Annexure A

Dear Members,

These proposed resolutions arise from significant concerns about the content of 'The 2020 RANZCP Clinical Practice Guideline (CPG) for Mood Disorders'[1]

<u>Risks emerging from the CPG's misrepresentation and omission of the evidence base for psychodynamic psychotherapy (PDP):</u>

(i) Discrepancies between RANZCP practice and education documents[1,2,4]

(ii) Negative impacts on psychoeducation and informed consent processes

(iii) Medicolegal risks for psychotherapists providing open-ended and long-term PDP for patients with depression,

(iv) In conjunction with recommended amendments to MBS 319 [3], threatens patient access to clinically appropriate PDP,

(v) Endangers the psychodynamic Psychotherapy Written Case (PWC) for trainees,

(vi) Criticism damaging to the reputation of RANZCP and its members,

(vii) Threatened availability of subspeciality PDP clinicians required to meet RANZCP training requirements and Member CPD needs.

Please register to vote

Or

Appoint Dr Melinda Jane Hill (ID 7018) as your proxy to vote FOR the proposed resolutions.

Abbreviated concerns include:

1. While published in ANZJP, the CPG is a RANZCP-funded, -produced and -formally endorsed guidelines, promoted as providing "up-to-date recommendations and guidance within an evidence-based framework, supplemented by expert clinical consensus" intended for multi-stakeholder use[1].

2. The CPG does not meet clinical practice guideline development standards.

RANZCP has responded to these concerns: "The Board has agreed to commission an independent external review that will inform approaches to developing future College CPGs".

This does not address the risks emerging from the current endorsed CPG content.

3. The CPG misrepresents and omits the evidence base for PDP.[2,4,5,6,7]

> "There is no evidence to support open-ended or long-term psychodynamic therapy."
>
> "Box 14. Psychological treatments for acute depression" (pg. 44)[1]

There are multiple clinical trials and meta-analyses that demonstrate long-term PDP leads to significant and sustained improvement of depression. Many psychotherapy trials provide long-term follow-up.[2,4,5,6,7]

Box 14's title is misleading; its references do not refer to 'acute depression', which is not defined. The heterogeneity of depression, and how to identify features that would suggest benefit or risks from PDP, are not elaborated.

The CPG content does not align with other RANZCP publications, including Position Statement 54 'Psychotherapy Conducted by Psychiatrists'[2] and the 2019 Faculty of Psychotherapy submission to the Royal Commission into Mental Health[4].

Leichsenring F. et al, 'Psychodynamic therapy of depression' (2021)[5] note in the CPG:

> "…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."[5]

Shedler (2022) in his presentation 'The efficacy of psychodynamic psychotherapy' discussed the evidence base and how it is misrepresented, expanding on his 2010 internationally acclaimed paper.[6,7]

4. The CPG makes disparaging and unreferenced remarks about PDP suggestive of bias.

"divergence from manualised depression treatment may reflect … a suboptimal occasion of care (e.g. a purposeless shift to unstructured or eclectic psychotherapy)." (pg. 42)[1]

"Detractors warn about the lack of standardisation (particularly in long-term variants).

… for detractors, this constitutes a missed opportunity for skill- development, and a risk factor for unaccountable practice."

"Box 13. Psychodynamic treatments and evidence-base clinical practice" (pg. 43)[1]

These comments disparage the expertise of specialist psychodynamic psychotherapists providing non-manualised psychotherapies. Their standards of clinical practice and by implication, ethical conduct, are made questionable.

"We encourage clinicians to remain skeptical about the evidence base generally…"

Box 13. Psychodynamic treatments and evidence-based clinical practice" (pg. 43)[1]

Clinicians and stakeholders are encouraged to "remain skeptical about the evidence base generally" *specifically* and *only* in relation to psychodynamic treatments; this suggests bias.

5. The CPG does not adequately address the importance of trauma in the treatment of mood disorders.

"…a new model for grouping the phenomenology of mood disorders… (the) ACE model" (pg. 11)[1]

The CPG misappropriates the ACE acronym - in use representing 'Adverse Childhood Experiences' - and does not address the requirement for a psychotherapeutic trauma-informed care and practice model.[4]

6. By denying the evidence base for open-ended and long-term PDP[1], the CPG threatens clinical practice and patient access to Medicare rebates for this treatment[3].

The Government is currently implementing the 2019 MBS Taskforce recommendations, which include amending Item 319 with the specifier *"for which there is an evidence base to support intensive psychotherapy as an effective treatment"*.[3] Maintained RANZCP endorsement of the CPG content relating to PDP threatens patient access to clinically appropriate PDP not available in the public system, risking worsening inequity.[4]

By highlighting the responsibility of psychologists *"…to only deliver evidence-based treatments… under Medicare"*[1], the CPG similarly imposes on psychologists' clinical practice and patient access.

<u>We submit these concerns, risks and our proposed resolutions to the membership for voting.</u>

Proposed resolutions:

i) The College forthwith remove its endorsement of the current CPG content relating to psychodynamic psychotherapy pending the outcome of the review referred to in paragraph (ii) below.

ii) The College commission a RANZCP working group, independent to the committee involved in the production of the current CPG:

a) whose membership includes clinicians with expertise and clinical experience in the psychodynamic psychotherapies; and
b) for the purpose of reviewing the evidence base, consulting with the clinical field and providing feedback, and if deemed appropriate, making recommendations to the College to amend relevant aspects of the current CPG content relating to psychodynamic psychotherapy.

iii) If determined appropriate by the independent working group, provide recommendations and a revised version of the specific CPG content relating to the psychodynamic psychotherapies in the assessment and treatment of Mood Disorders (including Complex and special presentations), referencing the contemporary evidence base, with a view to obtaining RANZCP endorsement and publication.

iv) The College promptly review the recommendations and any revised version of the abovementioned content and, subject to the recommendations of the independent working group, take immediate steps to replace the current CPG to facilitate multi-stakeholder reference.

References:

1. https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/mood-disorders-cpg-2020.aspx, https://doi.org/10.1177%2F0004867420979353

2. https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/psychotherapy-conducted-by-psychiatrists

3. https://www.health.gov.au/sites/default/files/documents/2020/12/taskforce-endorsed-report-psychiatry-clinical-committee.pdf

4. http://rcvmhs.archive.royalcommission.vic.gov.au/RANZCP_01.pdf

5. https://journals.sagepub.com/doi/pdf/10.1177/00048674211031481

6. https://www.ranzcp.org/practice-education/webinar-event-recordings/efficacy-of-psychodynamic-psychotherapy-a-lecture

7. https://jonathanshedler.com/PDFs/Shedler%20(2010)%20Efficacy%20of%20Psychodynamic%20Psychotherapy.pdf