

Submission to Productivity Commission Response to Mental Health: Draft Report

January 2020



AASW

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Australian Association
of Social Workers

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The Australian Association of Social Workers

The Australian Association of Social Workers (AASW) is the professional body representing more than 12,000 social workers throughout Australia. We set the benchmark for professional education and practice in social work, and advocate on matters of human rights, discrimination, and matters that influence people's quality of life.

The social work profession

Social work is a tertiary qualified profession recognised internationally that pursues social justice and human rights. Social workers aim to enhance the quality of life of every member of society and empower them to develop their full potential. Principles of social justice, human rights, collective responsibility and respect for diversity are central to the profession, and are underpinned by theories of social work, social sciences, humanities and Indigenous knowledges. Professional social workers consider the relationship between biological, psychological, social and cultural factors and how they influence a person's health, wellbeing and development. Social workers work with individuals, families, groups and communities. They maintain a dual focus on improving human wellbeing; and identifying and addressing any external issues (known as systemic or structural issues) that detract from wellbeing, such as inequality, injustice and discrimination.

Social workers' experience and training allows them to understand that the mental illnesses experienced by individuals, families, groups and communities are not caused or determined by a single factor. There may be intrinsic personal factors, combined with familial, psychological, economic, health, educational, employment, legal, social determinants or other societal issues that contribute and pose obstacles to people achieving positive mental health and wellbeing. These environmental stressors comprise the social determinants of physical and mental health and are a central focus for social workers in supporting people with a mental illness.

Our submission

The AASW welcomes the Productivity Commission's Mental Health: Draft Report (the Draft Report). As described in our first submission, the AASW takes a human rights approach to mental health and emphasises the importance of the social determinants of mental health. Therefore, the AASW welcomes the Draft Report's acknowledgement of the role of social and community factors, such as poverty, unemployment, family violence, lack of affordable housing as contributors to poor mental health.

The AASW also welcomes the Draft Report's recommendations that the whole mental health system be re-oriented around the needs of the people who use it and their families and carers; and that the surrounding support system be similarly re-oriented. In many ways the Draft Report's person-centered recommendations align with the person centred, rights based, multifaceted and systemic approach to service delivery that the AASW has advocated for in other forums.¹

To prepare this response, the AASW consulted widely with members on the recommendations and information requests contained in the Draft Report. This submission draws on their responses and can be understood as a companion to our first submission.

Responses

A health workforce that can deliver the changes needed

The Draft Report excludes Accredited Mental Health Social Workers (AMHSWs) from its description of professionals who specialise in mental health.² The AASW submits that this is a serious omission, given that AMHSWs are one of the few designated allied health professional groups eligible to provide private mental health services to people with diagnosable mental health conditions under Medicare.

As well as their qualifying degree with its core mental health curriculum, AMHSW's are members of the AASW who have gone on to develop their learning and experience in mental health. There are six criteria to be met to qualify for accreditation as an AMHSW, covering membership, employer verification, at least two years post qualifying experience and continuing professional development. One of the criteria; *'demonstrated ability and knowledge of clinical social work practice'* is established under exam conditions and externally assessed. To retain their status as a Medicare rebated provider, social workers must maintain their AMHSW status, requiring at least 50 hours of professional development each year, receiving professional supervision and conforming to the AASW's quality assurance process.

An AASW survey in 2018 showed that over 75% of AMHSWs have more than 10 years of practice experience. The majority of AMHSWs also have further training and qualifications with over 60% having post graduate qualifications.

In addition, AMHSWs have a wide range of specialisations (including mental health disorders and

¹ See for example: AASW Submission to the Victorian Royal Commission on Mental Health, AASW, 2019, <https://rcvmhs.vic.gov.au/submissions>

² Productivity Commission, *Mental Health Draft Report Vol 1*, 2019, <https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume1.pdf>, p27

focused psychological strategies as listed in the Medicare Benefits Schedule) across the age, illness and intervention spectrum. This is detailed in Table 1.

Table 1 Specialisations³

<ul style="list-style-type: none"> • Acceptance And Commitment Therapy • Business And Organizational Focus • Case Management • Cognitive Behavioral Therapy • Child Development • Community Development • Counselling • Criminology • Dialectical Behaviour Therapy (DBT) • Alcohol And Other Drugs • Eating Disorders • Education • Eye Movement Desensitization And Reprocessing 	<ul style="list-style-type: none"> • Family Or Couples Therapy • Grief/Trauma • Hypnotherapy • Palliative Care • Psychoanalysis • Psychotherapy • Depression • Panic Disorders • Generalised Anxiety • Adjustment Disorder • Sleep Problems • Sexual Disorders • Bereavement
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Therefore, the AASW submits that AMHSWs are indeed specialist mental health professionals.

Information request 3.2: Out-of-pocket costs for mental health care

AASW members have submitted extensive evidence of significant out-of-pocket costs of mental health care incurred by consumers or their carers. This is particularly the case for people in community based services.

It will come as no surprise that the inadequacy of income support payments, which makes day to day survival a significant stress, also makes the out-of-pocket costs of mental healthcare completely unaffordable, with the result that people living on Newstart cannot afford to pay for medication, childcare during appointments or travel to appointments. Social workers reported many instances where people’s mental health needs are unmet because of their inability to afford medication or to pay the unfunded segment of MBs rebated items. Social workers in rural areas report on the additional burden that arises from the cost of transport to treatment. They report instances of people’s health deteriorating after having been discharged from a mental health facility, particularly in rural areas.

One member has suggested that community transport organisations could work with volunteer drivers who would undertake mental health first aid training to enable mental health consumers access to transport support. Further, volunteers for this program could include people who have

³ ibid

previously experienced mental illness and this volunteer time could be counted against their Job Network obligations.

The AASW draws the commission's attention to the injustice of out of pocket costs being born by people whose treatment is not voluntary. Many of the people on community corrections orders, clients of child protection and people who are on compulsory treatment orders are either dependent on income support or have been living on low incomes, and so the prospect of sanctions, added to the cost of conforming to their orders can impose a significant stress on them.

Another aspect of the unfunded elements in the system is the difficulty that professionals face in receiving payment for delivering services. The following illustrates that many professionals also incur significant costs and are effectively subsidising the system by continuing to see people despite their lack of payment:

'I see a client in a Registered Aged Care facility. He is a Department of Veterans Affairs (DVA) client. It takes me an hour to get to and from the appointments. I had already spent several hours becoming a registered service provider for the DVA which took a couple of hours. After undertaking 10 sessions this year I then had to write a comprehensive report to ask for more sessions – at least two hours. Next, I wrote and sent letters to both his personal GP and the Residential Aged Care Facility GP – which took at least an hour. Then in October the DVA cancelled the newly approved 10 sessions, because its new policy required all workers to develop a case plan with measurable outcomes. I now visit this client pro bono as the time I would need to spend doing all the paperwork isn't worth it.'

– AASW member

Re-orienting health services to consumers

Draft Recommendation 5.2 Assessment and referral practices in line with consumer needs

The AASW endorses the Draft Report's attention on General Practitioners (GP's) as an important gateway to the system. The initial assessment of the person's level of need is the key to determining the person's overall treatment and trajectory. Ensuring that people are quickly and smoothly connected to the appropriate level of care is a necessary and minimum requirement of an effective system. Although we concur with the recommendation's intention that initial assessments conform to "best practice", the AASW submits that "best practice" must be defined purely in terms of the person's need, rather than being determined according to the proportions of people using a particular level of service.

This means that the AASW differs from the Draft Report with respect to the role of PHN's in establishing best practice in referrals. Although we agree that there is an appropriate role in educating GP's and funding intake services, the AASW departs from this recommendation's description of the action required of PHN's in the medium term. The recommendation is that if PHN's discover that "service use is not consistent with estimated demand", PHN's should make changes to the "assessment and referral system". This suggests that discrepancies arise because it is the referral system, which is inadequate or deficient, rather than the initial estimation of demand. The AASW's first submission to this inquiry described the holistic, 'person-in-environment approach to making an

assessment of a person's needs, and the importance of an underlying relationship based on trust. These elements are the necessary components of 'best practice' in assessment, in preference to whether the numbers of people using a particular level of care conform to expectations.

The recommendation envisages a leadership role for PHN's in reforming this aspect of the system. In this context, the AASW points to the unpublished report of the PHN Advisory Panel on Mental Health. This review found that PHNs' varied widely in their understanding of the Stepped Care approach and its implications for commissioning mental health services. For that reason, the AASW recommends that PHN's themselves should be the targets of reform and capacity building to enable them to fulfill an expanded role in providing better mental health services.

Draft recommendation 5.4: MBS Rebated psychological therapy

The AASW has made two submissions to the review of mental health items which is being conducted by the Mental Health Reference Group of the Department of Health's Medicare Benefits Schedule Review Taskforce. The submissions describe the AASW's vision for a person-centred, holistic, evidence-based, collaborative and systemic approach to MBS-funded mental health supports, arguing that some people need more than 10 sessions and proposing a process for determining this. The Mental Health Reference Group is currently reviewing all submissions and finalising its recommendations to the Minister for Health.

Without pre-empting the findings of the review, the feedback from AASW members on this proposal concentrated on the lived experience of the person undergoing the therapy as part of the evaluation. People undergoing this form of treatment start from a wide variety of environments and bring a wide variation in their level of need. Similarly, people's personal assessment of the effectiveness of the therapy will not always reflect the externally measured change in their symptoms. The last point that members contributed was that the benefits of treatment provided by Medicare rebated services continue to develop for some time after the person has finished treatment so that the evaluation would need to allow for this.

Draft recommendation 5.5. Encouraging more group psychological therapy

The AASW has often supported more frequent use of groupwork, but members experience as to the smallest number of people who can create an effective group process varies. One member pointed out:

Group therapy is effective but the logistics of getting people together plus many people's fear of exposure in a group are counter indicators. I would recommend that a minimum of 3 be considered.

– AASW member

While another said:

There is some evidence which suggests that four members does not constitute a group, because it doesn't allow for enough of the dynamic (which is a crucial part of what you work with in a group), so, personally, I regard this recommendation with some caution...It's important to be clear on how group therapy is defined and what are the essential characteristics of a group that offer therapeutic potential.

– AASW member

The AASW believes that more evaluation is needed to establish the minimum number of people who are needed in a group to ensure that it is effective.

Draft recommendation 5.6: Psychology consultations by videoconference

The AASW agrees that there are particular features that render videoconferences attractive to rural audiences. Nevertheless, outcomes vary according to whether they feature personal contact and the extent of this contact. Members feedback emphasises that videoconferencing can be useful when there is an established trusting relationship between the parties, but that it is almost impossible to establish such a relationship when videoconferencing is the only form of contact.

I see a number of clients via video conference and they all report that they are satisfied with this. I might add that all previously lived near me and saw me face to face but then moved away and wanted to maintain a therapeutic relationship with a known clinician.

– AASW member

Members also re-iterate the point in the first AASW submission about the dependency on the quality of the communications technology:

Living in FNQLD video conferencing is not fluent. Too many interruptions prevent building sound relations and positive forward movement.

– AASW member

Information request 5.1: Low-intensity therapy coaches as an alternative to psychological therapists

The AASW believes that discussions on this too often blur the distinction between the intensity of the intervention, and the qualifications of the workforce delivering the support. In the example provided in box 5.4 New Access (Vol 1, p 211) combines a low intensity program of coaching and a workforce of people with a relatively low level of qualification. However, not all low intensity services require a low level of qualification, nor should it always be delivered by people whose main qualification is their own lived experience. The AASW recognises that coaching and support are valid responses to some people's needs, but emphasises that the low level of intensity does not equate with a low level of skill in the provider.

My experience of a few of them has been frightening lack of knowledge of mental health issues other than their own personal experience; which is not outcomes based unlike what we are all required to provide. In no other field would personal experience rate as a qualification to treat people: "I've had a hip replacement – let me perform surgery on you"!

– AASW member

This does not mean that the AASW places no value on lived experience as an element in a therapeutic relationship. Instead, the ASW is concerned that most of the literature about lived experience ignores the fact that many highly qualified mental health practitioners also have lived experience, on which they draw in their professional work. Indeed, it is important that people with lived experience differentiate which aspects of their experience are appropriate to share and which are not; and that task itself is something that requires professional education and supervision.

Information request 6.1: Supported online treatment for CALD populations

AASW members' experience is that online treatment is suitable for some people who do not speak English as their first language, but it is not applicable for many others. On the one hand, it can provide information for those who don't want to go to see a GP or health professionals for help. On the other hand, the difference in the concepts relating to mental health in some languages or for some cultures do not easily translate into other cultures.

It can be difficult for other people to understand because of translation problems and the words used. Myself, I can speak and understand Vietnamese language well but even I find it difficult to understand when I read health information translated from English to Vietnamese.– AASW member

Reorienting surrounding services to people

Draft Recommendation 10.3 Single Care plans and 10.4 Care co-ordination services

The AASW welcomes the attention to these two aspects of the service system and their importance for the outcomes of the vulnerable people social workers work with. Having already described the emphasis that the profession places on a collaboratively built, strengths-based plans for holistic care; and on cross professional collaboration in implementing the plan, the AASW is pleased to see them included in the Draft Report. Members experience of creating and implementing these plans points to the importance of the initial diagnosis of people's needs in determining whether the plans will be effective.

Similarly, social workers' experience of care co-ordination is that it is essential that clear authority and accountability relationships are articulated within the team who will provide the care. A collaborative approach requires a high level of professional commitment and inter-professional respect from all members of the team. The AASW would welcome the opportunity for further input into the implementation of this recommendation.

Draft Recommendation 12.1: Extend the contract length for psychosocial supports

The AASW endorses this recommendation. Members' experience is that long term consistent support is necessary for people with complex chronic conditions and that the current situation creates uncertainty which is increasing the anxiety of people using services.

Draft Recommendation 12.2 and 12.3; Guarantee continuity of psychosocial supports, and NDIS support for people with psychosocial disability

On multiple occasions, the AASW has submitted that members have encountered many people with psychosocial disability who have been negatively impacted by the introduction of the NDIS, and subsequent transfer of funding from mental health services.⁴ Many people have been judged to be ineligible for NDIS funding and consequently have been left without any support at all. The AASW endorses these recommendations.

Draft recommendation 13.3 Family focussed and carer inclusive practice

⁴ See for example the AASW federal election platform topic: "People living with disability and the NDIS", <https://www.aasw.asn.au/social-policy-advocacy/federal-election-2019>

The AASW endorses this recommendation as it is completely consistent with the holistic, person-in-environment, strengths-based approach that social workers use, and that has already been described in our previous submission. Indeed, members have provided multiple examples of where they do this despite it not being claimable against the Medicare Rebate:

A father was referred to me for counselling but his daughter also came to the appointment with him because she wanted to give me some background information. She preferred to talk without her father. He agreed. It was useful to talk to her but I could not claim for the session because she was not my client.

– AASW member

A man with anger and alcohol problems was sent to me. I needed to speak to his family to verify many of the things he told me about his life and his work. However, I could not claim for this work.

– AASW member

A mother went to her GP and asked the GP to refer her son to me. The son refused to go to see the GP. The mother asked me to see her son at home as he refused to see anyone. The mother talked to me over the phone many times. I spent time listening to her, providing her counselling, support and advice. However, I couldn't claim for this work because she didn't have a mental health care plan, even though her son did.

– AASW member

Draft Recommendation 14.4 Income support recipients' Mutual Obligation requirements

The AASW supports this recommendation as part of a suite of reforms to the current income support system .

I agree wholeheartedly with this. I have spent dozens of pro bono hours assisting a 37 year old to get on the Disability Pension – currently with no success despite Centrelink acknowledging 6 different disabilities including PTSD, depression and anxiety. They won't give him the Pension until he has been treated by a Clinical Psychologist and "stabilised". This is despite me having a 10-year history of supportive work with him which apparently doesn't count as treatment.

– AASW member

The AASW has repeatedly argued that the low levels of payment, the compliance regime, the automated debt recovery scheme, proposed testing for drug use, and the cashless welfare card all serve to punish and demonise the recipients of income support in a way that can only be detrimental to their mental health.

I wholeheartedly endorse this. In my practice, it is very plain that financial stress is one of the biggest causes and maintainers of Anxiety. It surprises me that this is not more widely recognised. It would also be advantageous if Newstart recipients were not demonised by those in public leadership positions.

– AASW member

I have had many reports from clients that although they believed that they had complied with Job Search requirements that they had been told that they had not. This has contributed significantly to their mental health deterioration.

– AASW member

Draft Recommendation 15.1: Housing security for people with mental illness

The AASW endorses this recommendation. Currently, the application process for housing prioritises physical needs over mental health needs with the consequence that it is becoming increasingly difficult to find accommodation for people with mental health illness, particularly for single people.

Draft Recommendation 15.2: Supporting people with high needs to find and maintain housing

The AASW endorses this recommendation as a matter of urgency. Many organisations and services currently have a policy of no-exits into homelessness. Although this is a necessary and minimum requirement for a health and mental health system, it can only be implemented if all levels of government commit to substantial reform to current housing and homelessness policy. The AASW has been advocating for this through its membership of the “Everybody’s home” campaign.

In Perth, psychiatric hostels’ rent is commonly more than \$800 per fortnight, and consequently patients who only receive the NewStart Allowance have few accommodation options and cannot be discharged.

– AASW member

Early intervention and prevention

The wellbeing and mental health workforce within schools

The AASW welcomes the Draft Report’s attention on the importance of schools as the ideal place for all students to receive mental health services. School social work is a well-established and longstanding genre of social work, with its own Scope of Practice and set of practice standards.

The AASW concurs with the Draft Report’s point about the similarity between the way schools can deliver services, and the Stepped Care model. As a universal service schools provide a platform from which to provide primary prevention services to almost all young people, while also creating the perfect environment for making specialist services easily accessible in a non-confronting manner. This is especially important for young people who are facing significant challenges but do not identify as having mental ill health. For experienced school social workers this is a major advantage and source of motivation for their work.

Extensive feedback from members provides a detailed description of the contribution that school social workers make in terms of universal, early intervention or more intensive level. This can be characterised as ‘tiers’ of service.

Tier 1 is primary prevention: a platform of universal services to all students to increase social emotional learning. At this level social work staff implement or support programs by integrating them into the school’s mainstream offering to ensure that all practices promote the mental health of students. Examples submitted include:

- Incorporating a “restorative justice” approach into the school’s discipline policy,

- Coaching teachers in a whole class solution-focused teaching,
- Introducing cross-age mentor programs as a means to prevent bullying of younger students by older students,
- Incorporating self-care activities in the Year 7 Orientation Camp activities,
- Establishing parent support networks for the parents of students with special needs
- VCE and Year 8/9 exam stress seminars,
- Reviewing the school's publicity materials and online presence ensuring that they don't inadvertently contribute to stigma around mental ill-health,
- Organising Continuous Professional Development for staff around mental health issues.

Research indicates that these interventions help between 80 – 90% of students

Tier 2 is early intervention: in delivering the programs and services above, social workers can identify students whose mental health challenges create appear to have barriers to their learning. Staff are skilled to discreetly steer these students toward activities that are more targeted and which offer more structured support. These can include;

- mindfulness,
- anxiety prevention program,
- brief casework/counselling,
- social skills groups,
- anger management programs.

Sensitive handling of communications with parents and consultations with teachers are an important aspect of the well-being role at this level. Research indicates that this helps between 15-20% of students.

Tier 3 is tertiary, indicated and intensive intervention with a relatively smaller population of students who are presenting with mental health problems which impact their learning and wellbeing. At this level, individual and group counselling is offered, referrals to external services such as Headspace and Child and Adolescent Mental Health Services and occasionally, brief family work. These student's needs may present as behavioural problems and so may raise discipline issues which require sensitive handling by school leadership. Work for these students also requires extensive collaboration with child and youth mental health services, the child protection system, the youth justice system and the Family Court. Research indicates that between 1-5% of students will require this level of service.

Draft recommendation 17.5: Well-being leaders in schools

The complexity of the work described above, and the breadth and level of skill that it requires demonstrates why the AASW also endorses the recommendation that all schools should employ a dedicated student well-being team with a dedicated team leader position. School social workers concur with the Draft Report's recommendation that this person should be part of the school's leadership team to ensure that all school policies, procedures and operations support the mental health of the young people in the school.

Nevertheless, the AASW strongly disagrees with the Draft Report's conclusion that a teaching background is essential for this role. The work of integrating all the programs described above seamlessly into all aspects of a school's policies, operations and communications with the

community requires skills in organisational change, advocacy, program design, policy change, mediation, community development, counselling parents and court report writing. Feedback from members emphasised that social workers' skills and knowledge provide the most appropriate preparation for this role.

I have recently worked as a Professional Practice Leader in the Department of Education. I was aware that many schools in the region had only teachers in wellbeing positions. These staff had little capacity to deal with the complexities of student's lives, resorted to external referrals a lot of the time, contracted in private practitioners (mainly psychologists) who had no real linkage to the school and did not work systemically.

– AASW member

Well-Being staff who are teachers, are often conflicted about their professional identity. They are teachers first and foremost before they extend their roles to looking after the social and emotional problems of students. Most have no training or experience in working with families.

– AASW member

Psychologists who lead well-being teams may have a focus on individual psychopathology and direct services. They generally do not have a systemic orientation to their work and often do not interact much with families. However, the employment of social workers as well-being leaders provides the school with a bio-psycho-social and ecological lens, through which all student's mental health can be enhanced.

– AASW member

As Team Leader, I work closely with the Principal and Assistant Principal for Student Well-Being in meeting the mental health needs of students at our school. We are a responsive team and by increasing the profile of our service, have seen a significant increase in self-referrals by students over the last three years.

It is also important to note that some schools around the country are moving to embed allied health perspectives alongside those of educators, by employing these staff, not simply contracting them in to provide 'focused psychological strategies' under Medicare.

– AASW member

Pulling together the reforms

Draft Recommendations 22.1, 22.2 and 22.3

Currently AASW members grapple daily with the consequences of short-term funding cycles and a system characterised by gaps, duplication and inconsistency. Members' feedback for this submission features many examples of poor outcomes for vulnerable people which are created by the system itself. Therefore, the AASW strongly supports these recommendations as they reflect reforms for which the AASW has argued to previous government enquiries.⁵

⁵ See for example the AASW submission: Accessibility and quality of mental health services in rural and remote Australia, https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Submissions

Conclusion

The AASW welcomes this inquiry and its visions for a person-centred human services system. Its recommendations can bring improvements to the system which have been urgently needed for some time. The AASW looks forward to continuing its active role in system reforms which improve the health outcomes for vulnerable people and thanks the Productivity Commission for this opportunity to contribute.

And the AASW's first submission to this inquiry.



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