AASW
Australian Association of Social Workers

Our Work, Our Voice

2025 Accredited Mental Health Social Workers Survey Results

May 2026

The AASW surveyed Accredited Mental Health Social Workers (AMHSWs) across Australia between July and August 2025 to better understand their qualifications, work settings, client needs, funding arrangements, and the barriers affecting mental health service delivery.

The survey highlights a highly qualified and committed workforce delivering complex, trauma-informed mental health care across Australia. AMHSWs support clients experiencing significant psychosocial adversity and frequently undertake unfunded advocacy and coordination work to ensure client safety and continuity of care.

At the time of the survey:

3,655 AMHSWs nationally

575 AMHSWs completed the survey

15.7% completion rate

However, low rebates, administrative burden, inequity compared to other professions, and rigid scheme restrictions limit sustainability and access. Improving remuneration, recognition, flexibility in funding schemes, and integration across service systems would strengthen mental health outcomes for consumers while supporting the sustainability of this essential workforce.

A highly qualified and diverse workforce

AMHSWs are experienced clinicians with specialised training in mental health assessment and intervention.

Beyond their qualifying social work degree and AMHSW accreditation:

- 63% hold one or two additional relevant qualifications.
- 27% hold three or more additional qualifications

AMHSWs use a wide range of evidence-informed therapeutic approaches and modalities:

- Psychoeducation (90%)
- Trauma-informed practice (87%)
- Cognitive Behavioural Therapy (82%)
- Mindfulness-based approaches (73%)
- Acceptance and Commitment Therapy (64%)

They also undertake broader professional activities:

- Clinical supervision (68%)
- Family and couple therapy (47%)
- Report writing (31%)
- Individual client advocacy (84%)
- Service development and system advocacy (62%)

This reflects a workforce that not only provides therapy but also addresses systemic barriers and supports care coordination.

Where and how AMHSWs work

AMHSWs practise across metropolitan (58%), regional (39%), rural (15%) and remote (7%) areas, with some working across multiple regions. Most respondents reported being adequately booked, and 65% could offer an appointment within two weeks or less, demonstrating available workforce capacity. Most work in private practice in some capacity (88%).

Employment arrangements include:

- Sole trader private practice (63%)
- Full-time employment (23%)
- Part-time employment (25%)
- Group practice ownership or partnership (7%)
- Contacted (5%)
- Casual (2%)
- Other (4%)

Service delivery is flexible and multi-modal:

- 90% provide in-person services
- 79% use video telehealth
- 68% use telephone
- 28% provide outreach or home visits

Who AMHSWs support

AMHSWs work with individuals across the lifespan experiencing a broad range of mental health issues.

The most frequently presenting conditions were:

- Anxiety disorders (75%)
- Depression or mood disorders (66%)
- Complex trauma or developmental trauma (58%)
- Post-Traumatic Stress Disorder (53%)

Clients often present with significant co-occurring social and psychosocial needs:

- Trauma, including complex trauma and sexual abuse (91%)
- Grief and loss (83%)
- Suicidality or life crises (78%)
- Family violence (71%)
- Parenting support (62%)
- Loneliness (61%)
- Caring responsibilities (51%)

Referral pathways

GPs and client self-referral are the primary referral sources. Referrals from paediatricians, clinical psychologists and specialist physicians are infrequent. Many respondents reported that GPs are not always aware of the AMHSW role, which can limit referrals.

Barriers to therapeutic progress

Respondents consistently identified structural barriers that limit treatment effectiveness:

Administrative and unfunded work

Across multiple schemes, rebates do not adequately cover:

- Case management
- Report writing
- Case conferences
- Travel
- Advocacy and liaison

Funding limitations

The 10-session annual cap under Medicare's Mental Health Care Plan was widely regarded as insufficient for clients with complex trauma or long-term mental health conditions

86% reported that complex trauma or long-term conditions frequently required more sessions than funding allowed.

Social determinants

Limited funding to address housing, income insecurity, safety concerns and other social needs was identified as a major barrier to therapeutic progress.

Key schemes and funding streams

The most common funding pathways used in the previous six months were:

- **Medicare Better Access** (Focused Psychological Strategies) – 84%
- **Self-funded clients** – 61%
- **NDIS** – 46%

Other funding streams include victims of crime schemes, Employee Assistance Programs (EAP), workers' compensation, private health insurance, Department of Veterans' Affairs (DVA), and Primary Health Network (PHN) programs.

Medicare (MBS)

87% of respondents provide Medicare-funded services. However:

- 95% do not bulk bill all clients
- 32% do not bulk bill at all
- Only 5% bulk bill all clients

The primary reason is financial unviability due to low rebates. Overheads such as room rental, insurance, superannuation, unpaid leave and administration exceed the rebate for many providers

Respondents also reported inequity compared to psychologists, with lower rebates despite equivalent or higher levels of experience and work with complex trauma

The 10-session cap was described as a "one size fits all" restriction that does not reflect client need.

Department of Veterans' Affairs (DVA)

Respondents were generally positive about Open Arms programs but raised concerns about:

- Lower fees under standard DVA programs
- Restrictions on session length
- Administrative burden
- Lack of parity with psychology rebates

NDIS

46% of respondents provide NDIS services. While the scheme enables access for vulnerable clients, concerns included:

- Complex administrative requirements
- Travel restrictions affecting rural service delivery
- Inconsistent funding decisions
- Lack of recognition of AMHSWs' scope and skills

Victims of Crime and Justice Schemes

These schemes often allow longer-term trauma work but vary by jurisdiction. Issues include:

- Outdated fee schedules
- Delays in payment
- Unfunded report writing
- Administrative burden

Workplace and Injury Compensation

Respondents reported:

- Fee disparities compared to psychologists
- High administrative demands
- Inconsistent recognition of AMHSWs as mental health providers

Private Health Insurance

Private health insurance is used by a minority of clients. While administrative burden is low, rebates are modest and recognition of AMHSWs varies.

Top issues raised by members for advocacy to government and opportunities for further support

When asked to identify top advocacy priorities:

- 64% called for increased rebates and improved remuneration
- 42% identified recognition and parity with other professions as a priority
- 37% sought reduced scheme restrictions, particularly increasing MBS session caps
- 25% supported national registration and title protection

Respondents also called for expanded scope of practice, streamlined administration, improved care coordination, and broader social policy reforms addressing housing and financial insecurity

Respondents also identified the following opportunities for further support, training and resources:

- Affordable and advanced mental health training
- Support navigating Medicare, NDIS and other schemes
- Practical templates and resources
- Increased advocacy to raise awareness of AMHSWs
- Review of membership and accreditation fees

Conclusion

The AMHSW survey highlights a fundamental gap between the complexity of client needs and the way mental health services are currently funded and structured.

AMHSWs are delivering high-quality, trauma-informed care while also addressing broader social issues – however, despite demonstrated workforce capacity and flexibility in service delivery, system settings are constraining impact. Session limits that do not reflect clinical need, fee structures that undermine financial viability, and inconsistent recognition across schemes collectively reduce access for clients and impact sustainability for practitioners.

Addressing these issues through improved funding settings, stronger recognition of the AMHSW role, and better integration across service systems would help to enable the workforce to operate to its full scope. This would support more accessible, coordinated, and effective care for people with complex mental health needs across Australia.