



# Australian Association of Social Workers

**Submission to the Senate Community Affairs Committee Inquiry into  
Commonwealth Funding and Administration of Mental Health Services**

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## Executive Summary

The Australian Association of Social Workers (AASW) is the professional body representing social workers in Australia. The AASW is the accrediting body for all tertiary social work programs in Australia and also for the assessment of overseas qualified social workers. The AASW accredits social workers to provide services in the Better Access to Mental Health Services program.

Social workers in all fields of practice have at least some clients with mental health problems, often in combination with other difficulties. In all settings, social workers provide clinical services and coordinate care, including assisting clients with transitions along the continuum of care and liaison between mental health services and other required services.

AASW Mental Health Practice Standards<sup>1</sup> state that:

*“The purpose of [social work] practice is to promote recovery, restore individual, family, and community wellbeing, to enhance development of each individual’s power and control over their lives, and to advance principles of social justice. Social work practice occurs at the interface between the individual and the environment: social work activity begins with the individual, and extends to the contexts of family, social networks, community, and the broader society.”*

Social work in mental health takes particular account of the importance for clients’ mental health of fulfilling social relationships, adequate housing with stable tenure, and paid employment or other forms of meaningful daily activity.

Social workers are employed in specialist mental health services, and by 2004-05, made up a third of the allied health workforce for public mental health services<sup>2</sup>. In that year, social workers comprised the fourth largest professional group in the public mental health workforce after mental health nurses, medical staff and psychologists.

1,235 social workers are accredited to offer services in the Better Access program, where they provide specialist clinical services to clients with diagnosed mental health issues. In addition, social workers provide services to clients through DVA (Department of Veterans’ Affairs), State and Territory Workcover Authorities and Motor Vehicle Accident programs, and are often on panels for legal and court services for report including the family court.

Social Workers work in community mental health settings as well, and the AASW endorses the views of the Mental Health Council of Australia’s paper on community mental health published in 2010<sup>3</sup>.

With respect to the Better Access program, social workers were to be excluded from the program following the 2010 Federal Budget. Following a vigorous campaign and lobbying by the AASW, the Government announced in November that it would reverse that decision.

The AASW has warmly welcomed the announcements of additional funding and programs, and the creation of the National Commission for mental health, announced in the 2011 Federal Budget, and is working closely with the Government on the implementation of these measures. We are delighted to be able to make this submission to the Senate Community Affairs Committee Inquiry and are willing to give evidence to the Committee if requested.

## Summary of Recommendations

The AASW recommends the following:

1. The AASW calls for social workers, whether employed in primary health organisations, mental health organisations, community health organisations or in the NGO sector, to be a core element of the delivery of ATAPS Tier 3 funding.
2. A number of measures (expanded upon in the relevant section of the submission) that would ensure that clients of allied health providers of services through ATAPS are able to access a range of professionals that may suit their particular requirements.
3. The AASW calls for transitional arrangements to ensure that clients presenting with more complex issues within the Better Access program can receive them. The 'exceptional circumstances' provision of the program, by which a client is able to receive Medicare rebates for further sessions in a calendar year, should be reinstated while the new programs and funding streams are established.
4. The AASW calls for equal remuneration for identical therapeutic activity for all disciplines under the Better Access program.
5. The AASW strongly supports registration as the best mechanism to ensure the public, especially those with mental health issues, are offered high quality social work services and protected from poor practice standards, negligence and mal-practice. The AASW calls for credentialing of the social work workforce in the ATAPS program so that consumers and families have guarantees of quality of service and redress in the event of professional complaints.
6. The AASW calls on Government to remove the barriers to access, enabling social workers to provide mental health services to people who may have not engaged or presented to a GP with their mental health issues. In particular, the AASW calls for not for profit organisations to be adequately resourced to deliver care coordination under the new ATAPS funding streams.
7. The AASW calls on the new National Mental Health Commission to ensure that it addresses service provision to disadvantaged population groups and to report against these criteria.

## **(a) The Government's 2011-12 Budget changes relating to mental health;**

### **(b) changes to the Better Access Initiative:**

#### ***(i) the rationalisation of general practitioner (GP) mental health services,***

Consistent feedback from social workers involved in the Better Access program is that the quality and depth of referrals from GPs is not consistent and often reflects their business in their practice and their lack of intensive knowledge of mental health implications. The AASW is aware of referrals that are often brief handwritten notes and GP mental health plans frequently do not reflect a comprehensive intervention plan and understanding of the mental health circumstances of their patient. This is consistent with the busy GP practice.

#### ***(ii) the rationalisation of allied health treatment sessions,***

The AASW is aware of the findings of the research conducted as part of the Government's evaluation of the Better Access program which indicate that the average number of sessions for clients in the program is 5, and that only 13% of clients receive more than 10 sessions. The AASW agrees that the rationalisation will not have a large impact on the majority of clients.

The AASW would not dispute that, for patients who have mild mental health disorders, treatment length of between 4-10 sessions will generally provide adequate treatment and improve outcomes. However, there remains a significant cohort of clients who don't quite fit the 'mild to moderate' category and certainly do not fit 'acute, chronic and ongoing' assessment criteria. Historically, prior to ATAPS and Better Access, these were the clients who fell through the gaps. These are also likely to be the clients who have little or no choice in service provision and no ability to pay gap fees or fund services privately.

'Moderate' mental health presentations involve symptoms which are more disruptive and pervasive to individuals functioning than the mild disorders such as anxiety disorders such as agoraphobia, social phobia or a more severe depression in this category. There may be concurrent disorders occurring eg. anxiety and adjustment; mixed anxiety and depression. There is solid clinical evidence that indicates, on occasions, more than 10 sessions of approved focussed psychological strategies may be required to achieve positive mental health outcomes for people with these moderate presentations.

Importantly, AASW members in the Better Access Program have observed that some clients meeting the above diagnostic criteria have successfully accessed quality psychosocial treatment for the first time in their lives, as a direct result of improved treatment access opportunities provided by the Program.

These are often individuals with a degree of trauma in their backgrounds which presents concurrently with Axis 1 Mental Health Disorder symptoms. Social workers in the Better Access program are sufficiently experienced and trained to provide quality treatment to this group. However 10 sessions has been found to be inadequate to achieve sustainable positive outcomes for this community cohort's improved mental health.

Access and affordability issues mean that for many of these clients, the likelihood is they will 'fall through the gaps' between other programs and professionals. There is a lack of availability of psychiatric providers who are able to provide access to therapeutic interventions. Significant gap fees also often preclude financial access to psychiatric providers for this group.

***(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, and***

The AASW is not in a position to make an informed comment on the impact of these changes on GPs' care plans, but notes reports from social workers involved in the Better Access program that GPs' Care Plans are often brief and lack the detail required to assist the social worker in providing clinical and support services to their client.

Solid attempts at diagnosis and appropriate treatment are often made by GPs, but at times a comprehensive psychosocial assessment conducted by a social worker often leads to a more rounded understanding of their circumstances, including their mental health issues, and so may suggest a different mode of treatment to that requested by the referring GP. However it should be noted that comprehensive care planning often benefits from a collaborative approach between GP and the mental health professional. This collaborative approach can be achieved by a simple phone call consultation between GP and Social Worker where care planning can take place.

***(iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;***

While the reduction of sessions from 12 to 10 is based on solid evidence from the review of the program, the AASW is extremely concerned about the removal of the 'exceptional circumstances' provision for those clients who have benefited from additional services and will not easily access a suitable alternative service.

It is not good clinical practice to commence therapy with a client and have to discontinue or transfer care and this, in fact, can harm the client. The AASW recognises the new Federal Government funding and services announced in the 2011 Budget. These will assist clients with complex and ongoing issues, however these services will take considerable time to be established, operational, accessible and available to all those in the community who need them. While the AASW has warmly welcomed the doubling of the Access to Allied Psychological Services (ATAPS) funding and the implementation of Medicare Locals, we are yet to see eligibility criteria or other detail. We are yet to be fully assured that the cohort of clients that will be negatively impacted by the reduction in sessions in Better Access and the elimination of the "exceptional circumstances" arrangements, will, in fact, be able to receive services through new programs and initiatives.



Then there are those clients who fit neither 'mild' nor 'complex' assessment criteria, those who fall somewhere in between; who present with a moderate issue which could possibly be treated in 10-12 sessions but, in the course of therapy, disclose another problem or experience a crisis which necessitates the provision of a few more sessions to ensure stability and achieve the best outcome. The AASW is concerned to ensure that these clients will receive a service if Better Access cannot provide it after 10 sessions.

While some clients may be able to afford to pay the full out of pocket costs to continue to see their social worker, psychologist or occupational therapist, most will not, and will need to find an affordable and accessible qualified alternative. The Government and Opposition parties have all acknowledged the inability of many Australians to find a quality and affordable service, particularly those living in rural and remote parts of the country, and while the Government has made commitments to develop new funding streams and new services, extensive and suitable programs do not yet exist. Of immediate concern is what will happen to these clients in the interim while programs are established. In the longer term, the flexibility offered to Divisions of General Practice (and to Medicare Locals) means that it is impossible to guarantee an ATAPS program locally will meet the needs of a specific client.

The AASW acknowledges that State and Territory services cater to people with 'severe' needs, but also recognises that these are stretched and underfunded to deliver the services required by the community, particularly in rural and remote areas where they often is no State / Territory service.

The future ATAPS tier three will fill a crucial need in this regard as many of these people need a care coordination approach including gentle assertive follow up and strong engagement with families and communities. **This approach is the core domain of social work practice and the AASW recommends that social workers, whether employed in primary health organisations, mental health organisations, community health organisations or in the NGO sector, should be a core element of the delivery of ATAPS Tier 3 funding.**

**(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;**

The AASW is concerned with the transition times needed to introduce new systems for clients with complex and chronic disorders into the Tier 3 ATAPS Flexible Care packages program; these are still in the development stage and yet to be rolled out. The AASW is happy to provide advice to the Department to ensure these programs meet the needs of clients, particularly with reference to:

- those in rural and remote parts of the country;
- those with multiple and complex needs;
- those from disadvantaged backgrounds; and
- those requiring appropriate assertive follow up often through engagement with families and communities.

We understand from social workers who provide services through current ATAPS (Access to Allied Psychological Services) programs that at times these services are neither available nor accessible to a significant number of clients in our communities through Divisions of General Practice. This happens for a number of reasons:

- Divisions may choose not to refer to any allied health professions other than psychologists, which deprives clients of services they may need from a social worker or other professionals. Some Divisions have a very poor understanding of services provided by professionals other than psychologists which can mean that clients do not receive the quality of care that is available in other divisions.
- Services are 'capped' at the local (Division) level, meaning that once funds have expired for the financial year, services are no longer offered.
- The needs of this group are often multifaceted including the need to connect with families, friends and communities, a model of assertive community intervention not often familiar to the GP sector or other mental health professionals but a proven approach with people with moderate to severe mental illness.

Further, the AASW is aware of a number of consistent complaints from social workers in some Divisions of General Practice about a refusal to provide details of qualified professionals to referring GPs. AASW members report being told that their local Division 'only refers to psychologists' which contravenes the guidance given by DOHA. This means that in some areas clients are being denied the opportunity to see allied health professionals other than psychologists, when a social work approach may better suit their condition and needs. The AASW presents a case study regarding this below, and calls for:

- Equitable treatment for all eligible providers of mental health services under ATAPS, such as the provision of a list of eligible to all referring GPs;

- Accountability for funding to Divisions and Medicare Locals by transparent reporting of the allocation of these resources to different allied health providers;
- Any Division or Medicare Local that allocates a large proportion of ATAPS funding to only a few providers should be asked to show how they have provided information to their GPs and / or reasons for a lack of range of providers (in rural and regional areas there may not be many alternatives)

Please refer to our recommendations below regarding registration and credentialing for social workers in the ATAPS program for other relevant suggestions.

**Case Study 1: multi-disciplinary service in rural NSW** (Case studies are presented in the words of the member who provided them, and we have removed identifying information only)

Professional staffing includes specialist medical practitioners, clinical and registered psychologists, social workers, intern psychologist, speech pathologist and occupational therapist.

NB: Prior to threatened changes in Better Access in 2010 we had 4 Social Work Staff and 1 Psychologist – 2 working FT; 1 working 3 days/week; one working 2 days a week. Two staff left before the crisis was resolved as they feared for their economic/job security and were replaced by psychologists.

**1. Services provided:**

- Medicare:
  1. CDM/EPC items – Speech Pathology/Occupational Therapy
  2. Follow-up Allied Health (ATSI) - Speech Pathology/Occupational Therapy
  3. Better Access – Social Work; Registered Psychology; Clinical psychology
  4. Helping Children with Autism: Psychology/ Speech Pathology/Occupational Therapy
  5. Specialist Paediatrician
  6. Specialist Child and Adolescent Psychiatry
- FaHCSIA:
  1. Panel Provider – Helping Children with Autism
  2. Applying to be 'Better Start' provider
- Additional Programmes including: Workcover; EAP; DVA; VCT.
- Service Delivery: Centre based; Home; Pre-school/School; Nursing Homes and Hostels.

**2. Funding Received:**

- In 2008 applied for NRRHIP Funding to support Infrastructure and resources to establish Paediatric Allied Health facility.
- Received a grant in 2009 Federal Budget.
- We received a letter of support from the Division of General Practice to submit with our NRRHIP Application. It stated: *'In September 2008 the Division undertook an allied needs analysis of the whole Divisional area. This highlighted a number of issues*

surrounding patient access to allied health services. Within the area where the applicant is situated, a number of Allied Health Service deficits were identified. The priority areas identified in the area are as follows:

1. Speech therapy
2. Occupational Therapy
3. Exercise Physiology
4. Social Workers
5. Mental health nurse'

### 3. Access to ATAPS & Liaison with Division:

Approaches made to Division since commencement of practice. Have had various responses including:

- Program being evaluated
- May be calling for tenders soon
- Tenders have closed (immediately following above)
- And, consistently advised 'we have a provider in your area'

Four letters to Division (three to CEO) in past year and have had one response: this letter stated, in October 2010:

*'The Division has current contracts with services providers under the Access to Allied Health Services Program (ATAPS) to deliver psychology services in the area. Additionally current contracts are also held for services under the RPHS program in the area'.*

The letters have been dated 27/08/10; 19/10/10 (after no response to initial letter); 3/2/11; and 2/06/11. One response received on 21/10/10 (dated 10/10/10).

The psychology practice which currently holds the contract has been a continuous provider through the Division since 2003. To my knowledge, there have not been any public tenders for ATAPS. If there have, I have not received advice of this.

In addition a number of emails have been sent to the CEO; the last email was sent in March and there has been no response. Despite expressing a willingness to meet, the CEO indicated in March email that she had 'no plans to travel to my area until after Easter holidays. At this stage I have no definite plans'. No invitation issued for us to travel to meet at their offices.

Impacting on viability of our service: We have continued to receive enquiries from local GP's, including the Aboriginal Medical Service, to ask if we are able to provide ATAPS services, and further referrals from those GP's appear to decline or discontinue altogether when I advise them that we do not have access to the ATAPS Program.

The letter to the Division dated 3/02/11 raised our concerns regarding inaccuracies in the 'Service Directory' for the Area which is downloadable from the Division's website.

The directory lists under 'Psychologists' the practice which receives ATAPS funding under the practice name; our business is not listed under a practice name at all (it is not named in the directory as a service). Instead, only the Psychologists working at our practice are named individually with the practice address and phone number but no practice name. In our letter we also raised the issue that the 2 psychologists named were no longer working with the practice.

In the directory there is a section for 'Allied Health' which lists:

- Acupuncture
- Dentists
- Dieticians
- Physiotherapy
- Podiatry
- Psychology
- Speech Pathology

There are no entries for Social Work or Occupational Therapy. Also, our Speech Pathology service is not listed under that section. There has been no response to this letter and there have been no alterations to the Directory.

We are aware that the psychology practice which has ATAPS funding has a lengthy waiting list; some clients come to us after waiting for a service with that provider – we have been told by those clients that they are advised that the waiting list is 3 months. In contrast, we have no waiting period for appointments.

This indicates: ATAPS availability has a significant impact on referral practices and it disadvantages clients to have the service restricted to one provider as it impacts on accessibility.

NB: Just as an additional comment. I feel that it is important to note that we work in a financially disadvantaged area. We have a four tier level of fees and many of our clients are Bulk Billed. I do not draw any income from the service at all, even when working in a clinical capacity the income was used to support the service. In fact, as a family, we have invested heavily in maintaining the service and continue to do so.

While the AASW acknowledges that the situation across the nation will potentially change through provision of services via Medicare Locals and the doubling of ATAPS funding (over 4 years), we are concerned that there are currently 19 Medicare Locals who will not be fully operational for some months as contracts and funding is finalised. These organisations are highly unlikely to be able to provide the services needed by the clients currently serviced under Better Access, and new clients from 1st November 2011, when changes to the Better Access program are due to be implemented.

**The AASW calls for transitional arrangements to ensure that clients presenting with more complex issues can receive them. The 'exceptional circumstances' provision, by which a client is able to receive Medicare rebates for further sessions in a calendar year should be reinstated while the new programs and funding streams are established.**

### **(d) services available for people with severe mental illness and the coordination of those services;**

In addition to the mental health services provided directly by State / Territory Governments, the Federal Government and not-for-profit organisations, many other health and welfare agencies provide services to people with mental health problems. Examples include the homelessness and housing support services, which the Federal Government has rightly recognised provide a range of services to meet the needs of their clients including mental health services<sup>4</sup>.

Coordination is therefore a challenge and social workers, who all receive mental health training as a core part of their curriculum, are probably the only profession skilled to work across a range of services and settings, deliver a quality mental health service and make an appropriate referral to specialist mental health services when required<sup>5</sup>. Social workers, unlike the other core mental health professions of medicine, nursing, psychology and occupational therapy, are employed extensively in a wide range of non-mental health services. As a result they invariably encounter clients with mental health issues but, unlike non-mental health professions, social workers have the skills and knowledge to address issues as they arise, if appropriately supported.

This social work assessment and intervention process is often crucial to the multi-faceted needs of people likely to fall in to the Tier 3 program.

#### **CASE STUDY 2**

*A man in his 50's who has attended for approximately three years has a treatment resistant severe depression and anxiety disorder. He has attended a private psychiatrist for approximately one year. A number of treatment interventions including ECT and medication have not been successful and he and his supportive wife, on the advice of his psychiatrist, are now considering early retirement from a demanding administrative position. Transition to retirement inclusive of application for a DSP will be challenging for this man who has strong work values and has the potential for suicidal thoughts and further isolation from the wider community. The role of the social worker will be important in assisting with this transition. Interventions may include therapeutic counselling for the client and his wife as they adjust to retirement and linking him into services in the community where he hopefully may find fulfilment perhaps through volunteering etc. As this client has been suicidal only for a short time in the last three years, he would not have met public mental health eligibility criteria. The psychiatrist or his supportive GP do not have the time or skills to interface with community support services and to provide the therapeutic counselling required.*

Allied health practitioners working with clients in the Tier 3 ATAPS programs will need a wide range of therapeutic and organizational skills. These clients will have serious and complex

mental illness problems likely to impact on many life domains – family welfare, housing, poverty, and social relationships. Their mental health problems are often complicated by issues of alcohol and drugs, and borderline intellectual disability.

Work with this group requires specialist therapeutic skills in dealing with this complexity, applying multiple interventions, and working with several agencies across the health and human services sectors. Flexibility of approach is required, as workers will need to build purposeful therapeutic relationships with clients based on individual need. The complexity of needs means that this group is less likely to respond well to a single therapeutic model. Specific interventions to deal with identified mental health problems need to be applied within broader based approaches of care that address the complexity of both needs and context.

**Of all the allied health disciplines, accredited mental health social workers have the best skill set to work with this client group, both in direct therapeutic intervention and in co-ordinating care and the AASW calls for a greater engagement with social workers in ATAPS tier 3.** This argument is based on social workers' capacity to apply a range of therapeutic interventions such as problem solving, strengths-based approaches and solutions-focused interventions, to work with clients to meet individual outcome goals. Social workers are skilled in accessing and co-ordinating the various services needed for comprehensive care.

**(e) mental health workforce issues, including:**

***(i) the two-tiered Medicare rebate system for psychologists,***

The AASW notes that psychologists are one of the three allied health professions involved in Better Access, and referenced in AHMAC policy documents as core mental health professions. Social work, along with occupational therapy, provides a vital role in the provision of mental health services in Australia and we wish to ensure that the Committee is fully aware of the qualifications and training of social workers and therefore we will address the inequity of a two-tiered rebate between registered psychologists and social workers.

The Medicare Benefits Schedule Item Descriptor is exactly the same for each of the three professions providing Focused Psychological Strategies, namely registered psychologists, social workers and occupational therapists. The competencies and ethical obligations for social work practice are no different from other disciplines providing services under Medicare, it is therefore unjust, inequitable and illogical that remuneration is not the same for all disciplines.

A recent case example reported by a member was that she was asked to work in a GP practice. There was a psychologist already working in the practice. The social worker's fee was appropriately set at the same as the psychologist at \$125.00 per session. The gap payment for a client to see a psychologist was \$43.40, however for the social worker it was \$53.55. A number of clients felt unhappy about the additional cost and requested to see the psychologist instead of the social worker. As a consequence the social worker made the decision to reduce the session fee to \$15.00 so as not to disadvantage clients' access to social workers.

**The AASW calls for equal remuneration for identical therapeutic activity for all disciplines under the Better Access program.**

The AASW has calculated that this would cost \$1.7m per year if social work rebates are raised to the levels of registered psychologists, or could be achieved for no additional cost if social work rebates were lifted and general psychologists' rebates slightly lowered by \$1 per session for each Item Number<sup>6</sup>.

***(ii) workforce qualifications and training of psychologists, and***

The AASW notes that psychologists are one of the three allied health professions involved in Better Access, and referenced in AHMAC policy documents as core mental health professions. Social work, along with occupational therapy, provides a vital role in the provision of mental health services in Australia and we wish to ensure that the Committee is fully aware of the qualifications and training of social workers.

Accredited mental health social workers are specialist practitioners who possess a distinctive body of knowledge and skill in order to assess, diagnose and ameliorate problems, disorders and conditions that interfere with health bio-psychosocial function of individuals, couples, families and groups of all ages and background. Figures from an AASW<sup>7</sup> survey of members providing services in the Better Access program in 2010 revealed that:



- Accredited mental health social workers are highly qualified and skilled direct practice professionals.
- Nearly 50% working in private practice have over 20 years of experience with approximately 80% having over 10 years experience
- 60% have undertaken post graduate education and training to enhance their knowledge and skills in mental health.

Social workers in the Better Access program are accredited and ethically governed by the standards set by the AASW through their membership and the accreditation process and as a result social workers in the Better Access program deliver specialist clinical interventions of a high standard. The AASW calls on Government to ensure that all social workers employed in the provision of mental health services, through programs such as ATAPS, are subject to the same high standards of accountability through the accreditation and Ethical framework process of the AASW.

All Australian social workers have to complete a Bachelor (or Masters Qualifying) degree accredited by the AASW. Such courses exist at 26 Australian Universities<sup>8</sup>. (These degrees are four years in length (or two years if taken as a post-graduate degree following a BSc or BA)

As part of their accreditation to provide social work qualifications, Australian Schools of Social Work need to demonstrate how their curriculum meets specific standards in relation to mental health, ensuring that all graduating social workers have the skills, knowledge and values required to identify and address mental health issues wherever they practice. This is important, as social workers work across a wide range of sectors including hospitals and community health, Centrelink, family counselling services, child protection and family violence services, as well as homelessness and alcohol and other drugs services. It is well known that mental health issues are impacted upon, and in turn affect, a wide range of other aspects of people's lives, such as their employment, their family relationships, drug and alcohol usage and physical health. Social work's unique aspect is that it seeks to address mental health issues in coordination with the other aspects of people's lives that may need support and assistance.

To provide services under the Better Access program, social workers must not only hold a social work degree, but must meet a number of additional requirements, being:

- Hold current membership with AASW
- Meet the requirements of AASW Continuing Professional Development program
- Provide evidence of at least 2 years post qualifying supervised social work practice in a mental health (or related) work setting
- Demonstrate their work practice meets the 'Practice Standards for Mental Health Social Workers (AASW, 2008)
- Provide evidence of pre-qualifying, qualifying or post-qualifying education and training relevant to working in mental health
- Provide a referee statement from an employer or supervisor

As social work is not a registered profession in Australia, The AASW has successfully established a self regulating professional structure. The requirement of AASW membership ensures that social workers in the Better Access program are accountable through a robust national complaints system and have not been the subject of an ethical complaint which would prohibit them from holding AASW membership.

**The AASW strongly supports registration as the best mechanism to ensure the public, especially those with mental health issues, are offered high quality social work services and protected from poor practice standards, negligence and mal-practice. The AASW calls for credentialing of the social work workforce in the ATAPS program so that consumers and families have guarantees of quality of service and redress in the event of professional complaints.**

***(iii) workforce shortages;***

There is considerable evidence of a growing crisis from a shortage of qualified social workers in mental health settings. The number of social workers graduating from accredited courses has grown slowly over the past decade.

It has been noted that mental health services are poorly distributed in regional and rural areas, and in poorer urban areas of Australian cities. Data from the AASW members' survey<sup>9</sup> indicates that, among those members delivering services in the Better Access program:

- 37% work in rural and regional areas
- 67% provide services that are either bulk billed or at a reduced rate.
- The average gap payment for clients was \$20.00.

These workforce shortages also affect the health and community services sector more broadly, and people with mental health issues are prevalent across a range of these services.

**The AASW calls on Government to remove the barriers to access, enabling social workers to provide mental health services to people who may have not engaged or presented to a GP with their mental health issues. In particular, the AASW calls for not for profit organisations to be adequately resourced to deliver care coordination under the new ATAPS funding streams.**

**(f) the adequacy of mental health funding and services for disadvantaged groups:**

- (i) culturally and linguistically diverse communities,***
- (ii) Indigenous communities, and***
- (iii) people with disabilities;***

The AASW is aware of a number of claims that Better Access is poorly targeted at disadvantaged Australians and people with multiple needs. Social workers in the program are far more likely than any other profession to limit their fee to the Medicare rebate (67% charge no more than the rebate for some or all of their clients, despite the Medicare rebate being lower for social workers than for registered psychologists), and to provide services in rural and regional areas (37% are located in regional and rural parts of Australia)<sup>10</sup>.

The AASW is aware of a number of members offering innovative clinical and support services to clients in the Better Access program, and others doing the same through ATAPS funding.

**The AASW calls on the new National Mental Health Commission to ensure that it addresses service provision to disadvantaged population groups and to report against these criteria.**

Case studies to illustrate services to these population groups are below and the AASW is happy to work with Government and Medicare Locals in establishing further services to reach disadvantaged and 'harder to reach' populations. These case studies are presented in the words of AASW members.

**Case Study 3: Indigenous clients**

***"I'm the only Aboriginal social worker on the NSW Central Coast"***

***Presenting Issues:*** Domestic Violence, Sexual Assault, Depression, Anxiety, generational trauma and Post Traumatic Stress Disorder.

***Psychosocial issues:*** Poverty

*I see a lot of males going into the juvenile justice system (where there's a high suicide risk), behavioural issues. I'm asked to be involved in circle interventions. My referrals are not coming in via general practitioners but via the community network. I then send people to the GP for the mental health care plan. Then they're able to come and see me under Medicare. The GP referrals I do receive are for women and adolescents. In the past month I've received five domestic violence referrals.*

*I do home visits, people often don't have transport or the money for transport. It might be a case of money for transport or buying their medication. That's why often when people are on chronic health plans, they have to go to the dietician, the doctor, all the different appointments, they have sporadic attendance.*

*Between sessions I call clients, organise things, refer to other services and workers, attend appointments with them. None of this 'other' work is charged for. I bulk bill all my health care card holders, youth, Indigenous clients if money is an issue. If people are working and able to pay I do charge. My appointments are usually longer than the 'normal' 50 minutes. There is a lot of contact with Centrelink, early playgroups, linking people in to parenting courses, refuges, DOCS, health services – the doctor, dentist, getting people Medicare cards, drivers licence tests, go for walks with clients. I do the motivational interviewing while we're walking.*

**Outcomes**

*Keeping clients engaged, I rarely have 'no shows'. Diversion from gaol, death, I work on safety, mindfulness, the present, on identity. Clients I see are past early intervention.*

**Community Development**

*I am invited to do talks to University, TAFEs, managers on cultural competency. I also am asked to run workshops on cultural competency.*

**Case Study 4: Hearing Impaired clients accessing the only AUSLAN speaking Better Access provider in greater Sydney**

*Presenting Clinical Issues: Chronic depression, isolation, social anxiety*

*Psychosocial Issues: Isolation, Employment*

**Focussed Psychological Strategies Utilised:**

*Psycho-education*

*Motivational Interviewing*

*Skills Training (Problem Solving, Stress Management)*

*Relaxation Strategies*

*CBT*

**No. of sessions**

*6 with request for extension of 6*

**Bulk-billed: Yes**

**Cost to Medicare: \$420.00 - \$840.00**

**Outcomes:**

*Greater access to suitable support services (including vocational education), Reduced social isolation*

**Would this patient have managed to access mental health care if your service through Better Access was not provided?**

*I feel that the client would not have accessed "mainstream" counselling services had it not been for the existence of Deaf Counselling Services as it's the only services able to provide counselling in AUSLAN.*

**Extra services provided:**

- Longer appointments (up to 1½ hours)
- Counselling in the clients preferred language (AUSLAN)
- Advocacy and liaison with other organisations to meet client's service needs for
  - Employment related issues
  - Training
- Only signing counsellor in NSW (possibly Australia) providing bulk bill counselling services
- In home sessions for Deaf Blind client for whom travel is an added burden

**Organisational advocacy & liaison**

1. TAFE NSW
2. The Deaf Society of NSW
3. NABS (National AUSLAN Booking Service)
4. Local public transport service providers

**Community Profile**

There are approx 14,000 AUSLAN users in Australia with around 30% of those living in NSW. Deaf people experience rates of mental illness at averages above those of the hearing population. Furthermore, of the Deaf blind population it is reported that 90% suffer from some form of depression at one stage or another of their lives.

**Other relevant background:**

- Hardly any promotion has been undertaken with most referrals coming via The Deaf Society of NSW or people in the community.
- I have heard from many clients upon our first meeting "finally a counsellor who can sign, I've been waiting years with issues and now finally I can talk to someone about it"
- There is no alternative service available to AUSLAN users in the Deaf Community of greater Sydney

**Business Issues identified with the current level of Medicare Rebate:**

- I have been fortunate enough to have been provided an office by a Deaf community organisation which allows me to continue to provide services bulk bill.
- I feel if I was to charge a gap that it may inhibit some people from accessing counselling.
- I see Deaf Counselling Services as exactly that - a service not a business. Not many specialist services such as this exist in NSW and its providing an equality not yet experienced by the Deaf Community of NSW.
- On-line services are required to provide access to rural and remote AUSLAN users via services such as Skype.

**Case Study 5 – Graham****Clinical Presentation:**

Graham had just completed his first 6 sessions of counselling and a further 6 sessions had been requested of the GP. Last week, his last session, he presented quite despairing as he found out just before coming into counselling that his Centrelink New Start payment had been drastically reduced for that fortnight, because in January this year (3 months ago) he attempted casual work for 2 weeks but had to resign because of his pain issues. He notified Centrelink of this

*casual work and it seems it has finally caught up with him, with a subsequent reduction in his payment, due to the income received in January this year. He spoke of suicide that session and had the means, riding his motor cycle into a tree. I made the decision to extend our usual one hour session with him. It ended up lasting 2 and half hours. We walked around town. Got a coffee. Talked. I also helped him access a small amount of cash from a local community organisation. He was despairing because he said it seems no matter what he tries he can't seem to get ahead. All of this with a constant background of chronic back pain.*

*When this gentleman first came for counselling he presented with paranoid tendencies as his conversation focused on conspiracy theories in the form of how the world was out to get him. He also focused a lot on meta-physical explanations to his existence that were often quite fantasy filled and not grounded in reality in terms of how these explanations may help him contribute and participate more productively in society. However, with the following sessions his presentation has been more stable. He travels the 70 km round journey to see me, on his old motor bike that does nothing to improve his pain management as a result of severe back injuries incurred over many years in the mining industry. His 5 years of chronic back pain eventually forced him to leave this work because of his injuries and without compensation. Medical reports show he is unable to engage further in heavy duties.*

#### **Community capacity building**

*Graham's case is not unique in my case load. I am seeking private funding to run a pain management program in Margaret River. I have collaborated with St John of God Hospital in Bunbury, some 120 km north of Margaret River, our closest pain management centre. It is simply not possible for the 3 clients I see with pain issues to travel the 3 hour round journey to Bunbury each week for 6 weeks to participate in the pain management program. This is acknowledged by the staff at St John of God and they appear quite keen to have someone like me on board who can assist in my local area.*

*I am also seeking funding from private sources to begin running group programs for this profile of client. The groups will carry on from where the counselling sessions leave off. They will provide ongoing support. Life skills education and community access, support and advocacy for this group of long term unemployed as a result of pain and or mental health issues. Such programs are run by Relationships Australia, based in Bunbury, 120 km from Margaret River.*

#### **Better Access**

*I believe the Better Access to Mental Health Program to be absolutely brilliant. It would be extremely difficult for the clients I have briefly mentioned here to access affordable counselling if this program was not in place. The clients I have mentioned here I bulk bill. There are agencies in Margaret River that do offer free support for mental health patients, but their client base tends to be those with more severe presentations. I believe the clients I see are high functioning people who want to participate actively in society but are a product of multi-faceted dilemmas including pain, social isolation, poverty and depression.*

*I do find the Medicare rebate for social work mental health counselling is insufficient to effectively run a business fulltime particularly as I bulk bill 70% of my clients. However, I am very grateful for the opportunity and financial assistance the Federal Government offers counsellors such as myself in reaching and supporting clients who would otherwise not present for help and support due to the cost restraints in paying privately for counselling.*

## **Case Study 6: CALD clients**

**Presenting Clinical Issues:** *Depression, Anxiety, Grief and Loss, Trauma*

**Psychosocial Issues:** *Poverty, unemployment,*

**Statistics:** *Servicing over 150 clients*

**Client Population Profile:** *Western Suburbs of Melbourne; low income clients who can't afford fee for service providers; proportionally very few mental health practitioners. 84% of clients come from a culturally and linguistically diverse background (e.g. Chilean, Chinese, Italian, Burmese, Ethiopian, Argentinean, El Salvadoran) Many have come here as refugees, having experienced war trauma as well as dislocation; Over 80% clients are women.*

**Outcomes:** *young Turkish male, who had long-term substance abuse and mental health issues that prevented him from working. After our work he is now managing his mental health effectively and no longer abusing substances and working full-time*

**Billing arrangements.** *Bulk bill most clients*

**Agency liaison/partnerships/service provision to**  
*Hospitals, psychiatrists, schools, teachers*

**Regional Workforce shortages:** *Very few multilingual providers, very few bulk-billing services*  
**Impact of workforce shortages on client community**

### **Better Access**

*Divisions of General Practice have varying eligibility criteria for contracted allied health practitioners: some only contract clinical psychologists (e.g. Melbourne Division of General Practice, 301) or psychologists (PivotWest Division of General Practice, 306).*

*Multilingual worker saves health budget as cuts out interpreter cost*

- *The elderly Spanish-speaking women that I counsel who are in an aged care facility. Their English language skills have diminished with age. They face their final years in increasing isolation and anxiety. Before their referral to me they had no access to mental health services because psychologists were not prepared to visit them in their facility,*
- *The secondary school aged Burmese refugee sisters whose mother was involved in a car accident and is now comatose.*
- *A young Spanish-speaking woman who experienced multiple abuse in her childhood, who is being case managed by a psychiatrist. She has had previous specialist sexual assault counselling that was terminated by the service provider because it was traumatising their workers. Delivering the service, at no charge for her, in her mother language has enabled her to regain her sense of coping, improving the quality of her parenting and restored her marital relationship*

- *The many Spanish and Italian-speakers who have multiple health issues and so cannot afford to pay a fee for counselling. Before seeing me they were unable to access a professional to address their anxiety and depression*

**(g) the delivery of a national mental health commission;**

The AASW has warmly welcomed the announcement to create the national mental health commission. In particular, the Association recognises the role that a commission can play in offering an independent voice to Government on services and programs in relation to:

- monitoring and evaluation services;
- assisting Governments in the interface between Federal and State / Territory issues;
- providing scrutiny over service delivery across Departments and programs;
- providing advice on the needs of the mental health workforce across jurisdictions and departments.

All of these roles are crucial in the delivery of quality mental health services and will be strengthened by the inclusion of mental health care consumers and carers, as well as professionals, in leading roles in the Commission. The AASW looks forward to the establishment of the Commission and to working with Government and the Commission.



**(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups;**

The AASW is supportive of any means which will increase access for people with mental illness who require information, support and treatment interventions. There are several “e-health” online programs that have been trialled and researched, but the outcomes of impact of these online modalities to treatment are yet to be fully evaluated. The obvious issues of access and equity would arise, with broadband coverage not consistent, access to computers and the internet and computer literacy being pivotal.

There are some principles which we would advise Governments to consider when setting up programs in this area.

- The relationship between the client and the professional is a key determinant of success, and replicating this online can be difficult;
- Online services must not be used in place of, or seen as a less expensive alternative to, physically co-located services;
- There are a number of mental health telephony services (such as Lifeline) which have been successful over many years. Use of telephones enables far more clients to participate than a reliance on new technology.

**(j) any other related matter.**

The AASW thanks the Senate Committee for initiating this inquiry and is willing to provide evidence in session at a hearing if requested.

## Reference List

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- <sup>1</sup> Australian Association of Social Workers (2008) *Practice Standards for Mental Health Social Workers*, Canberra.
- <sup>2</sup> Department of Health & Ageing (2007) *National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy*. Canberra, Commonwealth of Australia.
- <sup>3</sup> Mental Health Council of Australia (2010) *Community Mental Health Guiding Principles July 2010* see <http://www.mhca.org.au/documents/publications/Community%20Mental%20Health%20Guiding%20Principles%20July%202010.pdf>
- <sup>4</sup> Federal Government (2008) *The Road Home*, see <http://www.fahcsia.gov.au/sa/housing/progserv/homelessness/whitepaper/Documents/default.htm>
- <sup>5</sup> AASW (2010) *Australian Social Work Education and Accreditation Standards*, see <http://www.aasw.asn.au/document/item/100>
- <sup>6</sup> Calculations are based on 2010 calendar year sessions and assuming the proportion of services across different allied health professions remains unchanged over future years. Explanations of calculations can be provided if required.
- <sup>7</sup> AASW (June 2010) – *Mental Health Social Work Continuing Professional Development Project Report* prepared by Assoc Prof Jennifer Martin.
- <sup>8</sup> For a full list of accredited courses please see <http://www.aasw.asn.au/whatwedo/social-work-education>
- <sup>9</sup> AASW (2008) survey of members engaged in the Better Access program, unpublished
- <sup>10</sup> *ibid*