Accredited Mental Health Social Workers

Qualifications, skills and experience

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AASW

Australian Association of Social Workers

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Introduction

The Australian Association of Social Workers (AASW) is the professional body representing more than 11,000 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.

Accredited Mental Health Social Workers: Qualifications, skills and experience

Accredited Mental Health Social Workers (AMHSWs) are highly trained and educated mental health professionals, meeting some of the highest standards of professional regulation in Australia. 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 or people 'at risk' of developing mental health conditions under the Commonwealth Medicare initiative. There are currently more than 2,200 AMHSWs working across major cities, regional, rural and remote regions. As a group of providers, AMHSWs are the second largest after the combined group of Clinical Psychologists and Registered Psychologists.

AMHSWs work from a biopsychosocial, whole-of-person perspective and their training provides an appreciation of the impact that social, environmental and cultural factors have on total health and wellbeing. Their person-in-environment approach (that is the bedrock of all social work education) makes AMHSWs experts in dealing with complexity. This is also akin to the National Disability Insurance Scheme framework of client-centred capacity-building therapeutic inputs that AMHSWs also provide. AMHSWs work with people across the lifespan (including children, adults and older persons) and provide a unique contribution to the mental health space in their holistic approach to working with a person. The advanced training that is expected of an AMHSW prepares and provides them with the skills for working with people with very complex presentations and comorbidities. They have the skills and knowledge to assess and intervene around the impact of physical illness, specifically chronic and advanced chronic or terminal illness has on a person's psychological wellbeing.

The AASW is responsible for the accreditation of AMHSWs and is committed to maintaining the high standard of practice of the profession in this sector.

This document provides an overview of the skills, knowledge and services provided by AMHSWs. This document is based on extensive analysis of AASW data, including 2013 and 2018 member surveys. To further illustrate the contribution of AMHSWs, case studies are included throughout.

1. Education and training

a. Accreditation: Education and training

This section provides an overview of the education, training and ongoing professional development that is required to become an AMHSW.

Social work is a tertiary-qualified profession recognised nationally and internationally. Social work undergraduate and postgraduate education provides graduates with a focus on holistic, whole-of-person and life-course approach, and as such social workers are skilled at providing assessments and interventions for people with complex presentations. Built on these foundations is the further credentialing of AMHSWs, equipping highly skilled mental health clinicians in assessment, diagnosis and treatment planning, complex case formulation, and the delivery of evidence-based therapeutic interventions across formative and life stages in collaboration with clients, where duty of care factors do not inhibit this process.

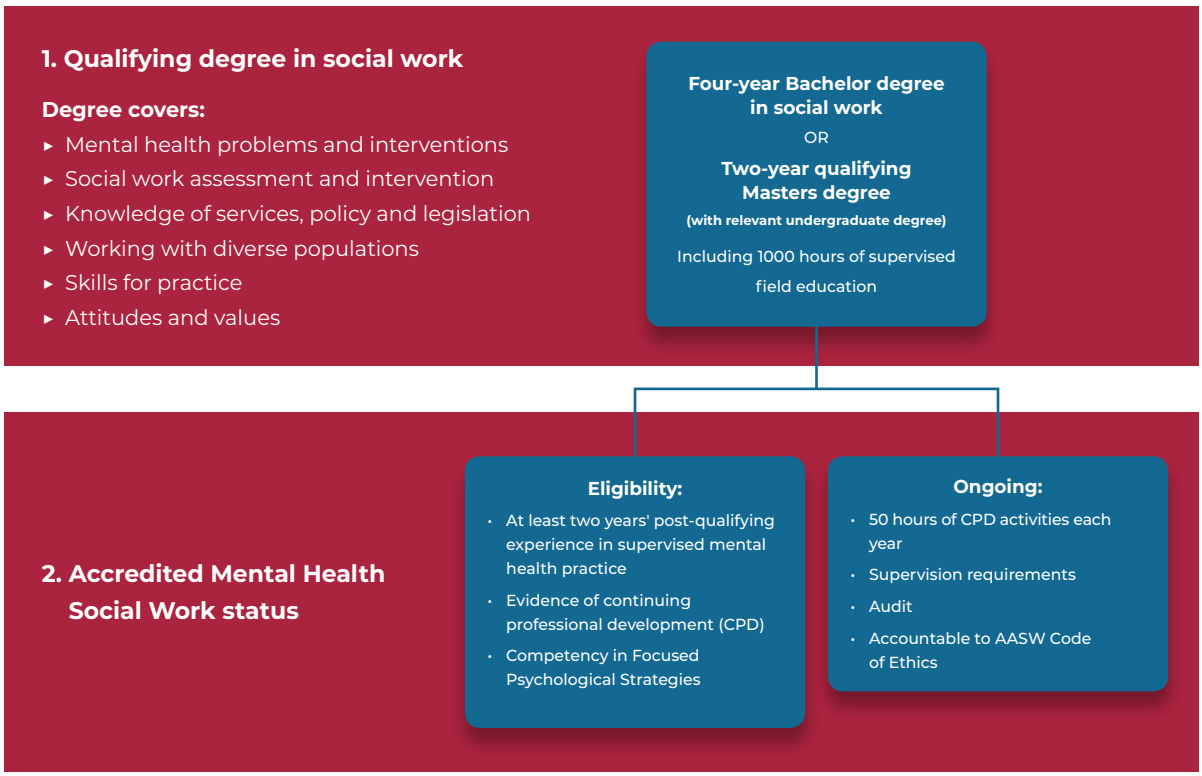

Figure 1. Education and training of AMHSWs

Qualifying degree in social work

All AMHSWs have a qualifying degree in professional social work practice. Mental health is essential core curriculum in accredited higher education social work programs. This means that all social workers are required to demonstrate an understanding of mental health issues and practice interventions before they graduate from their social work training at university.

The Australian Social Work Education and Accreditation Standards (ASWEAS) are applied by the AASW in reviewing and accrediting higher education programs. The AASW is an Accrediting Authority recognised by the Federal Government.

The essential core mental health curriculum for social work students covers:

1. knowledge for practice in mental health
2. practice and intervention skills in mental health
3. attitudes and values.

Throughout the degree, essential learning is gained on mental health problems and interventions, social work assessments and interventions, and relevant services, policy and legislation.

The contextual aspects of mental health are always part of social work learning, i.e. 'person in environment'. Cross-cultural practice and practice with Aboriginal and Torres Strait Islander peoples and communities, including an appreciation of intergenerational trauma, form part of every social worker's understanding and knowledge base. Additionally, social work learning includes an understanding of other groups experiencing high-level, complex trauma. This includes people with:

- a refugee and asylum seeking background
- those experiencing or who have experienced family violence
- and those within the child protection system.

The intersections of each of these with, for example, physical disability, illness or injury can add greater complexity and the education and training of social workers provides the ability to support such complexities.

The inclusion of specific mental health curriculum content in the education and accreditation standards is required by the AASW given that the AASW acknowledges that social workers in any practice setting will have at least some clients affected by mental health problems of varying severity and duration.

This reflects the prevalence of mental health problems in the Australian population, and the complex situations that clients are likely to be facing. In turn, clients can expect that social workers can recognise the nature of their difficulties, including mental health problems, and work collaboratively with them to resolve or improve their situation.

A full outline of the mental health curriculum content and guidance on the inclusion of core curriculum can be found in the ASWEAS Guideline 1.1: Guidance on essential core curriculum can be found in the ASWEAS Guideline 1.1: Guidance on essential core curriculum.

CASE STUDY 1: Medicare Better Access

Presenting Issues: JS (22) was referred to an AMHSW by his GP for support with his anxiety, panic attacks, excessive alcohol use and alopecia. JS talked about having 6 years of 'bottled stress', which had caused his hair to start falling out. He described various symptoms of anxiety: heart palpitations, feeling 'raw', physical tension, racing thoughts, and poor sleep. JS is the eldest of seven children, raised in a situation of familial domestic violence and poverty, and exposed to ongoing community violence. Therefore the impact of transgenerational trauma in JS's life has been considerable.

Therapeutic Process: JS saw an AMHSW 12 times for counselling sessions. The therapeutic methods used were predominantly cognitive-behavioural therapy, psycho-education and relaxation strategies. Each session focused on the subject matter presented by the client, as fits the theoretical frameworks of both methods.

Outcomes: JS reported experiencing improvements at various times through the counselling period. By the end of the series of sessions JS reported that he 'doesn't think about the old issues at all anymore'. The emotions of the old family issues feel 'as though they're completely gone'. JS identified the 'verbalising' involved in counselling as the process that helped him 'to let go of those feelings'. He described his perception of the old conflicts as now 'not relevant'. He reported that his hair was completely grown back.

Accredited Mental Health Social Workers

Social workers who are members of the AASW and who have gone on to develop their learning and experience in mental health can seek accredited status as Accredited Mental Health Social Workers (AMHSW). The AASW is an Accrediting Authority recognised by the Federal Government.

Gaining mental health accreditation

To become an AMHSW there are six criteria to the accreditation process.

A social worker must:

Criteria 1: Hold current membership of the AASW
Criteria 2: Have at least 2 years full-time equivalent (FTE) post-qualifying social work experience in a mental health setting. An applicant must be able to articulate how their experience meets the AASW Practice Standards for Mental Health Social Workers 2014
Criteria 3: Have received at least 2 years full-time equivalent (FTE) post-qualifying supervision in a mental health field
Criteria 4: Have met the Continuing Professional Development (CPD) requirements
Criteria 5: Demonstrate ability and knowledge of clinical social work practice
Criteria 6: Arrange an employer or supervisor to provide a referee statement.

Maintaining mental health accreditation

To remain eligible to provide mental health services as a Medicare provider, social workers must maintain their AMHSW status, including maintaining CPD and supervision requirements.

AMHSWs are required to complete 50 hours of CPD activities each year, including 20 hours relevant to mental health practice, and 10 hours relevant to the current list of Focused Psychological Strategies. These strategies are a requirement set by Medicare for all Allied Health professionals to ensure ongoing eligibility for providing services under the Better Access to Mental Health program.

CASE STUDY 2: Department of Veteran Affairs

Presenting Issues: RB (72) was referred to an AMHSW for PTSD. RB reported he had had nightmares for as long as he could remember. He said he had become a loner and didn't want to go out anywhere as he became anxious. He said he just couldn't trust people and had limited social support.

Therapeutic Process: RB saw an AMHSW over 8 sessions who provided trauma informed psychological treatments, including eye movement desensitisation and reprocessing (EMDR). Specific focus was placed on managing anxiety.

Outcomes: At the conclusion RB reported an improvement in daily functioning and management of his anxiety. At the suggestion of the AMHSW, RB has also joined a local group, which has greatly improved his confidence.

Practice Standards for Mental Health Social Workers

The AASW has outlined the required standards for mental health practice in the AASW Practice Standards for Mental Health Social Workers 2014. This document sits alongside the AASW Practice Standards as a clear statement by the professional association of the expectations of Mental Health Social Workers regarding the knowledge, skills and values utilised in their roles and functions, as well as the requirements of ethically sound and accountable practice.

The Mental Health Standards are an important practical guide for Mental Health Social Workers, those who use their services, and the broad community about the ways in which social work services are to be delivered.

Quality assurance and complaints process for misconduct

AMHSWs are subject to audit by the Mental Health Unit of the AASW to ensure these competency standards and ongoing learning are maintained. AMHSWs also agree to abide by the AASW Code of Ethics, to ensure high standards of ethics are maintained in the service provision.

Members of the community can use our Ethics Complaints Management process to make allegations of serious ethical misconduct by AASW members. A public list of social workers who are currently ineligible for AASW membership, and therefore unable to maintain their AMHSW status, is available on our website.

b. Further training: Experts in complexity

AMHSWs hold significant practice experience; an AASW survey in 2018 showed that over 75 per cent of AMHSWs have more than 10 years of practice experience. The experience and further training of AMHSWs 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.

The majority of AMHSWs also have further training and qualifications, with over 60 per cent having postgraduate qualifications (Table 1).

Table 1. AMHSW qualifications

Qualifications	%
Doctorate	3.30%
Masters degree	34.29%
Graduate diploma, Graduate certificate, Bachelor honours degree	28.92%
Bachelor degree	5.37%
Associate degree, Advanced diploma	3.30%
Diploma	12.80%
Certificate I–IV	11.98%

In addition, AMHSWs have a wide range of specialisations (including mental health disorders and focused psychological strategies (FPS) as listed in the Medicare Benefits Schedule) across the age, illness and intervention spectrum, as shown below.

- Acceptance and commitment therapy
- Business and organisational 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 desensitisation and reprocessing
- Family or couples therapy
- Grief/trauma
- Hypnotherapy
- Palliative care
- Psychoanalysis
- Psychotherapy
- Depression
- Panic disorders
- Generalised anxiety
- Adjustment disorder
- Sleep problems
- Sexual disorders
- Bereavement

2. Practice contexts, programs and funded services

Social workers practise in specialist mental health and generalist settings, including primary, secondary and tertiary services across Australia. AMHSWs provide supports across Australia, with approximately 40 per cent in rural and remote areas. Therefore, they provide an important contribution of mental health care in these very underserviced regions.

Programs and services

AMHSWs are registered providers with Medicare Australia. They have been assessed on behalf of the Commonwealth Government by the AASW as having specialist mental health expertise. AMHSWs are eligible to provide services through a number of Commonwealth funded supports and other schemes (See Figure 3).

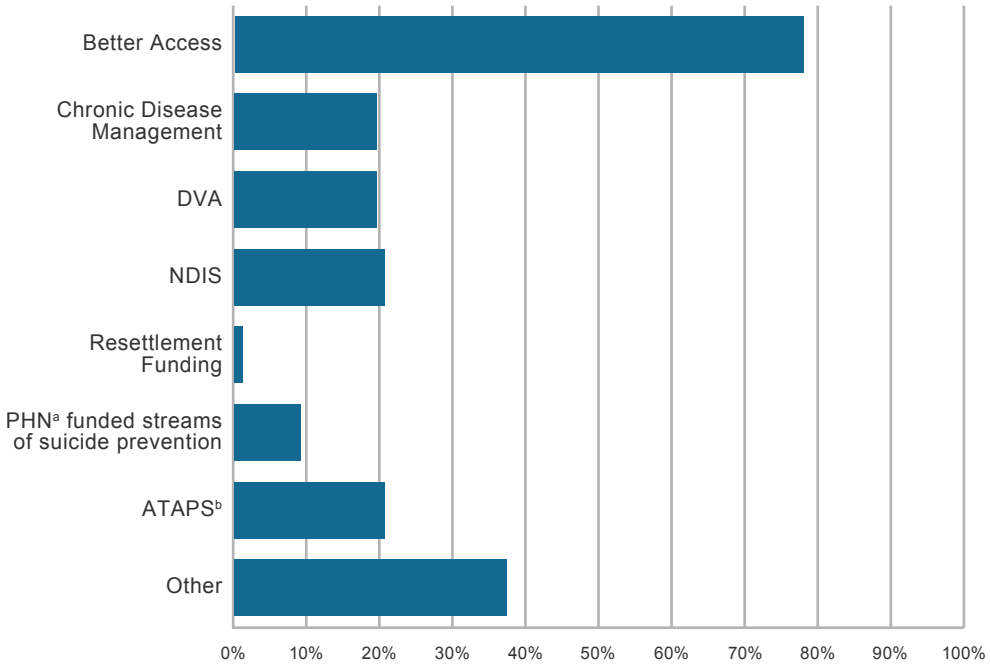

Figure 2. Programs

[a]Primary Health Networks
[b]ATAPS refers to all current programs delivered by Primary Health Networks that have replaced the Access to Allied Psychological Services (ATAPS) program.

Better Access to Mental Health Care

- A range of evidence-based strategies has been approved for use by allied mental health professionals utilising the FPS Medicare items. As outlined in the Medicare Benefits Schedule (MBS) book, these are:
  - psycho-education (including motivational interviewing)
  - cognitive behavioural therapy
  - relaxation strategies
  - skills training
  - interpersonal therapy (especially for depression).
- Focused psychological strategies can be delivered for individuals and groups
- Telehealth mental health treatment services for people in rural, remote and very remote locations.

Chronic Disease Management (Enhanced Primary Care)

- Counselling, coordination and support services delivered for the management of chronic disease. Accredited Mental Health Social Workers are eligible to provide these services under the category 'mental health worker'.

Non-directive Pregnancy Counselling

- The Non directive Pregnancy Support Counselling services are can be provided by AMHSWs to assist women who are concerned about a pregnancy.

Psychological Strategies (formerly known as ATAPS)

- Through Primary Health Networks, AMHSWs can deliver Focused Psychological Strategies through the Psychological Strategies program (formerly known as ATAPS).

Department of Veteran Affairs

- Working with veterans and serving Australian Defence Force (ADF) personnel, and their families, and providing psychosocial interventions.

National Disability Insurance Scheme

- Social workers can provide a range of supports through the NDIS, including:
  - therapeutic and counselling supports (individual and group)
  - behaviour support (assessment and development of support plans)
  - assistance in coordinating or managing life stages, transitions and supports
  - assistance to access and maintain employment or higher education
  - assistance with obtaining or retaining accommodation and tenancy.

Private health funds (Teachers Health)

Teachers Health Fund and its sub-brand, UniHealth Insurance, provide their 300,000 Top Extras Cover members with access to services provided by Accredited Mental Health Social Workers as a private health insurance benefit, including counselling and focused psychological strategies.

AMHSWs also provide services through:

- Cancer Council
- Country Fire Authority
- Community based rehabilitation
- Employment Assistance Programs (EAP)
- Cornerstone/Headspace
- Primary Health Networks
- WorkCover and WorkSafe
- Private health funds (Teachers Health)
- Private/fees for service
- Redress scheme
- Transport Accident Commission
- Victims of Crime
- Open Arms – Veterans and Families Counselling (formerly Veterans and Veterans Families Counselling Service (VVCS)

3. Mental health issues and populations

Specialists in complexity

AMHSWs maintain a multilevel focus in their engagement with people, analysing the change that needs to occur at an individual level as well as in their family and social contexts once again a 'person in environment' approach is key. This appreciation for the interaction between the individual and systems distinguishes AMHSWs from other professions. The advanced training that is required prepares and provides AMHSWs with the skills for working with people with very complex presentations and comorbidities.

AMHSWs bring a comprehensive approach to lessening the prevalence and impact of mental health conditions in the community. The considerable biopsychosocial research in this area reveals the interplay between individual, group and social factors, and that resilience and mental health are inextricably linked. Therefore, in addition to clinical interventions, AMHSWs work to strengthen a person's social capital, if needed and relevant. In private practice, this means facilitating clients' access to other necessary services that address the non-psychological problems affecting their mental health, in addition to encouraging participation or even actively connecting a client with social and community networks. Mobilising an individual's personal and social resources is crucial in effecting change, and this is something AMHSW are experts in.

Moreover, a strength of the social work perspective also allows the AMHSW to appropriately collaborate with other agencies, practitioners and allied health professionals to provide a holistic and case management approach to achieving best practice outcomes.

AMHSWs have significant expertise in assessment and providing therapies and intervention with a wide range of complex mental health needs, including:

- Abuse and trauma
- Acquired brain injury
- Adjustment disorders
- Anxiety
- Attachment disorders
- Autism spectrum disorder
- Bipolar
- Borderline personality disorder (BPD)
- Chronic pain, ill health
- Chronic self-harm
- Chronic suicidality
- Chronic, major depression
- Comorbidity
- Complex grief
- Complex trauma
- Dementia
- Developmental disorders
- Dissociative disorders
- Eating disorders
- Intergenerational trauma
- Obsessive compulsive disorder
- Personality disorders
- Psychosis
- PTSD
- Schizoaffective disorders
- Schizophrenia
- Social anxiety
- Substance misuse

AMHSWs also work with a diverse range of people including:

- Aboriginal and Torres Strait Islander peoples
- Adolescents, young people
- Women
- Men
- Adults
- Children
- Communities
- Couples
- LGBTIQ+ people
- People of low socioeconomic backgrounds
- Refugees and migrants
- Older people
- Parents and families
- Professional groups
- People in rural and remote areas
- Individuals and communities impacted by disasters and disaster recovery
- Veterans
- First responders
- People involved in the child protection system

AASW Accredited Mental Health Social Worker	The Accredited Mental Health Social Worker Collective Trade Mark is also a recognised symbol of expertise . Use of this trade mark is exclusively available and restricted to members of the AASW who have been assessed by the AASW, on behalf of the Australian Government, as meeting the standards to become an Accredited Mental Health Social Worker.

Figure 3. Accredited Mental Health Social Worker Collective Trade Mark

4. Assessments, therapies and interventions

Through comprehensive assessments and interventions, AMHSWs help individuals to resolve their presenting psychological problems, the associated social and other environmental problems, and improve their quality of life. This may involve family as well as individual counselling, and group therapy. Social workers recognise the broader implications of an individual having a mental illness and the impact on friends, family, work and education.

There is a continuously growing body of literature and evidence that demonstrates the effectiveness of social work services in health and mental health settings. [1,2] For example, a review of almost three decades of international research, undertaken in 2017, showed that social work services had positive benefits for both health and economic outcomes for vulnerable adults, children, pregnant women, and older adults. Overall, findings from this review, indicated that interventions involving social workers, whether through sole delivery, team leadership, or core membership on interprofessional teams, had positive effects on health outcomes and were less costly than usual care that did not include substantial social work services. These findings held across populations, health problems, and settings.

a. Psychosocial assessments and case formulation

Undertaking comprehensive and evidence-informed psychosocial assessments is the unique core of the social work scope of practice. AMHSWs draw on a broad range of theories, knowledge, research and skills to ensure comprehensive and holistic analysis of the client's situation. Psychosocial assessments are a primary practice tool of the social work profession, and different from other forms of assessment. Drawing upon their extensive training, AMHSWs bring specific skills and knowledge to an assessment process including considering a person's psychological wellbeing and social context. By understanding the impact of these factors AMHSWs can then identify and develop interventions to improve wellbeing and functioning.

Social work psychosocial assessments are primarily informed by ecological, systems and life-course theories as they highlight the complex relationship between individual and social factors that influence individual wellbeing. Social workers also utilise strength-based approaches in their assessment processes in order to identity and draw upon an individual's strengths and resilience. These can be both internal factors, such as skills and knowledge, and external factors, such as family and social supports.

When AMHSWs conduct psychosocial assessments they explore the physical, psychological and social aspects of the client and their situation. This includes problems and strengths in social role functioning; in meeting financial and other basic needs; in family interactions, significant relationships and other social supports, and cultural factors. To develop an assessment, sources of information include the client, the client's family and significant others, the assessments of other treating staff, and treatment records. Psychosocial assessments are both a final product and an ongoing process.

As professionally trained practitioners, AMHSWs are skilled in relationship building, counselling and interviewing skills. This is a clear distinction as social workers are adept at developing questioning styles that can be both sensitive to a client's circumstances, and obtain the necessary information to determine the most appropriate therapies and interventions. AMHSWs are trained in specific skills and knowledge in client engagement, including working inclusively and responsively with people from other cultural backgrounds to their own.

1. Steketee G, Ross A M, & Wachman M K. 2017. Health outcomes and costs of social work services: A systematic review. *American Journal of Public Health*, 107(S3), S256-S266.
2. Moriarty J, & Manthorpe J. 2016. *The effectiveness of social work with adults. A systematic scoping review.* King's College London, UK.

b. Therapies and interventions

When helping people with mental health disorders AMHSWs use a range of evidence-based interventions, the most common being:

1. cognitive behavioural therapy 82%
2. strengths-based approach/therapy 77%
3. mindfulness 77%
4. interpersonal therapy 65%
5. solution-focused brief therapy 65%
6. narrative therapy 51%.

1. Cognitive behavioural therapy

Through their training and education, AMHSWs are qualified to provide a wide range of interventions, for example, Cognitive Behaviour Therapy (CBT). There have been many studies of CBT and it is demonstrated to be effective in treating a number of mental illnesses and disorders, particularly anxiety and depression. [3,4,5] The CBT studies also revealed that there are mental health conditions and client circumstances which may respond positively to other interventions as well. [6,7]

2. Strengths-based approach/therapy

Strengths-based approaches are a research-based approach to psychological therapy that encourages therapists, as well as clients, to widen their focus from being largely problem-centred to also include clients' strengths and the things that go right in their lives. Balancing the illness focus of the *Diagnostic and Statistical Manual of Mental Disorders*, 'the aim of positive psychology is to catalyse a change in psychology, from preoccupation only with repairing the worst things in life to also building the best qualities in life'. [8]

3. Mindfulness

Mindfulness is a highly acclaimed and evidence informed experiential approach, which cultivates emotional, psychological and physical resilience and wellbeing. It brings together meditative practices with current scientific understandings of the brain. Mindfulness is increasingly being integrated into a variety of medical, educational, and business settings. Empirical evidence has indicated that mindfulness offers many health and resilience-based benefits for health care professionals often reducing risk of burnout. As social workers, we often utilise clinical models that incorporate mindfulness practices.

4. Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) is an evidence-based intervention for a variety of psychiatric disorders, including depression, anxiety, and eating disorders, across a wide age range of clients from children to the elderly. IPT is Medicare funded as a Focused Psychological Strategy and is recognised internationally as an empirically validated psychotherapy by the American Psychiatric Association, the American Psychological Association, the UK's National Institute for Health and Clinical Excellence, and the International Cochrane Collaboration.

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3. Whitfield G, & Williams C. 2003. The evidence base for Cognitive Behaviour Therapy in depression: Delivery in busy clinical settings. *Advances in Psychiatric Treatment: Journal of Continuing Professional Development*, 9, 21–30.
4. Hofman S, Asnaani A, Vonk I, Sawyer A, & Fang A. 2012. The efficacy of Cognitive Behaviour Therapy: A review of meta-analyses, *Cognitive Therapy Research*, *36*(5), 427–440.
5. Substance Abuse and Mental Health Services Administration. 2014. *National Registry of Evidence-based Programs and Practices 'Cognitive Behaviour Therapy for depression and anxiety disorders'*, US Department of Health and Human Services, http://www.samhsa.gov Accessed 4/5/2014
6. Shinohara K, Honyashiki M, Imai H, Hunot V, Caldwell D, Davies P, Moore T, Furukawa T, & Churchill R. 2013. Behavioural therapies versus other psychological therapies for depression. *Cochrane Database of Systematic Reviews*, DOI: 10.1002/14651858.CD008696.pub2. Accessed 20/1/2014
7. Dennis C, & Hodnett E. 2007. Psychosocial and psychological interventions for treating postpartum depression. *Cochrane Database of Systematic Reviews*, DOI: 10.1002/14651858.CD006116.pub2. Accessed 20/1/2014
8. https://www.researchgate.net/publication/11946304_Positive_Psychology_An_Introduction

Interpersonal therapy has a strong body of evidence for its effectiveness in treating commonly occurring mental illnesses and disorders. [9,10,11] It is particularly useful for depression linked to relationship difficulties. IPT is well suited for social workers, providing an evidence-based framework to utilise skills and techniques fundamental to many social work roles, including those for working on grief and loss, conflict, role transition and social skill development.

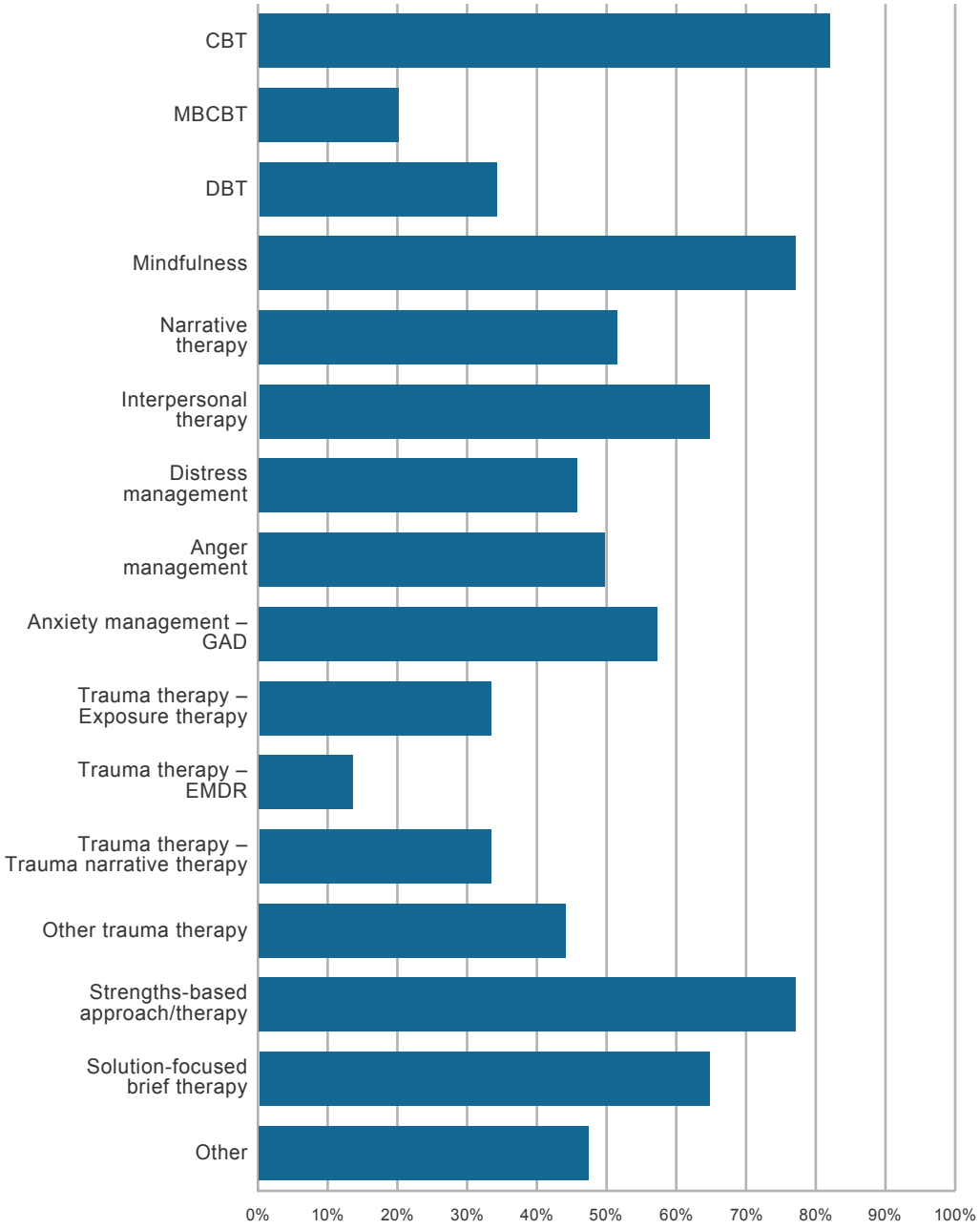

Figure 4. Therapies and interventions

9. Weissman M, Markowitz J, & Klerman G. 2000. *Comprehensive guide to interpersonal psychotherapy*, New York Basic Books, NY
10. Stuart S, & Robertson M. 2003. *Interpersonal psychotherapy; A clinician's guide*. Arnold, London.
11. Ravitz P. 'The interpersonal fulcrum – Interpersonal Therapy for treatment of depression'. *Evidence based psychotherapies*, Canadian Psychiatric Association, ww1.cpa-apc.org/Publications Accessed 29/4/2014

5. Solution-focused brief therapy

Solution-focused Brief Therapy (SFBT) is a short-term, goal-focused therapeutic approach, whereby the focus is on what client wants to achieve rather than on the problem. The approach is present and future focused, looking at solutions and the already present client resources to build upon and become the basis for ongoing change. The method is well regarded for its respectfulness to clients, use in time-limited contexts, and applicability to a wide range of presenting issues, including depression/anxiety, family and relationship issues, and drug/alcohol misuse.

6. Narrative therapy

Narrative therapy is 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. Narrative therapy was developed by an Australian clinical social worker and it is seen as a hopeful and respectful model of counselling and 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 the developing client agency in the future.

Conclusion

AMHSWs are highly valued members of Australia's mental health workforce delivering clinical social work services in mental health settings and utilising a range of evidence-based strategies. AMHSWs work with people across the lifespan (including children, adults and older persons) and provide a unique contribution to the mental health space in their holistic approach to working with a person. The advanced training that is expected of AMHSWs prepares and provides them with the skills for working with people with very complex presentations and comorbidities. AMHSWs are trained and educated professionals, meeting some of the highest standards of professional regulation in Australia. Accordingly, the profession of social work has a clear role and provides a unique contribution in the continuum of mental health services

OVER 2,000 AMHSWs ACROSS AUSTRALIA, WITH APPROXIMATELY 40% IN RURAL AND REMOTE AREAS

10 OVER 75% OF AMHSWs HAVE OVER 10 YEARS OF PRACTICE EXPERIENCE

AMHSWs PROVIDE PSYCHOLOGICAL SUPPORTS TO INDIVIDUALS, COUPLES AND FAMILIES ACROSS THEIR LIFESPAN

AASW
Accredited Mental Health Social Worker

ACCREDITED MENTAL HEALTH SOCIAL WORKERS (AMHSW)

EXPERTS IN COMPLEXITY

60% HAVE POSTGRADUATE QUALIFICATIONS, INCLUDING MASTERS AND DOCTORAL DEGREES

AMHSWs ARE REGISTERED PROVIDERS OF SERVICES UNDER MEDICARE AND OTHER PROGRAMS, INCLUDING NDIS, DVA AND SOME PRIVATE HEALTH FUNDS

AMHSWs USE A WIDE RANGE OF EVIDENCE-BASED THERAPEUTIC INTERVENTIONS IN HELPING PEOPLE WITH A WIDE RANGE OF MENTAL HEALTH DISORDERS

FOR MORE INFORMATION VISIT WWW.AASW.ASN.AU

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Case study

This section provides a detailed case study highlighting the skills and knowledge of AMHSWs.

Background

KM, a 27-year-old female, presented with a long history of family physical abuse commencing when she was four years of age. She was referred for therapy, particularly trauma and grief therapy by her general practitioner. KM's mother died suddenly at the age of 27 when KM was four. KM and her mother were both in a car accident when KM was one. Her mother sustained two broken cervical vertebrae and experienced significant unrelieved pain and headaches until her death due to opiate overdose. KM did not sustain any injuries. She continued to live with her biological father and brother for the next 10 years. At 14 she moved interstate to live with her maternal aunt as her relationship deteriorated between her and her father – KM reported him as 'angry, depressed, difficult and controlling'. KM remained with her aunt for 2–3 years, before she moved in with her first boyfriend. KM reported that they seemed to have a good relationship at first. She admired his physicality and problem-solving – reporting that she 'felt safe'. However this changed after two years when she remembers experiencing significant physical abuse by her partner and stated that he also became controlling, preventing her from seeing her family or friends, and became verbally abusive towards her. KM had started using marijuana when with her partner, often buying it for him. KM reported leaving this relationship and moving home to be with her biological father. She stated that 'at least he was family'.

KM moved out of her father's home after six months. She 'couch surfed' for 12 months then moved in with her second and current boyfriend. Her current boyfriend has a mental health diagnosis of post-traumatic stress syndrome from adolescent bullying and past violent abusive relationships but stated that he is on medication, and is able to enjoy life now. KM still uses marijuana on a regular basis, and has been prescribed medication by different GPs to help her mood and her sleep, which she reports as 'not good'. KM has not been assessed by a psychiatrist. She reported that she once saw a psychologist with her GP, but felt that they didn't understand her problems. KM stated that they (the counsellors and the GP) focused on her mother's death however KM reported that this was only part of the problem. KM reported that she didn't trust people, and felt uncomfortable around people. She has only has very short-term casual jobs in retail since leaving school at the age of 16.

Main issues

KM reported that her main issues were her ongoing use of marijuana, stating that she had concerns about it affecting her thinking and capacity to function; her uncontrollable anxiety and fear of people; making decisions difficult and her not being able to work or study. KM described her sleep as 'poor' and being in a constant state of exhaustion and that she needed help dealing with her past abuse and developing trusting relationships. KM stated that she wanted to be normal. KM was asked if her age – being close in age to when her mother died, was a concern for her, and she said 'that while this was on her mind often, that she didn't think about it too much'. She stated that she 'hated birthdays'.

Initial assessments and scales used

K10 (Kessler10) had been undertaken by the GP. Results showed: moderate stress, severe depression, and severe anxiety. DASS (Depression, Anxiety, Stress Scale), undertaken by the AMHSW 6 weeks post GP referral. This indicated severe stress, very severe anxiety and moderate depression. KM was asked if she had experienced any suicidal thoughts or thoughts that she wished that she was dead. KM denied such thoughts but stated that when she was little, she blamed herself for her mother's death and wished that she had died when she had. She stated that she feels 'unbearably sad' when she thinks about how and when her mother died, and that her understanding of her death and its impact on her has changed as she has grown older.

It could be argued that KM's depression has lessened over the six weeks prior to her first psychotherapy appointment as the GP had indicated that she had initiated some Focused Psychological Strategies at the first appointment – some sleep hygiene strategies, cognitive strategies and suggested that KM use an online mental health resource – 'Mindwaves'. KM indicated that she had used the online resource and found the sleep hygiene concept interesting and had been trying to implement some of the information.

Case formulation and treatment plan

KM (27) is presenting with significant psychological and biological issues that have a long history and may or may not have begun at the age of 4 at the time when her mother died. She is showing significant attachment issues, both in relation to her mother's death and the violent and difficult relationship with her father. KM did not describe her relationship with her aunt or her brother. She is presenting with a cognitive and development level below her chronological age as well as less than ideal body weight and stated dysmorphia. KM reports that her triggers include: reports of abuse on social media; not being understood; feelings of exhaustion – poor sleep, vivid nightmares, constant and circular thinking; Centrelink work requirements and appointments; and a lack of money allowing her to do anything positive or go anywhere.

KM has some protective relationships and behaviours. She reported to have a good relationship with her current boyfriend; she describes her new GP as being 'female and really understanding how I feel'; she shows some capacity for self-reflection and motivation and stated that she feels 'hopeful'.

KM indicated that she would be keen to start looking at developing a hierarchy of issues and problems, commencing with better ways to manage her social anxiety and sleep. We talked about needing to look at trauma therapy, but agreed that managing anxiety triggers would give her skills to manage difficult emotions now and when further therapy was commenced. Information was provided to KM about the connection between food and brain function and KM was advised to see a clinical nutritionist specialising in such disorders.

Monitoring progress and outcomes

KM was advised that her plan would be developed over several stages – initially helping her to manage difficult emotions, triggers and the impacts anxiety has on her body and functioning. Treatment will include: discussions regarding the connection between stress and her brain function; mindfulness practice; monitoring her posture and breathing patterns – looking at the sympathetic overload from chronic stress; information regarding scaling approaches to anxiety – such as SUDs (Subjective Units of Distress); and ways to integrate this into her daily life. Outcomes would include subjective assessments of mood and sleep improvements and it was explained that

measurement tools such as the DASS would be repeated at regular intervals. An additional tool – the WHODASS – would also be undertaken. This tool is a generic assessment measuring health and disability factors. It is used for all population groups, across all disease states, including physical, neurological and psychological. It was explained to KM that this tool will help her to monitor even small improvements in cognition, self-care, social interaction, participation and improvements in life activities.

Under KM's GP referral (Mental Health Treatment Plan) she will be able to access 10 individual sessions and 10 group sessions through Medicare. It was explained to KM that as a clinician working with Medicare and in collaboration with her GP, that I would report back to the GP on regular intervals. Consent and confidentiality was explained to KM and she was offered copies of all her session notes and reports to her GP if she felt she wanted to have copies of these. Initially weekly sessions were scheduled, with the frequency being decided in response to KM's progress and need.

Ongoing sessions and monitoring

KM attended all scheduled sessions in the first month. She indicated that she felt we 'understood her' and 'didn't spend all the time making her fill out forms and questions'. She indicated that she liked the approach used – integrating her mind and body. She stated that 'I didn't know what I ate affected my sleep and how I thought'. KM initially had difficulty with the mindfulness exercises, as she became hypervigilant to her breath and stated that she felt she was becoming 'obsessive' about breathing, which was increasing her stress. KM also stated that doing the body scan was distressing as it highlighted feelings of dysmorphia, stating: 'I can feel all my bones when I breathe like that' and expressing extreme dislike for this feeling and not feeling normal.

It was suggested to KM that she revisit her GP in order to have blood tests to check her thyroid and cortisol levels and any other tests/examinations to ensure that her symptoms did not have a biological origin. A letter was sent to the GP requesting these tests and reporting on the treatment plan, sessions to date and monitoring KM's engagement with therapy. The DASS was repeated at each second session and reported a reduction in anxiety and stress symptoms from severe to moderate, however the depression scale remained on moderate levels.

It was suggested to KM that her use of marijuana may be affecting her recovery. Research has indicated that marijuana use and intoxication definitely has an effect on the brain where it is found to hinder attention, long-term memory storage, and psychomotor skills. KM indicated that at this stage, however she was not prepared to stop smoking marijuana.

Utilising a strengths approach, KM was asked to scale her response to therapy after the fourth session, where she indicated that she had moved from an 8 (with 10 being the worst she had ever felt) to a 6. In her mindfulness sessions, she started to visualise her own improvement and had started to develop small goals. Psychological flexibility was introduced and added to her mindfulness practice. KM integrated the SUDs into her understanding of her anxiety and stress responses, and was able to manage and hold her distress when she felt she was experiencing a trigger. She reported at the fifth session, 'a letter came from Centrelink, saying that I had to start looking for work and that I couldn't have any more medical exemptions – instead of losing it completely, I sat down and initially felt numb, but could feel my brain start thinking'. This process of understanding the neural processes involved in neuroplasticity has assisted KM to understand what is happening when she reacts or feels unable to cope.

With KM's permission, she started to explore her feelings about her mother and the circumstances relating to her death. A trauma-informed, strengths approach using narrative strategies helped allow KM to gently uncover very difficult emotions. A DASS was repeated after the eighth session, and showed a reduction in her depression score to mild and her anxiety mild to normal. Her stress still reported moderate levels, but this can be understood in the context of her starting to try new activities and beginning to have confidence and hope in her future.

KM completed 10 individual sessions and indicated that she would request another MHTP from her GP to access further sessions in the new calendar year as she indicated that there would be significant triggers that she could already anticipate. KM chose to start group therapy as an adjunct to her individual sessions and had started relaxation and yoga sessions as well as an all-female local grief and loss support group.

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