Submission to Medicare Benefits Schedule Review

Re: Rebate equity for Accredited Mental Health Social Workers to that of Registered Psychologists, 'Better Access to Mental Health Services' program. Item numbers: 80150 – 80155 – 80160 – 80165 – 80170

October 2015

© Australian Association of Social Workers
National Office – Canberra
Unit 9, Block C
Trevor Pearcey House
28-34 Thynne Street
Bruces ACT 2617

PO Box 4956

KINGSTON ACT 2604

T 02 6232 3900

F 02 6230 4399

E advocacy@aasw.asn.au

www.aasw.asn.au

Table of Contents

Executive Summary *3*

Purpose of submission 3

Background 4

Eligible population and medical conditions for Better Access 5

The service 5

Equivalence of AMHSW education with Registered Psychologists 7

Equivalence of accountability and quality assurance processes 8

Work value 9

Summary *10*

Attachment 1 11

Attachment 2 12

Attachment 3 14

Executive Summary

This submission to the Medical Benefits Scheme (MBS) Review relates to an inherent inequity in rebates to Accredited Mental Health Social Workers (AMHSW) compared to Registered Psychologists under the Better Access to Mental Health Program. The submission requests an increased rebate equal to that of Registered Psychologists under this program for AMHSWs which can amount to $10 per session difference for relevant item numbers.

On advice from the former Department of Health & Ageing and the Minister for Mental Health in 2012, the AASW submitted a comprehensive case on the equity rebate issue to the Medical Services Advisory Committee (MSAC) in 2013. The response stated that since no new medical service was being proposed, MSAC was not in a position to assess the submission. As a result in June 2014 the AASW approached the government directly with our proposal. At the time, the National Mental Health Commission was undertaking a review of national mental health programs and the AASW was asked to make a submission to the Commission with a view to this issue being considered in the larger scheme of the review. The AASW lodged a submission to this review as suggested and the report of the Commission made a recommendation (Recommendation 13 point 9) in support of our submission.

> *Recommendation 13 point 9. Realign MBS benefits levels between allied health professionals: on the next indexation of MBS items, weight the first component of the increase to align MBS benefits for social workers and occupational therapists with those for registered psychologists, with any remaining elements of indexation then being distributed equitably across Better Access items (current differential is about 12 per cent or $8: parity would take up the first 0.9 per cent of any future indexation increase and cost $1.8 million).*

In addition to waiting for the Government response to the National Mental Health Commission's Review Report which favourably viewed our submission, the AASW is lodging this submission to the MBS Review.

Our submission firstly points out that the Medicare item descriptor, which is the basis for the rebate, is identical for Registered Psychologists and AMHSWs. The document goes on to present evidence of the equivalence of AMHSWs and Registered Psychologists on a number of key professional issues: competence, accountability, quality assurance and work value. Competence is established by examining the respective course contents and processes for skills acquisition. The accountability and quality assurance measures of the peak professional bodies, the Australian Psychological Society (APS) and the Australian Association of Social Workers (AASW), are also compared. Both are rigorous. The outcomes of an evaluation of *Better Access* by the Centre for Health Policy, Programs and Economics are drawn on to establish the effectiveness of *Better Access* and the work value of each profession involved in its delivery. Reference is made to the 'value add' of AMHSWs, in that as well as conscientiously addressing the clinical requirements of the *Better Access* program, they also address other aspects that improve resilience. It is therefore requested that on these grounds and in recognition of market place fairness, the Government acknowledge the equal contribution of AMHSWs to the *Better Access* program by approving the same rebate as that of Registered Psychologists for the relevant MBS item numbers.

Purpose of submission

In this submission the AASW will demonstrate that there are no valid reasons for there to be any

variance between the two rebates under Medicare for Registered Psychologists and AMHSWs providing services under the *Better Access* program. Where appropriate, peer-reviewed references will be cited in addition to the results of a December 2013 survey of AMHSWs. The table below provides information concerning the rebate discrepancies. The differences exist despite the service descriptors for the matched items (eg, 80100 and 80150) being identical (refer to Attachment 1).

Medicare designated fees and rebates for mental health consultations by profession

Registered Psychologist			Accredited Mental Health Social Worker			Difference in rebate
Item No.	**Fee**	**Rebate**	Item No.	**Fee**	**Rebate**	
80100	**$70.65**	**$60.10**	80150	**$62.25**	**$52.95**	**$7.15**
80105	**$96.15**	**$81.75**	80155	**$87.70**	**$74.55**	**$7.20**
80110	**$99.75**	**$84.80**	80160	**$87.55**	**$74.80**	**$10.00**
80115	**$125.30**	**$106.55**	80165	**$113.35**	**$96.35**	**$10.20**
80120	**$25.45**	**$21.65**	80170	**$22.35**	**$19.00**	**$2.65**

From 'Medicare Benefits Schedule: Allied Health Services 1 March 2014' Commonwealth Government

Background

AMHSWs are one of the few designated allied health profession groups eligible to provide private mental health services to people with diagnosed conditions under Medicare. As a group of providers, the nearly 1900 AMHSWs are the second largest after the combined group of Clinical Psychologists and Registered Psychologists. Since the commencement of *Better Access* in 2006 and without consultation with the AASW, the Medicare Rebate for AMHSWs has been less for each session of service than for Registered Psychologists. Nevertheless there are the same expectations of service delivery, quality and outcomes with identical item descriptors.

On advice from the former Department of Health & Ageing and the Minister, the AASW submitted a comprehensive case on the equity rebate issue to the Medical Services Advisory Committee (MSAC) in April 2013. Apart from factual information, the submission also contained official letters expressing support for AMHSWs from both the Royal Australian College of General Practitioners and the Royal Australian & New Zealand College of Psychiatrists. The AASW also presented a number of GP and Psychiatrist referees who were prepared to discuss the valued work of AMHSWs with the members of MSAC. (Both sets of references are contained in Attachments 2 and 3.) The feedback from MSAC in September of that year stated it was not within the scope of the Committee to consider a rebate issue for an existing program.

The AASW took up this decision with the Department of Health in December 2013, their suggestion being that the Association resubmit to MSAC. However it was understood by both the Department of Health officers and the AASW that the case was not a good fit with the role of MSAC and its documentary requirements. After considering this advice, given the previous experience with MSAC the AASW has chosen to approach the government directly (submission to the then Minister for Health the Hon Peter Dutton) with our proposal for equity in the rebate. As indicated above, the advice from this representation was to submit to the National Mental Health Commission to be considered in the National Review of Mental Health Programs and Services. The report of this review supported our equity

proposal.

The remainder of this submission provides extensive rationale for the increase in rebates for AMHSWs to an equal rate with Registered Psychologists when providing services under the Better Access to Mental Health program.

Eligible population and medical conditions for Better Access

Mental health problems can become evident at any age, however, most mental health conditions are first diagnosed in late adolescence and into adulthood. The *Better Access* program aims 'to improve treatment and management of mental illness within the community'[i]. It was introduced because the majority of people with more frequently-occurring (high prevalence) mental illnesses and disorders were not receiving treatment and care. High prevalence conditions include depression, anxiety, co-occurring anxiety and depression, and dual diagnosis (mental illness and substance misuse). This constituted a substantial unmet need. If left untreated, these conditions interfere with a person's thoughts, perception, memory, mood or behaviour and are associated with increasing distress or impaired functioning. In many instances, earlier intervention is considered necessary to avoid these conditions becoming more severe and disabling and thereby more costly to treat.

At the inception of *Better Access*, the Commonwealth stated that the program was neither designed nor intended to provide intensive, ongoing therapy for people with severe and persistent mental illness[ii]. At the same time it also acknowledged that there are some people with more complex needs who are using the services provided under *Better Access* for specific interventions under 'focused psychological strategies' and for care and support. However, GPs usually refer a person with a more intensive and/or less commonly occurring (low prevalence) mental illness to the public specialist mental health system or to a private Psychiatrist. Low prevalence, psychotic and non psychotic conditions include schizophrenia and bipolar disorder. However when a person with low prevalence disorders becomes symptomatically stable and there are ongoing emotional, cognitive and behavioural issues to address, a Psychiatrist can refer the person to an AMHSW or a Registered Psychologist. There is no age limit prescribed in *Better Access*, however, it is mainly accessed by the adult population.

The service

Better Access service provision

There are up to 10 individual allied mental health sessions available to a person with a diagnosed mental illness through *Better Access* in a calendar year (an initial six sessions with the possibility of four additional sessions after a GP clinical review). These services consist of:

- Focused psychological strategies services provided by GPs and/or
- Psychological therapy services provided by Clinical Psychologists and/or
- Focused Psychological Strategies (FPS) provided by appropriately trained psychologists, social workers and occupational therapists.[iii]

The majority of patients who are eligible for FPS are referred by GPs. AMHSWs and Registered Psychologists can accept referrals from GPs, Psychiatrists and Paediatricians, so the service provision and referral arrangements are not being challenged. There is no evidence that the medical professionals consistently refer clients with different presentations to psychologists than to social workers.

Interventions

The developers of the *Better Access* program identified a suite of Focused Psychological Strategies (FPS) as being short-term, largely evidence-based interventions for people with relatively common

mental disorders. FPS utilise Cognitive Behavioural Therapy, Behaviour Modification, Interpersonal Therapy, psycho education, relaxation strategies and skills training (eg. stress management, anger management). The common clinical themes with these interventions are that unhelpful or maladaptive thoughts, emotions and behaviours contribute to the persistence and degree of dysfunction from a mental health condition. There is also flexibility to include Narrative Therapy as an element of *Better Access'* FPS for clients of Aboriginal and Torres Strait Islander descent.

Evidence for the effectiveness of the interventions

There have been many studies of Cognitive Behaviour Therapy (CBT) and, to a lesser extent, Interpersonal Therapy. CBT has been demonstrated to be effective in treating a number of mental illnesses and disorders, particularly anxiety and depression[iv v vi]. Apart from single studies there have also been systemic reviews and meta analyses. The CBT studies also revealed that there are mental health conditions and client circumstances which may respond positively to other interventions as well[vii viii]. However these interventions have not been subjected to the same degree of investigation as has CBT.

There is more to be learned about CBT and other well known therapies. For example, it would be helpful to have a more nuanced knowledge concerning the specific disorders and conditions under which CBT (and other interventions) are best utilised. To this end, the Cochrane Collaboration - the gold standard in meta analyses - is undertaking a program of twelve reviews covering behavioural, cognitive behavioural, psychodynamic and other integrative, humanistic and 'third wave' psychological therapies compared with one another and treatment as usual. Examples of the reviews are contained in the endnotes[ix x xi].

Interpersonal Therapy also has a convincing body of evidence for its effectiveness in treating commonly occurring mental illnesses and disorders[xii xiii xiv]. It is particularly useful for depression linked to relationship difficulties. Narrative Therapy can be used with Aboriginal and Torres Strait Islander people. While there has been little outcomes based research in Narrative Therapy, its style suits the way Aboriginal and Torres Strait Islander people relate to difficulties in their personal world and to mental health issues.

Value add by AMHSWs

Social Workers maintain a dual focus in their engagement with people, analysing the change that needs to occur at an individual level as well as in their social context. This interactive individual and systemic analysis distinguishes social work from other helping professions. The goals of the *Better Access* program are to reduce psychological distress and improve mental health. It is feasible that timely and sufficient early intervention, early in life or early in the episode of a mental illness, will contribute to decreasing the prevalence of anxiety, depression and other mental health conditions. Reducing the burden of mental illness is likely to improve health, participation in education and the workforce, and eventually less use of the health, mental health and other services. However there will be individuals who despite receiving the benefits of therapy, experience conditions that undermine their mental health.

A more comprehensive approach to diminishing the prevalence and impact of mental health conditions in the community includes measures to improve resilience: protective measures that enhance the ability to preserve a measure of mental health in the face of adversity and harm reduction measures that enable a quick and effective recovery from adversity[xv]. The considerable bio-psychosocial research in this area reveals the interplay between individual, group and social factors[xvi]. Resilience and mental health are inextricably linked. It is understood that community and personal resilience and the development of protective factors are clearly influenced by the following inter relating variables:

- Environmental capital: structural factors of the natural and built environment that enhance community capacity for well being

- Social capital: networks and distribution of resources that enhance community cohesion and cooperation for mutual benefit
- Interpersonal capital: concerns healthy relationships
- Emotional and cognitive capital: individual skills and attributes to buffer stress[xvii].

The first two variables are largely out of scope for *Better Access.* The program and its service providers concentrate on the last two variables, interpersonal capital and emotional/cognitive capital, that are concerned with developing personal agency. However, in addition to clinical interventions (which focus on the last two variables), AMHSWs are concerned to strengthen a person's social capital, if needed and relevant. In private practice this means facilitating clients' access to other necessary services that address the non psychological problems affecting their mental health, in addition to encouraging participation or even actively connecting a client with social and community networks. Mobilising an individual's personal and social resources is crucial in effecting change[xviii].

Geographic access to service provision

A criticism of the *Better Access* program is that by relying on private providers, the program is widely available to people living in metropolitan areas compared to a scarcity on metropolitan fringes and in rural and remote areas. The AMHSW survey referred to earlier showed that the distribution of AMHSWs seemed to follow that of the population distribution. This suggests that as a professional group, AMHSW are able to deliver this important early intervention program to a more representative proportion of the population. The survey also found that the majority had over five years experience as an AMHSW.

Geographic location of AMHSW practice by % AMHSW responses and Australian Bureau of Statistics population data

Location options	% AMHSW Response	ABS % population distribution data 2009
Major City (inner & outer)	59.7	64
Regional Australia (inner & outer)	36.1	33.7
Remote and very remote Australia	4.1	2.3

From the AASW Accredited Mental Health Social Workers Survey December 2013

Equivalence of AMHSW education with Registered Psychologists

The choice of the comparator rests on the equivalent competence and work value of Registered Psychologists and AMHSWs. The table below summarises the key components of 'competence' in the two professions.

Components of professional competence

Components of 'competence'	Registered Psychologist	Accredited Mental Health Social Worker
Qualification requirements and qualification duration	A 4 year course in Psychology, usually BSc (Hons), with either two years supervised practice or a post graduate qualification in psychology.	Bachelor of Social Work (4 year) or a relevant Bachelor degree and a 2 year Masters of Social Work (qualifying) with at least 2 years post qualifying supervised practice experience - approximately 55% have 5 or more years, and AMHSWs often possess post graduate

Components of 'competence'	Registered Psychologist	Accredited Mental Health Social Worker
		qualifications.
Knowledge in a typical qualifying course for practice in FPS (taken from course information)	Human behaviour and its underlying psychological processes; measurement of psychological abilities, how abilities develop over the lifespan and the processes that govern the relationships between people and groups in society; an education in developmental, social, cognitive, and abnormal psychology.	A compulsory course component on mental health; human behaviour and development, personality development, life-cycle stages, family and social networks, health, disability, vulnerability and resilience; understanding the context of social work practice — structures, dynamics and their influences on society; cross cultural practice and Aboriginal and Torres Strait Islander cultures.
Professional skills for FPS in qualifying course	A science-based approach to understanding psychological issues; psychological assessment and survey skills; using interventions under a regulated supervision process.	Comprehensive bio psychosocial assessments leading to decisions about the most appropriate intervention; acquiring and practicing interpersonal and therapeutic skills and using interventions under a regulated supervision process; communication skills, both oral and written; critical analysis; qualitative and quantitative research methods.

It is apparent that both professions share core knowledge and skills, crucial to service delivery under the *Better Access Program*, as well as bringing a distinctive contribution.

The accompanying considerations to 'competence' are:

- accountability & quality assurance processes
- work 'value'.

Equivalence of accountability and quality assurance processes

The table below summarises the expectations of both professions with regard to accountability and quality assurance.

Registered Psychologist	Accredited Mental Health Social Worker
Must: - be a Registered Psychologist accountable to the Psychology Board of Australia (PBA) - have sufficient indemnity insurance - meet the PBA approved Continuing Professional Development requirements: 30 hrs pa, including 10 hrs in FPS related education & training	Must: - be an AASW member having completed an AASW accredited Social Work university course and adhering to the Association's Code of Ethics; AASW membership provides professional indemnity insurance - have at least 2 years post qualifying supervised practice experience in the mental

Registered Psychologist	Accredited Mental Health Social Worker
- receive regular clinical supervision - be subject to PBA and Medicare audits.	health or related field which meets the standards in the AASW Practice Standards for Mental Health Social Workers (2008). - be subject to a process to establish clinical competence - provide a referee statement and evidence of recent employment in therapeutic clinical practice - receive regular clinical supervision - meet AASW Continuing Professional Development (CPD) requirements: 50 hrs pa, including 20 hrs mental health plus 10 hrs FPS related education & training - be subject to AASW and Medicare CPD audits. While still seeking registration with NRAS, the AASW has released two key **Registered Collective Trademarks** only to be used by accredited social workers, of which AMHSWs form one group.

From the Australian Psychological Society and the Australian Association of Social Workers websites

The AASW and the APS implement strictly applied accountability and quality assurance measures.

Work value

Work value can be assessed by the outcomes of the work in question. The earlier references to the peer reviewed literature on Focused Psychological Strategies demonstrated the effective outcomes of appropriately applied practice. In addition, the AASW refers to the two components of the 'Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative' (2010), which studied consumers and their outcomes in component A and other *Better Access* providers in A2.

'Better Access consumers respond well to the care they receive through the initiative. Not only are they extremely satisfied with the skills of the providers they see and the quality of the treatment they are offered, but they also make statistically significant and clinically meaningful gains when assessed by standardised mental health outcome measures. Many report that their symptoms reduce, their psychological distress diminishes, and their overall wellbeing improves.' (Component A)[xix]

'*Consumers who receive care from these providers recognise them as skilled specialists with much to offer in terms of cognitive and behaviour therapies. These consumers commonly report that the treatment offered ...... results in reduced symptomatology, decreased psychological distress and improved general well-being*.' (Component A2)[xx]

Finally, an Australian study assessed whether professional social workers provided specific training in brief cognitive behavioural strategies could deliver this therapy. The structure of the study involved a

randomised control trial in a primary health setting. A brief educational intervention was used in the experimental group. Compared with the control group, the specifically trained group significantly improved their objectively measured competence as well as their subjective perceptions of competence in delivering the cognitive behavioural strategies[xxi]. In the *Better Access* program, all mental health providers are required to undertake initial then annual professional development in Focused Psychological Strategies. The results of this study lay to rest any doubts about AMHSW capabilities in delivering services under *Better Access*.

The AASW sets a high bar for qualified social workers to become an AMHSW and is confident of their ability to deliver Focused Psychological Strategies. It is worth stating here that other national and state programs do not discriminate against social workers. For example, the National Disability Insurance Agency reimburses privately contracted AASW AMHSWs the same as other professionals who provide services under the NDIS. Similar arrangements apply under the Access to Allied Psychological Services (ATAPS) program and in DVA's Veterans and Veterans Families Counselling Services.

Summary

This submission presents evidence of the equivalence of AMHSWs and Registered Psychologists on a number of key professional issues: competence, accountability, quality assurance and work value. Competence is established by examining the respective course contents and processes for skills acquisition. The accountability and quality assurance measures of the peak professional bodies are also compared. Both are rigorous. The outcomes of an evaluation of *Better Access* by the Centre for Health Policy, Programs and Economics are drawn on to establish the effectiveness of *Better Access* and the work value of the professions involved in its delivery. Reference is also made in this submission to the 'value add' of AMHSWs in that they consciously address the clinical requirements of the program and also those aspects that improve resilience. It is therefore requested that the Government recognise the equal contribution of AMHSWs to the *Better Access* program by approving the same rebate as that of Registered Psychologists for the MBS item numbers: 80150, 80155, 80160, 80165 and 80170.

Attachment 1

Example of Focused Psychological Strategies MBS item descriptors for a 20-50 minute consultation.

Registered Psychologist

MBS Item 80100

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service – lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

From Medicare Australia *Medicare Benefits Schedule: Allied Health Services 1 March 2014* Commonwealth Government Online ISBN: 978-1-74186-085-6 Publications approval number: 10586 p55

Accredited Mental Health Social Worker

MBS Item 80150

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a social worker registered with Medicare Australia as meeting the credentialing requirements for provision of this service – lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

From Medicare Australia *Medicare Benefits Schedule: Allied Health Services 1 March 2014* Commonwealth Government Online ISBN: 978-1-74186-085-6 Publications approval number: 10586 p57

Attachment 2

Letters of support from the Royal Australian & New Zealand College of Psychiatrists and Royal Australian College of General Practitioners.

13 May 2013

Ms Glenys Wilkinson
Chief Executive Officer
Australian Association of Social Workers
PO Box 4956
Kingston ACT 2604

By e-mail to: ceo@aasw.asn.au

Dear Ms Wilkinson,

Re: Clinical competence of Accredited Mental Health Social Workers

Thank you for your correspondence dated 6 May 2013 requesting that The Royal Australian and New Zealand College of Psychiatrists (RANZCP) consider providing the Australian Association of Social Workers (AASW) with a letter of support regarding clinical competence of Accredited Mental Health Social Workers.

The RANZCP acknowledges that Accredited Mental Health Social Workers are valuable members of multidisciplinary mental health teams.

The RANZCP further recognises the significant role of Accredited Mental Health Social Workers and the important skills they contribute to the mental health care of patients.

Should you wish to discuss this matter further I invite you to contact Ms Jessica Spiers, Manager External Relations, via jessica.spiers@ranzcp.org or on (03) 9601 4926.

Yours sincerely

Dr Maria Tomasic
President

Ref: 3044

309 La Trobe Street, Melbourne VIC 3000 Australia
T +61 3 9640 0646 F +61 3 9642 5652
ranzcp@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

Healthy Profession.
Healthy Australia.

22 May 2013

Ms Glenys Wilkinson
Chief Executive Officer
Australian Association of Social Workers
Level 4 / 33-35 Ainslie Place
Canberra City ACT 2600

Dear Ms Wilkinson

Re: Request for letter of Support regarding clinical competence of accredited Mental Health Social Workers.

Thank you for your letter dated 26 April 2013 informing the Royal Australian College of General Practitioners (RACGP) of the different pay scales currently affecting social workers working with Access to Allied Psychological Services (ATAPS) and the Better Access Initiative and for your request for a letter of support to be submitted to the Medical Services Advisory Committee.(MSAC)

Whilst, the RACGP is aware that many general practitioners (GPs) do refer to social workers for the care of patients under these programs and patients benefit as a result of your members' care, the College is not an industrial advocacy body and as such is not aware of the historical reasons for the difference in rates for your members.

Nonetheless, we regard the provision of quality services to patients in all locations to be very important and acknowledge that remuneration of a professional can, and often does, influence their ability to provide and sustain quality care.

We wish you well in your application to the Medical Services Advisory Committee and hope to talk to the MSAC representative when approached in due course.

Yours sincerely

M. C. Rawlin.

Associate Professor Morton Rawlin
Chair, RACGP Victoria Faculty

23 MAY 2013

The Royal Australian College of General Practitioners
100 Wellington Parade, East Melbourne, Victoria 3002 Tel +61 3 8699 0414 Fax +61 3 8699 0400
www.racgp.org.au ACN 000 223 807 ABN 34 000 223 807

Attachment 3

GP and Psychiatrist referees who were prepared to discuss the valued work of AMHSWs with the members of Medical Services Advisory Committee.

General Practitioners

- Dr Rachel Harvey
  Naas Street Primary Health Care Clinic
  1-5 Naas Street
  TENTERFIELD NSW 2372
  Ph: (02) 6739 5200
  Email: Rachel.Harvey@hnehealth.nsw.gov.au

- Dr Maxine Manifold
  Seaport Medical Practice
  3/29 Seaport Boulevard
  LAUNCESTON TAS 7250
  Ph: (03) 6333 0460 or 0419 360 748
  Email: maxineonline@iinet.net.au

- Dr Michelle Johnston
  GP Practices in Landsborough & in Montville
  MALENY QLD 4552
  Ph: (07) 549 9023 or 0429 474 281
  Email: mich.johnt@bigpond.com

Psychiatrists

- Dr Peter Norrie
  Director of Clinical Services
  Canberra Hospital & Health Services and
  Chief Psychiatrist
  Mental Health, Justice Health and Alcohol & Drug Services
  CANBERRA ACT 2600
  Ph: 0434 604 200
  Email: Peter.Norrie@act.gov.au

- Dr Nathan Kalyanam
  Snr Psychiatric Consultant
  Bayside Mental Health Services and Darling Downs Health Service and Senior Lecturer
  Department of Psychiatry
  University of Queensland QLD 4067
  Ph: 0411 165 067
  Email: Nathan_Kalyanam@health.qld.gov.au

End Notes

[i] Department of Health website 2014 *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative* Commonwealth Government http://www.health.gov.au/mentalhealth-betteraccess Accessed 28/5/2014

[ii] Department of Health *Fact sheet: Transition arrangements for the allied mental health services available under the Better Access initiative* Feb 2012 Commonwealth Government http://www.health.gov.au/mentalhealth-betteraccess Accessed 28/5/2014

[iii] Medicare Australia *Medicare Benefits Schedule: Allied Health Services 1 March 2014* Commonwealth Government Online ISBN: 978-1-74186-085-6 Publications approval number: 10586 p43

[iv] Whitfield G & Williams C 2003 'The evidence base for Cognitive Behaviour Therapy in depression: delivery in busy clinical settings' *Advances in Psychiatric Treatment: journal of continuing professional development*, 9, pp21-30

[v] Hofman S, Asnaani A, Vonk I, Sawyer A & Fang A, 2012 'The efficacy of Cognitive Behaviour Therapy: a review of meta analyses', *Cognitive Therapy Research*, 36(5) pp427-440

[vi] Substance abuse and Mental Health Services Administration 2014 *National Registry of Evidence based Programs and Practices 'Cognitive Behaviour Therapy for depression and anxiety disorders'*, US Department of Health and Human Services http://www. samhsa.gov Accessed 4/5/2014

[vii] Shinohara K, Honyashiki M, Imai H, Hunot V, Caldwell D, Davies P, Moore T, Furukawa T & Churchill R. 2013 'Behavioural therapies versus other psychological therapies for depression' *Cochrane Database of Systematic Reviews*, Issue 10. Art. No.: CD008696. DOI: 10.1002/14651858.CD008696.pub2. Accessed 20/1/2014

[viii] Dennis C and Hodnett E 2007 'Psychosocial and psychological interventions for treating postpartum depression', *Cochrane Database of Systematic Reviews*, Issue 4. Art. No.: CD006116. DOI: 10.1002/14651858.CD006116.pub2. Accessed 20/1/2014

[ix] Churchill R, Moore THM, Caldwell D, Davies P, Jones H, Furukawa TA, Lewis G & Hunot V. 2010 Cognitive behavioural therapies versus other psychological therapies for depression (Protocol). *Cochrane Database of Systematic Reviews*, Issue 9. Art. No.: CD008698. DOI: 10.1002/14651858.CD008698. Accessed 4/5/2014

[x] Hunot V, Moore T, Caldwell D, Davies P, Jones H, Furukawa T, Lewis G & Churchill R. 2010 Cognitive behavioural therapies versus treatment as usual for depression (Protocol). *Cochrane Database of Systematic Reviews*, Issue 9. Art. No.: CD008699. DOI: 10.1002/14651858.CD008699. Accessed 4/5/2014

[xi] Churchill R, Moore T, Davies P, Caldwell D, Jones H, Lewis G & Hunot V, 2010 Psychodynamic therapies versus other psychological therapies for depression (Protocol). *Cochrane Database of Systematic Reviews 2010*, Issue 9. Art. No.: CD008706. DOI: 10.1002/14651858.CD008706. Accessed 4/5/2014

[xii] Weissman M, Markowitz J & Klerman G 2000 *Comprehensive guide to interpersonal psychotherapy*, New York Basic Books, NY

[xiii] Stuart S & Robertson M. 2003 *Interpersonal Psychotherapy; a clinician's guide* Arnold London

[xiv] Ravitz P 'The interpersonal fulcrum – Interpersonal Therapy for treatment of depression' *Evidence based psychotherapies*, Canadian Psychiatric Association, ww1.cpa-apc.org/Publications Accessed 29/4/2014

[xv] Davydov D, Stewart R, Ritchie K & Chaudieu I, 2010 'Resilience and mental health' *Clinical Psychology Review*, 30 (5) 479-495

[xvi] Ibid

[xvii] Friedli L 2009 *Mental Health, resilience and inequalities*, World Health Organisation Europe p23

[xviii] Duncan B, Miller S, Wampold B & Hubble M (eds) 2009 *The heart and soul of change second edition: delivering what works in therapy'*, American Psychological Association pp100-101

[xix] Pirkis J, Ftanou M, Williamson M, Machlin A, Warr D, Christo J, Castan L, Spittal M, Bassilios & Harris M 2010 *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative Component A: a study of consumers and their outcomes Final Report,* Centre for Health Policy, Programs and Economics, University of Melbourne p2

[xx] Pirkis J, Williamson M, Ftanou M, Machlin A, Warr D, Castan L, Christo J & Harris M 2010 *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative Component A2: a study of consumers and their outcomes (focussing on the occupational therapy and social work sectors) Final Report,* Centre for Health Policy, Programs and Economics, University of Melbourne p2

[xxi] Armstrong G, Blashki G, Joubert L, Bland R, Moulding R, Gumm J & Naccarella. L. 2010 'An evaluation of the effect of an educational intervention for Australian social workers on competence in delivering brief cognitive behavioural strategies: a randomise control trial', *BioMed Central Health Services Research*, (10) pp304-312

Submitted for and on behalf of the Australian Association of Social workers Ltd

Glenys Wilkinson
Chief Executive Officer