National Association of Practising Psychiatrists

SUBMISSION TO TREASURY

DISCUSSION PAPER

REFORM TO DEDUCTIONS

FOR SELF-EDUCATION EXPENSES

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EXECUTIVE SUMMARY

- *The Treasurer's announcement to place a cap on deductible self-education expenses is ill-conceived and pays no attention to downstream costs that will accrue to Govt.*
- *These proposals will negatively affect training in all areas of psychiatry. In particular, they will have a devastating impact on training in long-term intensive psychiatric treatment. Future workforce shortages will result, and productivity will fall.*
- *Patient outcomes will suffer as a direct consequence of restricted access to proper care.*
- *Self-education, achieved by conference / seminar attendances or journal subscriptions, forms part of AHPRA requirements for registration.*
- *The Treasurer's proposals run counter to the National Mental Health Plan 2009 – 2014 and important National policy agendas set by COAG & Productivity Commission.*
- *Lesser care, by a lesser trained workforce, will not meet need and capacity constraints.*
- *The average figures used to form the basis of the cap is unrealistic in our circumstances, given the intensity and complexity of legitimate expenses in a broad field.*
- *Continuing education is crucial to maintaining evidence-based practice; Australia's geographical isolation makes it imperative that travel expenses be allowed to maintain standards.*
- *It is the responsibility of the Australian Government to ensure that the education, training and resources are available to enable psychiatrists to practice in a competent and ethical manner. Treasury ignores this.*
- *Recommendations are made to address the issues.*

Introduction

On April 13 2013, the Hon Wayne Swan (Treasurer; see Appendix) announced a proposal to cap self-education expenses to $2000 per annum. It was claimed to "*better target work related self-education expense deductions as part of a package of reforms…".*

In justification of this measure that aims to save $520 million over the forward estimates, the Treasurer argues that he aims to curb people from obtaining "*…significant private benefits at taxpayers' expense"*. No evidence is provided as to the extent of this problem, but the proposals, in a general and sweeping way, will now preclude deductions on training expenses, journal subscriptions, stationery and attendances at seminars, workshops and conferences.

The National Association of Practising Psychiatrists (NAPP) argues that this contradicts current requirements to maintain accreditation both with AHPRA, and relevant Colleges; it runs counter to various National policy objectives already in place; it will reduce the workforce in a highly skilled area, and reduce achievement of proper standards of care; it will lead to poor patient outcomes; and it will add to community cost-burdens as a result of ongoing capacity constraints.

NAPP acknowledges this to be a time of fiscal difficulty for the Government, given the context of the world economy. However, the rationale given for these proposals seems ill-conceived; they are to provide monies for educational reform, while at the same time disadvantaging an already vulnerable group in the community which in turn will cost the Government considerably more money in general health expenditure.

We argue too, that these proposals enshrine inequity; not only inequity of access to proper care, but inequity in who can (*corporations via fringe benefits tax*) and who cannot (*sole traders, so most professionals*) claim tax concessions for necessary ongoing training and professional development.

NAPP notes that there is a consultation period, where submissions are sought by 12 July, 2013. NAPP is therefore grateful for the opportunity to put its case against these measures.

The Problem / Context

The Treasurer's recent proposals, in our opinion, will only make an existing (bad) historical situation worse for patients, providers and carers. Placing the issue in a broader mental health context, an attempt to rectify the "Beazley black hole" in 1996/7 led to cuts to CMBS rebates for long-term intensive psychiatric treatment. The aim then too, was to save in the order of $400 million. NAPP argued this would have a detrimental impact on treatment access, patient care and outcomes.

Importantly, NAPP argued this would have a negative impact on the *training* of mental health professionals / psychiatrists, particularly those wishing to provide long-term intensive psychiatric treatment. NAPP argued it would be a dis-incentive.

This has indeed been the case, with the number of applicants for training dropping substantially. NAPP is fully aware of the difficult global economic conditions that Governments need to navigate.

However, NAPP represents practitioners in a very complex area. Psychiatry has within it many subspecialties such as Child & Adolescent psychiatrists, those working in the fields of Trauma, Acute psychiatric care, Geriatric psychiatrists, Medico-legal & Forensic specialists and Researchers. All are complex fields with a need to maintain contact with colleagues to maintain standards; conferences, journals and meetings are the only way to maintain expertise, standards and registration.

We argue then, that it makes little sense to pursue policies that can only exacerbate cost-burdens and create workforce shortages.

Training & Treatment Issues

Research shows that long-term intensive psychiatric treatment is a necessary treatment for particular groups of patients who have frequently been highly traumatised, have often failed prior treatment, and who often have (co-morbid) disorders involving debilitating personality disturbances as well as a formal psychiatric disorder. These patients are the psychiatric equivalent of patients needing "intensive care" in medical units.

NAPP argues that ignoring (by reducing training incentives) the long term pervasive effects of personality disturbances (so called Axis II issues in the Diagnostic and Statistical Manual for Mental Disorders IV) as they influence psychiatric conditions is a serious policy omission. Outcome, including incorporating gains of treatment, is fostered by the technical ability of the psychiatrist.

These specialised treatment skills have proven efficacy for a significant group of children, adolescents, and adults who suffer from complex forms of chronic and severely disabling mental illnesses such as depression, anxiety, post-traumatic and dissociative disorders, personality disorders, psychoses, and ongoing suicidal risk.

Outcome and treatment are intertwined, as treatment is necessarily long-term for some patients (eg where chronicity is an indicator for treatment) in order to effect enduring changes. Restricting or impairing this treatment modality inevitably reduces the effectiveness of psychiatrists dealing with these issues. Outcome and treatment are connected to training.

It seems self-evident that reducing incentives to train, or reducing the capacity to maintain adequate standards of practice, will reduce patient access to these treatment modalities and lead to poor outcomes.

NAPP expects applications for training to be reduced even further than in 1996/7. This is critical since the patients referred to above are complex and difficult. Research supports the finding that this *(untreated)* group often uses large amounts of resources by way of increased PBS costs and general medical costs.

Training, for example, in long-term intensive psychiatric treatment is long, arduous and expensive. Training, for clarification, is not mere theoretical learning but relies heavily on gaining practical experience in fraught emotional situations, often involving death, suicide, illness, bereavement, trauma and so on. All sub-speciality training is complex and costly, and requires oversight.

It includes, in one example of a particular sub-speciality which highlights the policy problem, different and necessary components such as clinical case work (5 hours per week), supervision (3 hours per week), didactic theoretical components (3 hours per week) , personal work (5 hours per week) to understand conscious and unconscious motivations for behaviours and emotions, observational studies and ongoing feedback from senior clinicians. Training is much more than an academic pursuit. *All training is after normal work duties, equating to 11 hours per week, or 440 hours pa, of professional tuition at a quaternary level, paid after tax.* Trainers thus need proper remuneration as this forms part of their daily clinical work. Trainees struggle as it is, to find the requisite fees for such training. Training in such areas is only provided in private settings; no such intensive training exists in the public sector. This is not the case in the UK and other major economies, where training *is* available in some public settings; this preserves such expertise for patient care.

The Royal Australian & New Zealand College of Psychiatry provides a basic training in the psychotherapies, for example, as well as an advanced training module. This involves private expense of around $15,000. *To specialize further however, involves a significant financial outlay over the several years of training.* The cost-burden of training is not easily affordable; and it will become less affordable.

Such training, therefore, can cost in the order of $50,000 per annum, due to the complex nature of what is required to attain these skills, as described above. This figure derives from the hours per annum (440 in our example) remunerated at $113 per hour for Trainers, a quite low professional hourly rate. All Colleges and their subspecialities will face similar dilemmas of how to maintain expertise and ensure productivity is maintained for medical practitioners and patients.

Training in long-term intensive psychiatric treatment, being complex and involved as it is, necessarily requires that skills be maintained. This can *only* be achieved by ongoing discussion with colleagues, such as in peer review meetings, or attendance at seminars and overseas conferences.

Attendance at *overseas* conferences is arguably more necessary to maintain skill levels, than in other professions, and in other countries. We are geographically isolated; colleagues in Europe are able to personally confer with others at conferences several times a year; and clinical case discussion is often only useful if it's face to face with colleagues. Given that such expertise is highly specialized, the relatively smaller numbers of Australian practitioners do need personal contact with others to discuss cases, now that we live in a rapidly changing and globalised world.

Access to journal articles in the field is another element of maintaining proper standards. Such Continuing Professional Development (CPD) is unfortunately targeted too in the budget announcement. The maintenance of quality care is only possible with adequate resources.

NAPP argues that the budget proposals are too wide-ranging and blunt. They will act as a dis-incentive to undertake an already difficult training. This will reduce the numbers of skilled psychiatrists in this area. In turn this can only exacerbate existing problems of access to treatment, and lead to poor outcomes and worsening productivity.

Psychiatrists also provide training, consultation and supervision to a broad range of mental health professionals and health services, both public *and* private. *Such oversight and supervisory consultation would be lost to these sectors, to the detriment of patient care.* NAPP believes therefore, that the wider adverse social and professional impact of the proposed self-education expense cap will ultimately cost the government much more in human and financial terms than the cost of its continued support for the expenses of necessary postgraduate professional training programs.

Policy Issues

As NAPP has argued, the Treasurer's budget proposals to cap self–education expenses will make an existing problem of poor access and inequity much worse.

NAPP is also concerned, however, that these proposals run counter to the thrust of existing policies, below, involving the complex area of mental health care provision in Australia.

Fourth National Mental Health Plan

NAPP is concerned that proposed outcomes would be inconsistent with the aims of the National Disability Scheme and related mental health priorities that NAPP strongly supports. We believe this proposal works against the aims of the Fourth National Mental Health *Plan*, which specifically targets better health outcomes over the period 2009 – 2014. In particular, and to recap, the National Mental Health *Strategy* aims to *(emphasis ours)*:

- *promote the mental health* of the Australian community
- *reduce the impact of mental disorders* on individuals, families and the *community*
- *assure the rights* of people with mental disorders…
- ensures that all Australians with a mental illness can *access effective and appropriate treatment* … to enable them to participate fully in the community.

The Fourth National Mental Health Plan promotes an integrated, whole-of-government response to the improvement of mental health outcomes over the period 2009–2014, with (five) priority areas, eg:

- social inclusion and *recovery*
- *service access,* coordination and continuity of care
- *quality improvement* and innovation

It seems self-evident that the stated objectives of the Treasurer's proposals run counter to the issues of recovery, access and improvement. They thereby exacerbate inequity.

Productivity Commission & COAG

The Productivity Commission Research Report into the Australian Health Workforce, brought down on 19th January 2006, claims, in its Foreword:

"*Many of the arrangements under which the workforce operates are under considerable pressure, as are health workers themselves. The headline indicator of this is a workforce shortage …"*

In reviewing and recommending these reforms, some key points were made:

- Australia is experiencing workforce shortages across a number of health professions
- the demand for health workforce services will increase while the labour market will tighten
- It is critical to increase the efficiency and effectiveness of the available health workforce

It would appear that the Commission acknowledged that we had a world class health system based on expertise. But it ignored the ethos that undermined health care by underfunding hospital and community services.

The Australian Medical Association too, said at the time that workforce shortages in mental health were increasingly apparent and were producing sub-optimal outcomes for patients: *"The Government must ensure there is a well trained and highly motivated psychiatrist Workforce".*

In a COAG Communique (Rudd, Swan & Roxon, 2010) regarding key objectives in the COAG reform agenda, the Ministers state this as key Health and Ageing priorities:

- Improve health outcomes and the sustainability of the health system
- Increase access to primary and community healthcare (GPs.. mental health practitioners)
- National registration and accreditation scheme for health professionals

Clearly, the recent Budget proposals run counter to these objectives in NAPP's view.

Mental Health Statement of Rights and Responsibilities 2012

NAPP will let The Statement speak for itself: "Australians expect to receive safe and high-quality health care when they are unwell. For those who are experiencing a mental illness or problem, access to timely assessment, individualised care planning, treatment and support is paramount. The opportunity to achieve recovery is of vital importance. Mental health services exist to meet the needs and preferences of consumers and to improve their mental health.

A limited review of the 1991 Mental health statement of rights and responsibilities (the Statement) was identified as a key action of the Fourth National Mental Health Plan. Building on the original statement's validity and utility, the review has focused on updating it against modern mental health care concepts and contemporary human rights legislation.

The revised Statement reflects recent developments in the language, concepts and legislative context of the contemporary mental health and human Mental Health Statement of Rights and Responsibilities 2012 rights field.

The Statement is consistent with Australia's international obligations, particularly the United Nations Convention of the Rights of Persons with Disabilities, the Convention on the Rights of the Child and state and territory human rights instruments. It is envisaged that states and territories will consider the statement in the context of their mental health operations, policy, legislative, prevention, promotion, education, quality improvement and workforce development initiatives".

NAPP strongly supports the updated review of the Statement of Rights and Responsibilities.

In particular NAPP supports Part III of the Statement, involving the Promotion of Mental Health and the Prevention of Mental Illnesses (p9). Restricting training in long term treatment, *which this will do*, necessarily impinges on these areas insofar as it will restrict people being treated in the community, and will prevent treatment that allows work and productivity to continue.

Further, NAPP strongly supports Part VI of the Statement, involving the Rights of Providers.

NAPP is especially cognizant of the following clauses in the Statement of Rights and Responsibilities *(emphases ours)*:

(43) This statement acknowledges the qualifications and expertise of service providers in the private, public and non-government sectors and recognises their contribution to planning with, and the assessment, support, care, treatment, rehabilitation and recovery of mental health consumers (p21).

(44) People who provide services throughout the social…and mental health systems are entitled to:

(a) have their professional qualifications and capabilities acknowledged ….*and*

(c) work in optimal conditions of service delivery and employment including the right to ongoing training and a safe and supportive work environment

(45) People who provide services throughout the social, justice, health and

mental health systems have the responsibility to (p22):

(a) provide the highest quality, evidence-based, best practice… individualised care planning, ….and recovery services to mental health consumers without stigma and discrimination..*and*

(v) participate in the development of professional ethical standards that accord with international human rights principles

Part VIII : Governance :

(49) Australian governments have the responsibility to:

(a) fund, administer and coordinate high-quality… recovery-focused … services

(b) develop, implement and review explicit standards for all sectors of service delivery …

(c) encourage, promote and evaluate a continuous culture of quality improvement …

(d) provide access to mechanisms of complaint and redress …

(e) provide services that are subject to quality assurance, … and to ensure standards are met

(f**) ensure there are adequate levels of professionally trained and qualified staff**

(g) **ensure a capacity for, and a commitment to, the maintenance .. of staff knowledge and skills**

(h) **provide** optimal **work conditions** to staff providing mental health services

(i) **provide ongoing training** and a safe and supportive work environment to staff providing mental health services**.**

NAPP further notes, and supports, the following in the Statement:

Mental health legislation

(51) This statement recognises that mental health and related legislation in each state and territory should protect the rights and support the responsibilities contained in this statement. This includes relevant Commonwealth legislation …". (p26)

NAPP sees it as self-evident that these policy objectives should be adhered to, as devised in the National Mental Health Strategy. It makes no sense to add to existing suffering by reducing access to care by virtue of increased workforce shortages that

will result from these proposals. Inevitably this can only lead to added cost-burdens on the community.

Evidence Base

We are mindful of the Government's need to encourage evidence-based practice across all fields. This includes long term intensive psychiatric treatment. NAPP is aware of the oft-repeated *misinformation* that such treatment is not evidence based.

NAPP strongly rejects this. As an aid, we publish at the end of this Submission an extensive list of References supporting the evidence, efficacy and cost-benefits of providing such treatment.

Taxation Issues

These proposals, we assume, will impact mostly on sole traders and therefore impact on a considerable number of medical practitioners. It is unclear if those with practice companies employing several doctors will be allowed to continue to claim deductions.

But the governments discussion paper also raises the spectre of employers being targeted. Clause 64 suggests they will be liable for Fringe Benefit Tax on education expenses spent on their employees above the threshold.

It states: As part of this proposed measure, the otherwise deductible rule may no longer apply to education expenses in excess of the $2000 cap. This may result in employers being liable for Fringe Benefit Tax on any education expenses over the cap of $2000, incurred by them on behalf of their employees.

AMA vice-president Professor Geoffrey Dobb claimed the proposal was a contradiction of assurances given by government that employer-funded education would not be subject to Fringe Benefits Tax.
(*http://www.6minutes.com.au/news/latest-news/cpd-tax-could-cost-employers-too).*

That this will severely impact on psychiatric training appears inevitable. It seems a gross injustice that a company (eg Woolworths) could pay for training for one of its employees who works in the HR Department, and have it fully deductible but a professional, sole trader, can't have the same tax treatment.

Under the current ATO system, D4 refers to work-related self-education expenses, while D5 refers to other work related expenses.

There seems to be no guidance provided by the Treasurer in the budget as to whether he is going to a) introduce the $2K cap to the current D4 definition or b) introduce the $2K cap to the current D5 definitions [*i.e. D4 currently excludes formal education courses provided by professional associations; and seminars, education workshops or*

conferences connected to work and says that these should be claimed at D5] or c) change the definitions for one or one or both D4 & D5 categories and apply the cap.

Current law allows conference expenses to be deducted under the general deductibility rules for D5 (other work related expenses). If this remains unchanged, then CPD will be untouched. Furthermore currently employers are not liable for fringe benefits tax for education and training they provide to their employees.

In the absence of any specific denial, we must assume from the examples given by the Treasurer that the government is trying to target conference and professional development expenses now being claimed under D5 (see above).

This, NAPP argues, directly counters the mandatory requirement for our doctors to incur these expenses as part of their licensing procedures let alone their personal desire to maintain their skills at the highest level.

Legal Issues

NAPP understands that AHPRA has recently endorsed the idea of *clinical* care by *non*-medically trained allied health workers in some circumstances. This will now be the subject of a Supreme Court action, and possibly a High Court action will follow. Reducing clinical expertise will, perhaps in an unintended way, facilitate the emergence of a less qualified and less expert workforce. This can only have negative consequences for patient care and outcomes. NAPP asserts that this will be an unintended consequence of the Budget proposals. (www.ranzco.edu)

Remedial Policy Options

In the interests of maintaining the highest possible standards of patient care, professional practice, and continuing professional development NAPP would urge Treasury not to cap legitimate specialist professional training programs and Continuing Professional Development (CPD) expenses at this time, as proposed in the Treasury Discussion Paper. NAPP urges a thorough review of this policy, its methods and objectives.

NAPP believes that the adverse social and professional impact of the proposed self-education expense cap will ultimately cost the government much more in human and financial terms than the cost of its continued support for the expenses of legitimate and necessary postgraduate professional training and Continuing Professional Development programs.

NAPP requests that the cap on self-education expense deductions be withdrawn as a matter of urgency.

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REFERENCES

Australian Productivity Commission

http://www.pc.gov.au/__data/assets/pdf_file/0003/76161/annualreport0607.pdf

Evidence Base

Barber, J. P., & Crits-Cristoph, P. (Eds.) (1995). *Dynamic therapies for psychiatric disorders. Axis I* New York: Basic Books.

Barkham, Michael; Rees, Anne; Shapiro, David A; Stiles, William B; et al. (1996) Outcomes of time-limited psychotherapy in applied settings: Replicating the Second Sheffield Psychotherapy Project. *Journal of Consulting & Clinical Psychology. Vol 64(5),* 1079-1085.

Bateman, Anthony; Fonagy, Peter. (1999) Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry. Vol 156(10),* 1563-1569.

Bateman, Anthony; Fonagy, Peter. (2001) Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: An 18-month follow-up. *American Journal of Psychiatry. Vol 158(1),* 36-42.

Baradon, T., Broughton, C., Gibbs, I., James, J., Joyce, A., & Woodhead, J. (2005). *The practice of psychoanalytic parent-infant psychotherapy. Claiming the baby*. London: Routledge.

Bateman, A., & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder. Mentalization-based treatment*. Oxford: Oxford University Press.

Clarkin, J., Yeomans, F., & Kernberg, O. (2006). *Psychotherapy for borderline personality. Focusing on object relations*. Washington, DC: American Psychiatric Publishing.

Caleo, J. S., Stevenson, J., Meares, R. (2001) An economic analysis of psychotherapy for border line personality disorder patients. *The Journal of Mental Health Policy & Economics. Vol 4(1),* 3-8.

Cozolino, L. (2002) *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain.* New York, W. W. Norton.

Cozolino, L. (2006) *The Neuroscience of Human Relationships: Attachment and the Developing Social Brain.* New York, W. W. Norton.

Doidge, Norman. (1997) Empirical evidence for the efficacy of psychoanalytic psychotherapies and psychoanalysis: An overview. *Psychoanalytic Inquiry. (Suppl)*, 102-150.

Fonagy, P. & Moran, G.S. (1991). Understanding psychic change in child analysis. *International Journal of Psychoanalysis,* 72, 15-22.

Fonagy, P., Target, M. (2002). The History and Current Status of Outcome Research at the Anna Freud Centre . *Psychoanalytic Study of the Child,* 57:27-60.
Etchegoyen, H. R. (1999). *The fundamentals of psychoanalytic technique* (Revised Ed.). London: Karnac Books.

Fonagy, P., & Target, M. (1996). A contemporary psychoanalytical perspective: Psychodynamic developmental therapy. In E. Hibbs & P. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders. Empirically based strategies for clinical practice* (pp. 619-638). Washington, DC: American Psychological Association.

Fonagy, P., & Target, M. (2002). Psychodynamic approaches to child therapy. In F. Raslow & J. Magnavita (Eds.), *Comprehensive handbook of psychotherapy. Vol. I. Psychodynamic/object relations* (pp. 105-129). New Jersey: John Wiley & Sons.

Fonagy, P., Moran, G. S., Edgcumbe, R., Kennedy, H., & Target, M. (1993). The roles of mental representations and mental processes in therapeutic action. *The Psychoanalytic Study of the Child, 48,* 9-48.

Gabbard, G. O. (2004). *Long-term psychodynamic psychotherapy*. Washington, DC: American Psychiatric Publishing.

Hall, Jane; Caleo, Sue; Stevenson, Janine; Meares, Russell. (2001) An economic analysis of psychotherapy for borderline personality disorder patients. *The Journal of Mental Health Policy& Economics. Vol 4(1),* 3-8.

Hardy, Gillian E; Barkham, Michael; Shapiro, David A; Reynolds, Shirley; et al. (1995) Credibility and outcome of cognitive-behavioural and psychodynamic-interpersonal therapy. *British Journal of Clinical Psychology. Vol 34(4)*, 555-569.

Hardy, Gillian E; Barkham, Michael; Shapiro, David A; Stiles, William B; Rees, Anne; Reynolds, Shirley. (1995) Impact of Cluster C personality disorders on outcomes of contrasting brief psychotherapies for depression. *Journal of Consulting & Clinical Psychology. Vol 63(6)*, 997-1004.

Hardy, Gillian E; Shapiro, David A; Stiles, William B; Barkham, Michael. (1998) When and why does cognitive-behavioural treatment appear more effective than psychodynamic-interpersonal treatment? Discussion of the findings from the Second Sheffield Psychotherapy Project. *Journal of Mental Health. Vol 7(2)*, 179-190.

Heinicke, C.M. & Ramsey-Klee, D.M. (1986). Outcome of child psychotherapy as a function of frequency of session. *Journal of the American Academy of Child Psychiatry, 14*, 561-588.

Hau, S., & Leuzinger-Bohleber, M. (Eds.) (2005). *Psychoanalytic psychotherapy*. Position paper of the German Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatic und Tiefenpsychologie.

Kachele H, Krause R, Jones E et al (2000). An Open Door Review of Outcome Studies in Psychoanalysis. Fonagy P, ed London International Psychoanalytical Association. Available at http://www.ipa.org.uk

Kennedy, E. & Midgley, N. (2007). *Process and outcome research in child, adolescent and parent-infant psychotherapy: a thematic review.* London: North Central London Strategic Health Authority.

Keller W, Westhoff G, Dilg R, Rohner R, Studt HH. (2006). Effectiveness and utilization of health insurance benefits in long-term analyses: Results of an empirical follow-up study on the effectiveness of Jungian Analysis. http://www.uni-saarland.de/fak5/krause/ulm97/keller.htm

King, R (1998) Evidence-based Practice: Where is the Evidence? The Case of Cognitive Behaviour Therapy and Depression. *Australian Psychologist*, 33, 83-95.

Leichsenring, F & Rabung, S (2008) Effectiveness of Long-term Psychodynamic Psychotherapy: A Meta-analysis . *JAMA.* 300(13):1551-1565.

Lieberman, A. F., Van Horn, P. & Ghosh Ippen, C. (2005). Towards evidence-based treatment: Child-Parent psychotherapy with preschoolers exposed to marital violence. J. *Amer. Acad. Child. Adolesct. Psychiatry,* 44(12): 1241-8.

Lush, D., Boston, M., Morgan, J. & Kolvin, I. (1998). Psychoanalytic psychotherapy with disturbed adopted and foster children: a single case follow-up study. *Clinical Child Psychology & Psychiatry, 3,* 51-69.

Meares R, Stevenson J, Comerford A (1999), Psychotherapy with borderline patients: I. A comparison between treated and untreated cohorts. *ANZ J Psychiatry 33(4,* 467-472.

Meares, Russell; Stevenson, Janine; D'Angelo, Roberto. (2002) Eysenck's challenge to psychotherapy:A view of the effects 50 years on. *Australian & New Zealand Journal of Psychiatry. Vol 36(6),* 812-815.

Midgley, N. & Target, M. (2005). Recollections of being in child psychoanalysis. A Qualitative Study of a long-term follow-up project. *The Psychoanalytic Study of the Child, 60,* 157-177.

Midgley, N., Target, M. & Smith, J. (2006). The outcome of child psychoanalysis from the patient's point of view: A qualitative analysis of a long-term follow-up study. *Psychology and Psychotherapy: Theory, Research and Practice, 79,* 257-269.

Midgley, N., Anderson, J., Grainger, E. Nesic, T. & Urwin, C. (Eds.) (2009). *Child Psychotherapy and Research: New Approaches, Emerging Findings.* London: Routledge.

Milrod, B, Busch, F, Leon, AC, Shapiro, T, Aronson, A, Roiphe, J, Rudden, M, Singer, M, Goldman, H, Richter, D, & Shear, MK. (2000) Open Trial of Psychodynamic Psychotherapy for Panic Disorder: A Pilot Study. *Am J Psychiatry 157*:1878-1880,

Muratori, F., Picchi, L., Bruni, G., Patarnello, M. & Romagnoli, G. (2003). A two-year follow-up of psychodynamic psychotherapy for internalising disorders in children. *Journal of American Academy of Child Adolescent Psychiatry, 42,* 331-339.

Nichols, M. P., & Schwartz, R. C. (1991). Psychoanalytic family therapy. In M. P. Nichols & R. C. Schwartz (Eds.), *Family therapy: Concepts and methods* (pp. 179-227). Boston, MA: Allyn and Bacon.

Osimo, F. (2003). *Experiential short-term dynamic psychotherapy. A manual*. Bloomington: 1stbooks.

Pestalozzi, J., Frisch, S., Hinshelwood, R. D., & Houzel, D. (1998). *Psychoanalytic therapy in institutional settings*. London: Karnac Books.

Reid, S., Alvarez, A. & Lee, A. (2001). The Tavistock autism workshop approach: Assessment, treatment and research. In J. Richter & S. Coates (Eds.), *Autism – the search for coherence* (182-192). London: Jessica Kingsley.

Richardson P, Kächele H, Renlund C (eds) (2004). Research on psychoanalytic psychotherapy with adults. London: Karnac.

Robin, A. et al. (1999). A controlled comparison of family versus individual psychotherapy for adolescents with anorexia nervosa. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 1482-1489.

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

Sandell R, Lazar A, Grant J, Carlsson J, Schubert J, & Falkenström F. *Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP)* http://www.ipa.org.uk/research/sandell.asp

Schachter, A. (2009). *The adult outcome of child psychoanalysis: A long-term follow-up study.* Unpublished PhD thesis, University College, London.

Schachter, A., & Target, M. (2009). The adult outcome of child psychoanalysis: the Anna Freud Centre long-term follow-up study. In N. Midgley et al. (Eds.), *Child psychotherapy and research:new approaches, emerging findings.* London: Routledge.

Shapiro, David A; Barkham, Michael; Hardy, Gillian E; Morrison, Leslie A. (1990) The second Sheffield psychotherapy project: Rationale, design and preliminary outcome data. *British Journal of Medical Psychology. Vol 63(2),* 97-108.

Shapiro, David A; Barkham, Michael; Rees, Anne; Hardy, Gillian E; et al. (1994) Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting & Clinical Psychology. Vol 62(3),* 522-534.

Shapiro, David A; Firth, Jenny. (1987) Prescriptive v. exploratory psychotherapy: Outcomes of the Sheffield Psychotherapy Project. *British Journal of Psychiatry. Vol 151,* 790-799. Royal Coll of Psychiatrists, England

Shapiro, David A; Firth-Cozens, Jenny. (1990) Two-year follow-up of the Sheffield Psychotherapy Project. *British Journal of Psychiatry. Vol 157,* 389-391.

Shapiro, D A., Barkham, M., Rees, A., Hardy, G. E., et al. (1994) Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting & Clinical Psychology. Vol 62(3),* 522-534.

Shapiro, David A; Rees, Anne; Barkham, Michael; Hardy, Gillian. (1995) Effects of treatment duration and severity of depression on the maintenance of gains after cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting & Clinical Psychology. Vol 63(3),* 378-387.

Shapiro, D. A., Firth, J. (1987) Prescriptive v. exploratory psychotherapy: Outcomes of the Sheffield Psychotherapy Project. *British Journal of Psychiatry. Vol 151,* 790-799. Royal College of Psychiatrists, England.

Shedler J. (2009) The Efficacy of Psychodynamic Psychotherapy. http://www.internationalpsychoanalysis.net.2009.11.12 In press *American Psychologist*.

Stevenson, Janine; Meares, Russell. (1992) An outcome study of psychotherapy for patients with borderline personality disorder. *American Journal of Psychiatry. Vol 14 (3),* 358-362.

Stevenson, Janine; Meares, Russell. (1999) Psychotherapy with borderline patients: II. A preliminary cost benefit study. *Australian and New Zealand Journal of Psychiatry 1999*; 33:473–477.

Szapocznik, J. et al. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. *Journal of Consulting and Clinical Psychology, 57,* 571-578.

Target, M. & Fonagy, P. (1994a). The efficacy of psychoanalysis for children with emotional disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 33,* 361–371.

Target, M. & Fonagy, P. (1994b). The efficacy of psychoanalysis for children: Prediction of outcome in a developmental context. *Journal of the American Academy*

of Child & Adolescent Psychiatry, 33, 1134-1144.

Target, M. & Fonagy, P. (2002). Anna Freud Centre studies 3: The long-term follow-up of child analytic treatments (AFC3). In P. Fonagy (Ed.) *An open door review of outcome studies in psychoanalysis* (2nd ed.), (141–146). London: International Psychoanalytic Society.

Trowell, J. et al. (2002). Psychotherapy for sexually abused girls: psychopathological outcome findings and patterns of change. *British Journal of Psychiatry, 180,* 234–247.

Trowell, J., Joffe, I., Campell, J. [Correct spelling?] Clemente, C., Almqvist, F., Soininen, M., Koskenranta-Aalto, U., Weintraub, S., Kolaitis, G., Tomaras, V., Anastasopoulos, D., Grayson, K., Barnes, J., & Tsiantis, J. (2007). Childhood depression: a place for psychotherapy: an outcome study comparing individual psychodynamic psychotherapy and family therapy. *European Child and Adolescent Psychiatry. 16,* 157–167.

Valbak, K. (2004). Suitability for psychoanalytic psychotherapy: A review. *Acta Psychiatrica Scandinavica, 109,* 164-178.

Wallerstein, R. S., & Hoch, S. (1992). Psychoanalysis and psychoanalytic psychotherapy. Similarities and differences: Conceptual overview. *Journal of the American Psychoanalytic Association, 40,* 233-238.

Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014

http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-f-plan09

Statement of Rights and Responsibilities 2012:

http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/8F44E16A905D0537CA257B330073084D/$File/rights.pdf

APPENDIX A

Quick Reference to Treasury Discussion Paper / Q & A

Question 1: In your industry or field, are there studies or courses that that must be completed in order to meet license requirements?

Post-graduate training in long term intensive psychiatric treatment is *only* available from private providers. Continuing CPD is mandated as part of AHPRA requirements – see p4 & p9/10.

Question 2: Is training undertaken in your industry predominantly held in Australia or overseas? Can you provide examples?

Training is undertaken locally. But ongoing CPD requirements (see above) and maintaining skills necessitate meetings at overseas seminars and conferences. Australia's geographic isolation necessitates this to maintain standards of care and expertise – see p6.

Question 11: Are there any unintended consequences from the proposed reforms?

Yes; NAPP anticipates fewer specialist mental health practitioners, poorer patient outcomes , supervision and consultation will become less available for mental health practitioners, inadequate support for Continuing Professional Development, significant social costs from reduced specialist treatment availability, increased disability and unemployment welfare costs. Experienced clinicians will become scarce. See p4, p6 and p 7 – 10.

Question 12: What practical aspects of the proposed reforms need further consideration?

In the interests of maintaining the highest possible standards of patient care, professional practice, and continuing professional development NAPP urges Treasury not to cap legitimate specialist professional training programs and Continuing Professional Development (CPD) expenses at this time.

Rather, remedial policy options described might be considered more fully, or the proposals delayed until such time as a full enquiry into the matter can more accurately define how to achieve Treasury objectives. See p12.

APPENDIX B

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Reforms to self-education expense deductions

The Government will better target work related self-education expense deductions as part of a package of reforms to make a down-payment on the National Plan for School Improvement.

The Government values the investments people make in their own skills and recognises the benefits of a tax deduction for work related self-education expenses. However, under current arrangements these deductions are unlimited and provide an opportunity for people to enjoy significant private benefits at taxpayers' expense.

Education expenses include formal qualifications and associated tuition fees, textbooks, stationery and travel expenses and also conferences, seminars and self-organised study tours.

Without a cap on the amount that can be claimed under this deduction, it's possible to make large claims for expenses such as first class airfares, five star accommodation and expensive courses.

The Government will retain the incentive to invest in work related self-education through tax deductions and will introduce a cap on expenses to ensure the system remains fair.

From 1 July 2014, work related self-education expenses will be more fairly targeted through an annual cap of $2,000 a person.

Currently employers are not liable for fringe benefits tax for education and training they provide to their employees – this treatment will be retained, unless an employee salary sacrifices to obtain these benefits. This is in recognition of the need to encourage employers to continue to invest in the skills of their workers.

This is a targeted reform and the majority of those with self-education expenses will not be affected by this change.

According to the most recent ATO data, the typical claim for formal qualifications is less than half the proposed cap at $905. For other expenses, such as conferences, seminars and workshops, including those held locally, the typical claim is only a few hundred dollars, remaining well below the cap.

The Government will consult closely with employees and employers to better target this concession while still supporting essential training.

This reform will save $520 million over the forward estimates period. *Brisbane*

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