648 in childhood health care costs; $10,530 in adult medical costs; $144,360 in productivity losses; $7,728 in child welfare costs; $6,747 in criminal justice costs; and $7,999 in special education costs. The estimated average lifetime cost per death is $1,272,900, including $14,100 in medical costs and $1,258,800 in productivity losses. The total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment … in 2008 is approximately $124 billion. In sensitivity analysis, the total burden is estimated to be as large as $585 billion" (Fang X et al 2012). The average lifetime cost for victims of non-fatal childhood sexual abuse is approximately US$300,000

(Brown DS et al 2011). The economic burden of childhood maltreatment in East Asia and the Pacific region was estimated at US$194 billion, accounting for up to 2.52% of the region's GDP (Fang X et al 2015).

In Australia, the annual budgetary cost of unresolved childhood trauma is estimated to be as high as $24 billion (Kezelman C et al, 2015).

Pegasus economics estimate a cost of $5281 to the Government budget from each suicide and / or suicide attempt in Australia; $14.35 billion / annum total cost of alcohol abuse to society; $27 billion annual Government expenditure related to depression; and $56 billion spent in direct and indirect costs relating to overeating and obesity (Kezelman C et al, 2015). Alcohol and drug use and overeating, categorised in the Blue Knot Foundation paper as negative outcomes, "are common compensatory behaviours, which provide immediate partial relief from the emotional problems caused by traumatic childhood experiences. The chronic life stress of these developmental experiences is generally unrecognized and hence unappreciated as a second etiologic mechanism" (Felitti VJ and Anda RF, 2010). "Evidence presented before the Royal Commission into Institutional Responses to Child Sexual Abuse demonstrates that most survivors have experienced at least two negative outcomes from their prior abuse. ASCA's 1300 data analysis established that of those reporting the impacts of their abuse, 72% had experienced multiple impacts" with cumulative costs (Kezelman C et al, 2015). V-FoP directs the Royal Commission to the Blue Knot Foundation publication, "The cost of unresolved childhood trauma and abuse in adults in Australia" for these details and recommendations as to how to reduce these costs (Kezelman C et al, 2015).

Addressing child sexual, emotional and physical abuse alone could lead to a potential minimum gain of $6.8 billion for the combined Federal, State and Territory Government budgets. The minimum gain from addressing the problem of childhood trauma more generally is estimated at $9.1 billion and this relates "mainly to costs impacting taxation and government spending… The estimate does not include the intangible costs such as pain and suffering" (Kezelman C et al, 2015).

Mental Health Disorders in Australia are the leading cause of non-fatal disability with 1 in 4 years lived with a mental health or substance use disorder. A current mental illness was associated with an average of one lost day from work and three days of reduced performance in the month prior to the survey. Lost work productivity due to mental disorders, such as personality disorders and substance-related disorders, contributes a loss of AUD $2.7 billion each year (Project Air Strategy for Personality Disorders, 2015).

Economic benefits and cost-effectiveness of psychotherapy treatment:

Provision of psychotherapeutic treatments have demonstrated significant savings and other economic benefits in relation to healthcare costs, disability claims and other societal costs (Lazar SG 2014; Meuldijk D et al 2017, Project Air Strategy for Personality Disorders 2015; Brazier J et al 2006; Brettschneider C et al 2014).

APPENDIX 1

There is research indicating psychotherapy is both clinically effective and cost-effective for patients with personality disorders, depression, comorbid depressive depression, anxiety disorders (including PTSD, panic, phobic, obsessive-compulsive, and generalised anxiety disorders), substance misuse and substance use disorders, schizophrenia, as well as for children and adolescents with learning disorders and severe psychiatric disorders (Lazar SG, 2014). In the management of schizophrenia, several modalities of psychotherapy have demonstrated to be both effective and cost-effective by restoring function and decreasing relapse and medical costs (Lazar SG, 2014).

Patients with personality disorders are among the most chronically impaired patient groups, are unemployed for longer periods, have more drug problems, suicide attempts, criminal behaviour, child abuse, and heavy use of general and mental health care with significant societal costs (Lazar SG, 2014). There are a number of psychotherapies that are clinically effective and cost-effective for patients with personality disorders, including Borderline Personality Disorder (BPD), Antisocial Personality Disorder and Narcissistic Personality Disorder. The factors that contribute to the cost-effectiveness of extended intensive psychotherapy for these patients include savings from decreased sick leave, decreased medical costs and decreased hospital costs (Lazar SG, 2014). Patients treated with Long Term Psychodynamic Psychotherapy (LTPP) with a mix of diagnoses showed substantially reduced health care use and sick leave (Lazar SG 2014). The positive effects of LTPP persist after treatment termination and after three years, costs of treatment were counterbalanced.

Adding psychotherapy to psychotropic medication yields significant health gains and is more cost-effective than medication alone. Psychotherapy can enhance the cost-effectiveness of psychotropic medications both by increasing compliance and also in terms of reducing admissions (Lazar 2014). “Psychotherapy for the medically ill with concomitant psychiatric illness often lowers medical costs, improves recovery from medical illness and improves mental health outcomes, and at times even prolongs life compared to similar patients not given psychotherapy” (Lazar SG, 2014). While psychoanalysis is costlier to provide, it has been demonstrated to be more effective from a health-related quality perspective with decreased consumption of health care, higher work productivity and greater long-term economic benefits (Berghout et al, 2010; Beutel M et al, 2004).

Research into the cost-effectiveness of therapy for Personality Disorders:

Much of the research regarding cost-effectiveness of the psychotherapies has been conducted in relation to treatments for patients diagnosed with personality disorders, as patients with these diagnoses tend to be high service users with subsequent high service utilisation costs. There is a marked need for further research into the cost-effectiveness of psychotherapeutic treatments for patients across many areas of need.

Intensive appropriate psychotherapy for patients with Borderline Personality Disorder is not only clinically efficacious but can result in reduced clinical need for medications, resulting in reduced prescriptions (Broadbear JH et al, 2016) with potential for reduced PBS costs. Grenyer et al 2018 noted that providing specialist long term evidence-based approaches for

treating BPD has significant cost benefits with the decrease in hospital service length of stay and decreased presentation to hospital led to a savings of USD$2,720 per year.

Despite the length of treatment involved, the available economic data is very promising.

In 1999, an Australian study looked at thirty individuals (19 female, 11 male) treated psychotherapeutically (psychodynamic interpersonal conversational method) for one year, with two sessions each week (Stevenson J and Meares R, 1999). The cost for hospital admission for the thirty patients across the twelve months prior to the psychotherapy intervention was $684,346, ranging from $0 to $143, 756 / patient. The cost of hospital admission twelve months after the psychotherapy intervention was $41,424, ranging from $0 to $12,333 / patient. For the thirty patients there was a decrease of inpatient costs of $642,922, which represents an average decrease per patient of $21,431. Using the schedule fee and assuming two visits per week for fifty weeks, the estimated cost of psychotherapy is approximately $13,000 per patient or about $390,000 for the cohort. This represents a total saving of $253,000 or a saving per patient of $8431. In 2005, a further five-year outcome study was published. Except for one measure, the improvements evident one year following treatment were maintained four years later (Stevenson J et al, 2005). An economic study showed that the state saved about AUD$8000 per patient in the year following treatment. A more comprehensive study, including patient's use of emergency, ambulatory services, diagnostic services, and medications, showed a saving of just over AUD$18,000 per patient. It is not unreasonable to suppose that this economic benefit was continued to the 5 year mark (Stevenson J et al, 2005).

This study is referenced by The NHMRC Clinical Practice Guideline for Management of Borderline Personality Disorder (2012) along with data from UK clinical trials that suggest MBT with partial hospitalisation was potentially more cost-effective than treatment as usual and that CBT was unlikely to be more cost-effective than other treatments in people with BPD.

The Project Air Strategy (2015) sought to improve the capacity of mainstream mental health services to manage and treat personality disorders and to expand specialist treatment options, including improved referral pathways between generic and specialist treatment. The project delivered education and supervision programs in addition to the provision of expert psychotherapeutically-informed and psychotherapy interventions. Key outcomes of the pilot included presentations in Emergency Departments significantly reduced and admissions and length of stay in hospitals significantly reduced. One year of psychotherapy was associated with an average decrease in inpatient costs of AUD$21,431 per patient with BPD. Findings suggest a suitable psychotherapy treatment cost for BPD will save the State at least AUD$8000 per patient a year following therapy.

In a more recent article, Grenyer et al, 2018 noted that providing specialist long term evidence based approaches for treating BPD has significant cost benefits. In their program, the decrease in hospital service length of stay, decreased presentation to hospital led to a savings of USD$2,720 per year.

APPENDIX 1

A systematic review and cost offset analysis of economic evaluations of psychological treatment for BPD was published in 2017 (Meuldijk 2017). It included 30 economic evaluations providing cost data related to interventions for BPD across 134,136 patients and had good methodological quality. The mean cost saving for treating BPD with evidence-based psychotherapy across studies was US$2988 per patient per year. A further mean weighted reduction of US$1551 per patient per year (range $83 - $29392) was found compared to TAU. Evidence based psychological treatment was both less expensive as well as more effective. The mean cost saving for treating BPD with evidence-based psychotherapy across studies was US$2988 per patient per year (Meuldijk 2017).

An analysis in 2014 of the projected costs of treatment for BPD in Europe demonstrated a cost benefit ratio for treatment of BPD of 1.52, meaning that for each Euro invested, 1.52 can be generated within a year and there were benefits to the QALYS (Wunsch EM et al, 2014).

Supervision

In another section of this submission, the important role for reflective supervision has been highlighted. Good reflective supervision may have positive quantitative economic impacts both in terms of positive workforce impacts as well as in improved clinical outcomes. This would be an area that could substantially benefit from further research.

9. What psychotherapeutic practice can contribute to the VPMHS: Evidence

In Australia, New Zealand and internationally, the cost of mental illness to the community in both human and economic terms is growing (Hosie et al, 2014). Many psychiatric conditions are complex and severe, and involve significant comorbidity. Many require psychotherapy, including intensive longer-term treatments, which has been demonstrated to be cost-effective when compared to the costs of multiple hospital emergency attendances and psychiatric inpatient admissions (Stevenson et al, 2005) (TOR # 2.4). Intensive psychotherapeutic treatment has been shown to diminish symptoms, improve occupational function, the capacity to engage in personal relationships, positive self-esteem and wellbeing (Wilczek et al, 2004). People who have received psychotherapy have decreased vulnerability to relapse and their recovery is sustained (TOR # 1, 2, 2.1, 4, 4.2, 4.4, 5).

Psychotherapy is an important component of the overall treatment for low prevalence disorders such as schizophrenia and bipolar disorder. Equally, psychotherapy is an important component of the treatment of high prevalence disorders such as anxiety, depression and substance abuse (TOR # 1, 1, 2.1, 4, 4.1, 4.2, 4.4, 5). These disorders often occur at a time when individuals are establishing their own families and the potential for transgenerational transmission of mental health problems is at its highest (TOR # 3). The high prevalence disorders may be as debilitating and disruptive as the psychoses, for patient, carers, family and community.

APPENDIX 1

The perception that psychodynamic and psychoanalytic approaches lack empirical support does not accord with available scientific evidence. Psychodynamic psychotherapy benefits individuals who present with depression, eating disorders, panic, somatoform disorders, substance-related (alcohol and other drug) disorders, personality disorders (including Borderline and Narcissistic) and some forms of anxiety (Fonagy, 2015; Shedler, 2010; Leichsenring, 2005; Milrod et al., 2007). Psychodynamic psychotherapies have demonstrable efficacy for a variety of high and low prevalence disorders as well as benefiting symptoms such as suicidality. These psychotherapies are equipped to respond to symptoms such as patient despair, which is associated with increased rates of suicide (TOR # 1, 2, 2.1, 4, 4.1, 4.2, 4.4, 5).

Psychotherapy has been found to be superior to treatment-as-usual and the benefits of psychotherapy not only endure but increase with time, a finding that has now emerged from at least five independent meta-analyses (Abbass et al., 2006; Anderson and Lambert, 1995; de Maat et al., 2009; Leichsenring, Rabung and Leibing, 2004) (TOR # 1, 2, 2.1). In keeping with increasing and enduring benefits over time, economic analyses demonstrate reductions in service utilisation costs over time in these cohorts (See Section 8) (TOR # 2.4).

The empirical evidence for the efficacy of psychotherapy for a wide range of mental health problems is very strong with the effect size between treated and untreated individuals produced by quantitative reviews ranging from 0.6 to 0.8 (Smith and Glass, 1977; Wampold, 2007). In general, outcomes for different psychotherapies are equivalent and no form of psychotherapy has proven superior to any other (Fonagy, 2015; Pampallona et al., 2004; Beutler, 2009; Wampold, 2010). Evidence shows psychotherapy to be more effective than antidepressant medications (Levy et al, 2014). Shedler (2010) cites two major antidepressant meta-analyses as demonstrating effect sizes of 0.31 (Turner et al 2008, synthesising 74 studies) and 0.17 (Moncrief et al, 2004, 9 studies). This should be compared with effect sizes for psychodynamic therapy as cited by Shedler of between 0.78 and 1.8, and for CBT of between 0.58 and 1.0 (TOR # 1, 2, 2.1)

More than 40 meta-analyses have been conducted on the outcomes of patients who have depression (Cuijpers and Dekker, 2005) with results indicating that most psychological treatments that have been studied produce substantial effects in terms of symptom reduction and increased well-being (Cuijpers et al., 2008). Research examining the relative effectiveness of psychotherapy versus medication has generally found similar benefits (Hollon, 1996; Fonagy, 2015) and in depression, adding psychotherapy to the medication treatment regime can improve patient outcomes (Pampallona et al, 2004) (TOR # 1, 2, 2.1, 4, 4.2). Evidence that depressive and anxiety disorders often respond more reliably to psychotherapeutic intervention than to medications is frequently neglected (Levy et al, 2014). Some studies suggest psychotherapy can produce better responses to medication (McKay et al, 2006) (TOR # 1, 2, 2.1, 4, 4.2).

Longer-term psychodynamic psychotherapy (one year and longer) benefits individuals with complex disorders and a high level of vulnerability to psychopathology (Caspi et al, 2013; Patalay et al, 2015). In the treatment of patients with Borderline Personality Disorder (BPD),

a number of studies have shown maintenance of improvement for at least five years after long-term psychotherapy (RANZCP Position Statement 54, 2019) (TOR # 1, 2, 2.1, 5). Novice therapists, for example psychiatrists-in-training with limited psychotherapeutic experiences, can be trained to provide effective psychodynamic treatment (Stevenson and Meares, 1992; Haliburn and Baker, 2014; Barkham et al 2017).

Evidence is accumulating that, in order to be effective, interventions for treatment-resistant depression may need to be longer and more complex than first-line treatments of depression (Hollon and Ponniah, 2010) and that follow-ups should be longer (Rawlins, 2008) with enduring improvement in depression scores and greater improvements on measures of social adjustment (TOR # 1, 2, 2.1).

Of the limited psychotherapy provided in the VPMHS (itself a fundamental issue), there has developed an overrepresentation of Cognitive Behavioural Therapy (CBT) across the last decade. CBT has a strong evidence base in the treatment of many mental disorders. Access to training and provision in this form of psychotherapy, while possible, is still inadequate to meet patient and psychiatrist needs. It is important to note however that some researchers dispute the evidence base that exists for CBT over the other psychotherapies (Cuipers P, 2016; Kazadin A, 2007). Claims of the superiority of CBT over other treatments have been challenged (Wampold et al, 2017; Johnsen et al, 2015). Concerns have been raised about flaws in the methodology of CBT research and that CBT research inaccurately represents other therapies as ineffective. There is research that suggests the Cochrane criteria may not be applicable to or may distort the clinical relevance of psychotherapy research (Leichsenring et al, 2015).

It has been noted also that the therapeutic alliance, which supports effective CBT is based on principles and practices of attunement, fostered in psychodynamic psychotherapy (Leahy, 2008; Kazantzis et al 2017). When the problem-solving approaches within CBT treatment become “stuck”, it can be a clinical indicator that the application of a trauma-informed psychodynamic approach is required. For some patients, the focus on symptoms can be experienced as a failure of clinicians to recognise their individual person.

Building the capacity to research multiple aspects of the psychotherapies - for example effective components and / or outcomes of psychotherapeutic treatments - into the VPMHS would be a valuable component to system reform (TOR # 2.4, 2.5). This is currently hampered by not only a specific lack of training and funding for research but also by Activity Based Funding that does not remunerate clinical research and training time. A review of funding models, such that training, supervision and research supporting psychotherapy are integrated within best practice rather than excluded from current Activity-Based Funding, is required.

There is a need also to develop understandings as to what early-life mental health services and psychotherapeutic interventions most effectively reduce lifespan vulnerabilities to mental illness associated with early-life adversity and trauma, e.g. childhood exposure to parental mental illness, family violence / breakdown, parental substance abuse, parental criminality,

poverty, educational problems, migration, caregiver absence, neglect or abuse (TOR # 2.5).

10. Suicide & Self-harm: Roles for the Psychotherapies

One of the most challenging areas of mental health care assessment and treatment is that of suicidality and self-harming behaviours. Research and reviews have tended to focus on public and doctor education, media approaches, screening at risk populations, restricting access to suicide means, treatments, and internet support or hotlines (Zalsman, et al, 2016). A 2016 review in the Lancet found that psychodynamic and “integrative” psychotherapies had level 4 evidence of support in suicide prevention, while there was greater interest in, and therefore support for, interventions involving Cognitive Behavioural Therapy (CBT) and Dialectical-Behaviour Therapy (DBT) (Zalsman, et al, 2016). In adolescents, a metanalysis found that psychotherapies were of benefit regarding self-harm, especially those with multiple sessions which had a family component (Ougrin, Tranah, Stahl, Moran, & Asarnow, 2015)

The presence of active suicidal ideation (thoughts) and / or behaviours in an individual and also the experience of near or completed suicide for those remaining behind is distressing for patients, carers, families, and communities. The assessment of states of self-harm and suicidality require comprehensive, reflective approaches and expertise.

Suicide is usually the outcome of an emotionally-charged process. Suicidality is more complicated than ‘feeling depressed’ and the failure to recognise and treat this reality is one of the main reasons for failed treatments, ‘treatment resistance’ and suicide in mental illness.

Suicidality - suicidal states of mind and behaviours - can develop amidst states of significant distress, emotional pain and desperation, which can be precipitated by a recent loss, conflict or anniversary. There can be histories of chronic and /or complex trauma or more recent traumatic experience(s) which are felt to exceed the individual’s coping resources and supports. Sometimes, the precipitating event is clear and the person's distress is readily apparent, but at times, feeling ashamed can lead people to hide their pain and distress, and act on their impulse; grieving friends and family members may feel shocked that they ‘didn’t see it coming’. Suicidality can emerge amidst experiences of anger and rage, hopelessness, helplessness, experiences of rejection and / or abandonment, as well as blame of oneself or of others and grievance. There can be an experience of personal unworthiness, which can deteriorate into a sense of disintegration of one’s sense of self (Briggs S 2010; Goldblatt M 2014). In either case, the suicidal individual typically feels a sense of despair driven by feelings of isolation, disconnection, meaninglessness and can feel that 'No-one really understands' (Plakun EM 1994; Kernberg OF 2003).

The experience of feeling misunderstood can be exacerbated by assessment in which the clinician relies on a categorical 'risk assessment' checklist (Briggs S, 2010). While useful, these tools are limited in their ability to understand deep emotional torment and the ambivalence that can co-exist when suicidality is present. It is via the psychotherapeutic assessment and unfolding therapeutic relationship that the deeper meaning and emotional

dimensions of a patient's self-harm and / or suicidality can become elaborated and addressed (Briggs S 2010; Goldblatt M 2014).

Clinical research informed by psychodynamic psychotherapies has identified a number of stages, each with characteristic features, where psychodynamic psychotherapy has particular contributions to make, which enable the patient to feel understood by the clinician; this in turn arouses hope that help is possible. An empathic, psychotherapeutic approach can allow emotional contact to be made with suffering individuals, facilitate individualised assessment at depth, guiding and underpinning emotionally-attuned therapeutic interventions, which can not only save lives but engage the person in psychotherapeutic, and at times multidisciplinary and multimodal treatment, from which further healing can become possible.

A psychodynamic and trauma-informed psychotherapeutic approach can be useful at various stages of suicidality:
1. Pre-crisis, as a preventative measure, when past traumas and current stressors can be sensitively elicited, discussed and worked through.
2. At times of crisis, when sensitive, non-judgemental listening might reach a person in despair and allow for the development of an experience of not feeling alone.
3. Post suicide attempt, when there can be a heightened recognition of the level of distress and an opportunity to review and potentially work through unresolved issues.

Given the prevalence of suicidal ideation (thoughts) and action in patients presenting to mental health services, it is essential that psychiatrists-in-training and the MHS workforce receive adequate quantity and quality of training in psychotherapeutic approaches to presentations of suicidality and self-harming behaviours. Clinical and theoretical teaching and experiences in psychodynamic understandings of suicide and self-harming behaviours adds to the quality of clinical services in every area of the mental health system, from inpatient unit, to community clinic, from emergency department and crisis services, to medical and surgical ward where patients might be admitted after attempted suicide or self-injury for medical treatment (Robertson J, 2018).

Reducing Suicide and Self- Harming Behaviours in People with Borderline Personality Disorder

Borderline personality disorder (BPD) is the unfortunate name of a serious mental illness involving severe emotional pain and high levels of suicidal and self-harming behaviours. Many clinicians, carers, and people with BPD have advocated changing this name because of its pejorative connotations. The favoured alternative title is Complex Post Traumatic Stress Disorder (CPTSD), which shares many - but not all - features of BPD. CPTSD applies to those cases in which the effects of chronic childhood trauma on the developing brain and personality are paramount. The fact that some cases of BPD have no history of childhood trauma and that around 50% of its aetiology has been linked to genetic factors involving inborn temperament has been a significant factor precluding change to the diagnostic nomenclature in the main classificatory system, the Diagnostic and Statistical

Manual (currently DSM-5) (American Psychiatric Association, 2013).

BPD occurs in around 1% of the general population in Australia, with one study of people aged 24-25 years finding a prevalence of 3.5% (National Health and Medical Research Council, 2012). The rate of completed suicide in this serious mental illness lies between 4-10% (National Health and Medical Research Council, 2012), while suicidal ideation is pervasive and chronic in most cases. Suicidal behaviours, including suicide threats and attempts that do not result in death are much more common than completed suicide. 80% of people with BPD make at least one suicide attempt in their lifetime, while many make multiple attempts (National Health and Medical Research Council, 2012). Suicidal behaviours are evidence of the severe degree of emotional pain people with BPD experience. Clinical experience has shown that completed suicide is more likely to occur in states of despair, particularly when an individual has given up hope of getting help with their suffering or feels abandoned by others.

Psychotherapy is the primary and principal treatment for BPD (National Health and Medical Research Council, 2012) yet access to psychotherapy in Victoria is limited, particularly in the public sector. Research over more than 20 years has shown that the rates of suicide and self-harming behaviours in BPD significantly decrease usually within the first 12 months of BPD- specific psychotherapeutic treatments, and that these rates further reduce over time (McMain S et al, 2012; Bateman A & Fonagy P, 2009; Doering S et al, 2010). Other features of BPD (including emotional dysregulation, impulsivity, number of inpatient days, frequency of attendance at ED's, levels of anxiety and depression), also decrease in the course of effective psychotherapy for BPD during the first 12 months of treatment in most cases. It is important to note that effective treatment for BPD always includes a psychotherapeutic approach and can be provided by mental health clinicians who have not received training in any of the BPD- specific modalities of psychotherapy, but have been trained to employ the factors common to those treatments and receive adequate quality and quantity of clinical psychotherapy supervision while providing the treatment (Bateman A & Krawitz R, 2013). Psychotherapy for BPD is needed for over a minimum of 12 -18 months in most cases. However, many cases of BPD require a longer course, while others need a further course or courses of psychotherapy or supportive interventions over time.

Deliberate self-harm occurs in 75-80% of cases of BPD (Doering S et al, 2010). Forms of self-harm include cutting, head banging and burning, the latter with cigarettes or more damaging means. Self-harming actions are aimed at reducing unmanageable emotional distress. It has been shown that these behaviours lead to the release of endorphins in the body which has a pain-relieving effect. They can also cut across unbearable dissociative experiences, induce dissociation to relieve pain, and replace unbearable emotional pain with physical pain, in addition to the behaviour's many possible psychological meanings (eg expressing anger or hatred of self or other, punishing self or other, letting out inner badness, among many others).

The BPD-specific empirically validated psychotherapies include Dialectical-Behaviour treatment (DBT), Mentalization-based treatment (MBT), Transference-focused

psychotherapy (TFP), Schema-focused therapy (McMain S et al, 2012; Bateman A & Fonagy P, 2009; Doering S et al, 2010). Structured psychotherapeutic approaches that include the factors common to these specific modalities have been shown to be roughly equivalent to the BPD-specific treatment modalities in efficacy (Bateman A & Krawitz R, 2013). As mentioned above, 'Common Factors' treatments can be conducted by experienced mental health clinicians who lack specialised psychotherapy training but receive adequate quality and quantity of education and psychotherapy clinical supervision during the provision of treatment.

Given the evidence, it is an indictment of public mental health services in Victoria that access to effective psychotherapy for BPD is so limited. While some Victorian area mental health services offer access to DBT or more rarely MBT, access to these treatments is dependent on patients living in the area of the service. Effective psychotherapy should be accessible for all with BPD who need it.

BPD responds well to treatment. As mentioned above, studies show that when suicidality and self-harming behaviours decrease in response to effective treatment and that the decrease is maintained and further increases over time. Psychotherapy for BPD also decreases inpatient days, attendance at emergency departments, and improves patients' quality of life (McMain S et al, 2012; Bateman & Fonagy, 2009; Doering S et al, 2010; Bateman A & Krawitz R, 2013). The availability and accessibility of effective psychotherapy for people with BPD is of profound importance to reduce the suffering and improve functioning of people who otherwise experience severe, often unremitting, emotional pain.

11. VPMHS Workforce issues

The recent Victorian Workforce report found that there was "insufficient funding for psychotherapy services in the public sector", that there was "a lack of recognition within the public sector of the value of psychotherapy in the healing process" and that a "diminution of psychotherapy services in the public sector is affecting trainee access to training and supervision in psychotherapy" (RANZCP Victorian Psychiatry Workforce Report, 2017).

Psychiatrists and other highly-trained clinicians leave the VPMHS to work psychotherapeutically in the private system. This reduces the pool of clinicians with psychotherapeutic expertise available to provide assessment of complex patients, as well as psychotherapeutic treatment. It results also in the reduction of psychiatrist psychotherapists available in the VPMHS to provide support, supervision, teaching and leadership roles for psychiatrists-in-training and the multidisciplinary team.
Lack of exposure to psychotherapeutically-informed continuity of psychiatric care in the VPMHS-based psychiatric training program means that psychiatrists moving into and working in the private MHS can lack these skills. There is a lack of developed expertise and confidence also in competently providing psychotherapeutic treatments. This might be part of the steady and continuing rise in psychiatrist use of MBS item number 291 (MBS item number 291 refers to assessment, diagnosis and treatment recommendations made by a psychiatrist in one single consultation with a patient) (Department of Human Services,

2019a). The psychiatrist doing this assessment does not undertake further treatment of the patient. Additionally, the current MBS financially incentivises psychiatrists to provide these single session assessments, in addition to (for other patients) briefer (shorter time duration) and less frequent treatment sessions. Related to these factors, there has been a diminishment in psychiatrist use of psychotherapy-related MBS item numbers inclusive of 306, 316 and 319 (MBS item number 319 typically signifies ongoing twice weekly or more frequent psychotherapeutic treatment of complex and more severely disturbed patients) (Department of Human Services, 2019b, Department of Human Services, 2019c, Department of Human Services, 2019d). MBS item numbers 306, 316 and 319 are a life line to accessing psychiatric psychotherapeutic treatment in the private mental health system for many severely ill patients, often diagnosed with personality disorders, who have histories of complex trauma, seeking and needing evidence based longer-term, more intensive psychiatric psychotherapy with a specialist psychiatrist psychotherapist.

Often these patients suffer from severe personality disorders / sequelae of complex developmental trauma, psychotic disorders / vulnerability to psychotic deterioration, eating disorders (anorexia nervosa, bulimia nervosa), treatment resistant mood and anxiety disorders, substance-related disorders, somatoform disorders, comorbid medical illness(es) etc and who are only able to access psychotherapeutic treatment in the private MHS via psychiatrist psychotherapists. In part, this relates to the requirement for psychiatrist attendance-linked Medicare MBS numbers and safety net rebates, often as a consequence of psychosocial and occupational impairment. These patients are often not able to afford to access psychotherapeutic treatments provided by appropriately-trained non-medical psychotherapist psychologists, social workers, OTs etc in the private MHS, who do not have access to longer term / ongoing MBS rebates. Secondarily however and separate to access to MBS rebates, these patients typically have mental health presentations of marked complexity and often with significant comorbidity and risk that benefit from and can require the expertise and complex skill set of psychiatrist psychotherapists (TOR # 1, 2, 2.1, 4, 4.2, 5). “The psychiatrist is the only professional whose differential diagnosis includes consideration of medical conditions, with appropriate referral, who can prescribe psychotropic medications… and who also provides psychotherapy” (Clemens et al, 2014) (TOR # 1, 2, 2.1).

Without access to MBS rebates and psychiatric psychotherapeutic treatment conducted by private MHS psychiatrist psychotherapists, many of these patients would require treatment in the VPMHS, resulting in increases in costs secondary to emergency department presentations and psychiatric inpatient admissions.

The Victorian Faculty of Psychotherapy envisions the current lack or shortage of access to longer term non-structured psychodynamic psychotherapies provided by psychiatrists in the VPMHS will be reflected in the Victorian private MHS within the next two decades without significant systemic and psychiatric training reform. This has already been demonstrated in the US and “...surveys show a steady and alarming decline in practice of psychotherapy by psychiatrists, along with a decline in job satisfaction” (Clemens et al, 2014).

APPENDIX 1

12. Misconceptions:

- All mental illness is treated by medication.
- The role of the psychiatrist is medication management.
- Psychotherapy is the domain of psychologists.
- Psychotherapy is a treatment for “the worried well”.
- There is one-size-fits-all psychotherapy.
- Patients are ‘treatment resistant’ when they have not been able to access or engage in evidence-based psychotherapeutic treatment(s).
- Psychotherapy can be provided by clinicians without significant experiential skills development and without adequate frequency and quality of supervision.
- Patients who fail to respond to one modality of psychotherapy should not be offered other forms of psychotherapy.
- Only one form of psychotherapy might be required to treat a patient.
- All psychotherapies are long term.

13. The need to align the VPMHS with contemporary international human rights

The current limited provision of psychotherapy in the VPMHS creates a system of inequality. Patients with complex trauma, treatment-resistance, comorbidity, personality disorder and many other presentations generally need regular and longer-term psychotherapeutic treatment, which is usually only accessible to those able to afford treatment in the private system.

The UN Special Rapporteur report on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (the right to health) emphasized that “a human rights approach to health implies the incorporation of the principles of non-discrimination, accountability, participation and empowerment, and the need to go beyond the narrow biomedical model so that holistic, equitable and ethical care is provided to the population, in particular to those in most need” (UN Human Rights Council, 2017) (TOR # 1, 2, 2.1, 2.4, 4, 4.1, 4.2, 4.3, 4.4, 5).

The current VPMHS, under significant pressure and workload, typically only has capacity to provide a biomedical model of treatment. “Overreliance on pharmacological interventions… is inconsistent with the principle of doing no harm, as well as with human rights”. “While psychotropic medications can be helpful, not everyone reacts well to them and in many cases they are not needed. Prescribing psychotropic medications, not because they are indicated and needed, but because effective psychosocial and public health interventions are not available, is incompatible with the right to health (UN Human Rights Council, 2017) “Psychiatry without a psychological perspective is arguably in danger of degenerating… (and) risks becoming social care with added coercion” (Denman, 2010).

APPENDIX 1

There is a need for intervention to restore and protect psychological-mindedness and reflective process in psychiatry. Further, there is a profound need for the funding and provision of accessible psychotherapeutic treatments within the VPMHS on a large scale (TOR # 1, 2, 2.1, 2.4, 3, 4, 4.1, 4.2, 4.4, 5). To be fit for purpose, these would be situated off site from acute inpatient psychiatric units, and provided from separate outpatient community clinics. Patients would attend voluntarily. The centres would provide training for psychiatrists-in-training (and members of the MDT) in psychotherapeutic clinical skills and expertise, which would be completed during protected time increments and as part of mandatory psychiatric training (TOR # 2.2, 2.3, 2.4, 2.5).

The failure of the Victorian government to provide publicly available and broadly accessible trauma-informed psychotherapeutic treatments is a breach of the Australian Charter of Healthcare Rights, which emerged from the Australian Commission on Safety and Quality in Healthcare 2008. The Australian Charter of Healthcare Rights indicates that all Australians have a “right to health care”, and a ”right to receive safe and high quality care” (Australian Commission on Safety and Quality in Health Care, 2008). The current VPMHS, lacking in broadly accessible, developmentally and psychotherapeutically-informed modalities and frameworks for management, which align with trauma-informed care, fails to provide medical care that is safe and in which patients are protected from retraumatisation.

Given that psychotherapeutic treatment is the first line evidence-based treatment for many psychiatric presentations, especially trauma-related syndromes and personality disorders (TOR # 1, 2, 2.1), the current VPMHS fails to meet this standard. The lack of provision and accessibility of psychotherapeutic treatments, which recognise the impact of trauma on the development of personhood and identity, is in breach of the person’s “right to be shown respect, dignity and consideration” (Australian Commission on Safety and Quality in Health Care, 2008). There is a failure of consideration of the persons of our patients when this aspect of treatment is not provided.

The current system, with deficits in the capacity for psychologically-minded general psychiatric treatment and lacking in specific individualised psychotherapeutic treatments that “works with the person first”, representing “the humane side of psychiatric care” (Clemens et al 2014) fails to meet Section 10 of the Victorian Charter of Human Rights and Responsibilities (Victorian Charter of Human Rights and Responsibilities, 2006). There is a breach of the patients’ right to “protection from …cruel, inhuman or degrading treatment” (Victorian Charter of Human Rights and Responsibilities, 2006).

The Victorian Government Solicitor’s Office states that while “no specific definitions of ‘cruel, inhuman or degrading’ treatment…. are present in the International Covenant on civil and political rights (ICCPR) or the Torture Convention …the following principles have been established through international jurisprudence regarding the scope of this prohibition”:

- “Degrading treatment is treatment that humiliates or debases a person… it is treatment that shows a lack of respect for a person, or diminishes a person’s dignity

and causes feelings of fear, anguish or inferiority capable of breaking a person's moral and physical resistance."

- "Ill treatment may involve both physical and mental pain or suffering, however there is no specific requirement that severe pain be inflicted."
- "It is not necessary for the harm to be intentionally inflicted."
- "To be within the scope of prohibition, the harm must be carried out by a … person acting in an official capacity; however, the purpose for which it was carried out is immaterial" (Victorian Government Solicitor's Office, 2017).

Listening to patients and psychiatrists' experiences of treatments in the VPMHS, these are not uncommon experiences. One psychiatrist writing of her dissatisfaction… and burnout working in the VPMHS, stated "*It was a dehumanising experience, for me as a psychiatrist, and I believe for the patients and other clinicians. The agendas of the system and the participants (staff, patients) on the surface resemble each other but in essence they are different*" (deidentified professional submission to the Victorian FoP, 2019). "Respecting the autonomy of persons with mental disabilities necessitates 'our own emancipation from institutional thinking and practice'' (Cosgrove et al 2019 referencing Mezzina et al, 2019). Psychiatrists can and do leave the VPMHS in order to provide a different quality of care in the private MHS but for many patients, this is not possible.

In a recent precedent case in the USA, *David Witt, et. al. v. United Behavioral Health (UBH)* (Wit v United Behavioural Health, 2017), the United States District Court for the Northern District of California found that UBH "illegally denied mental health and substance use coverage" when it "used internally developed medical necessity guidelines that comprehensively fell short of accepted standards of care" (American Psychiatric Association, Psychiatric News Alert, 2019). Judge Spero outlined that "accepted standards call for… effective treatment (which is defined as the requirement of) ...treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms", "Effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration", that "appropriate duration for … health disorders is based on the individual needs of the patients; there is no specific limit on the duration of such treatment" and that "the determination of the appropriate level of care for patients with mental health and / or substance use disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient" (TOR # 1, 2, 2.1).

Judge Spero wrote "... the Court finds, by a preponderance of the evidence, that in every version of the Guidelines in the class period, and at every level of care that is at issue in this case, there is an excessive emphasis on addressing acute symptoms and stabilizing crises while ignoring the effective treatment of members' underlying conditions", indicating the scope of treatment provided did not meet that "consistent with generally accepted standards of care". "…the court recognized that mental and substance use disorders are chronic illnesses and rejected the insurer's practice of treating patients only for acute symptoms" (American Psychiatric Association, Psychiatric News Alert, 2019). The parallels with the current VPMHS are evident.

APPENDIX 1

The current VPMHS discriminates against patients presenting with personality disorders, complex trauma, treatment-resistance, comorbidity etc who are for the most part unable to access evidence-based psychotherapeutic treatments, which are only minimally or not available in the VPMHS.

For patients with the sequelae of complex trauma, often diagnosed as having personality disorder, especially Borderline Personality Disorder (BPD), psychotherapeutic treatment is the first-line evidence-based treatment (TOR # 1, 2, 2.1) and yet is largely unavailable in the VPMHS. The National Health and Medical Research Council (NHMRC) published clinical practice guidelines for the management of Borderline Personality Disorder in 2012. The NHMRC guideline made a consensus-based recommendation that for most people with Borderline Personality Disorder, effective treatment with a structured psychological therapy can be provided within mainstream public or private community-based mental health services, via individual appointments (with or without group sessions), by therapists with access to peer consultation and clinical review (National Health and Medical Research Council, 2012). It is extremely difficult for the many patients who are unable to access or afford this treatment in the private MHS to access such treatments in the VPMHS.

A precedent legal case against the Victorian government in the matter of human rights violations is possible when the currently provided VPMHS fails to provide accepted standards of psychiatric care, inclusive of evidence-based psychotherapeutic treatments that address the individual's underlying condition, often trauma-related.

Psychotherapeutic treatment, within a therapeutic relationship that offers a secure continuity of care, is the only treatment that addresses the underlying core emotional and relational sequelae of complex trauma (TOR # 1, 2, 2.1). The Victorian government's failure to provide adequate and accessible, first line evidence-based psychotherapeutic treatments for serious mental illness would not be accepted in other medical specialties. In the VPMHS, patients typically have to deteriorate to states of significant self-harming and / or suicidality before becoming able to access case management and / or psychotherapeutic treatment, itself available in very small numbers and typically time-limited.

Currently, there is one person with a formal diagnosis of BPD that completes suicide in Victoria every week and these numbers fail to identify the vast number of people without formal diagnosis or meeting subthreshold levels of symptoms for diagnosis within current paradigms (Rao, 2018). It is to be noted also that the diagnostic label BPD is in itself a polarising and stigmatising term, that some psychiatrists are calling to be removed from use (Prosser Scully, 2017) and as such, these numbers are likely underrepresented. Requirement of this diagnostic label to access psychotherapeutic treatments could also be considered to be in violation of section 10 of the Victorian Charter of Human Rights and Responsibilities. It is well recognised that patients presenting with the BPD diagnostic label receive a poorer standard of care within the medical system due to the substantial stigma and negative responses the diagnostic label arouses. Likewise, the requirement for patients to have a specific diagnosis applied in order to access MBS 319 - typically patients with

complex trauma and functional impairment - can be stigmatising and detrimental to patients' wellbeing and sense of self. Lastly, the recording of a MBS number which signifies significant and stigmatising information regarding mental illness diagnosis and functional status, which can be accessed by multiple parties via the My Health Record electronic medical record, raises privacy concerns.

14. Conclusions

There is a profound need for psychologically-minded and trauma- informed, reflective process and expertise in the assessment, diagnosis and treatment of mild, moderate and severe mental illness in the VPMHS.

There is no one-size-fits-all psychotherapy for mental illness or patients of the VPMHS.

Assessment for, and the provision of psychotherapy, needs to be individualised to the patient's needs.

There is an urgent need for a wide range of evidence-based, best practice psychotherapeutic (psychotherapy) treatments to be made available and accessible to meet patient, carer and family needs and across the lifespan and in ensuring that there is an equivalence of care between the Victorian public and private mental health systems. There is a need for brief / short term, medium term and for a percentage of patients, longer term psychotherapy treatments (TOR # 1, 2, 2.1, 3, 4, 4.1, 4.2, 4.3, 4.4, 5).

A review of funding models, such that training, supervision and research supporting psychotherapy are integrated within best practice rather than excluded from current Activity-Based Funding, is required.

Psychiatrists-in-training and members of the multidisciplinary team require early and adequate increased exposure to a range of psychotherapeutic treatments in their training in the VPMHS in order to develop experience and expertise in psychologically-informed assessment, referral and treatment of patients (TOR # 1, 2, 2.1, 2.2). The current state of the VPMHS, lack of resources and various constraints are impairing skill development and the capacity for a holistic best practice psychiatry able to meet individual patient needs in Victoria. Without psychotherapy and the capacity for psychological mindedness and reflective process seen as a valuable and integral part of the work, the current VPMHS and psychiatric system can be considered unsafe for patients, carers and the workforce.

Given the well-established evidence base for psychotherapeutic treatments, including as first line treatment for patients with Borderline Personality Disorder (TOR # 1, 2, 2.1), the absence of easily accessible psychotherapeutic treatments in the VPMHS is iatrogenically damaging and is failing patients, their carers and families. Currently in Victoria, there is one completed suicide each week by a patient with a formal diagnosis of Borderline Personality Disorder. The failure in provision of the diverse range of evidence based psychotherapeutic treatments is an indictment of the current VPMHS.

APPENDIX 1

The capacity of patients to access evidence based psychotherapeutic modalities of treatment, in line with their individual needs, is a human rights issue in Victoria (TOR # 1, 2, 2.1).

APPENDIX 1

Part 2: *Prioritised recommendations for changes within the VPMHS, in order for patient, carer, family and workforce needs to be met, and to ensure the current system safeguards human rights.*

1) Enhancing Psychological Mindedness within the VPMHS

V-FoP makes the following recommendations for short term implementation intended to, over the short, medium and longer terms, increase psychological mindedness, reflective process and mentalisation capacities within the psychiatric workforce, which underpin best general psychiatric and mental health care practice, as well as respect, compassion and empathy, with benefits for the patients, carers and families of the VPMHS as well as the broader medical / health system and workforce.

These core skills facilitate psychiatrists, the MDT, the emergency workforce etc to become better able to hear and respond to patients, carers and families' distress and needs, and create a workplace, which is trauma-informed and increasingly safe from secondary traumatisation of patients, carers and families and vicarious traumatisation of the workforce (TOR # 1, 2, 2.1, 2.2, 2.3, 3, 4, 4.1, 4.2, 4.4, 5).

i) Staffing & Workforce:

Our major funding recommendations concern new workforce positions for Psychiatrist Psychotherapists and Psychiatry Psychotherapy Training. The costs of this proposal are relatively modest in relation to the overall mental health budget. Full costing needs to be undertaken, but the Faculty of Psychotherapy estimates costs in the region of $10 for $15 million per annum for this proposal if fully implemented. These costs can be compared to the costs of increasing acute inpatient beds, which is another way of responding to the crisis in the provision of public mental health services. Based on the 2019 Victorian State Budget, funds of $23.3 million need to be allocated in order to provide 28 additional inpatient beds (Victorian State Budget, 2019-2020).

The Faculty of Psychotherapy is not suggesting that an increase in psychotherapy provision in the VPMHS can substitute for an increase in acute inpatient beds. An increase in acute inpatient beds is likely to be necessary, not least because of the time-frame necessary for more adequate development of psychotherapeutically-informed community services. Nevertheless, as argued above, the capacity of services to contain patients in the community through being more psychotherapeutically-informed, can be expected to slow the rate of growth of demand for acute inpatient beds.

APPENDIX 1

a) Funding for (additional) 1.0 EFT Psychiatrist Psychotherapist positions at each Victorian Area Mental Health Service (AMHS):

Role provision	**Benefits** (TOR # 1, 2, 2.1, 2.2, 2.3, 2.4, 3, 4, 4.1, 4.2, 4.4, 5)
Teaching for psychiatrists and psychiatrists-in-training, as well as the multidisciplinary team (MDT), extra-AMHS hospital staff (e.g. ED staff, medical / surgical teams as needed in conjunction with CL Psychiatry etc)	Developed understanding of patient complexity, trauma and developmental origins of mental illness, reduction of stigma within the mental health and greater medical system. Educate staff re psychodynamic principles in developing understanding of patient behaviour and presentations leading to psychologically and trauma-informed care and practice.
Psychotherapy supervision	Facilitating psychiatrists-in-training to develop knowledge of; psychotherapeutic principles and practices; understandings of attachment and development across the lifespan; the processes of building the therapeutic relationship / therapeutic alliance; the requirements for developing a safe therapeutic and treatment environment for the patient and treating team. Improvement of communication skills, empathy, reflective / mentalisation capacities. Role modelling of professional attitudes, leadership, ethics, boundaries etc There is an increased capacity for the integration of psychosocial, cultural, relational / attachment models with the biomedical model for the development of a holistic psychiatric understanding.
Secondary consultations for complex patients presenting to the emergency department and on the inpatient psychiatric wards.	Secondary consultation can provide expert psychotherapeutically-informed assessment, diagnostic review, review of current and past managements (optimisation of management) Patient groups to benefit include those presenting with complex trauma, 'treatment-resistance', recurrent self-injury and suicidality, sociocultural factors.
Lead Reflective Process (Balint Style) groups for psychiatrists and psychiatrists-in-training & the MDT; to be potentially extended to emergency departments Common issues presented in Balint groups are "chronic unexplained symptoms, apparently inappropriate demands, excessive	Increased patient centredness, increased clinician confidence & professional self-esteem, increased clinician competence in encounters with patients. Increased professional satisfaction and workforce morale, improved psychological medical skills, ordering fewer pathological tests, higher levels of patient satisfaction and reduced workforce burnout (McKensey & Sullivan, 2015). Potential for increased retention of psychiatrists & workforce within the public MHS when they feel adequately supported. Reduction in stigmatising attitudes and behaviours within the medical system towards patients with mental illness / trauma.

APPENDIX 1

dependence, non-compliance with treatment, cultural misunderstandings, involvement of third parties (such as employers, family members etc), bad news, death, dying, bereavement, drug seeking and suicidality (Lustig, 2016).	Balint Reflective Process Groups fall within Trauma-Informed Care and Practice. A team that openly discuss the diverse emotional and behavioural responses of patients and clinicians can form a more integrated understanding of what is occurring clinically, allowing for attuned and targeted treatment responses. (Benjamin et al, 2019) *Note: Balint style Reflective groups require creation and maintenance of a safe space, where material (emotional responses, thoughts etc) is treated with respect and confidentiality, to remain within the group. These groups cannot be linked with assessment of any type, including professional progression and professional performance without the function of the group becoming impaired and undermined.*
Formal process of peer support for psychiatrist psychotherapists within the public MHS and peer review group comprising those in this role.	Protects against burnout and builds system cohesion Quality control Identification of areas of resistance / barriers to implementation and development of the role system-wide Potential development of a state-wide secondary consultation psychotherapeutically-informed service
Training of the next generation of psychiatric psychotherapy supervisors and psychotherapists	Workforce succession planning - upskilling of the next generation. Workforce retention Development of workforce capacity Development of a state wide psychotherapy curriculum moving into contemporary psychiatric practice. Evolution of the state MHS to a Trauma Informed and Trauma Integrated System of Care.
Psychiatrist psychotherapists to be afforded a role in the review of AMHS clinical risk	Developments in psychologically-informed leadership and governance.

b) <u>Develop and embed 2 x 0.5 EFT Psychiatrist-in-training Psychotherapy positions at each Victorian Area Mental Health Service (AMHS).</u>

These positions allow for the experiential development of clinical skills in psychotherapeutic modalities of care (Feiler et al, 2017). Ideally these roles would be embedded within areas of the VPMHS where complex trauma is highly prevalent and psychotherapeutic treatments have a substantial evidence base (TOR # 1, 2, 2.1, 3, 4, 4.1, 4.2, 4.4, 5). These include perinatal, mother-baby, Child & Adolescent, Aboriginal / TSI Health Services, Addiction Psychiatry, Forensic Psychiatry, Old Age Psychiatry. These positions will need access to adequate quality and quantity of clinical psychotherapy supervision.

This is another way of increasing numbers of psychiatrists-in-training and deficits in training positions, as well as production of psychiatrist quotas to meet community need, for example in the fields of Child & Adolescent Psychiatry and Addiction Psychiatry. “Psychotherapy experience during training makes psychiatry more appealing” as a professional pathway (RANZCP Victorian Workforce Report, 2017) (TOR # 2.2)

ii) Environmental factors & workplace safety

The current VPMHS, under immense pressures as described, has limited capacity to provide sensitive, trauma-informed psychiatric best practice and care. There is not a standard best practice environment of workplace safety that prevents the iatrogenic (re)traumatisation of patients and vicarious traumatisation of staff.

Complex-PTSD has only recently become an official diagnosis in the International Classification of Disease 11th Revision, the ICD-11 (World Health Organization, 2018). It is still not recognised in the current, Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5 (American Psychiatric Association, 2013), which is more widely used in Australia. Complex Trauma thus remains neglected in health care (Adults Surviving Child Abuse, 2012) and is often not part of assessment and treatment considerations. The link between trauma and presentation is often lost (Benjamin et al, 2019), preventing adequate psychologically- and trauma-informed assessment and psychotherapeutic psychiatric management, and resulting in the loss of the individual person and their experience.

There is the need for fundamental VPMHS inpatient unit change, returning to a model of the therapeutic community or therapeutic milieu. The Royal Commission is directed to Benjamin et al’s 2019 text ‘Humanising Mental Health Care in Australia. A Guide to Trauma-Informed Approaches’ for details of changes that are required to make VPMHS inpatient units safe for both patients and the workforce. There needs to be a consistent standard of best practice care provided across the different Victorian public mental health systems.

Another facet of workplace safety is the capacity of psychiatrists to provide individualised continuity of care. Psychiatrists are not content working in the current VPMHS and are leaving the VPMHS to move into the private MHS. Between 2011 and 2014, the proportion of psychiatrists that worked only in the private sector increased significantly from 34% to 45%, while the proportion that worked in both the public and private sectors declined significantly from 43% to 31% (RANZCP Victoria Workforce Report, 2017).

APPENDIX 1

Some of the attractions for psychiatrists of working in the private MHS that are not currently possible within the VPMHS are:

Features	Benefits
Being able to review patients for duration and frequency of appointments as indicated by clinical need	Psychiatrists hold significant risk working with patients who are significantly disturbed, psychotic, can be self-harming, suicidal, or pose risks to others (children, family, others). Psychiatrists in the current VPMHS do not feel able to spend as long with these patients as is clinically indicated due to the multiple system pressures. When patients are not adequately contained, risk is not adequately contained and psychiatrists feel not only inadequately contained but resentful of the system. Burnout is high. Psychiatrists leaving the system strips expertise gained over many years from the VPMHS. This staff turnover demoralises the workforce and patient. There is iatrogenic damage to existing therapeutic relationships, as well as to the capacity within the system to develop therapeutic treatment relationships.
Capacity to build continuity of care	Being able to develop therapeutic relationships with patients is not only good clinical practice but it leads to meaningful experiences both for patients and clinicians. This has positive impacts on patient clinical outcomes as well as on clinician work satisfaction and workforce retention.
Capacity to provide psychologically-informed, psychotherapeutic models of care	See section below
Being able to provide trauma-informed care and practice	See section below

APPENDIX 1

2. Greater access to psychotherapeutic (psychotherapy) treatments

i) The Victorian Faculty of Psychotherapy recommends that the Victorian government fund and establish specialist public mental health system multidisciplinary psychotherapy community clinics, providing multiple modalities of evidence-based best practice psychotherapeutic treatments with an individualised, whole of life focus, for patients, carers and families.

ii) Further, we recommend that in addition to psychotherapeutically-trained members of the multidisciplinary team staffing these clinics, that psychiatrists-in-training, in all years of training, are allocated ½ day (0.1 EFT) of protected, weekly (same-day), clinical time training and working in these clinics, in order to develop further expertise in reflective process and mentalisation and to build and develop clinical understandings and skills in the provision of psychotherapeutic assessment and treatment (TOR # 1, 2, 2.1, 2.2, 2.3, 2.4, 2.5, 3, 4, 4.1, 4.2, 4.3, 4.4, 5).

What would a public psychotherapy community service provide?

Some benefits for patients:

- Access to evidence-based psychotherapeutic treatments currently not accessible or of only very limited availability and accessibility in the VPMHS. These include brief / short-term individual and group psychotherapies, with the capacity to provide a smaller percentage of patients following specialist psychotherapist assessment (this cohort may include patients with frequent hospital / emergency attendance, patients with significant personality disorder, self-harm or suicidality, failure to respond biomedical treatments / 'treatment resistance' etc) medium and time-limited longer term psychotherapy (TOR # 1, 2, 2.1)

Modalities of psychotherapy that could be made available include:

CBT: Cognitive Behavioural Therapy: Individual and Group	**DBT: Dialectical Behavioural Therapy:** Individual and Group
SFT: Schema Focussed Therapy: Individual and Group	**TFP: Transference Focused Psychotherapy:** Individual
MBT: Mentalization Based Therapy: Individual and Group	**CAT: Cognitive Analytic Therapy**
ERP: Exposure Response Prevention: For patients with OCD / Anxiety Disorders, Individual and Group	**EMDR: Eye Movement Desensitization & Reprocessing:**

APPENDIX 1

	For patients with PTSD and other trauma-related disorders - Individual and Group
Psychoeducation: This form of psychological support can provide guided information within a supportive paradigm, focusing for example on medications, mental health system literacy for patients and carers, evidence-based harm minimisation approaches. Patient groups which can benefit include those with anxiety disorders, depressive disorders, trauma-related disorders, including PTSD, Borderline Personality Disorder and Complex Post-Traumatic Syndromes, including dissociative disorders, patients with problematic alcohol and drug use etc	**ACT: Acceptance & Commitment Therapy:** Individual and Group
Supportive Psychotherapy: Supportive psychotherapy can be beneficial for patients who require psychological support to return to previous level of functioning or maintain current level of functioning; this can include patients with psychotic disorders and / or patients with crisis-related presentations. This can have a CBT-framework or have a psychodynamic orientation, depending on the patient's needs and capacities at that time.	**Family Therapy** **Parent-Infant Psychotherapy** **Child Psychotherapy**
Conversational Model Psychotherapy: Individual	**Relational Psychotherapy:** Individual and Group
Art Therapy: Individual and Group	**Music Therapy:** Individual and Group
Somatosensory / Sensorimotor Psychotherapy: Individual and Group	**Psychodrama:** Individual and Group
Social and life skills group therapies: Individual and Group	**Motivational Interviewing:** For patients with addiction, eating disorders - individual
STDP: Short Term Dynamic Psychotherapy: Individual	**LTPP: Long Term Psychodynamic Psychotherapy:** Individual and Group

APPENDIX 1

PIT (Psychodynamic Interpersonal Therapy) Individual, short term intervention; benefits for patients with psychophysiological presentations, or those with self-harm presentation(s) to the Emergency Department.	**PAP: Psychoanalytic Psychotherapy:** Individual
Group therapy (structured / psychodynamic / psychoanalytic forms)	***Psychoanalysis:*** Individual (for selected high needs, high service utilisation patients)

Benefits for patients include (TOR 1, 2.1, 4, 4.2, 5):

- Capacity to develop continuity of care treatment / therapeutic relationships with psychiatrists and psychotherapeutically-trained members of the MDT within the VPMHS
- Movement from a predominantly biomedical paradigm to a holistic, individualised, biopsychosocial treatment and health paradigm, that is trauma-informed.
- Patients who require or benefit from medication management in conjunction with psychotherapy treatment are facilitated to have their care needs integrated in a single treatment relationship.
- Engagement with mental health services which respect and meet fundamental human rights.
- Community centres have the capacity to co-locate and integrate various other health and psychosocial resources, such as sexual health care, exercise and dietetics support, financial and legal support and advocacy.

For psychiatrists, psychiatrists-in-training and members of the multidisciplinary team:

- Capacity to have enhanced training experiences (teaching, supervision, Balint-style reflective process groups) within a designated, psychotherapeutic, trauma-informed 'facilitating' environment

- Development of psychotherapeutically-informed clinical skills, as well as clinical skills in the provision of psychotherapeutic treatment modalities. "Especially for the psychodynamic and cognitive-behavioral therapies, supervised treatment of numerous cases is required to acquire comfort and security in using the distinctive techniques of each modality and systematically applying them to a range of clinical conditions. Years of experience with a variety of patients are essential to reach proficiency as a therapist - let alone as a teacher, supervisor, consultant and psychotherapeutically sophisticated leader of a treatment team. Without the ability to offer psychotherapy to a variety of patients over time, technical skills, clinical

judgement, and interest in engaging in psychotherapeutic relationships with patients will wither away" (Clemens et al, 2014).

- Development of a holistic, biopsychosocial, developmentally and trauma-informed model of psychiatric best practice and care, along with experience in providing continuity of care (TOR # 1, 2, 2.1)

- Appropriate clinical space (set up for psychotherapy practice) in which to see VPMHS patients for psychotherapy assessment as well as treatment provision, both individual 1:1 and group. Currently psychiatrists-in-training struggle to find appropriate consulting spaces in the VPMHS in which to see their psychotherapy long case patient; there is little capacity to extend psychotherapy provision within the VPMHS without the development and funding of appropriate spaces for this treatment.

Ringfenced time for psychotherapy in all psychiatrists-in-training positions is an opportunity to extend trainees' psychotherapeutic skills, attitudes and behaviours, via continuity of care relationships with patients, alongside supervision and professional development (Feiler et al 2017) (TOR # 2.2).

Psychiatrists will benefit from these clinical experiences in the assessment of multiple patients for psychotherapy, and in being facilitated to have a greater role in psychological treatment provision. This can facilitate understandings regarding the various psychotherapies in terms of how they differ, what they offer and in being able to refer patients to psychotherapy treatments appropriate to their needs and capacities (TOR # 1, 2, 2.1, 2.2, 2.3, 2.4, 3, 4, 4.1, 4.2, 4.4, 5). "The public wants and expects their psychiatrists to be more, not less, psychotherapeutically-skilled… Future psychiatrists lacking in psychotherapeutic skills will be handicapped in the face of the wide range of diagnoses and personalities they will encounter in their practice, and politically marginalized if all they have to offer is medication and management" (Holmes et al, 2007).

For the greater psychiatric and medical health system:

- Creation of psychotherapy community centres allows for the capacity to pool resources, such as supervisors and teaching. It is likely that these centres will seek to employ specialist psychotherapists, both psychiatrists as well as appropriately credentialed psychologists and other members of the MDT, able to provide specialty expertise in their areas of psychotherapy, both in treatment provision and training / supervision etc Longitudinal devaluation and exclusion of psychotherapy from the VPMHS has resulted in difficulties accessing adequate expertise in teaching and supervision, especially in public area mental health services outside of urban centres (TOR # 2.2, 2.3, 2.4, 4.3)

- Site at which pilot trials of various psychotherapies can be run, embedded into a psychotherapy research and service development program component; potential for

development of Victorian Psychotherapy Academic EFT from which clinical papers can be authored etc (TOR # 2.5)

What is required for the establishment of psychotherapy community clinics?

- Designated, appropriate to psychotherapy, 'facilitating' environment:
  - Off-site from acute inpatient services (It is possible that existing VPMHS outpatient infrastructure could be utilised but will require repurposing for community psychotherapy provision).
  - Ground-level
  - Capacity to maintain environment with limited changes or disruptions
  - Capacity for audiovisual equipment for teaching psychotherapy interview technique / Mirror observation facilities for training and supervision.
  - Development of system for medical record storage that is appropriate to psychotherapy; IT systems etc that are maintained separately from general medical / health system records given the nature of psychotherapeutic material (Clemens et al, 2014)

Each clinic should be set up and staffed to provide, at a minimum, Supportive Psychotherapy, Psychoeducation, Psychodynamic Psychotherapy (both short and medium / longer term PDP) and Cognitive Behavioural Therapy (CBT) in order to meet acceptable standards of psychotherapy treatment provision and service a large number of patients and their needs.

Beyond this, the infrastructure of the clinics should be designed to train and roll out the other therapies across the state of Victoria to public patients, according to the training and expertise of the staff at individual clinics. There needs to be an adequate expansion of DBT, MBT etc psychotherapies within the VPMHS within the foreseeable future.

iii) Maintenance of current Medicare Benefits Scheme provisions

It is important for the Royal Commission to be aware that the current MBS facilitates many patients to be held therapeutically within the private MHS. Funding of the recommendations made within this document should not be weighed against funding of the MBS; it is not a one or the other measure. The recommendations in this document are additional requirements in order to meet community and workforce needs, which have been chronically under-resourced. Reductions in access to the MBS or rebates will result in a movement of patients currently held in the private MHS into the VPMHS, with a subsequent increase in VPMHS costs that outweigh those of subsiding care in the private MHS. Changes that reduce patient access to intensive psychiatric psychotherapy with psychiatrist psychotherapists via changes to the MBS would likely increase patient suicides (Medicare working party, 2015).

There is a misconception that psychiatrist psychotherapists working in the private MHS see "the worried well". Not only is this vastly untrue but it is a devaluation and pejorative

dismissal of both psychiatrist psychotherapists and their expertise, as well as the distress and needs of their patients.

Psychiatrist psychotherapists working in the private MHS, typically having completed years of additional psychotherapeutic training and clinical supervision, treat a range of patients and complex presentations that can include complex trauma, personality disorders, dissociative syndromes, psychotic syndromes, mood and anxiety syndromes including treatment-resistance, eating disorders, self harming, suicidality, and profound distress / despair (correlated with suicide risk), often with addiction or Alcohol and Other Drug (AOD) syndromes and medical / physical health comorbidities that are intrinsically interconnected and affected by / affect mental health needs.

Typically, patients who attend psychiatrist psychotherapists for their psychotherapeutic treatment are more chronically impaired, and carry levels of risk that are greater than the patient cohort that attends non-psychiatrist psychotherapists. Hence, expenditure to develop and sustain psychiatric psychotherapy is justified and necessary.

APPENDIX 1

3. Implementation of Trauma-Informed Care & Practice (TICP) within the VPMHS

TICP is a "fundamental shift in mental health organisation and delivery" with "the need for a realignment of the knowledge base, power and responsibility". Unless this occurs, "There is an inevitable risk of co-option: that trauma-informed approaches will come to mean little more than treatment as usual repackaged as trauma-informed" (Sweeney & Taggart, 2018) (TOR # 2.4).

“An understanding of the five principles of trauma-informed care is necessary at all levels of service provision to enable transformational outcomes (Bateman J et al, 2013). Substantial organisational change is required to achieve this… Recognition is needed that the achievement of “a truly trauma-informed” health system requires no less than “a process of reconstitution within our organisations from top to bottom” (Bloom and Farragher, 2011: p2) and involves all stakeholders in an organisation, from coalface staff to the upper echelons of management (TOR # 2.4).

The Royal Commission are directed to the text ‘Humanising Mental Health Care in Australia’ (Benjamin et al, 2019) for details re translating from principle to practice and operationalising trauma-informed care, moving beyond systems that are trauma-informed to being trauma-integrated and trauma-transformative. Trauma-integrated services focus away from individual trauma symptoms, and toward the individual, as a whole person, and as part of a network of (therapeutic) relationships that are strengthened as a basis for change (Tucci, 2016). In keeping with this model, there is a requirement for funding of research that explores and develops key performance indicators, KPIs, appropriate to various modalities of psychotherapeutic treatment, which recognise that individuals gain benefit in different ways, and that allow for capture of meaningful developments for patients and treatment (TOR # 2.4, 2.5).

Barriers to the introduction of TICP

Barrier	Details	Recommendations
The pressures of the public mental health system and day-to-day service delivery	• Funding constraints • Demands of timetabling • Staff availability	Significant service planning will be required within the greater MHS and with state government involvement in order to adequately address this barrier, which poses the greatest risk to the implementation of a contemporary, human rights and trauma-informed model of psychiatric practice. It is likely that greater staffing will be required, some of which may be provided by increasing psychiatrist-in-training numbers in order to increase quotas of Child & Adolescent Psychiatrists, currently inadequate to meet population needs

APPENDIX 1

		(RANZCP Victorian Workforce report, 2017) The ½ day each week for psychiatrists-in-training to be training and working in outpatient psychotherapy clinics will need to be mandated as compulsory in order for services to ensure this requirement is met. When psychotherapy experiences are not mandatory, they become removed from work practices in the face of system pressures.
The role of human "mindsets": The human mind has developed ways of thinking about and responding to the world (conscious and unconscious) which function to protect individuals, and groups, from anxiety and from trauma.	The threat that trauma poses to "the existing worldview and mental models upon which human service delivery is built" should be particularly noted. Stress and trauma negatively impact human reflective capacity and the capacity to engage with change. This has relevance at all levels of process: from the clinical coal face to the system and process of Royal Commission examination, development of recommendations and their subsequent implementation.	"... if the paradigm of trauma-informed care is to become standard practice, what is needed...are broad-ranging alliances strong enough to counter the social pressures to deny (trauma) (Herman, 1997). As Felitti and Anda have said of the findings of the Adverse Childhood Experiences study: "The potential is huge. So too is the likelihood of clinician and institutional resistance… Actualising the benefits of this paradigm shift will depend on first identifying and resolving the various bases for resistance to it" (Felitti and Anda, 2010) This, they say, "will require far more planning than would be needed to introduce a purely intellectual or technical advance" (Benjamin et al, 2019).

Trauma-informed care and practice "poses a formidable challenge to the biomedical model of psychiatry and mental health, and given the high individual and collective cost of trauma and its multiple impacts across a range of indicators - psychological, physical, financial, and social - the stakes for failing to comprehensively introduce the paradigm are high" (Benjamin et al, 2019). The increasing concern about human rights makes this an emerging area of legal interest with potential ramifications for clinicians, systems of healthcare provision and the governmental departments which fund and develop health care provision and legislation.

APPENDIX 1

Summary of Recommendations (TOR # 1, 2, 2.1, 2.2, 2.3, 2.4, 2.5, 3, 4, 4.1, 4.2, 4.3, 4.4, 5):

The Victorian government is requested to support, establish and provide ongoing funding for:

1) 1.0 EFT Psychiatrist psychotherapist position(s) at each Victorian Area MHS to provide multiple roles and functions as detailed in the V-FoP submission, Part 2, Section 1, i, a.

2) 2 x 0.5 EFT Psychiatrist-in-training psychotherapy positions at each Victorian Area MHS embedded into areas of need in which psychotherapeutic assessment and treatment has a substantial evidence base, as detailed in the V-FoP submission, Part 2, Section 1, i, b.

3) Development of greater access to psychotherapeutic models of care within the VPMHS. V-FoP calls for the Victorian Government to fund the development of Community Centres with key focus on the provision of multiple modalities of psychotherapeutic treatments for patients in the VPMHS, as detailed in the V-FoP submission, Part 2, Section 2, i

4) Ring-fenced clinical time for psychiatrists-in-training and psychiatrists working in the VPMHS for the development of core psychotherapy expertise in addition to the provision of evidence-based psychotherapeutic treatments, as detailed in the V-FoP submission, Part 2, Section 2, ii

5) A review of funding models, such that training, supervision and research supporting psychotherapy are integrated within best practice rather than excluded from current Activity-Based Funding, is required.

6) Protection and indexed maintenance of current MBS Psychiatry Item Numbers, 306, 316 and 319 which are typically used to provide psychiatric psychotherapeutic treatment to patients in need, as detailed in the V-FoP submission, Part 2, Section 2, iii.

7) Reform of the VPMHS to ensure Trauma-Informed Care and Practice (TICP) is at the heart of the VPMHS structure and service delivery. This will be a medium to longer term process that will require collaboration; it is likely a work group will need to be funded to provide scope as to how this can be practically legislated and enacted (Part 2, Section 3).

The Victorian Faculty of Psychotherapy welcomes the opportunity to discuss and expand upon all of the various themes in the submission document with Royal Commission into Mental Health. Additional information can be provided on request.

APPENDIX 1

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APPENDIX 1

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