Commonwealth Government

Medicare Benefits Schedule (MBS) Review

Response to the report from the Mental Health Reference Group

Occupational Therapy Australia submission

June 2019

Occupational Therapy Australia Limited ABN 27 025 075 008 | ACN 127 396 945
6 / 340 Gore St. Fitzroy VIC 3065
Ph +61 3 9415 2900 | Fax +61 3 9416 1421 | Email policy@otaus.com.au | Website www.otaus.com.au

Introduction

Occupational Therapy Australia (OTA) welcomes the opportunity to provide a submission in response to the report from the Mental Health Reference Group advising the MBS Review Taskforce.

OTA is the professional association and peak representative body for occupational therapists in Australia. As of March 2019, there were more than 21,000 registered occupational therapists working across the government, non-government, private and community sectors in Australia. Occupational therapists are allied health professionals whose role is to enable their clients to participate in meaningful and productive activities.

Occupational therapists provide services such as physical and mental health therapy, vocational rehabilitation, chronic disease management, assessments for assistive technology and home modifications, and key disability supports and services.

As noted in our earlier submissions to the review, mental health service provision is a core area of practice for occupational therapists dating back to the beginning of the profession more than 100 years ago. Occupational therapists work across the spectrum of mental illness, providing services to people with mild, moderate and severe mental health conditions. They deliver services to people with relatively common conditions such as anxiety disorders, as well as more severe conditions that require targeted interventions, such as psychosis, trauma-related disorders and complex presentations with multiple/chronic conditions involved. In addition, as is common across all professions working in mental health who complete additional training to be competent to do so, suitably trained occupational therapists also provide interventions such as psychotherapy, counselling and other psychological strategies.

Occupational therapists are accredited to provide services under the Commonwealth Government's Better Access to Mental Health initiative, with around 1,000 OTA members currently endorsed to work within this scheme.

Response to the recommendations in the report

Recommendation 1 – Expand the Better Access Program to at-risk patients

OTA endorses this recommendation.

While including 'at-risk patients' will have an impact on demand, evidence supports early identification and early intervention because they can have a positive effect on the health outcomes of this group of people. The importance of early identification and early intervention has been identified in the 3rd, 4th and 5th National Mental Health Plans, as well as other government documents such as the Council of Australian Governments (COAG) National Action Plan for Mental Health.

McCrone et al (2015) also found that such early intervention would be a cost-effective approach to mental health care, with Bond et al (2015) finding some indication of enhanced outcomes through early intervention approaches.

Occupational therapists are experts in assessing – using evidence-based tools – and understanding the impact of a condition such as a mental illness on patients' function in their daily roles and activities. Cross et al (2016) point to the importance of occupational therapists within early intervention mental health programs and approaches. An occupational therapist's assessment processes can contribute to the early identification of and intervention for functioning problems, and the ability of people with a mental illness to participate in the community, employment and education.

Recommendation 2 – Increase the maximum number of sessions per referral

Occupational therapy is a client-centred strengths-based discipline. Treatment should therefore reflect patients' needs and levels of functioning. Bond et al (2015) comment on the need for interventions to be able to be delivered intensively if required, which the current limit on sessions can preclude.

While OTA endorses this recommendation, the process of accessing the supplementary sessions should not interrupt, or should have minimal impact on, the flow of treatment and its delivery to ensure maximum health outcomes.

Recommendation 3 – Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness

OTA supports the move to sessions being provided over a 12-month period rather than during the course of a calendar year to ensure consistency of access for all Australians. We also endorse the proposed three-tiered system.

OTA strongly supports the recommendation that criteria beyond diagnosis be used to determine the tier threshold levels, including:

- Severity of symptoms;
- Duration of condition;
- Impact of disorder on functioning (occupational therapists are best skilled to determine the impact of a person's condition on their functional capacity);
- Response to previous treatment;
- Complexity; and
- Social Determinants of health (for example education level etc).

Thieme et al (2015) report the need for the design of mental health services to move beyond an illness perspective to a wellbeing perspective.

OTA strongly recommends that there be no restrictions placed on which Better Access endorsed clinicians can provide services on which tier. Cross et al (2015) included a wide range of professionals in their study on effective outcomes in mental health intervention, including occupational therapists and social workers, as well as dietitians, and physical and exercise therapists. The choice of the most appropriate mental health professional for a given patient should be left to the referring GP or psychiatrist.

OTA is of the view that there is no need to limit the options of those Australians seeking help from their preferred clinician when there is already an established clinical overseer to evaluate what is in the best interests of the patient. This is especially true given the maldistribution of the allied health workforce across Australia, and when evidence points to the quality of the therapeutic alliance as being more important than any particular therapeutic technique. The referring doctor can make the decision based on:

- The known capability of local clinicians available or the suitability of telehealth services;
- The best fit of profession/skill/expertise with the patient's specific mental health need/s;
- The current therapeutic alliance with the existing clinician, and whether ongoing engagement with a known clinician might obtain better outcomes for a hard-to-engage patient than commencing with a person more qualified/experienced to treat a specific condition or need (evidence has shown that a therapeutic alliance is a predictor of recovery and health outcomes in patients);
- Progress that has been made so far by the current clinician, and the anticipated progress that might be possible with another individual; and
- The impact of no intervention during periods spent waiting for highly effective clinicians to be able to accept the patient onto their caseload.

Recommendation 4 – Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups

OTA supports the establishment of a separate working group to review the current rebate structure. OTA supports a new, balanced and diverse working group or committee with a membership that will limit bias in the acknowledgement of different disciplines. We note that the original group included a majority of psychologists and did not properly represent or acknowledge other disciplines. Cross et al (2015) point to the need for a range of professions to be involved in mental health services in order to achieve effective outcomes.

We support the proposal that this working group not be comprised of representatives from the various stakeholder professional groups, as it would continue to result in the ongoing stalemate regarding capability to provide services to clients with mental health diagnoses in Australia.

As a result of the decision made in 2010 to exclude occupational therapists and social workers from the Better Access to Mental Health program, many occupational therapy practices were rendered unviable. This decision was subsequently reversed when it became apparent to government that a substantial number of patients relying on occupational therapists for optimum mental health care had been profoundly disadvantaged. Regrettably, it took nearly twelve months for the decision,

which had no basis in scientific evidence – indeed Erlandsson et al's (2017) systematic review into the effectiveness of occupational therapy in specific mental health interventions found that occupational therapists achieve excellent outcomes with those they work with, utilising an approach unique amongst the health professions, that of a focus on the everyday and meaningful activities of life – to be reversed; in that time many occupational therapy practices had been dismantled in anticipation of a substantial loss of work. Those practices that did survive are only now recovering from this event.

Throughout the course of this review, representatives from other professions – including those on the advisory committee reviewing mental health items – have questioned the inclusion of occupational therapists in the Better Access program, as well as their role in mental health care more broadly, despite the evidence base (Erlandsson et al, 2015; Long et al, 2017). OTA representatives who appeared before the committee last year encountered negative attitudes from those in attendance which were evident from the non-verbal language on display (eye rolling, crossed arms, shaking of heads etc.). Despite the undisputed evidence base underpinning the occupational therapy profession, only one occupational therapist was appointed to this committee. In contrast, there were around ten psychologists on the group who, while dominating discussions, were ultimately unable to reach any sort of agreement on the best course of action for their own profession.

Occupational therapy is a profession that has its origins in mental health and is a part of every public mental health team in the country (and the Western medical world) (Wilcock, 2001). OTA rejects categorically the argument that occupational therapists should be prevented from working in mental health because they are not required to hold postgraduate qualifications to work with complex clients or those with a dual diagnosis. Occupational therapists are prepared by their pre-registration degree (delivered at undergraduate or masters level) to work with consumers experiencing mental health issues across the spectrum of complexity (World Federation of Occupational Therapists (WFOT), 2016; Occupational Therapy Council (OTC), 2018). In addition, occupational therapists work almost exclusively with complex and dual diagnosis cases. Moreover, occupational therapists often perform a case management role (Lloyd et al, 2002) and, significantly, are sought after to perform complex functional assessments by people with psychosocial disability seeking access to the National Disability Insurance Scheme (NDIS) (Russi, 2014).

Within many public mental health services (e.g. CAMHS services), clinicians from a range of mental health backgrounds have traditionally done the same work (Perkins et al, 2017). Their expertise has developed from postgraduate therapeutic training (i.e. family therapy or child and adolescent psychotherapy). Supervision has also occurred across professions in public mental health settings.

An undergraduate degree in occupational therapy equips graduates with the necessary skills to work safely and effectively in mental health, including in excess of 1000 hours of supervised practice hours (WFOT, 2016; OTC, 2018; Occupational Therapy Board of Australia (OTBA), 2018). While we acknowledge that additional training and qualifications only enhance that efficacy, the comparative dearth of negligence claims made against occupational therapists and the high regard in which we are held by our patients and within the public mental health sector support our argument that

additional qualifications are not required in order to work effectively in this space (Osborne and Stein, 2016).

According to the Australian Health Practitioner Regulation Agency's (AHPRA) 2017/18 Annual Report, there were 59 notifications made about occupational therapists and 733 made about psychologists. This equates to 0.3% of registered occupational therapists having a notification made about them compared with 1.9% of registered psychologists.[1]

Reducing access for clients, including those with the most complex needs, to the clinical expertise of occupational therapists does a profound disservice to these clients (Robinson et al, 2016). It also does an injustice to our members, who have had to work hard to establish their reputation with referral sources – as too few GPs realise that occupational therapy is a profession grounded in mental health care.

Accordingly, OTA would welcome an unbiased evaluation of the value of occupational therapy in maximising outcomes for patients and the health system through the delivery of mental health care under Medicare Benefits Schedule items.

OTA also encourages the new working group to consider including other professions, that have evidence of their value to patients with mental health conditions, in the list of endorsed Better Access professions (specifically psychiatric nurses).

Beyond endorsing the need for an independent working group, we would also argue that the idea of limiting certain items to certain professions serves to diminish the importance of the referring doctor's role (GP or psychiatrist), downgrading this role from one of clinical judgement to that of gatekeeper (Gask et al, 1997). Doctors are the most likely to be familiar with services in their local area, and should therefore be free to use their clinical judgment as to who will best meet the needs of their patient.

Such an arrangement is far preferable to a nationwide rule requiring patients to see a clinician that their GP/psychiatrist may not think is the best person to meet their needs. OTA endorses a system in which the doctor is the clinical overseer, as this is more likely to be a personalised system producing the best possible results for the individual client. Any system that removes clinical decision making from the doctor must ipso facto be less informed.

Rebate structure

OTA reiterates its call for the introduction of a flat rate in respect to rebates across the professions included in the Better Access initiative. There is currently a sizeable disparity between the rebates for services provided by psychologists, and those provided by occupational therapists and social workers. This lack of consistency can lead to significant out-of-pocket expenses for consumers who are often not made aware of the differences in rebates prior to commencing treatment. As Medicare is an insurance system, rebates should be the same for all parties considered able to provide the service. We firmly believe that the new working group should be tasked with addressing this issue.

[1] https://www.ahpra.gov.au/annualreport/2018/notifications.html

The current rebate structure allows clinical psychologists who provide the same focused psychological strategies as occupational therapists to be paid a much higher rebate. Rebates are based solely on disciplinary title, irrespective of years of clinical practice, areas of expertise or completion of advanced therapeutic training. Occupational therapists are educated at both undergraduate and masters level prior to registration (OTC, 2018), depending on the programme, placing their baseline qualification on par with that of a clinical psychologist.

One of our members reported that, in their experience working in a clinic which provides specialised treatment for young people with psychotic disorders and co-morbid mood and personality pathology, they are often allocated clients with greater diagnostic complexity than their clinical psychology colleagues under the MBS. Not all clinical psychologists who deliver services through Better Access have experience treating high prevalence disorders, such as anxiety or depression, or have acquired skills to treat complex mental disorders. As an occupational therapist with the necessary skills and experience to work in an acute mental health service, this provider is allocated complex clients who are either unable to access tertiary mental health services due to the limited resources and rising acuity criteria, but whose needs are deemed too complex to be serviced by primary care providers.

Under Medicare, a new graduate psychologist receives greater remuneration than an experienced occupational therapist or social worker, even those with 30 years' clinical experience and advanced psychotherapy training, despite being requested to provide a standardised intervention as prescribed in a mental health care plan.

Our members have reported that ensuring compliance with quality standards precipitates additional out-of-pocket expenses including the annual completion of focused psychological strategy CPD, professional indemnity insurance, OTA membership, AHPRA registration and fortnightly external supervision. Their income barely covers their costs, despite treating clients with more complex needs than those of other better paid, but sometimes less experienced, allied health providers. Additionally, the nature of occupational therapy intervention is frequently more time intensive per session (to obtain the quickest improvements overall), regularly working in the context of the activity in which the person's worst symptoms manifest in order to rewire the parts of their brain where the issue is embedded. It is imperative that occupational therapists get at least the same rebate as other clinicians for the hour that is claimable.

<u>Example 1</u>

You can rarely assist a person to address their trauma-based avoidance of people by telling them 'how to go out'. Occupational therapists 'take them out'. If the best way of doing that, for a particular person, is going to the local darts club social afternoon, then their occupational therapist goes with them, providing the clinical support needed to treat their anxiety in that situation. Participation, if it is not to be marked out as abnormal, needs to be for the entire time – which is never within an hour's duration.

Example 2

For an adolescent with depression who struggles to get out of bed in the morning, the occupational therapist might go to the home during their morning routine to assist with demonstrating and implementing parental strategies to facilitate a successful arrival at school.

The current MBS rebate structure produces unsustainable working conditions for skilled allied health providers who are not clinical psychologists. Without equal remuneration for MBS providers – who are required to perform the same interventions – well-trained, skilled, experienced and capable clinicians will have no choice but to leave the private sector workforce.

Following the well-researched theory of early intervention in psychiatry, it is widely accepted that the provision of good clinical care in the early phases of mental illness can ease pressure on tertiary and emergency systems, preventing acute presentations and subsequent loss of income for clients who are hospitalised as a result of their condition going untreated (McCrone et al, 2015; Bond et al 2015; Cross et al, 2016). The current state of the MBS, with few well-trained clinicians in primary low fee settings and growing waiting lists, has contributed to heightened instances of illness being treated at an acute stage. This in turn places further strain on our already overloaded tertiary and emergency services (Blount and Miller, 2009). Should remuneration be aligned for all MBS providers, more skilled occupational therapists and other clinicians will be more likely to remain in the primary sector, thereby treating presenting issues in their early stage and easing pressure throughout the system.

Non-attendance at appointments

OTA also recommends that therapists be able to gain a rebate, or be able to bulk bill, for telephone-based sessions when an appointment has been missed or as need arises.

Non-attendance at scheduled appointments is a significant issue for occupational therapists who provide services through Medicare-funded programs such as Better Access. Those who are most in need of an appointment are often those most likely not to attend because of functional challenges.

OTA has been advised that the take home pay of occupational therapists engaged by not-for-profit organisations is barely enough to cover the clinician's costs. One therapist reported that a prominent youth mental health service takes 14% of the amount they are paid per consultation, and they receive nothing if clients miss appointments. Once practice and supervision costs are factored in, providers are left with earnings well below the minimum wage.

The occupational therapy role in mental health

One OTA member reported that many of their skilled and capable occupational therapy colleagues choose not to work in mental health due to the false perception that private therapists practicing in this area are in some way 'illegitimate'.

Focused psychological strategies, which are prescribed under mental health care plans, are a set of acquirable therapeutic modalities, similar to other interventions that occupational therapists learn. With professional training, clinical practice and supervision, occupational therapists are able to provide these interventions by way of a holistic approach, with precision and compassion, and from

a client-centred perspective. Occupational therapists complete rigorous training throughout their university degree, which features, among other things, core motivational interviewing skills, substantial clinical practice hours, family-based skills and group therapy. Occupational therapists also undergo training in psychology/neuropsychology, anatomy (including in some instances group practical dissection)/neuroanatomy and physiology/neurophysiology.

Occupational therapists are not restricted to providing focused psychological strategies, with many therapists able to provide much more specific therapies (e.g. psychotherapy).

To be eligible for Better Access endorsement, occupational therapists are required to:

- Be registered with the Occupational Therapy Board of Australia;
- Be a member of Occupational Therapy Australia;
- Have a minimum of two years' supervised practice as an occupational therapist working in mental health;
- Be able to provide evidence of recent relevant mental health practice, supervision and active engagement in CPD; and
- Be able to provide evidence of recency in Better Access relevant practice.

All endorsees need to satisfy all units of competency as set out in the Australian Occupational Therapy Competency Standards (AOTCS) and meet the National Practice Standards for the Mental Health Workforce 2013.

Endorsees are required to undertake CPD that is relevant to the Better Access program, focusing on the development of skills and knowledge, and the needs of the client group.

In conjunction with an array of additional factors (i.e. occupational therapy being an evolving discipline with growing body of evidence as described by Turner (2011)), the perception of occupational therapy's 'illegitimacy' or 'inadequacy' in the private mental health field – in comparison to other allied health professions – has a cyclical relationship with the disparity of financial remuneration in the sector.

OTA firmly believes that better pay for skilled occupational therapists alongside other MBS providers will lead to more skilled therapists choosing to work and remain in the mental health sector. This will result in greater public interaction with occupational therapists in mental health, and enhanced recognition of their services. Most importantly, this will result in better, and steadily improving, patient outcomes.

Recommendation 5 – Reduce minimum number of participants in group sessions

OTA endorses this recommendation, as it makes group intervention a viable and very valuable tool (which it currently is not). It also means group sessions can take place in regional, rural and remote communities where it is not possible to get a sufficient cohort for the previous criteria to be met.

Recommendation 6 – Add a new group item for therapy in larger groups

OTA endorses this recommendation. Psychoeducation (rather than therapy) groups can occur with larger cohorts both safely and effectively.

Recommendation 7 – Enable family and carers to access therapy

OTA strongly endorses this recommendation for the reasons specified in the report. This is especially important when working with children, as seeing the child without involving their parents in the assessment and ongoing work is never best practice (OTA, 2016). Following a thorough assessment, it would be most helpful for ongoing work to be with the parents and not the child individually, despite it being the child who was initially referred.

Recommendation 8 – Measure Better Access outcomes

OTA strongly endorses this recommendation for the reasons specified in the report. In particular, we call for a single outcome measure to be sourced/developed that is applicable across diagnoses, complexity, profession and context. This would pave the way for comparative evaluation, facilitating ongoing improvement of service delivery for clients with mental health issues, and add to the evidence base supporting best practice work.

Recommendation 9 – Update treatment options

OTA strongly endorses the recommendation that the range of treatment options be expanded to include other evidence-based modalities. In addition to those therapies listed in the report, we recommend that the following be added to the list:

- Activity modification and prescription;
- Sensory interventions;
- Psychoeducation;
- Psychoanalytic psychotherapy (with both children and adults);
- Skill and capacity building interventions (including therapies to improve social skills);
- Physical health/sleep interventions;
- Social and emotional wellbeing interventions which better reflect work with Aboriginal and Torres Strait Islander clients;
- Family Based Therapy (FBT) and Multi Family Therapy (MFT);
- Family Talk – an intervention designed to support parents with depression;
- Let's Talk About Children – an evidence-based method that trains professionals to have a structured discussion with parents who experience mental illness;
- Action over Inertia (time-use intervention);
- Behavioural activation;
- Low Intensity Cognitive Behaviour Therapy (LICBT);
- Cognitive Processing Therapy (CPT) for post-traumatic stress disorder (PTSD);
- Mindfulness strategies;

- Exposure therapy;
- Distress intolerance profiling and planning;
- Safety planning;
- Relapse prevention; and
- Other occupational therapy approaches which target and measure functional gain.

We note that 'CBT' should not be the acronym for therapy xiv in the document (Trauma-focused cognitive behaviour therapy). CBT should be standalone as it is a broad term that covers many interventions.

OTA believes that inclusion criteria should be developed in addition to Level I and Level II evidence to enable emerging therapies to be added to the list. This will minimise the risk of the list becoming out-of-date and needing to be regularly reviewed. It is unclear why specific therapies were added to the list and others excluded, and OTA requests clarification around the criteria that were used by the group. We also recommend that mental health professionals from different disciplines be included in future decision-making processes to ensure that listed therapies genuinely reflect the breadth of services available.

OTA requests that consideration be given to extending consultations to 1.5 hours, as members have reported that it is difficult to provide an effective service in one hour.

OTA recommends that the term 'mental health' replace the word 'psychological', thereby minimising the scope for confusion among clients who struggle to understand the difference between an occupational therapist and a psychologist. The common term, on a national level, is mental health. It is broadly understood and Medicare should adopt the more widely understood terminology. Continued usage of the term 'psychological' has also contributed to the misconception that only psychologists are accredited to provide services under Better Access. We therefore disagree with the recommendation on pages 48-49 of the report that 'focused psychological strategies' be rebranded as 'psychological therapies'.

Recommendation 10 – Unlink GP focused psychological strategy items from M6 and M7

OTA believes that patients should be able to receive mental health-focused interventions from their GP and their mental health clinician.

Recommendation 11 – Encourage coordinated support for patients with chronic illness and patients with mental illness

OTA strongly endorses this recommendation, as people with chronic physical health conditions nearly always have mental health issues either complicating the severity of the physical condition, or as a result of having a chronic physical condition. Those with co-occurring conditions who do not meet the eligibility criteria for Better Access require coordinated support to minimise the effects of these conditions. Baxter et al (2016) completed a meta review of interventions for this group of consumers and concluded that integrated community care programmes focusing on lifestyle and risk behaviours were the most effective.

Occupational therapists frequently find themselves de facto case managers in coordinating multidisciplinary care. Currently, only GPs can claim a rebate for case conferencing. It is OTA's contention that allied health professionals should also be remunerated for something that is such a significant part of their daily work.

Recommendation 12 – Promote the use of digital mental health and other low-intensity treatment options

OTA endorses this recommendation.

Recommendation 13 – Support access to mental health services in residential aged care

OTA endorses this recommendation, especially when evidence reports that between 10 and 15% of older people experience depression. Rates of depression among people living in residential aged care facilities are believed to be much higher, at around 35%. Anxiety and social isolation are also major mental health-related issues for this population (Creighton et al, 2016; Franck et al, 2016).

Recommendation 14 – Increase access to telehealth services

OTA strongly endorses this recommendation. We would also recommend that patients in regional centres (i.e. geographically not eligible for telehealth because they are not in remote areas) be able to access telehealth services from a provider who is not located in their regional centre.

Conclusion

It is of ongoing concern to members of OTA that occupational therapists and social workers are not mentioned in the title of Better Access along with the other health professionals who provide services through this initiative. The Department of Health continues to refer to the initiative by its official title – *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS.*

The existing title neglects the role of occupational therapists and social workers in this initiative and, as such, is misleading. Consumers may wrongly assume from the title that they can only access services provided by psychiatrists, psychologists and GPs; as a result, this wording has the potential to exclude occupational therapists and social workers from the initiative. In fact, GPs themselves are often not aware that occupational therapists and social workers provide services under Better Access and frequently need to be alerted to the referral criteria.

The mislabelling of the initiative should have been rectified by now, given our repeated insistence that the important contributions made by occupational therapists and social workers in the delivery of mental health care not be overlooked.

We strongly encourage the Taskforce to consider revising the name of the initiative to include reference to occupational therapists and social workers, or adopting an altogether more inclusive and concise title such as *Better Access to Mental Health Services.*

OTA thanks the Taskforce for the opportunity to provide feedback on the Reference Group's report. We would be more than happy to provide further information on any of the issues raised in our submission should this be required.

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