Threats to the future of psychodynamic psychotherapy in psychiatric practice.

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15th February 2022

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I will be addressing:

- RANZCP 2020 Mood Disorders Clinical Practice Guidelines
  - Misrepresents and omits the evidence base for psychodynamic psychotherapy (PDP), and
  - Poses threats to clinical practice, psychiatric training, and patient access to appropriate and necessary PDP treatment.
- Broader national and international context of devaluation, misrepresentation and denial of the efficacy, cost-effectiveness and value of PDP.
- Sociopolitical pressures to remove psychiatrists from providing psychotherapy treatments and continuity of psychotherapeutically- and trauma-informed mental health care.

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RANZCP Mood Disorders Clinical Practice Guidelines

- Peer group concerns re the newly published CPG's representation of PDP.
- June 2021: Initial letter to RANZCP, signed by 47 psychiatrists, citing issues of process & content, inc that the CPG:
  - Presented a misleading & limited depiction of depression
  - Appropriated the acronym ACE - already in common use representing 'Adverse Childhood Experiences'
  - Furthered negative attitudes and stigma towards patients with the diagnosis of borderline personality disorder, decontextualised patients and ignored structural aspects of the mental health system that lead to their re-traumatisation.
  - Failed to adequately detail effect sizes of psychotherapy treatments alongside those of psychotropic medications.
  - Made unreferenced statements that were disparaging of the clinical expertise and ethical codes of conduct of psychodynamic psychotherapists, such as "divergence from manualised depression treatment...may reflect a suboptimal occasion of care … a purposeless shift to unstructured or eclectic psychotherapy" (page 42) and that focus on therapist insight and the therapeutic relationship could be considered "a risk factor for unaccountable practice" (page 43).
  - Erroneously and misleadingly asserted in Box 14 "Psychological treatments for acute depression" that "there is no evidence to support open-ended or long-term psychodynamic psychotherapy". Acute not defined nor included in referenced texts.

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Our group highlighted to the College:

- There is a robust evidence base for PDP leading to significant and sustained improvement of depressive symptoms.
- Multiple references inc British Psychoanalytic Council re the "*strong and expanding evidence base*" for PDP, that noted it "is effective for many *common mental disorders, including depressive disorders…",* that *"longer-term (treatment) is more effective than shorter forms of therapy for the treatment of complex mental disorders"* … These had been provided to the CPG committee during the drafting process.
- The published CPG however, encouraged clinicians to "remain skeptical about the evidence base generally" *specifically* in relation to psychodynamic treatments and evidence-based clinical practice.
- The CPG's position was not in keeping with, and undermined, other College publications, including the Faculty of Psychotherapy submission to the Victorian Royal Commission into Mental Health and College Position Statement 54 'Psychotherapy Conducted by Psychiatrists'.

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August 2021: 137 Member signatories

Requested immediate retraction of the CPG and amendment with the evidence base

Multiple concerns re the continued presence of the CPG on the College website & journal:

- (i) misleading the public about the evidence base for PDP,
- (ii) providing incorrect information regarding PDP,
- (iii) negatively impacting processes of psychoeducation and informed consent,
- (iv) detriment to patients currently in psychiatric / psychotherapeutic treatment and
- (iv) the CPG places psychiatrists in a difficult legal position should patients believe psychiatrists are "not following guidelines" – i.e. using PDP.

Reputational damage of College members and the RANZCP.

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Re-submission September 2021: 174 signatories

RANZCP response October 2021:

- "You have highlighted the gap between what we know is helpful in clinical practice and what the strength of the evidence provides for us."
- Signatories were encouraged to support research in the psychotherapies, *as if the evidence base does not already exist*, and apply for a College research grant.
- Implicit acknowledgment re process issues in the CPG production; "an external review of guidelines development processes is being commissioned with the objective being a contemporary process".
- No engagement with Member-identified risks: Members invited to provide a response or commentary to ANZJP.

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ANZJP Correspondence (i)

July 2021: ANZJP Commentary by Leichsenring et al

- Professor of Psychotherapy Research, Germany. Main research foci include Psychotherapy research (inc treatment manuals), Evidence-based psychotherapy, Anxiety … depressive disorders… personality disorders, and Research methods"
- Noted "several factual errors leading to erroneous conclusions and recommendations with regard to the treatment of mood disorders. These errors refer to (1) the evidence for psychodynamic therapy in complex presentations, (2) the evidence for long-term psychodynamic therapy, (3) the stability of treatment effects, (4) the response rates achieved by psychodynamic therapy in depression and (5) the role of regression and insight in psychodynamic therapy."

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ANZJP Correspondence (ii)

November 2021: Letter to ANZJP on behalf of signatories;

- "the CPG findings are unreliable as the result of major factual errors, most notably the statement … that "There is no evidence to support open-ended or long-term psychodynamic therapy". We sought the CPG to be retracted "in order to correct the literature and ensure its integrity".
- The ANZJP Editorial Board responded, noting "your belief that there is sufficient evidence for (psychodynamic psychotherapy) to be recommended. We do not offer a view either way on this… … Even if the decision to omit psychodynamic psychotherapy as a recommended treatment for mood disorders was considered to be an error, we believe that this would not rise to a level that would require retraction of the manuscript. The assessment of whether a particular treatment has sufficient evidence to be recommended as a treatment requires judgement as to how the evidence is weighted, and it is understandable that differences of opinion will occur. The debate with respect to this is best conducted in an academic spirit, and to that end ANZJP is committed to publishing alternative views".

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Oct – Dec 2021: Repeated process of seeking Members Requisition General Meeting (MRGM)

- 184 signatories seeking Members Requisition General Meeting, under the Constitution (~ 3.5% of the Fellowship population)
- Supported and endorsed by the Binational Faculty of Psychotherapy. Endorsed by NAPP.
- 2 unsuccessful submissions despite MRGM requisition amended in accordance with RANZCP feedback.

>>> Delays, obstructionistic bureaucracy and complicating legalese requiring our group to seek legal assistance.

Subsequent legally-drawn letter to RANZCP 24th December 2021:

"…we wish to respectfully remind the Directors of their overarching fiduciary, common law and statutory obligations to act in good faith and in the best interests of the Company as a whole, including its Members (many of whom have been, and continue to be, substantially prejudiced by the matters the subject of the proposed resolution)"

Provision to RANZCP of a further legally-drawn MRGM requisition for review & clarification as to whether it meets the required 'threshold' for the Board to call a GM.

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RANZCP Response: 9th February 2022

Did not respond whether the provided requisition met the 'threshold'; MRGM obstructed

"…even in the event that the General Meeting is successfully requisitioned, the resolutions currently proposed, if passed, would still be non-binding advisory resolutions. In a legal sense, Directors may have regard to them but are not obliged to do so".

The College "has committed" to "timely commissioning of an independent external review of the evidence for psychodynamic psychotherapy which would in part inform additional work, including potentially amending if relevant the content in the CPG". "the College is liaising with external consultants to undertake this work via a formal request for quotation".

Repeated recommendation for Members & FoP to submit a paper to ANZJP "which would accommodate a quicker corrective action process". Abnegation of responsibility for the College-funded, produced and endorsed document.

No response to the requests to remove College-endorsement of the CPG while the content re PDP is under review.

"Our respective positions on this matter are aligned…".

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MBS Taskforce Psychiatry Clinical Committee Recommendations:

Medicare item 319

- Currently facilitates patients, typically with complex developmental trauma and often presenting with mood disorders, to access the appropriate, open-ended and longer-term psychiatric PDP, which for many would be otherwise inaccessible, especially given such therapy is generally not available in the public system.
- The Taskforce Psychiatry Clinical Committee (2020) recommended the amendment of 319 to read: "… if the patient has a complex and severe mental health disorder **for which there is an evidence base to support intensive psychotherapy as an effective treatment".**
- Clearly how the evidence base is defined has flow on effect for the definition, application and life of MBS item 319 and patient access.

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2019: The Ontario Ministry of Health & Long Term Care's Proposal

- Proposal by Ontario MoH "to radically limit psychotherapy provided by psychiatrists and family physicians".
- Dr Norman Doidge; "a battle for the soul of psychiatry**…** that will eventually get (psychiatrists) out of the business of ongoing care… … If it goes through, it will … turn psychiatrists from "treaters" into "consultants" who will diagnose patients in a single session, and make recommendations for others to follow, then wave goodbye. Diagnose, and adios. … It is a one-size-fits-all plan, and a quick-fix mentality".
- 16 visits / year chosen to reflect long-term psychotherapy practice (LTPP) / 48 visits intensive LTPP.
- Proposal to limit reimbursement beyond 24 visits / year
- LTPP compared to "nonessential cosmetic surgery". Patients needing intensive LTPP viewed as a "drain on the system".
- Patients with major depression to receive CBT / IPT, 1:1 or group, 16 – 20 sessions over 3 – 4 months by a therapist in accordance with a treatment manual.
- Financial incentives proposed for psychiatrists to see new / acute patients (to increase system capacity) rather than providing LTPP; "an incentive that cruelly disfigures, debases and guts the doctor-patient relationship".

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- Clinical Professor of Psychiatry, Dr Susan Lazar, noted that the practice of psychotherapy without limit in intensity or duration was "now being viewed with skepticism".

- In the CPG, we see the same encouragement of skepticism and disparaging attitude towards the practice and efficacy of PDP, the devaluation of non-manualised psychotherapies, the same attacks on the credibility, ethical practice and professionalism of psychiatrist psychodynamic psychotherapists.

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Parallels in the 2019 Australian Government Productivity Commission draft report

- Subspecialist psychiatric psychotherapy → "talking therapies" → Barrier to GP access to psychiatrists for 291 consults (implicitly real, needed CL psychiatry)
- No capacity built into the RV system to recognise psychiatric psychotherapy and continuity of care as efficacious *and* cost-effective specialty practice, i.e. 'matching consumers to the right level of care'. Trauma not included in the TOR.
- Spotlight focus on the 10% of psychiatric patients in Australia who need more than 10 consults a year (? monthly review), accounting "for just under 40% of total psychiatric consultations" and then → tiny subgroup, "…some consumers have dozens of consultations. About one thousand people had more than 50 such consultations".

Constructed Logical Conclusions:

- Psychiatrists dishing out "an unlimited number of sessions" in a picture of extravagance, wastefulness of resources and unnecessary servicing.
- Resources being misused / should be reallocated.
- Patients could be moved from psychiatric care to "alternative supports", including low intensity coaches, to increase access to psychiatrists
- Diagnose & Adios!
- Implicit movement towards stepped care model, as in the UK

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The data from Medicare actually demonstrated:

- ↑ MBS 291 uptake
- ↓ psychiatrist time spent w established patients … ↓ from 7 to 5 o/p appts (2000 – 2018)
- ↓ MBS 306, 316, 319 psychotherapy & psychotherapeutically-informed continuity of care

Mirrors trends in US outpatient psychiatric psychotherapy:

- Between 1996 - 2016, visits to a psychiatrist involving psychotherapy ↓ from 44.4% to 21.6%
- Between 2010 - 2016, about half of psychiatrists no longer provided psychotherapy at all.

Bringing together this data with that from the Vic Royal Commission into Mental Health:

- Clear relationship between the nature of the public MH & training system & the nature of private psychiatric practice
- Implications for re-visioned system(s): Will there be system capacity for psychiatric psychotherapy & continuity of care or will psychiatrists / trainees be kept or moved even further towards high acuity, brief, biomedical management?
- How does the College address the conflicts between acute system needs and the acute and longer-term needs of trainees and the profession?

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Addressing the CPG: Only one part of addressing devaluation & diminution of psychotherapy practice & competencies

2019: Binational FoP submitted formal recommendations to RANZCP that psychotherapy training for registrars needed expansion for devt of core skills, capacities and competencies.

European Board of Psychiatry mandatory psychotherapy component within European psychiatric training schemes comprises:

- Defined numbers of psychotherapy cases for clinical experience
- Minimum of 120 hours of theoretical teaching
- Minimum of 100 hours of clinical case supervision
- Psychodynamic, CBT and systemic theories should be taught
- Supervisors should be qualified
- Personal therapy is highly recommended
- Training should be publicly funded.

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Submission supported by TRC:

"concerned that Trainees may not be adequately exposed to psychotherapy "in practice" across the full range of settings and disorders"

"The general culture of mental health services in which we do … our training may not give us the necessary exposure to continuity of care, development of therapeutic relationships, different modalities of psychotherapy etc"

Trainees "may not acquire the appropriate skills, knowledge and experience necessary to provide psychotherapeutic care for clients with complex needs or nuanced leadership of teams who treat complex clients ..."

"By necessity we occupy service jobs which are often time- pressured, high-turnover, resource-poor, and in many cases do not view psychotherapy as part of their "core business"."

"There is a focus on formal Diagnosis to support funding structures, and formulation is often seen as a skill to learn for exams rather than a part of daily practice to inform patient-centred treatment plans. In addition to not acquiring adequate mastery of psychotherapy to enrich our assessments and treatment plans, we are also concerned that Trainees miss out on the professional and personal rewards that can occur when clients are seen over a period of time and recover"

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"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."

(Jeremy Holmes et al, 2007)

2021 Progress: a RANZCP meeting to scope development of surveys to collect data as to whether psychotherapy training requires expansion…

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2021: UK RCP, Faculty of Medical Psychotherapy Vice-Chair, Dr Jessica Yakeley:

Amidst College "promotion of psychiatry as a profession which takes a biopsychosocial approach… some of us have felt that there has been a drift away from considering the psychological aspects of the patient's difficulties."

"at least 4 key areas in which arguably many psychiatrists lack the confidence and/or skills:

- constructing psychologically-informed formulations,
- being able to prescribe/recommend psychological treatments,
- being able to conduct psychological treatments, and
- engaging in psychological research"

"If we do not take the view that psychiatry is a psychological profession this potentially has profoundly negative consequences for clinical care, psychiatric training and retention, and the perception of our identity as psychiatrists by our colleagues, patients and the general public."

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Implications & risks emerging from the CPG conclusions & College endorsement:
How will practice be shaped over time?

- Will trainees be able to see patients with depressive presentations for their psychotherapy long case?
- Will trainees (be reqd to) ingest the CPG model to pass exams? How will they be exposed to "alternative views" and experiential learning training in the public system?
- Psychiatrists and trainees may be dissuaded to pursue PDP training & practice, in a culture where this is progressively devalued and dismissed, including by their Membership College.
- Imminent shortage of psychiatrist psychotherapy supervisors already on the horizon
- Restriction of MBS Patient rebates. Decreased patient access & practice scope. Impacts on stigma.
- Conflicts relating to discrepancy between formal guidelines & personal / professional practices: not uncommon for psychiatrists & trainees to seek PDP, including for their own mood disorders. Moral injury & Vicarious traumatisation.
- ↑ difficulty for psychiatrists to access specialty psychiatrist psychotherapists for second opinion
- How will psychiatrist psychotherapists providing open-ended or longer-term PDP for patients with depression, fare in the medicolegal system in the event of an adverse outcome, when our College says the treatment has no evidence?

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The corruption of 'evidence based treatment', COI and clinical practice guidelines

- Professor Nancy McWilliams: "Despite lip service to continuity of care, our system fragments that continuity at every step of the help seeking process… and among the powerful, clinical values, clinical wisdom and patient preferences are often treated with contempt".

- She noted a "perfect storm… bringing together a confluence of factors", including "… interests of drug companies in framing mental suffering in terms of discrete conditions for which they can target medications; the interests of funders of treatments, whether government or private, in saving costs in the short term; … a preference for taxonomies that pursue reliability at the expense of clinical inference, idiographic understanding, complexity and dimensionality; incentives for academics to do quickly publishable research that cannot embrace real life clinical complexity; … wishful thinking and avoidance of noticing connections between mental disorders … poverty, … traumatic experiences, …and other toxic prejudices …" as contributors.

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- 2/3 CPG committee relevant COI: 58% declared financial grants or pharmaceutical company support with 8% (1 of 12) holding shares / options in a pharmacogenetics company.
- 1/3 declared no potential COI to the research, authorship and / or publication of the CPG.
- 2 CPG committee members sat on MBS Taskforce Clinical Psychiatric Committee providing recommendations re 319
- Primary author & Editor of ANZJP while CPG in production, referenced PDP psychiatrists as "those prone to over-interpretation and those who have chosen to practise a simulacrum of psychiatry" (May 2021)
- In an Editor's reflection re ANZJP publishing policy declared "poor science and bad practices that are simply wrong (turkeys) need to be identified and stamped out. The *ANZJP* aims to choke such turkeys and ensure that unhelpful or self-serving efforts are expunged" (Dec 2015)

- Confidentiality agreements bind Members of RANZCP committees
- COI declarations from College leadership or Board Members not released to Membership routinely.
  ? Relevant re maintained endorsement of the CPG

- The College seems to want the credibility of claiming all psychiatrists have specialty psychotherapy skills but without having to adequately address the significant concerns of its own specialty Psychotherapy Faculty and psychotherapist Members
- It has been suggested that psychiatrist PDP might find themselves on the College CPG cutting room floor because we hold the testimonies of the patients who have experienced iatrogenic harms emerging from psychologically-, trauma- and dynamically-uninformed psychiatric treatments.

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- "… the very definition of 'evidence-based treatment' has become corrupted. The original concept of evidence-based practice, derived from the field of medicine, includes three overlapping spheres to guide treatment – relevant scientific research, therapists' clinical judgment, and patients' values and preferences." The fields of psychology and medicine have "adopted the evidence-based practice model" and "then promptly stripped … two-thirds of its key components while the remaining third was severely restricted: the spheres of therapists' clinical judgment and patients' values/preferences have been subordinated, and the third component, relevant scientific research, has been reduced to mean only data from RCTs; other experimental formats, such as naturalistic, quasi-experimental and observational, are eliminated."

Linda Michaels, Co-Founder of PsiAN (Psychotherapy Action Network)

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2019: APA's CPG for the treatment of PTSD in Adults:

- More than 57,000 American psychotherapists and patients opposed the APA PTSD guideline "that powerful and effective treatments and other forms of evidence besides RCTs had been left out…".
- The CPG Chair wrote about how use of the Institute of Medicine's (IOM) model, "…necessary for … establishing … scientific credibility", led to the guideline "being developed in a relative vacuum… in which the long history of psychotherapy outcome research was treated as non-existent" and which "would not provide what the average clinician needed in terms of practical treatment guidance".
- They noted their concern "that psychologists (as well as other mental health professionals and third parties such as family members and insurance companies)… might mistake the recommendations of the guideline for the final word…".

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Current review of the UK NICE draft guideline on the Recognition and Management of Depression in Adults:

49 organisation stakeholder document indicated the guideline "not fit for purpose and if published will seriously impede the care of millions of people in the UK suffering from depression, potentially even causing clinical harm" and called for a "full and proper revision of the guideline".

- The guidelines "methodological approach… inherently favours (a) medical trials over psychological trials; and (b) particular psychological treatments over others. This is not an acceptable scientific stance and creates biases that are based on subjective choices rather than good scientific evidence of treatment effectiveness".
- "wide ranging …serious omissions and misinterpretations" and a quality assurance and overall process that "appear to fall short of acceptable scientific standards and lack scientific integrity".
- "… As the Health Foundation and Cochrane Collaboration have stressed, creating sound policy requires that we draw on a diverse range of evidence…".
- "the draft guideline … poses a serious threat to patient choice and will result in patients being offered a limited selection of treatments, which may not be the treatments that have the best chance of relieving their suffering (and which in turn will contribute to poor cost-effectiveness in the long term)".

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2019: Landmark US legal case - Wit vs United Behavioral Health

The Judge found that the Insurer had a COI that had significant impact on decision-making. The Insurer:

- "failed to apply medical necessity guidelines … consistent with generally accepted standards of care".
- Utilised Guidelines that prioritised crisis stabilization and insufficiently emphasised effective treatment of co-occurring and chronic conditions.
- Internal insurer communications made clear this derived from financial self-interest.

Significantly,

- 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" and the Judge outlined that;
- "accepted standards call for … effective … treatment of the individual's underlying condition and is not limited to the alleviation of the individual's current symptoms".
- **"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".**

2020: Subsequent to the Wit finding, California Bill (SB855) "expressly forbids insurers from limiting benefits or coverage for mental health and substance use disorders to short-term or acute treatment".

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My Conflicts of Interest:

- Psychodynamic / psychoanalytic psychotherapist psychiatrist
- Make my living via the provision of PDP
- Paid by my patients, who receive Medicare rebates, including for items 319, 306, 316.
- Member / Voluntary Committee work: Victorian Association of Psychoanalytic Psychotherapists (VAPP), Melbourne Association of Psychodynamic Psychiatry, (MAPP) RANZCP Faculty of Psychotherapy, National Association of Practising Psychiatrists (NAPP)
- PDP Teaching / Supervision (paid / unpaid)

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