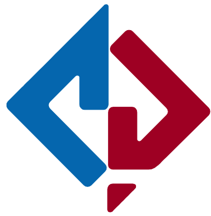

Submission to the Recommendations from the Report from the Mental Health Reference Group 2018 – MBS Review Taskforce

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Introduction

Who we are

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 have a strong voice on matters of social inclusion, social justice, human rights and issues that impact upon the quality of life of all Australians.

Social workers are key partners in the mental health sector and, given our commitment to improving the health and wellbeing of all Australians, we welcome the opportunity to contribute to the Medicare Benefits Schedule (MBS) review.

Mental health in Australia

It is beyond debate that Australia is currently facing a significant mental health crisis. The Australian Bureau of Statistics (ABS) estimates that approximately 45% of Australians have experienced a mental health disorder in their lifetime, with the most recent data identifying that 20% of Australians are currently experiencing some form of mental health issues in the last year.[1] [2] The daily impacts are significant and affect the lives of every individual, group and community across Australia. As social workers, we are on the frontlines of service delivery and see the devastating impacts.

Mental health is an integral and essential component of health. The World Health Organization (WHO) constitution states: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. An important consequence of this definition is that mental health is considered more than just the absence of mental disorders or disabilities. 'Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world.'[3] This statement from WHO captures the bio-psychosocial dimensions of good mental health (also known as the Social Determinants of Health). It goes on to also identify the multiple factors that can compromise a person's mental health: specific psychological, personality and biological factors; socio-economic – inadequate income and education; social environmental – rapid social change; gender or racial discrimination; risks of violence, and personal – unhealthy lifestyle, physical ill health.

It is the position of the AASW that in order address these mental health challenges, Australia needs a person centred, rights based, multifaceted and systemic approach to service delivery. We believe, and this is based on the evidence [4], that Medicare funded mental health services - including the "Better Access to Psychiatrists, Psychologists and General Practitioners" initiative (Better Access) - play an integral part in assuring that every Australian is provided the supports they need to reach their full potential.

The social work profession

It is the AASW's position that social workers have a clear and important role in the delivery of mental health services under the MBS. Social work is a tertiary-qualified profession recognised nationally and

[1] https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1819/Quick_Guides/MentalHealth
[2] https://www.blackdoginstitute.org.au/docs/default-source/factsheets/facts_figures.pdf?sfvrsn=8
[3] https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response
[4] http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval-sum

internationally that supports individuals, families, groups and communities to improve their wellbeing. 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 knowledge.

Social workers provide a unique and significant contribution to the field by maintaining a dual focus on both the individual and family/contextual domains, and it this understanding that distinguishes social work from other health professions in the sector. Social workers are regularly involved with individuals and families experiencing complex social, psychological, family and institutional dynamics. Social workers offer a unique and valuable contribution in providing appropriate and targeted services and therefore have a clear role in the provision of effective mental health services.

Accredited Mental Health Social Workers

Accredited Mental Health Social Workers (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 stated in our recently published report ***Accredited Mental Health Social Workers: Qualifications, skills and experience***, (see attachment) [5] there are currently more than 2200 AMHSWs across Australia. Data on the location of social workers across Australia indicates that over 40% of practice in regional, rural and remote regions [6], and therefore provide an important contribution of mental health care in these very underserviced regions.

As a group of providers, AMHSWs form the second largest group after the combined group of Clinical Psychologists and Registered Psychologists. AMHSWs are highly trained professionals, meeting some of the highest standards of professional regulation in Australia.[7] The AASW is responsible for the accreditation of AMHSWs and is committed to maintaining the high standing and practice of the social work profession.

AMHSWs have a breadth of training and experience in assessing and treating people who have mental health disorders. Furthermore, they are committed to collaborative practice, recognising the individual's role in treatment planning and the individual's right to have a knowledgeable, skilled practitioner who is guided by ethical principles / a Code of Ethics. Social work undergraduate and postgraduate education has a focus on holistic, whole of person and life course approach and as such can provide assessment and interventions for people with very complex presentations. Built on that is the further credentialing of AMHSWs, equipping highly skilled mental health clinicians in assessment, diagnosis and treatment planning and the delivery of evidence based therapeutic interventions across formative and life stages. A core standard for AMHSWs is collaborative and interdisciplinary practice. This core skill set is highly regarded in both acute and primary care settings, and along with mental health skills and knowledge, provides significant value in chronic disease management and care coordination.

The use of a whole of person approach to mental health provides AMHSWs with a unique skill set which is very useful in offering a holistic and stepped care approach across heath care settings. The advanced training that is expected of AMHSWs provides them with the skills for working with people with very complex presentations and co-morbidities.

AMHSWs are committed to improving the lives of the people they work with and as such provide a valuable contribution to the mental health sector.

[5] https://www.aasw.asn.au/document/item/11704
[6] Ibid
[7] https://www.aasw.asn.au/document/item/11311

MBS Review Recommendations: Our main points

Our submission builds on our previous work to the MBS review and will expand on several key points, fundamentally arguing for a significant improvement to mental health services with a focus on need, equality of access and workforce considerations.

Our submission has two main parts:

- Response to the recommendations from consultation paper.
- The AASW proposed model for Better Access Mental Health supports. This is the Better Access model the AASW has developed in consultation with members and will be references in the recommendations.

The social work profession and Better Access

Once again, the AASW highlights two key professional issues which we have raised previously and which need to be part of any future reform: Recognition in the title and pay parity.

- **Recognition:** It is of ongoing concern to AASW that the official title of the initiative is "Better Access to Psychiatrists, Psychologists and General Practitioners". The existing title neglects the role of mental health social workers and occupational therapists 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 General Practitioners (GPs); as a result, this wording has the potential to exclude occupational therapists and social workers from the initiative. The AASW proposes that the initiative needs to be called "Better Access to Mental Health Care".

- **Pay parity:** Under the MBS fee schedule Accredited Mental Health Social Workers are paid less than psychologists for providing the same services. AASW continues to advocate for reform and that the pay structure better reflect the skills, training and qualifications of the professionals providing supports.

Key Recommendations

- Ensure a person-centred, holistic, evidence-based, collaborative and systemic approach to MBS-funded mental health supports
- Support the recommendation to extend MBS Better Access to clients who do not meet the full criteria for a mental health diagnosis but are at risk of developing a mental health condition
- Support the recommendation to increase the number of sessions to up to 40 per calendar year, taking into consideration complex need, not just mental health diagnosis
- Support the greater focus on group work and improved access to supports for family members and carers
- Support the recommendation that the list of approved therapies be reviewed and expanded
- Support the recommendation for inclusion of greater recognition of individual mental health support and therapy for residents in aged care facilities
- Support the expansion of digital mental health and telehealth services.

1. Our response to the recommendations

In this section, we will provide a response to the key recommendations.

1. Expand the Better Access program to at-risk patients

The AASW welcomes this initiative as it provides an important new approach for Medicare mental health services. A greater consideration for the complexity of how poor mental health is experienced regardless of diagnostic thresholds is a significant step towards making the service system more inclusive, more reflective of need, and more proactive rather than reactive.

This measure provides a more comprehensive approach to diminishing the prevalence and impact of mental health conditions in the community. Resilience and mental health are inextricably linked.[8] The ability to work with people "at-risk" (or sub-threshold as they will be referred to from now on) provides an important measure to the general community to improve resilience. It is these protective measures that enhance the ability to preserve a measure of mental health in the face of adversity; and to undertake the harm reduction measures that enable a quick and effective recovery from adversity.[9] The considerable bio-psycho-social research in this area reveals the interplay between individual, group and social factors and the need for a support system that understands how mental health is experienced beyond diagnostic labels.[10]

It is the core philosophy of all social workers that we need to start where people are at. Many people have 'sub threshold' symptoms or co-morbidities that make diagnosis difficult. People may also have significant social issues that make them more vulnerable to psychological distress, for example: family violence, chronic trauma, homelessness, unemployment or insecure employment, the struggle to survive on inadequate Centrelink payments, sole parenting and other family responsibilities or family conflict. AMHSWs have repeatedly identified that there is a significant group of people who miss out on much needed services due to a lack of diagnosis. Providing services for these groups begins to address a significant equity of access issue, and recognise the contribution of the social determinants of health and their impact on wellbeing.[11]

If services continue to be restricted to individuals with only a medical or psychiatric diagnosis, then we are neglecting the significant proportion of people that have psychological distress and whose symptoms don't match those of the DSM-V or the ICD -10.

The WHO and the Fifth National Mental Health and Suicide Prevention Plan, asks mental health services to consider the Social Model of Mental Health and for greater integration of the issues related to having physical health and mental health conditions. The inclusion of the sub-threshold group would also include people experiencing significant psychological distress and living with cancer, chronic and serious physical issues (for example Multiple Sclerosis, Motor Neurone Disease, and Chronic Obstructive Pulmonary Disease). It would prevent such people having to have a diagnostic 'label' or needing to undergo unnecessarily extensive and invasive assessments prior to accessing appropriate, quality, individualised mental health services where they live. This initiative would be an important step towards reducing and challenging the stigma sometimes associated with poor mental health.

The AASW recommends that to determine who is eligible for below-threshold services, that Medicare policies include the use of well-validated assessment tools to determine psychological distress. This

[8] Davydov , Stewart R, Ritchie K & Chaudieu I, 2010 'Resilience and mental health' Clinical Psychology Review, 30 (5) 479-495
[9] Davydov , Stewart R, Ritchie K & Chaudieu I, 2010 'Resilience and mental health' Clinical Psychology Review, 30 (5) 479-495
[10] Ibid
[11] https://www.who.int/social_determinants/en/

could include the Hospital Anxiety and Depression Scale (HADS) [12], Distress Thermometer (DT) [13] and the outcome tools including the WHO Disability Assessment Schedule (WHODAS) [14] and the Health of the Nation Outcome Scales (HoNOS).[15]

The AASW supports any measure that looks at providing evidence-based, timely and early intervention (early in life or early in the episode of a mental health issue), as it will contribute to decreasing the prevalence of anxiety, depression and other mental health conditions. Providing much needed supports to a neglected group is also likely to improve their health, participation in education and the workforce, and eventually less use of the health, mental health and other services.

2. Increase the maximum number of sessions per referral

The AASW is supportive of this measure, given the evidence base for the number of sessions required to provide an effective course of treatment (as stated in the consultation paper on page 92). An initial 10 sessions (rather than 6) enables better engagement with the client and improved planning and continuity of work, and therefore improved outcomes.

Clients will sometimes not disclose to the GP their history of abuse or early trauma, so the GP may be unable to make an appropriate assessment of their level of need. We have concerns that this recommendation may lead to a situation where GPs are making an arbitrary decision on the number of sessions. Some people with complex diagnoses are quite socially stable and live very well with their illness, and some people who have what may appear to be less complex, may need significantly more sessions, depending on the impact the illness or diagnosis has on their functional capacity. The AASW proposes a requirement that the clinician communicates with the GP at the 4th session, but that the reminder of the 6 sessions are assumed, not dependent on the review taking place.

While supporting the extension to 10 sessions, given the evidence base stated in the consultation document regarding the number of sessions needed for an effective course of treatment, the AASW believes the review provides an opportunity to extend this further. As seen in our model (see AASW Model for Better Access) we propose that an initial 20sessions are made available with a GP review at the 10-session point. This would be in line with best practice and evidence base for a whole range of conditions, including generalised anxiety disorder, panic disorder, post-traumatic stress disorder (PTSD) to name a few.[16]

Ultimately the sessions provide an important amount of time to build empathetic and trusting relationship, which are the foundations of any effective treatment. There is significant evidence to demonstrate the importance of the need for positive relationships to provide effective treatment.[17] [18] Social workers are highly trained in relationship-building and bring significant skills including the capacity to foster trust, demonstrate empathy, and engage in collaborative decision-making to enable partnership in change processes. Increasing the number of sessions would make significant strides towards assuring that the foundations for effective support are created.

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC183845/
[13] https://www.ncbi.nlm.nih.gov/pubmed/23795426
[14] https://www.who.int/classifications/icf/whodasii/en/
[15] https://www.amhocn.org/publications/health-nation-outcome-scales-honos
[16] http://www.health.gov.au/internet/main/publishing.nsf/Content/58EFEA022C2B7C49CA2583960083C4EA/$File/Report%20from%20Mental%20Health%20Reference%20Group.pdf
[17] https://psycnet.apa.org/record/2002-01390-002
[18] http://psycnet.apa.org/journals/int/26/3/300/

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

The AASW provides general endorsement as clients with more complex mental health conditions and co-morbidities would be able to receive mental health services that are more appropriate to their individual needs. We believe the recommendation is consistent with best practice guidelines for a stepped care model. As stated previously the evidence is clear that for conditions like Bipolar Disorder, Obsessive Compulsive Disorder, severe anxiety or depression, chronic PTSD, Eating Disorders, twenty or more sessions are needed for good clinical outcomes. Extending the number of sessions also allows for better continuity for longer term therapy especially within a psychodynamic framework.

It is the position of the AASW that the number of sessions needs to take into consideration complex need, not just mental health diagnosis. There needs to be greater clarity and consideration for the allocation of sessions so that we do not have an arbitrary situation where the GP decides the number of sessions. The AASW opposes the idea that the level of tier someone can access should be solely dependent on the diagnosis. Some people with complex diagnoses are quite socially stable and live very well with their illness, and some people who have what may appear to be less complex may need significantly more sessions, depending on the impact the illness or diagnosis has on their functional capacity.

As stated previously, the AASW's proposed model would see all clients being referred for 20 sessions – as Better Access allowed prior to the changes in 2011. Clinicians and GP's would collaborate with the client to work out the best therapy and number of sessions that may be required. Clients should be able to access the additional number of sessions, i.e., 10 or 20 depending on severity and functional disability.

If new information is revealed, or significant trauma is identified and the appropriate number of sessions identifies that 20 more sessions may be necessary, then the clinician and the GP collaborate to identify the care of the client and the psychological therapy that is required. At the 10th session, a case conference – phone or face to face – with the GP and the clinician may be warranted and funded under Medicare (currently only the GP receives a rebate for case conferencing). Some client presentations for issues such as severe eating disorders, chronic self-harm, post-vention in suicide ideation, severe PTSD, chronic trauma, severe anxiety / death and health anxiety / significant adjustment issues, requests for euthanasia, may immediately warrant a referral for the 40 sessions that need to be available and are well supported by available evidence. The above collaborative practice, and evidence of such, should apply.

The AASW is also concerned that the use of the term "Focussed Psychological Strategies (FPS)" does not recognise that all professional trained mental health clinicians accredited by Medicare have to be able to provide Psychological Therapies (PT). FPS form part of PT and treatment planning. The term FPS is a term with no validation or evidence and we request that this be changed to reflect the specialised nature of the training and work being delivered.

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

The AASW supports the continuation of the current group but with revision and expansion of the members, as the report itself states: to "carefully consider membership of the group to ensure unbiased,

balanced and well-informed discussion and recommendations”. Maintaining key portions of the current membership (with additional and equitable representation), also recognises the prior knowledge gained by members of the MBS Review group from their participation in previous briefings and meetings.

In considering new members, much greater consideration needs to be given to the diversity of the workforce, even within the same professional groups. For example, different rebate items disproportionately disadvantage people from regional, rural and remote communities where, from client and member feedback, Clinical Psychology and general psychology providers appear to be scarcer than in metropolitan regions. Having a higher rebate and payment structure for certain clinical groups disadvantages both clients and clinicians – clinicians who attract the lower rebate are less able to bulk bill as the rebate does not cover the costs of providing a competent and high quality service. AMHSWs and Mental Health Occupational Therapists and a proportion of psychologists are in significantly higher numbers than other professional groups in regional, rural and remote Australia. the AASW believes that it is important that the composition of the work reflect and represent the workforce.

On the issue of rebate and access to sessions, the AASW once again asserts our position that all psychological therapies through Better Access should be delivered by the current providers for the same hourly rate. We once again call on the government to address the pay parity issue identified in our previous submissions.[19] Despite the Medicare Rebate for AMHSWs currently being less for each session of service than it is for Registered Psychologists, there are the same expectations of service delivery, quality and outcomes with identical item descriptors. The AASW maintains that there are no valid reasons for there to be any variance between the two rebates under Medicare for Registered Psychologists and AMHSWs providing services under the Better Access program.

As outlined in our recently published report,[20] the AASW sets a high bar for qualified social workers to become an AMHSW and is confident of their ability to deliver Focused Psychological Therapies. It is worth stating here that other national and state programs do not discriminate against social workers. For example, the National Disability Insurance Agency (NDIA) reimburses privately contracted AASW AMHSWs the same as other professionals who provide services under the National Disability Insurance Scheme (NDIS). Similar arrangements apply in the Department of Veterans’ Affairs’ Open Arms Service, (which was previously the Veterans and Veterans Families Counselling Service).

The AASW recommends a recognition of the clinical competence and training of all accredited mental health clinicians providing mental health therapies under the Better Access initiative, without holding one group as being more competent. Mental health clinicians, from all professional groups, must meet strict accreditation and practice requirements from their professional bodies and from Medicare to practice under Better Access. All mental health clinicians must be proficient in providing evidence based therapies for a range of mental health presentations. The division between professions, due to the historical and political perspectives, should ideally be discussed by an ‘expert’ clinical body and referred to the Minister or a new Clinical Taskforce to resolve the differences between professional groups regarding competence and capacity to deliver complex mental health interventions; and to determine the rebate items appropriated to each group.

5. Reduce the minimum number of participants in group sessions

Group therapy is an effective form of delivering psychological therapies and works well as an adjunct to individual therapy. The AASW is generally supportive of this move as way of making group sessions more accessible. A distinction needs to be made between the number of participants needed to start a

[19] https://www.aasw.asn.au/social-policy-advocacy/campaigns-consultation/mbsreview
[20] https://www.aasw.asn.au/news-media/2019-2/amhsws-are-experts-in-complexity-new-report-published-today-says

group and the number needed to run a session. While two people may be appropriate to run a session, this is too small a number to establish a group. There are many issues contributing to this and a key factor is that having fewer than four group members makes a group dynamic (which facilitates the group process and outcomes) very difficult. Furthermore, by most agreed upon definitions, two people does not constitute a group.[21]

Reducing the number makes it easier to provide groups for people with complex mental health issues to access group based support, especially if larger group could exacerbate their issues. Additionally, in rural communities, the requirement for between six and ten people discriminates against these populations where it may only be possible to regularly have up to four people come to a group, or only four clients with similar group therapy needs. Fundamentally, it cannot be assumed that all people can fit into similar groups. Groups must be appropriate and responsive to the individual needs of each person and not a one-size-fits-all approach.

6. Add a new group item for therapy in larger groups

The AASW is supportive of this move as it recognises the complex level of skills and knowledge that is required to run a group this size. Where it is appropriate, larger generalist groups – such as with mindfulness, relaxation groups, general information groups, psychoeducation or support groups – would need two facilitators to enable the group to be appropriate and responsive to the needs of the group. Being able to provide for 2 clinicians to be rebated to attend ensures that the participants receive the best experience and support within the larger group setting.

We would like to highlight some issues with wording of the recommendation. In particular, the need to revise the statement in the recommendations from “by one or two psychologists, lasting for at least 60 minutes.” to incorporate AMHSWs and other relevant mental health professionals.

7.

7a: Enable family and carers to access therapy
7b: Enable family and carers of people receiving mental health services to access therapy

The AASW endorses the recommendations pending greater detail on the policy. The measure recognises the importance of an individual’s social support systems in terms of both the supports family and carer provide as well as the impacts on them. As social workers, this is an important inclusion as it recognises the significance of the systems and social impacts on a client’s mental health presentation and their role in developing wellbeing. This measure enhances collaboration, increases engagement and recognises carers/support people as valuable resources in the process of recovery.

Although both recommendations are important, taking from the currently availble10 sessions, prevents access to an appropriate number of sessions for people for whom 10 or more sessions would be more clinically responsible. An additional Medicare Item number – 800BB, allows for data to be created to identify the number of sessions being provided to family members and care givers, so that the usefulness and benefits of such item numbers and support being provided can be monitored and measured. It allows the family and care givers to be able to receive appropriate psychoeducation and individual support and to collaborate more effectively (with the client’s consent) and ensure better mental health outcomes.

[21] Doel, M. (2006) Using Groupwork, Routledge, Oxon

8. Measure Better Access outcomes

Developing or using a consistent outcome measurement tool (as is the case with the NDIS, Headspace and Disability Support Pension) encourages best practice and allows for the data to be collated about the usefulness or effectiveness of certain therapies or approaches. The AASW supports this measure and concurs with the statement in the report that "monitoring outcomes in psychological therapies is important both for the welfare of the client and to confirm the effectiveness of treatment."

Currently, different measurement tools are used in each health care setting and these tools cannot be compared against each other. Also, it is important that the outcome tool measure functional disability or social impairments of the mental health presentation/diagnosis; and the relationship between the therapeutic plan developed with the client, and the outcomes anticipated by both the client and the clinician.

The Australian Government set up the Australian Mental Health Outcomes and Classification Network in 2003, in 'order to provide leadership to the mental health sector to support the sustainable development of the National Outcomes and Casemix Collection (NOCC) as part of routine clinical practice'.

The outcomes tools that are recommended (and are also recommended for the NDIS and DSP) are:

1. Health of the Nation Outcome Scale (there is an adult and child version)
2. Life Skills Profile
3. Mental Health Phase of Care
4. Living in the Community Questionnaire

Additionally, there is the World Health Organisation Disability Assessment Schedule (WHODAS. 2.0) to which we have already referred.

All these outcome assessment tools are holistic and include physical health, social issues and systemic – macro (political, environmental) issues as part of the assessment framework. This approach is congruent with social work as it applies a bio-psycho-social perspective to the person and their mental health issues. the AASW recommends further exploration and perhaps a trial of these assessment tools and their appropriateness within specific health and community (primary) care settings. The consistent use of outcome scales would also assist with the decisions about the competence of professional groups to deliver psychological therapies to specific populations groups and for specific diagnoses.

9. Update treatment options

As stated in our previous submission, the AASW supports this measure. Due to the increase in evidence-based therapies since the inception of the Better Access program, the AASW supports the recommendation that the list of approved therapies be reviewed and additional therapies be included.

For example, Interpersonal Therapy has a convincing body of evidence for its effectiveness in treating commonly occurring mental illnesses and disorders.[22] [23] [24] It is particularly useful for depression linked to relationship difficulties. Narrative therapy is a widely recognised strengths-based and client-centered approach to collaborative work with clients that seeks to re-author the problem-based personal stories that can come to dominate how people think and act.[25] Narrative therapy was developed by an Australian clinical social worker and it is seen as a hopeful and respectful model of counselling and

[22] Weissman, M., Markowitz, J., & Klerman, G. (2000). Comprehensive guide to interpersonal psychotherapy, New York Basic Books, NY
[23] Stuart, S. & Robertson, M. (2003). Interpersonal Psychotherapy: A clinician's guide, Arnold London
[24] Ravitz, P. (YEAR?). The interpersonal fulcrum – Interpersonal Therapy for treatment of depression, *Evidence based psychotherapies*, Canadian Psychiatric Association, ww1.cpa-apc.org/Publications Accessed 29 May 2014
[25] https://dulwichcentre.com.au/narrative-therapy-research/

community work. Therapists work with clients to make meaning of their life's events and experiences through a re-storying process that places the client in control of the way her/his story is told and witnessed. Together, client and clinician explore and discuss alternative stories, and then identify the client's preferred stories, with a focus on developing the client's agency in the future.

The current list of approved therapies is based on very old data and research. There are many more therapies that have had their effectiveness proven and should be included, especially in relation to the recognition and increased capacity to understand the impact of trauma, the role of nutrition and functional neuroscience, and the efficacy of 'third wave' psychological therapies in providing services that meet individual client needs. Given the rapid emergence of more brain-based therapies (for example Eye movement desensitisation and reprocessing EMDR,) and the time needed for efficacy studies to be completed, evaluation would need to be conducted by those aware of current methodologies. Currently listed interventions more limiting in terms of what practitioners use in the current environment.

Additionally, the level of evidence needs to be expanded to include evidence other than Level 1 and 2 evidence. Not all therapies can use randomised controlled trials, or similar approaches – and evidence has to include therapies that have level 3 and 4 – such as narrative and dignity therapy with people with physical health or terminal illnesses; EMDR for people with trauma, Exposure Therapy for trauma.

Finally, the AASW recommends greater clarity about the report's intention in the phrase; "Frequently review and update the list of therapies covered under the MBS", especially in relation to the possible timeframes.

The AASW supports the inclusion of the following interventions:

- Acceptance and commitment therapy (ACT)
- Dialectical behaviour therapy (DBT)
- Emotion-focused therapy
- Eye movement desensitisation and reprocessing (EMDR)
- Family intervention (FI)
- Psychodynamic therapy
- Metacognitive therapy (MCT)
- Mindfulness-based cognitive therapy (MBCT)
- Schema-based therapy
- Solution-focused therapies
- Exposure treatments
- Narrative therapy
- Narrative exposure therapy
- Trauma-focused cognitive behaviour therapy (CBT)

Furthermore, the AASW would welcome the opportunity to be involved in any review of therapies or approaches

10. Unlink GP focused psychological strategy items from M6 and M7 items

The AASW recognises that there some circumstances in which this could benefit a client; and therefore, acknowledges some of the propositions concerning engaging previously "unengaged" people. GPs have several other Medicare Rebate items that they can use when providing psychological therapies or strategies for clients. Using the client's current 10 sessions and providing therapies that may not be included in the treating mental health clinician's treatment plan limits the capacity of the mental health

clinician to provide effective treatment for the client. Often neither the mental health clinician nor the client are aware that the GP has used some of the 10 allocated sessions, creating a great disadvantage for the client.

We would like to see further detail about this policy before providing full support., In particular we are concerned that it may create service inequities because some clients may be able to access twice as many sessions with a mental health professional depending on the training of their GP.

11. Encourage coordinated support for patients with chronic illness and patients with mental illness

The AASW endorses this recommendation as an important step towards addressing significant issues with the current service delivery system for people with chronic illnesses. The Australian system of chronic disease prevention and management is fragmented. This leads to poorly coordinated care that is not client centred and is contrary to best practice guidelines. The current model of funding has created 'professional silos' where medical and allied health workers work independently of each other leading to poor overall services and outcomes, especially for those in lower socioeconomic and disadvantaged groups. Furthermore, international studies have shown that the incorporation of social workers into chronic disease core treatment teams can have positive effects on patient wellbeing and health outcomes leading to reduced hospital admissions.[26] [27]

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

The AASW provides general support for this measure but would encourage the government to significantly invest in research to determine effective treatment options and how they would be used to reach poorly supported groups. Digital mental health presupposes access and competency in the use of Information and Communications Technology (ICT). A key point on the use of technology mental health is greater consideration for literacy and how problems with Australia's ICT infrastructure would pose major barriers to accessing supports. Digital mental health measures need to be implemented in conjunction with public education and awareness campaigns for older Australians and people from Culturally and Linguistically Diverse communities.

13. Support access to mental health services in residential aged care

Social workers have a long and proud tradition of working together with older Australians towards active ageing. This includes a strong commitment to self-determination, dignity and respect. The AASW recommends that all residents in Residential Aged Care Facilities (RACFs) be able access to appropriate Enhanced Primary Care and mental health services with a GP referral regardless of their funding source. Once again, the AASW highlights the concern that residents of aged care facilities continue to be ineligible for services under Better Access, despite there being no evidence that they experience these conditions at a lower rate than any other group in the community. People living in residential aged care may find it difficult to access external supports due to financial, physical and cognitive constraints. We are cognisant that the RACF funding instrument includes support for psychological wellbeing in the funding of aged care workers and additional services to residents. This

[26] Sommers LS, Marton KI, Barbaccia JC & Randolph J, 2000, 'Physician, nurse, and social worker collaboration', *Primary Care for Chronically Ill Seniors*, 160(12):1825-1833.
[26]
[27] Fouche C, Butler R & Shaw J, 2013, 'Atypical alliances: The potential for social work and pharmacy collaborations in primary health care delivery'. *Social Work in Health Care*, 52(9), 789-807

funding, however, is inadequate to fund the provision of appropriately trained mental health clinicians for the range of mental health concerns that older people face. In line with the NDIS, all people should have 'choice and control' over the support they may require or have been using prior to entering a RACF.

14. Increase access to telehealth services

The AASW supports this measure and would like to see the telehealth service expanded to individuals who, due to their diagnosis, are unable to access face-to-face supports; such as people with complex, chronic or terminal physical health issues, complex mental health and physical health issues, disabilities that impact on access, and severe mental health issues such as severe social anxiety, eating disorders, people expressing suicidality. We support and congratulate the government's recent measures to expand telehealth to drought-affected farmers. We believe this highlights the significant potential for expansion for a whole range of groups who due to their condition, location or both may find it difficult to access appropriate services.

Pivotal to this initiative is the greater investment in improved internet access. There is significant international evidence to highlight the benefits of investing in telehealth services and we draw attention to the Ontario Telemedicine Network.[28]

[28] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4892212/

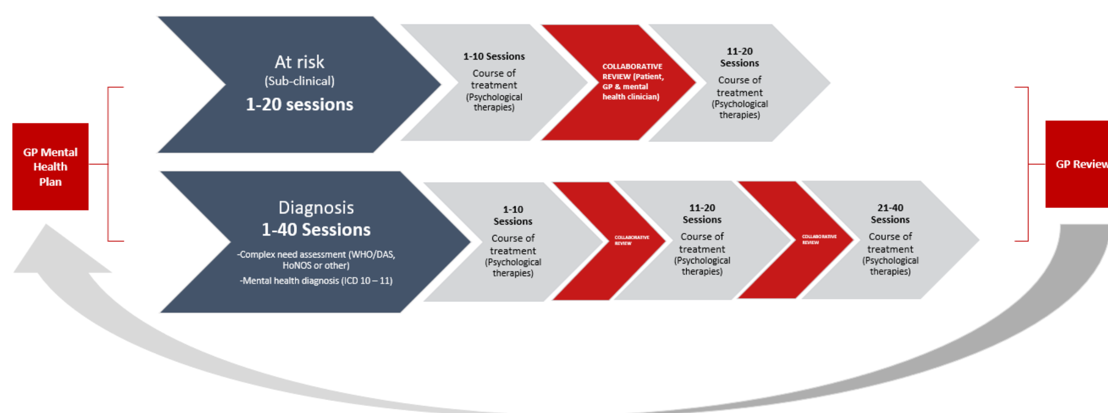
2. AASW Model for Better Access

This section of our submission provides an **overview** of the AASW proposed structure for individual Better Access sessions.

Social workers are trained to understand and assess 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 or other societal issues that contribute to or pose obstacles to people achieving positive mental health and wellbeing. These environmental stressors are the social determinants of physical and mental health and are a central focus for social workers in supporting people with a mental illness.

The AASW strongly believes that a system that provides mental health supports must be driven by this core understanding.

Diagram 1 (Larger version on page 17)



Psychological therapies: All therapy sessions available within the anniversary year and at every level delivered by current* Better Access providers for the **same hourly rate**
(*Accredited Mental Health Social Workers, Clinical Psychologists, Registered Psychologists and Occupational Therapists)

The AASW Model for Better Access is informed by key principles as stated in our position statement on mental health.[29]

This includes:

- acknowledgement of the rights of people with mental health problems, as set out in the United Nations Principles For The Protection Of Persons with Mental Illness and the improvement of mental health care[30]
- focusing on the interface between the individual and the environment and recognise the impact of social, economic, and cultural factors on individual and societal mental health and wellbeing[31]
- seeking to build on individual and community strengths to empower people to exercise more direction over their life and process of recovery[32]
- promoting recovery by, in part, enhancing people's power and control over their lives and advancing social justice principles

[29] https://www.aasw.asn.au/document/item/3284
[30] United Nations (2001). Principles for the protection of persons with mental illness and the improvement of mental health care: General Assembly Resolution 46/119. New York: United Nations
[31] Tew, J. (2008). Social perspectives on mental distress. in T. Stickley & T. Basset (Eds) (2008) Learning about Mental Health Practice (pp.235-252). Chichester: John Wiley & Sons Ltd.
[32] Rapp, C. A. & Goscha, R. J. (2012). The Strengths Model: A Recovery-Oriented Approach to Mental Health Services. New York: Oxford University Press, 3rd Edition.

- drawing on a range of well researched approaches, which may include individual counselling and support, family psycho-education, group work and community development, research and policy development[33]
- taking particular account of the importance to consumers' mental health of fulfilling social relationships, adequate and stable housing, paid employment, and other forms of meaningful daily activity[34]
- supporting the participation of consumers and their carers in all aspects of mental health care, including - but not limited to - involvement in treatment planning, service evaluation, and service and policy development.

A model based on need

The AASW model is supportive of many of the recommendations from the report and expands on several points. The model extends supports to those at risk and focuses on the concept of complexity over diagnosis.

As proposed in the AASW's model, all clients could be initially being referred for 20 sessions with a collaborative review point at the 10-session mark between the patient, GP and mental health clinician.

Clinicians and GP's would collaborate with the client to work out the best therapy and number of sessions that may be required. Clients should be able to access the additional 10 sessions, depending on severity, and social and functional disability.

If new information is revealed, or significant trauma is identified and the appropriate number of sessions identifies that 20 more sessions may be necessary, then the clinician and the GP collaborate to identify the care of the client and the psychological therapy that is required. At the 10th session, a case conference – phone or face to face – with the GP and the clinician is highly recommended and funded under Medicare (currently only the GP receives a rebate for case conferencing).

Clients with a diagnosis and have had a complex need assessment undertaken, are eligible to access up to 40 sessions initially, with a collaborative review (between the patient, GP and mental health clinician) at 10 and 20 sessions.

Some client presentations for issues such as severe eating disorders, chronic self-harm, post-vention in suicide ideation, severe PTSD, chronic trauma, severe anxiety / death and health anxiety / significant adjustment issues or requests for euthanasia, may immediately warrant a referral for the 40 sessions that need to be available, and that are well supported by available evidence.

Psychological therapies

All therapy sessions available within the anniversary year and at every level, should be delivered by current Better Access providers for the **same hourly rate** (this includes Accredited Mental Health Social Workers, Clinical Psychologists, Registered Psychologists and Occupational Therapists).

The list of approved Psychological Therapies should include the current Focussed Psychological Therapies approved through MBS and the inclusion of the therapies recommended in the report.

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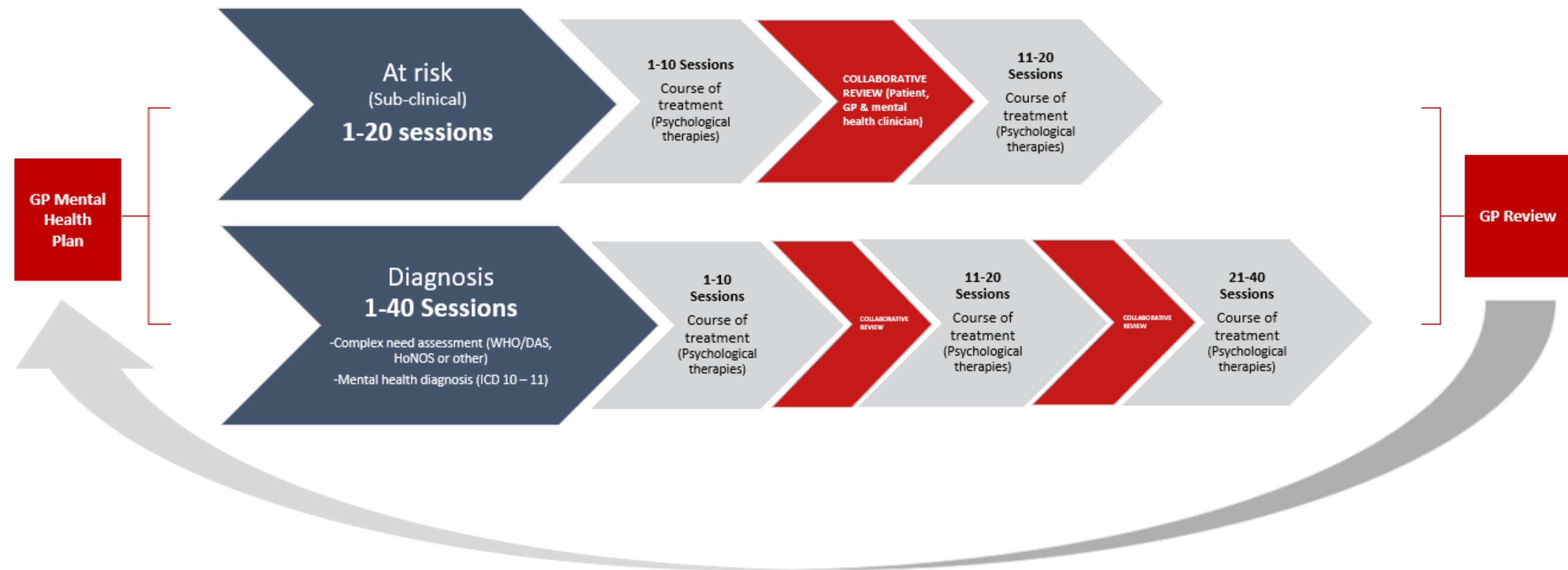
[33] Bland, R., Tullgren, A., & Renouf, N. (2009). *Case Management and Community Mental Health.*
[34] Leff & Warner, 2006

Diagram 2

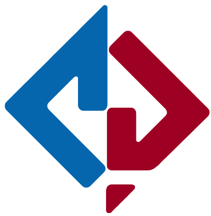
Model for MBS Better Access



Psychological therapies: All therapy sessions available within the anniversary year and at every level delivered by current* Better Access providers for the **same hourly rate** (*Accredited Mental Health Social Workers, Clinical Psychologists, Registered Psychologists and Occupational Therapists)

Conclusion

The AASW welcomes the opportunity to make a contribution to this inquiry and continuing to work together for a healthier and more just Australia.



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