## Increase visits of psychological care

*The National Mental Health Commission review of all mental health services*

- 10 visit limit "by far the biggest complaint" from mental health professionals (Vol 3, p 14).
- Mental health professionals suggest either restore 18 visit limit, or alternatively, more equitable distribution of access to sessions with psychiatry at 50 sessions (Vol 3, p 14).
- Top suggestion from the public was to increase the number of sessions (Vol 3, p 11).
- Cited case study of a patient calls for "around 20 visits" (Vol 2, p 119).
- Commission states that "artificially curtailing the number of sessions" leaves suicidal people "'lost' to the system and without professional support" (Vol 2, p 118)
- "The Commission also considers that the number of sessions offered under Better Access should be based on clinical need and outcomes, rather than a pre designated number of sessions." (Vol 2, p 153)

*Relevant research from Randomised Clinical Trials (RCTs)*

*The National Institute of Mental Health 'Treatment of Depression Collaborative Research Program':*

- Largest RCT worldwide on treatments for depression
- The chief researcher (Elkin, 1994) writes "What is most striking in the follow-up findings is the relatively small percentage of patients who remain in treatment, fully recover, and remain completely well throughout the 18- month follow-up period."
- The average rate of recovery from depression was just **24% of patients achieved remission** from active treatments (CBT, IPT, medication, or a combination) delivered across 16 weeks.
- The main article on follow up outcomes from the NIMH project concludes that "The major finding of this study is that **16 weeks** of these specific forms of treatment is insufficient for most patients to achieve full recovery and lasting remission."

Elkin, I. (1994). The NIMH Treatment of Depression Collaborative Research Program. Where we began and where we are. In: A. E. Bergin & S. L. Garfield (Eds.), Handbook of Psychotherapy and Behavior Change (4th edn.) (pp. 114–139). New York: Wiley.

*A more recent (2013) large-scale high-quality RCT for psychological treatments of depression:*

- All participants met entry criteria of depression with diagnostic criteria assessed via MINI interview criteria and symptom severity using Hamilton Depression Rating Scale (N=341)
- **16 sessions** of CBT were delivered with assistance/guidance from treatment manuals
- The researchers state that "only **22.7% of the patients achieved remission** at post treatment, with 40% seeking additional treatment afterward"
- They conclude: "Our findings indicate that a substantial proportion of patients…require more than time-limited treatment to achieve remission." (p. 1047)
- The researchers added that "Since residual depressive symptoms have been found to be the main predictor of future relapse (34), our findings also indicate that psychotherapeutic treatment needs to be improved. The findings suggest that clinicians and policymakers should be realistic about the expected outcome of time-limited depression treatments and should bear in mind that mandated limits on treatment duration may lead to under treatment of depression." (p. 1048)

Driessen, E., Van, H. L., Don, F. J., Peen, J., Kool, S., Westra, D., Hendriksen, M., Schoevers, R. A., Cuijpers, P., Twisk, J. W. R., & Dekker, J. J. M. (2013). The efficacy of cognitive-behavioral therapy and psychodynamic therapy in the outpatient treatment of major depression: a randomized clinical trial. *American Journal of Psychiatry, 170,* 1041–1050.

- Reviews of controlled trials typically regard 'brief therapy' to mean up to 20 sessions.

*Relevant research from dose-response studies*

- Dose-response studies measure symptom severity session-by-session. They track outcomes continuously to find the point at which patients show statistically significant change and clinically meaningful change (i.e,. a reliable change bringing symptom severity closer to the mean for a normal population than a dysfunctional population).
- Dose-response studies typically evaluate the 'effective dose' (ED) point where either 50% of patients (i.e., ED50) or 75% of patients (ED75) have improved.
- There have now been 7 large dose-response studies about psychological care. I have provided a typical case example below. A summary of these studies can be accessed online.

*A large dose-response study in Australia (2010) comparing results to worldwide samples:*

- After 10 sessions of therapy 50% of patients show some signs of improvement. Of those with at least 'moderate' depression, only 34.7% show clinically significant change.
- After 18 sessions of therapy 75% of patients show some signs of improvement. Consistent with studies in the US these results showed 23 sessions were needed to improve for 70% of patients who had at least 'moderate' levels of symptom severity.
- The large-scale Better Access evaluation conducted here in Australia (2011) shows that over 80% of people begin therapy with 'high' to 'very high' levels of symptom severity.

Harnett, P., O'Donovan, A., & Lambert, M. J. (2010). The dose response relationship in psychotherapy: Implications for social policy. Clinical Psychologist, 14(2), 39-44.

*Relevant research from Headspace*

*A recent study published in Medical Journal of Australia tracked outcomes at various session points:*

- Outcome data was collected after sessions 1, 3, 6, 10, and 15, with a single 90 day follow up.
- Overall there was a statistically significant improvement for 36.1% of people, however, clinically significant change was only reached by 21.1% of the sample.
- Follow-up data was revealing, with Box 2 showing significant change after therapy ended, but only for those who completed a longer course of treatment (i.e., 15 sessions). Psychologist Julian McNally provides some interesting commentary on that finding.
- The researchers highlight the importance of the number of sessions to treatment outcome: "Improvement was predicted by greater distress (OR, 1.03; 95% CI, 1.02–1.04) and lower psychosocial functioning (OR, 0.94; 95% CI, 0.94–0.95) at service entry, and by **attending a greater number of service sessions** (OR, 1.16; 95% CI, 1.10–1.22)."

*Relevant research about relapse prevention*

A recent (2007) meta-analytic review of relapse and recurrence of depression for CBT responders:

- The review includes 28 studies following 1880 patients with major depressive disorder
- The acute phase of treatment in these studies is typically an initial 12 sessions of CBT.
- For those who initially respond well to CBT treatment, 29% relapse-recur within 12 months and 54% relapse-recur within 2 years.
- Over a mean of 68 weeks, the relapse rate of CBT is 39% and for pharmacotherapy was 61%. Adding medication to CBT doesn't reduce relapse rate significantly compared to CBT alone.
- Continuation CBT significantly reduces relapse rate. Averaging over 41 weeks, continuation CBT had a relapse rate of 12% and non-active controls have a relapse rate of 38%.
- Continuation phase of CBT is typically comprised of 10 further sessions (total ≈ 20 sessions)

Vittengl, J. R., Clark, L. A., Dunn, T. W., & Jarrett, R.B. (2007). Reducing relapse and recurrence in unipolar depression: a comparative meta-analysis of cognitive-behavioral therapy's effects. *Journal of Consulting and Clinical Psychology, 75*(3), 475-88.

*Treatment Guidelines*

- National Institute of Clinical Excellence (NICE) in the UK recommend that "For all people with depression having individual CBT, the duration of treatment should typically be in the range of **16 to 20 sessions over 3 to 4 months**" (Rec 1.5.3.2)
- Department of Defense and Veteran's Affairs in the US recommend continuation of therapy 9 to 12 months after the initial acute depressive symptoms resolve, to prevent relapse (p 7).
- Australian Psychological Society (APS) cites studies of CBT, IPT, and brief dynamic therapy, of a typical length of between 16 to 20+ sessions of care.
- BeyondBlue Guide to What Works for Depression recommends up to "24 weekly sessions" of cognitive behaviour therapy (CBT) or (IPT). NOTE: same finding in BB guide for anxiety.
- The Australian Association of Cognitive Behaviour Therapy (AACBT) state that a typical course of treatment in CBT is between 5 and 20 appointments long, but can take longer.
- The Royal College of Psychiatrists in the UK recommend that CBT occurs for up to 20 visits delivered in weekly to fortnightly sessions across a 6 month period.
- The Mayo Clinic provides world class health and mental health care in the USA and recommends CBT for a duration of 10 to 20 sessions varying on a number of factors beyond symptom severity.

*International Expert Opinion*

- In a recent training workshop about CBT, Dr Aaron T Beck (who invented cognitive therapy) made it clear that the number of sessions needed varies as a function of many other variables besides symptom severity. These factors include the patient's level of support, their personality, and their learning abilities. A clip of this is freely available on YouTube.
- Dr Aaron T Beck felt so strongly about this point that he wrote to our Minister for Health, Peter Dutton, saying that "24 visits or possibly more" would be optimal for the treatment of depression. You can read his letter online.
- The Executive Director of the Australian Psychological Society (APS), Lyn Littlefield, stated the following when asked about the number of sessions available via Medicare: "We agree that not even under the first iteration of Better Access was the number of allowable sessions based on the evidence. The figure for the number of sessions was an arbitrary one decided on by the Government at the time."

## Revise the classification system for 'Generalist' versus 'Clinical Psychologist'

*Major points*

- Different rates of Medicare support for the same treatment is unfair on patients.
- Disadvantaged people are most heavily impacted by receiving less support from Medicare.
- Despite different MBS item numbers the types of treatment are not differentiated.
- No differences in patient demographics or treatment outcomes have been identified.

*Open Letter from Dr Bill Saunders (Clinical Psychologist)*

- Previously in charge of Clinical Psychology training at Curtin University for many years.
- Points out evidence that background training in Clinical Psychology makes no difference to treatment outcomes.
- Cites communication with the National Chair of the APS College of Clinical Psychology (at the time Dr Deborah Wilmoth) who confirmed that there is no compelling evidence showing the superiority of Clinical Psychologists in mental health care.
- The open letter is freely available online.

*Articles in the journal Clinical Psychologist (2010) by Dr Tim Carey*

- Identifies that there is no difference in the operational definitions of 'focused psychological strategies' and 'psychological therapy' Medicare items (from the article):
  *"O'Kearney and Wilmoth maintain that these items are different types of services, with the psychological therapies requiring ''more independent clinical decision making'' (p. 81) and ''more expertise'' (p. 81). If this is the case, it is not expressed in the MBS. For psychological therapies, ''In addition to psychoeducation, it is recommended that cognitive behaviour therapy be provided. However, other evidence-based therapies – such as interpersonal therapy – may be used if considered clinically relevant'' (p. 722). For focused psychological strategies, ''A range of acceptable strategies has been approved'' (p. 726). Five strategies are listed: psychoeducation; cognitive behavioural therapy; relaxation strategies; skills training; and interpersonal therapy (p. 726). Thus, there seems little to justify describing these items as different types of therapy and it is unclear where the ''independent'' versus ''prescribed'' distinction emphasised by O'Kearney and Wilmoth is operationalised. The most defensible conclusion is that the two different items are, in fact, the same type of therapy."*
- Later points out that the expertise of other psychology specialists with advanced mental health care training of the exact same length as Clinical Psychologists (i.e. 8-10 years) is presently being rejected by the two-tiered system, without basis: "To suggest that a psychologist with a masters or doctorate in health psychology, forensic psychology, or counselling psychology (for example) does not have the necessary expertise to provide evidence-based psychological therapies is clearly fallacious." (p. 70)

Carey, T. A., , Rickwood, D. J., & Baker, K. (2010). Tying up some loose ends: A rejoinder's rejoinder. *Clinical Psychologist, 14*(2), 70-71

*International criticism of the two-tiered Medicare system in Australia*

- Highlights the convergence of Clinical and Counselling Psychology since the 1990s.
- Identifies the "faulty assumption that clinical psychologists are more specifically trained in and work with more serious mental health issues and client presentations" (p 25)
- Cites public surveys showing that public opinion about other psychologists has been skewed by the two-tiered Medicare classification system for psychologists.
- Points out that since the two-tiered classification system was introduced by Medicare, we have seen post-graduate (masters, doctorate, and PhD) Counselling Psychology courses disappear. Prior to 2006 there were five APAC accredited Counselling Psychology programs across Australia – now there are is just one full time program (at Curtin University).
- Argues that there is "no reliable evidence that clinical psychologists are more skilled or highly trained than other psychologists (Grant et al., 2008), or achieve better outcomes (Pirkis, Ftanou et al., 2011)."
- Concludes that more equity across levels of Medicare support is called for.
- Suggests that the present dichotomy in Medicare terminology be replaced with terms that are professionally neutral. That is, 'focused psychology therapy'/'psychological treatment' to be replaced with 'psychological care'. Similarly, 'generalist'/'clinical psychologist' should be replaced with 'applied psychologist' (as already exists in the NHS).

Meteyard, J., & O'Hara, Denis (2015). Counselling Psychology: A view from Australia. *Counselling Psychology Review, 30*(2), 20-31.