



# **Access to Allied Psychological Services (ATAPS) Consultation Report**

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The Australian General Practice Network (AGPN) represents a network of 112 local organisations (general practice networks), as well as eight state and territory based entities. Collectively these organisations are known as the Network. More than 90 per cent of general practitioners and an increasing number of allied health professionals and practice nurses are members of their local GPN. The Network is involved in a wide range of activities, including health promotion, early intervention and prevention strategies, health service development and delivery, data and information management, chronic disease management, medical education and workforce support.

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# Table of contents

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<b>1.</b>	<b>Executive Summary .....</b>	<b>3</b>
<b>2.</b>	<b>Introduction .....</b>	<b>7</b>
<b>3.</b>	<b>Current Context .....</b>	<b>7</b>
<b>4.</b>	<b>Consultation Process .....</b>	<b>12</b>
4.1	Aims and Objectives .....	12
4.2	Workshops .....	13
4.3	Structured Interviews .....	14
<b>5.</b>	<b>Key Findings: Consultation Forums and Interviews .....</b>	<b>14</b>
5.1	Who could benefit from FCP's, Who are they not suitable for .....	15
5.2	Referral pathways .....	16
5.3	Commonwealth/State relationships .....	17
5.4	Implementation Models.....	18
5.5	Funding Models.....	19
5.6	Workforce .....	20
5.7	Implementation Support .....	21
<b>6.</b>	<b>Suggestions for Consideration .....</b>	<b>22</b>

## Appendices:

Appendix 1	Flexible Care Packages for People with Severe Mental Illness Discussion Paper .....	25
Appendix 2	Consultation programme examples .....	33
Appendix 3	Consultation attendee list .....	35
Appendix 4	Small group questions .....	39
Appendix 5	Consultation summaries.....	40
Appendix 6	GP Structured Interviews performa .....	57

# 1. Executive Summary

In December 2010, the Department of Health and Ageing (DoHA) announced a national consultation process to discuss the Flexible Care Packages (FPCs) to be introduced as part of the Tier 3 ATAPS Program on April 1 2011. Consultation forums were held in each capital city from 19 January 2011 to 8 February 2011. AGPN was tasked with undertaking a supplementary consultation to provide a Network-wide report to DoHA in response to the consultation Discussion Paper released in January 2011.

AGPN held five face-to-face consultations in Melbourne, Adelaide, Sydney, Brisbane and Perth during the same timeframe as the DoHA consultations with 113 members of the Network participating. This was supplemented with some individual interviews with general practitioners. The focus of the AGPN consultations was to provide a perspective on the operational and systemic factors that need to be considered in rolling out this initiative as well as the support infrastructure required by the Network to implement a quality program. General Practice Networks (GPNs) have been responsible for fund holding, planning and implementing the ATAPS Program since its inception and therefore bring a wealth of experience to the discussion on how the FCPs can be effectively implemented. The Network welcomes the opportunity to provide feedback and input on the FCPs.

FCPs are being introduced at a time of considerable development in the primary health care sector. GPNs are in the process of transitioning to Medicare Locals which will now be accelerated and enhanced following the COAG National Health Reform Heads of Agreement made on 13 February 2011. The expanded ATAPS Program will, in the future, be driven through Medicare Locals who will be responsible for the planning, implementation and evaluation of primary health care services. FCPs will also be introduced in the context of other significant Commonwealth funded mental health programs (eg. Personal Helpers and Mentors, Rural and Remote Mental Health Services measure, Mental Health Nurse Incentive program and Day-to-Day Living) and state-funded programs (eg. Mental Health Shared Care, Partners in Mind). This demonstrates that service integration, streamlined referral pathways, service partnerships and clear articulation of roles and responsibilities of different sectors will be fundamental to a successful program.

The key findings of the Consultation reflected the need for much greater recognition of the planning, co-ordination and partnership development functions that will need to be undertaken to implement a quality ATAPS Program. The Network was very vocal in

supporting the notion that “one size does not fit all” and that local service delivery models will need to be developed in response to the funding allocation, services already available and local needs. This approach is aligned with the role and function of Medicare Locals in providing comprehensive and integrated primary health care which is responsive to community needs. The Network was also explicit at identifying key components of a national support infrastructure which will be required to assist GPNs deliver an expanded quality ATAPS Program.

The Network has welcomed the FCPs as a valuable addition to the ATAPS Program as it addresses service gaps, provides opportunity for more individually tailored care and a holistic approach. The Network is also well positioned through GPNs and emerging Medicare Locals to lead the implementation of the FCPs through an expanded ATAPS program. However, to do this effectively, there are a number of key areas that need consideration. Following are some key messages from the Network:

### **Implementation Strategy**

The consultation process identified the need for ***a funded lead in time or establishment phase*** to prepare the groundwork for the effective and efficient delivery of FCPs. This should be at least six months and it would enable GPNs to scope the target group for the packages, map the service providers, integrate programs, design a model, develop or enhance partnerships, develop intake and triage services where appropriate, ensure internal policy and procedures are in place (ie risk management, clinical governance etc), recruit appropriate staff and promote the FCPs to GPs, consumers, carers and community sector. It is unrealistic to expect that GPNs would be able to deliver services immediately as the partnerships, service providers, workforce and protocols have to be in place.

Furthermore, the Network is suggesting that ***an implementation strategy is developed by each GPN or Medicare Local which demonstrates an incremental or phased approach to service provision***. This will include an establishment phase, implementation phase and an expanded implementation phase.

### **Commonwealth/State Relationships**

Underpinning the effective implementation of the FCPs will be strong partnerships between primary health care, state funded mental health services and NGOs. The Network strongly advocates for ***high level dialogue between DoHA and***

***State/Territory Directors of Mental Health Services to establish parameters for the linkages and referral pathways between the state system and primary health care and the integration of commonwealth and state based programs at the division level.*** This needs to happen prior to the commencement of the initiative.

In addition, there is an ongoing need for ***a funded mechanism at the jurisdictional level to maintain and sustain the ongoing interface between primary health care and state mental health services***, particularly where there is significant investment in primary mental health care programs by the state government. This would include development of policy and guidelines, dissemination of information, provision of input and facilitation of linkages.

### **Funding Models**

There needs to be greater acknowledgement and recognition for the co-ordination, planning and management tasks that are required to deliver an expanded ATAPS Program. The Network strongly suggests that ***GPNs/Medicare Locals need funding for co-ordinators and/or clinical leaders who can plan, co-ordinate and manage the ATAPS program including maintaining partnerships with local mental health services and NGOs and keeping GPs engaged.***

The consultations were also unanimous in supporting the need for ***more flexibility with the way funding can be utilised and that it would be preferable to link it to desired outcomes and deliverables, than Tiers.***

It was agreed that the current funding model of an 85/15 split between service provision and program support was no longer viable and would not produce a quality program.

### **Implementation Support**

There are a range of support needs that the Network will require to ensure the implementation of a quality program. These include a national communication strategy and information clearinghouse where the evidence, resources, models of good practice can be accessed, national frameworks and guidelines that can be adapted at the local level, templates and tools to assist contract management, partnership development and evaluation.

***Investing in the workforce was also strongly supported by the Network through ensuring access and availability of multidisciplinary workforce development programs and enhancing and strengthening provider networks such as the Mental Health Professionals Networks.*** Support for developing recruitment and retention models for the ATAPS workforce including incentive schemes, developing the credentialing process and ensuring the availability of clinical supervision were all seen as ongoing requirements for a quality program.

The Network suggests ***that there is greater investment needed in implementation support which is vital to implementing a quality program. Furthermore, this implementation support should be provided at a national level and co-ordinated by AGPN.***

## 2. Introduction

The Department of Health and Ageing (DoHA) announced in late December 2010 a national consultation to seek feedback and input from a range of stakeholder groups (including General Practice Networks) on the proposed Flexible Care Packages (FCPs) to be introduced on 1 April 2011 as Tier 3 of the ATAPS Program. A Discussion Paper was released (Appendix 1) as well as the consultation forums, DoHA invited written submissions. AGPN was invited to co-ordinate five representatives of the Network to attend the DoHA consultations to be held in each of the capital cities between 17 January and 8 February 2011. In recognition of the Network's leadership responsibilities in relation to the administration of the ATAPS Program, DoHA tasked AGPN in their current contract to conduct a wider consultation of the Network to supplement their consultation process.

AGPN subsequently conducted its own national consultation which consisted of five face-to-face workshops in Melbourne, Adelaide, Sydney, Brisbane and Perth designed to dovetail with the DoHA consultations, this was augmented by individual GP interviews. The consultation process was conducted in January/February 2011 with more than 100 members of the Network from a range of different roles (ie CEO, Finance Manager, Mental Health Manager, Clinician, Program Officer) participating.

This report provides an overview of the consultation process, key findings and suggestions for consideration in the development of the program and funding guidelines.

## 3. Current Context

The introduction of Flexible Care Packages is occurring at a time of significant developments in the primary health care sector. There are a range of contextual factors that need to be considered in relation to the implementation of the FCPs. These include:

- Expansion of the ATAPS Program in response to the recommendations outlined in the Review of ATAPS
- Primary Health Care Reform and Establishment of Medicare Locals
- Other Commonwealth funded mental health programs in primary health care (ie MHNIP, PHAMS, Better Access)
- State government funded mental health programs delivered through the general practice networks for a similar target group as the FCPs

## **Expansion of the ATAPS Program in response to the Recommendations outlined in the Review of ATAPS**

The Review of the ATAPS Program undertaken in 2009 and reported in February 2010 identified four areas for change and improvement:

- Better addressing service gaps
- Increasing efficiency
- Improving quality
- Encouraging innovation

The Review was also explicit in stating that the ATAPS Program would become more targeted and move to changed funding arrangements based on a tiered funding model. As a consequence of the Review, new funding arrangements were introduced in July 2010 in the form of Tier 1 and Tier 2 funding. Tier 2 funding was provided for delivering ATAPS services “to hard to reach groups” and included children, women in the perinatal period, people affected by the Victorian bushfires, people with mental illness experiencing homelessness, indigenous Australians and people at risk of suicide. These new funding arrangements have been introduced without a comprehensive set of guidelines articulating clearly the flexible pathways for referral and provision of treatment plans. Furthermore, the Minimum Data Set (MDS) has taken six months to be updated to enable Tier 2 data to be entered. This impacts on general practice networks being able to deliver a ‘quality’ program. The haste with which Tier 2 was introduced without sufficient time to update the guidelines and the MDS is of concern to General Practice Networks with respect to a 1 April commencement date for Flexible Care Packages. To introduce a more complex Tier with a complex client group requiring new service partnerships and models of care with insufficient preparation time is regarded as risky in terms of an effective implementation strategy.

## **Primary Health Care Reform and Establishment of Medicare Locals**

The General Practice Network is currently at the commencement of a significant transitional process towards the establishment of Medicare Locals. By June 2012, the General Practice Networks in their current form will no longer be funded by the DoHA and will be replaced by Medicare Locals. It is anticipated that the first tranche of Medicare Locals will be in place by July 2011. Medicare Locals will be responsible for the regional planning, implementation and evaluation of primary health services including ATAPS and other mental health programs in their designated areas.

The lack of alignment between the introduction of Flexible Care Packages and Medicare Locals will cause some contractual and legal issues as contracts will need to be novated if General Practice Networks have contracts for FCPs in April and then transition into a Medicare Locals by July. The Network's preference would be for a more streamlined process and minimisation of additional administrative requirements.

### **Other Commonwealth programs in Primary Health Care (MHNIP, PHAMS, Better Access)**

It will be important for the Flexible Care Packages to be integrated with other Commonwealth Programs such as Mental Health Nurse Incentive Program, (MHNIP) Personal Helpers and Mentors (PHAMS), Day-to-Day Living and Better Access. Questions have been raised regarding the difference between the Flexible Care Packages and the MHNIP and how it will link to the PHAMS Program.

Another significant program that has an impact on the delivery of ATAPS in rural areas is the **Mental Health Services in Rural and Remote Areas Measure**. This measure has invested \$72.3 million over five years commencing in 2006/07 to provide more allied and nursing mental health services, including those provided by social workers, psychologists, mental health nurses, occupational therapists, Aboriginal health workers, and Aboriginal mental health workers in rural and remote communities throughout Australia. This included \$20.6 million specifically earmarked for drought-affected communities throughout Australia.

This measure complemented Medicare Benefits Schedule (MBS) funded services to provide better access to mental health services, and was designed to build on ATAPS as part of the *Better Outcomes in Mental Health Care* program, the *More Allied Health Services* (MAHS) program and the *Mental Health Support for Drought Affected Communities* (MHSDAC) program. The five year funding period for this measure will be completed in June 2011.

General Practice Networks in rural areas needing funds under this measure have used it to leverage infrastructure to support ATAPS.

## **State funded Primary Mental Health Care Programs**

Some of the significant programs that are state funded that need to be considered in relation to the FCPs are:

### ***Mental Health Shared Care Program (SA Health)***

The Mental Health Shared Care Program, delivered through the General Practice Network in South Australia provides services for people aged 18 or over with low prevalence, severe and complex mental disorders being managed in the primary health care setting. This program funded by SA Health has been in existence for three years and has recently been funded for a further three years. The program also targets the following sub population groups: Aboriginal and Torres Strait Islander people, women in the perinatal period and people who are culturally and/or linguistically diverse. The Program aims to:

- reduce demand for emergency and acute services through effective collaborative primary health care crisis prevention;
- increase the capacity of general practitioners to manage patients with severe and complex mental illness
- improve communication, collaboration and referral pathways between general practice, government and non-government mental health services (plus any other relevant services); and
- provide early intervention, care, information and referral services

All General Practice Networks in South Australia receive funding for the Mental Health Shared Care Program. The funding enables General Practice Networks to employ or contract clinicians to provide the services. The Shared Care Program also funds clinical supervision, supervision training and has developed a Clinical Guidelines Framework. Some clinicians are based in practices while others work from the General Practice Network. The Program is co-ordinated by GPSA who are the contract managers.

## ***Mental Health, Drug and Alcohol and General Practice Shared Care Advancement Grants Program (The Shared Care Project) NSW Health***

The Shared Care Project is being delivered in 10 NSW General Practice Networks to establish and embed a system of shared care and service linkage between mental health, drug and alcohol and general practice at a primary health care level. The project provides a grant for each of 10 General Practice Networks to engage a mental health or drug and alcohol clinician to work with general practices and provide a clinical and service coordination role. Most of the clinicians are mental health nurses who will also be supported by GP NSW to complete their credentialing status with the Australian College of Mental Health Nurses by the end of the project. GP NSW has engaged a part time clinical nurse consultant to manage the project and provide professional support and supervision for the shared care clinicians.

Clinicians work at a primary health care level supporting the management of patients with complex mental illness and/or drug and alcohol disorders. All clinicians have at least one day a week quarantined to be devoted to improving service linkages, developing pathways to care, and attending professional supervision, training and network meetings. Divisional clinicians are in a unique position to not only provide treatment of complex conditions at a general practice level where many patients would prefer to be managed, but also have the knowledge, expertise and ability to link with other federal, state government and non government service providers, resulting in improved coordinated and shared care.

A submission for extended and expanded funding has been submitted.

### ***Partners in Mind (Qld Health)***

During 2005-2006, General Practice Queensland (GPQ), with funding from the Australian Government Department of Health and Ageing (AGDHA) and Queensland Health (QH), coordinated the *Partners in Mind (PIM)* initiative. The initial focus of *PIM* was to develop a primary mental health care framework, and achieved this through extensive consultation across the sector.

In 2007, implementation commenced in seven demonstration sites and a state-wide coordinator was established at GPQ.

Queensland Health recently provided substantial funding to GPQ to support the implementation of the Framework. In 2009, the *PIM* initiative was implemented in a total

of 12 sites, building on the experience of the initial seven demonstration sites. Capacity funding for the General Practice Networks and new Queensland Health positions enhanced joint work between the public mental health services and general practitioners.

The 12 implementation sites across Queensland are:

Townsville, Rockhampton, Emerald, Sunshine Coast, Brisbane North, Brisbane South, Ipswich, Logan, Gold Coast, Cairns, Bayside and Moreton Bay.

The *PIM* initiative consists of six action areas, which are:

1. Partnership and Joint Planning
2. Education and Training
3. Resource Development
4. Policy, Processes and Procedures
5. Establishing New Positions/Programs
6. Linking With Existing Initiatives/Programs

Implementation of the project is the joint responsibility of the local General Practice Networks and District Mental Health Services.

These contextual factors demonstrate that the primary health care landscape is becoming increasingly crowded with mental health programs and services and will need increased investment in co-ordination and linkage to minimise duplication and maximise efficiency.

## **4. Consultation Process**

AGPN conducted supplementary face-to-face consultations in five jurisdictions: Victoria, South Australia, NSW, Queensland and Western Australia as it was deemed that five representatives from Tasmania, Australian Capital Territory and Northern Territory at the DoHA consultations were sufficient to enable input from all General Practice Networks in those jurisdictions.

Individual interviews were also held with general practitioners.

### **4.1 Aims and Objectives**

The objectives of the AGPN consultations were as follows:

- To gain information from the network about key elements required for an effective ATAPS program, with a focus on Tier 3 FCPs

- To identify the infrastructure required to implement an expanded ATAPS Program
- To share information gathered through the DoHA consultations
- To identify key issues and solutions to put forward to DoHA consultations
- To inform the content of a report to DoHA on Network views and requirements.

The DoHA Discussion Paper (Appendix 1) formed the basis for the Consultations.

## 4.2 Workshops

The State Based Organisations (SBOs) were instrumental in assisting with the organisation of the workshops and disseminating information to the Network. Due to the tight schedule of the DoHA consultations and the timeframe for the reporting, some AGPN workshops were held prior to the DoHA consultation and some after. AGPN encouraged and supported General Practice Network Representatives attending DoHA consultations to also attend AGPN consultations to ensure flow of information. AGPN also supported representatives from the Australian Capital Territory and Northern Territory to participate in the Sydney and Perth Consultations respectively.

<b>State</b>	<b>Date</b>	<b>Location</b>	<b>Attendees</b>
Victoria	20 January	Melbourne	24
South Australia	27 January	Adelaide	12
NSW	2 February	Sydney	36
Queensland	3 February	Brisbane	24
Western Australia	9 February	Perth	17
<b>TOTAL</b>			<b>113</b>

Participants at the workshops included: CEOs, Finance and Business Managers, Mental Health Program Managers, ATAPS Co-ordinators, ATAPS Clinicians and Mental Health Program Officers.

The workshops were facilitated by Jennie Parham, Principal Network Adviser-Mental Health, AGPN and Meriel Schultz Consultant to AGPN. The focus of the workshops was on operational and implementation issues using the DoHA Discussion paper as a reference

point and on finding solutions that will build a robust Tier 3 ATAPS program for both service providers and consumers.

The Program for the consultations consisted of:

- An introduction and outline of the day
- Brief overview of the ATAPS review and progress to date
- Feedback from those attending DoHA consultations
- Identification of key themes
- Identification of gaps
- Infrastructure requirements
- Identification of outstanding issues and solutions

Refer Appendix 2 for examples of Programmes. Appendix 3 provides lists of participants who attended and Appendix 4 provides a list of the questions used for small group discussion at the workshops.

Following each workshop, summaries of the small group feedback and key messages were provided to the workshop participants. Appendix 5 provides examples of the summaries. In each jurisdiction, AGPN also encouraged the state based organisations and individual General Practice Networks to provide separate submissions if they had specific points to make.

### **4.3 Structured Interviews**

As the workshop format is difficult for GPs to participate in due to time constraints, individual interviews were held with a small group of GPs. Appendix 6 provides a copy of the Interview Questions.

## **5. Key Findings: Consultation Forums and Interviews**

Despite the challenges and timing of the introduction of the Flexible Care Packages, there was unanimous support for them by the Network. The Network welcomed the FCPs stating they added value to existing programs by providing clinical and non-clinical services, funding for care co-ordination and linkage and the potential for more holistic consumer based care. The key findings of the Consultation have been grouped around the questions outlined in the Discussion Paper.

## **5.1 Who could benefit from FCP's, Who are they not suitable for?**

There was agreement across the Network that the FCPs should not be determined by diagnosis alone but should also be based on need and functionality. The need for non clinical psychosocial support services is driven by the impact that the illness is having on an individual's day-to-day functioning. The Network also had a view that even though a person might be eligible for a FCP, there needed to be an assessment process undertaken by the Division as to their suitability. Guidelines need to articulate exclusions.

From a Network perspective, FCPs were regarded as suitable for the following:

- People who have not been able to access services previously under Tier 1 and Tier 2 and need clinical and non-clinical services
- People who do not meet the criteria for services under the state system but have severe mental illness
- People who have severe mental illness and reduced functionality
- Carers and family members of people with severe mental illness to be able to access non-clinical services

FCPs were regarded as not suitable for the following:

- People in an acute phase of their mental illness or needing crisis intervention services
- People with dementia
- People receiving case management services from the state funded system
- People who can afford private services

Client populations that need greater clarification are people with personality disorders and those with significant eating disorders. Some were of the view that the FCPs allowed General Practice Networks to provide more innovative and customised programs for these client groups while others had the view that people with personality disorders could create a bottleneck and therefore would require demand management strategies from the outset. Some also had the view that people with complex mental illnesses and personality disorders required specialist skills and interventions which was the perceived responsibility of specialist mental health services funded by the states and territories.

The value of the FCPs, identified by the Network are:

- enable holistic care to those most in need
- provide ability to purchase non-clinical services

- give legitimacy to the function of care co-ordination which is essential for this client population
- promote partnerships between service providers
- streamlines pathways of care and provides more integrated care

**Key messages:**

- **General Practice Networks welcome the FCPs as they provide the opportunity for holistic care**
- **FCPs need to be based on functionality as well as diagnosis, not diagnosis alone**
- **Need to be explicit about exclusion criteria**
- **Give General Practice Networks flexibility with regard to inclusion criteria**
- **Reduce the burden on GP's to provide 'care co-ordination' role**

## 5.2 Referral pathways

There was robust discussion in the consultation forums regarding “who” should refer. There was a strong view from some consultations that it should be limited to GPs in the first instance as the intent of the Program is to support GPs who are managing patients with severe mental illness in primary health care. In other consultations, there was an equally strong view in opening it up to other providers to refer such as allied health professionals, mental health nurses and NGOs despite the demand versus supply issues it would create. Another view coming from the Qld consultation was a referral pathway similar to Tier 2 which enables flexible referral pathways but still requiring a GP assessment as soon as possible.

Concerns were raised in all consultations about referrals from the state system to primary health care and the real potential for cost-shifting. The Network strongly supported the need for assessment and triage processes provided by the Division to enable clients to receive the most appropriate services and better integration of services. It was also identified that there was a lack of articulation of the evidence base in the DoHA discussion paper and that this needed to be remedied immediately. Articulation of the evidence on who would benefit from clinical and non-clinical services and the types of services that are effective would further assist in targeting the right people for FCPs.

One of the key issues raised was the need for an exit strategy for clients in order to ensure ongoing throughput and access to services.

**Key Messages:**

- ***There will not be sufficient funding to provide FCPs to everyone who is eligible***
- ***GP needs to be the primary referring agent***
- ***Allow for flexible referral pathways similar to Tier 2 where other providers can refer but GP will need to see the client as soon as practicable***
- ***Need for an articulated exit strategy***
- ***Need for an articulated evidence base***

**5.3 Commonwealth/State relationships**

There was emphatic support from the Network for increased dialogue between DoHA and state and territory governments in relation to roles and responsibilities of each level of government with regard to the interface and linkages between Commonwealth funded programs such as ATAPS, MHNIP with State funded programs such as Shared Care and Partners in Mind.

Services provided to people with severe mental illness has largely been the domain of state and territory funded health services and NGOs and so although the Commonwealth's foray into this territory is welcomed there will need to be much clearer articulation of the boundaries and partnerships required to ensure integration of services on the ground. FCPs will not be effectively implemented without the support of state funded crisis intervention services, access to psychiatric assessments and advice and specialist services provided by the states and territories.

Clarification was sought in all consultations regarding the difference between the MHNIP and the FCPs and between some state funded programs such as the Mental Health Shared Care Program in SA. The fact that there is now a plethora of state and Commonwealth funded programs being delivered by General Practice Networks increases the need for co-ordination and integration of programs and services at the local level. This has implications for the funding and service delivery models.

Lessons learned from the Mental Health Shared Care Program in SA relevant to the FCPs are:

- Importance of engagement, relationships and partnerships between primary health care and state funded mental health services
- Adequate resourcing to develop supporting infrastructure such as clinical governance models, psychiatric service systems, management protocols, clinical supervision etc.
- An articulated evidence base that supports the model
- A funded six month establishment phase prior to service provision

- Education and promotion of program to GPs
- Limiting referrals to GPs in the first instance

**Key messages:**

- ***Need for dialogue between DoHA and state/territory mental health services re referral pathways and protocols***
- ***Greater articulation of the linkages between FCPs and the MHNIP and PHAMS Program is required -maybe a flow chart***
- ***Need for ongoing partnership development role between general practice networks/Medicare Locals and state mental health services***
- ***Greater investment in ATAPS planning and co-ordination roles at the regional level***

#### **5.4 Implementation Models**

The consultations gave a clear message that the models for implementation would need to be determined by the level of funding, availability of services and providers and geography. One size does not fit all and models would be different across the Network reflecting the differences in service infrastructure required to support this initiative. It was vital that there was “flexibility” to design and develop the models at the local level. Different models for service delivery were identified such as direct service provision, sub-contracting and brokerage. In some cases, there may be a combination of all these models in the provision of clinical and non-clinical services.

The Network were of the view that effective implementation of FCPs would require a planning phase to design the model, develop the partnerships and recruit the appropriate workforce as few General Practice Networks had this in place to begin immediately. It would also require addressing the co-ordination and linkage issues with other Commonwealth and state funded programs. Many General Practice Networks could see synergies with the MHNIP, PHAMS and the state funded shared care programs and would need to explore how they could be integrated.

Most General Practice Networks also identified the need to have triage and assessment processes in place to ensure clients were receiving the most appropriate services. Many General Practice Networks see their role as appointing care co-ordinator(s). These roles have implications for recruitment of additional staff with the appropriate skills.

Another approach to implementation that was raised in the consultations was a phasing in of the FCPs in recognition of the fact that there will not be sufficient funding to provide FCPs for everyone who meets the criteria. The phasing in could be done in different ways (eg population group, geography, referral pathway). For example, in an area where there

is a **headspace** service, the FCPs could initially be available to young people and then, over time, available to other population groups. In a rural area, it might involve making the FCPs available to those in regional areas where there are non clinical service providers initially and then when outreach services have been established, offer them to people living in nearby smaller towns. Another example of phasing in could be limiting referrals to GPs only in the first instance to assess demand before opening it up to other providers. However, this further demonstrates the need for a planning phase prior to service provision to develop the implementation plan.

A key component of all models was support for clients in a crisis and access to specialist mental health services and psychiatric assessment. Tier 3 was also seen as a step down service for those who were being discharged from the state system.

Clinical governance frameworks, risk management strategies and demand management strategies were all aspects of implementation that General Practice Networks would need to have in place to provide services for this client group.

**Key messages:**

- **Local planning models will be determined by level of funding and availability of services and providers**
- **Different models include direct service provision by General Practice Networks, sub-contracting and brokerage**
- **Effective implementation will need a planning phase to design the service delivery model, develop appropriate partnerships and recruit appropriately skilled staff**
- **Greater investment to be made in program co-ordination and planning as well as integration with other services.**

## **5.5 Funding Models**

Funding was one of the most consistently raised issues discussed at the consultations. Overall, the Network were advocating for a review of the funding model and the way the funding can be used. Some of the key issues raised in relation to funding were;

- Greater flexibility in the way funds are used. The current 85/15 split between program services and program support and administration will limit the quality and impact of an expanded ATAPS program into the future
- Preference should be given to simplify ATAPS funding and potentially rearrange the funding so it is aligned to outcomes rather than in discrete tiers with no flexibility to move between.

- Funding for ATAPS including FCPs need to allow for funding of co-ordination and planning as well as service provision and program administration. Increasingly, General Practice Networks will need to have clinical governance frameworks, risk management strategies, demand management strategies and centralised assessment processes which will need higher level co-ordination and management skills.

**Key messages:**

- ***Funding disbursement and usage model needs to be reviewed***
- ***Greater flexibility in use of funds***
- ***Current system of 85/15 split for service provision/administrative support a barrier to success going forward***
- ***Funding needs to include line items for co-ordination and planning as well as service provision and administrative support***

## **5.6 Workforce**

There were many issues raised at the consultations in relation to the workforce and service provision. Some rural areas (for example, Emerald in Qld) have difficulty in recruiting clinicians to provide ATAPS Tier 1 and 2 before Tier 3 has even commenced. Others have a limited supply of GPs and allied health services. Other workforce issues related to recruiting triage clinicians and care co-ordinators. It was suggested by one GP that all General Practice Networks or Medicare Locals will need an ATAPS Co-ordinator. Credentialling, clinical support, supervision and workforce development were all raised as important issues in maintaining a quality service.

There was also recognition for General Practice Networks in areas which have not been providing services to people with severe mental illness that there are a range of risk management strategies that they would need to have in place. Many are not equipped with duress alarms, for example.

**Key messages:**

- ***Innovative approaches to addressing recruitment and retention issues are required***
- ***All Divisions/Medicare Locals will need funding for ATAPS Co-ordination and clinical leadership over and above the current 15per cent program support provision***
- ***Need for clinical governance and risk management policy and procedures***
- ***Credentialling of the ATAPS workforce is regarded as important to providing a quality program***
- ***Need for guidelines in recruiting care co-ordinators***
- ***Funding for clinical supervision will need to be considered as clinicians employed by Divisions under ATAPS have mandatory supervision requirements that impact on credentialling***

## 5.7 Implementation Support

Given the role of GPNs as fundholders, planners and implementers of an expanded ATAPS program, a key component of the consultation was a discussion of the requirements to support GPNs in their role. GPNs have continued to be supported by SBOs following DoHA de-funding the Development and Liaison officer positions as of September 2010 particularly where the SBO has maintained a mental health resource (ie Qld, NSW, Vic, ACT, NT).

The Network recommended that the infrastructure support be separately funded and co-ordinated at a national level by AGPN. Infrastructure requirements include:

- Development of guidelines and frameworks at a national level that can be adapted for the local level (ie clinical governance, guidelines for recruitment of allied health professionals)
- Information on the evidence-base supporting the Flexible Care Packages
- Central clearing house of information, resources, good practice models, evidence – based interventions that is accessible by a range of stakeholder groups
- Opportunities for networking and sharing of knowledge, experience and information including maintaining a state-based network support function
- Templates and planning tools that assist with contract management, partnership development and program administration
- Development and sharing of protocols and proformas for assessment and triage
- Improved data collection processes and agreed minimum data sets
- Support for developing strategies for addressing recruitment and retention issues
- Ensuring access and availability to multidisciplinary workforce development programs for both clinical and non-clinical service providers
- Accessing appropriately qualified and experienced clinical supervisors
- Facilitating and strengthening linkages with the Mental Health Professionals Networks

### **Key messages:**

- ***Investment in implementation support for GPNs will be a critical factor in the implementation of a quality ATAPS Program***
- ***Implementation support be funded at a national level separate from program funding and co-ordinated by AGPN***

## 6. Suggestions for Consideration

The General Practice Networks have welcomed the opportunity to provide feedback and input to the national consultation on the introduction of FCPs through the ATAPS Program. As fundholders of the ATAPS Program and other Commonwealth and state mental health programs, General Practice Networks are well placed to provide input from the perspective of the operational and implementation factors that need to be considered in rolling out this initiative. Throughout the consultation process AGPN has been committed to seeking views on solutions and ideas for making FCPs work on the ground, not just raising issues. As a result, a number of key themes have emerged which are outlined below with associated suggestions for consideration:

### Implementation Strategy

Prior to the consultation, the Network were concerned about the timeframe for implementation based on their previous experience with the introduction of Tier 2 funding arrangements. However, through the consultation process, it became clearer what needs to happen at an operational level to deliver the FCPs: scoping the target group for the packages, mapping the service providers, integrating programs, designing a model, developing or enhancing partnerships, developing intake and triage services where appropriate, ensuring internal policy and procedures are in place (ie risk management, clinical governance etc), recruiting appropriate staff and education and promotion of the FCPs to GPs, consumers, carers and community sector. It became increasingly evident that ***a funded lead in time or establishment phase is required*** to prepare the groundwork for the effective and efficient delivery of FCPs. This should be at least six months. In that time, General Practice Networks or Medicare Locals can do the groundwork and prepare a detailed proposal outlining the model for delivering the FCPs based on the funding allocated and the features of their communities.

It is unrealistic to expect that General Practice Networks would be able to deliver services immediately as the partnerships, service providers, workforce and protocols have to be in place. Approximately 12 General Practice Networks or 10% of the Network indicated at the Consultations that they were close to being ready.

Even with the establishment phase, realistically there needs to be an incremental or phased approach to implementation. As its not clear exactly how the funding will work, there is concern that demand will outweigh supply and the targeting of the FCPs will be important. The Network is suggesting that ***an implementation strategy is developed***

**by each Division or Medicare Local which demonstrates an incremental or phased approach to service provision.** This will include an establishment phase, implementation phase and an expanded implementation phase.

### **Commonwealth/State Relationships**

Underpinning the effective implementation of the FCPs will be strong partnerships between primary health care, state funded mental health services and NGOs. The Network strongly advocates for **high level dialogue between DoHA and State/Territory Directors of Mental Health Services to establish parameters for the linkages and referral pathways between the state system and primary health care and the integration of commonwealth and state based programs at the division level.** This needs to happen prior to the commencement of the initiative. Maybe through the COAG process, there could be a joint statement of how the two levels of government intend to work together on this initiative.

In addition, there is an ongoing need for **a funded mechanism at the jurisdictional level to maintain and sustain the ongoing interface between primary health care and state mental health services,** particularly where there is significant investment in primary mental health care programs by the state government. This would include development of policy and guidelines, dissemination of information, provision of input and facilitation of linkages. There is opportunity for cost-sharing of this mechanism or resource by commonwealth and state as there are reciprocal benefits for both parties.

### **Funding Models**

There needs to be greater acknowledgement and recognition for the co-ordination, planning and management tasks that are required to deliver an expanded ATAPS Program. The Network strongly suggests that **General Practice Networks need funding for co-ordinators and/or clinical leaders who can plan, co-ordinate and manage the ATAPS program including maintaining partnerships with state mental health services and NGOs and keeping GPs engaged.**

The consultations were also unanimous in supporting the need for **more flexibility with the way funding can be utilised and that it would be preferable to link it to desired outcomes and deliverables, than tiers.**

It was agreed that the current funding model of an 85/15 split between service provision and program support was no longer viable and would not produce a quality program.

### **Implementation Support**

There are a range of support needs that the Network will require to ensure the implementation of a quality program. These include a national communication strategy and information clearinghouse where the evidence, resources, models of good practice can be accessed, national frameworks and guidelines that can be adapted at the local level, templates and tools to assist contract management, partnership development and evaluation.

***Investing in the workforce was also strongly supported by the Network through ensuring access and availability of multidisciplinary workforce development programs and enhancing and strengthening provider networks such as the Mental Health Professionals Networks.*** Support for developing recruitment and retention models for the ATAPS workforce including incentive schemes, developing the credentialing process and ensuring the availability of clinical supervision were all seen as ongoing requirements for a quality program.

The Network suggests ***that there is greater investment needed in implementation support which is vital to implementing a quality program. Furthermore, this implementation support is provided at a national level and co-ordinated by AGPN.***

***The Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program***  
**January 2011**

**How to provide input or comment**

You are invited to provide written comment on this Discussion Paper. Submissions can be sent by post or email and should be sent to the Department of Health and Ageing (the Department) by **11 February 2011**.

**Content of submissions**

Your submission should include:

- Name and full contact details (including email address), company name (where applicable) and designation of submitter;
- Comment on areas/questions set out in the discussion paper;
- Any other relevant information (for example, any technical, economic or business information, or research based evidence supporting the view being expressed); and
- Identification and discussion of any perceived omissions in the discussion paper or alternative approaches.

**Confidentiality of submissions**

Your submission may be published on the Department's website: [www.health.gov.au](http://www.health.gov.au). If you wish any information contained in your submission to be treated as confidential, please clearly identify such information, and outline the reasons why the information should be treated confidentially. Note that general disclaimers in covering emails will not be interpreted as specific requests for submissions to be treated confidentially. The Department will, however, use its best endeavours to ensure that any information identified as sensitive is treated in confidence.

**Address for submissions**

Electronic submissions should be emailed to: [ATAPS@health.gov.au](mailto:ATAPS@health.gov.au)

Hard copy submissions should be sent to the following address:

Director  
Community Services Section  
Mental Health and Suicide Prevention Programs Branch  
Department of Health and Ageing  
MDP 602  
GPO Box 9848  
CANBERRA ACT 2601

**Questions relating to submissions**

Any questions relating to submissions should be directed to: [ATAPS@health.gov.au](mailto:ATAPS@health.gov.au)

## **Purpose**

The purpose of this paper is to seek the views of key stakeholders on elements of the new Flexible Care Packages for People with Severe Mental Illness (FCPs) measure, which is being implemented through Access to Allied Psychological Services (ATAPS) arrangements and which encompasses additional clinical services, non clinical support and case coordination for people with severe mental illness.

## **Background**

### 2010 National Health Reform:

On 20 April 2010, the Australian Government and state and territory governments, with the exception of Western Australia, reached an historic agreement at Council of Australian Governments (COAG), on health and hospitals reform. The establishment of the National Health and Hospitals Network (NHHN) represents the most significant reform to Australia's health and hospitals system since the introduction of Medicare.

Under the NHHN Agreement, the Australian Government will take full funding and policy responsibility for primary mental health care services for common disorders such as anxiety and depression of mild to moderate severity, including those currently provided by states and territories.

The Australian Government has also signalled its determination to improve services for people with severe mental illness. As part of the 2010-11 Budget, \$175.8 million was allocated to improve the mental health system as part of the NHHN. This includes:

- \$78.8 million over four years to deliver up to 30 new headspace youth friendly services, provision of extra funding for the existing 30 headspace sites, and improvements to telephone and web-based support services for young people. The locations of the first ten new headspace centres were announced on 24 July 2010 by Minister Roxon. These new services will be established by headspace this year;
- \$25.5 million over four years to expand the Early Psychosis Prevention and Intervention Centre (EPPIC) model in partnership with interested states and territories; and
- \$13 million over two years under the Mental Health Nurse Incentive Program.

Importantly, this includes \$58.5 million over four years to deliver Flexible Care Packages to better support up to 25,000 people with severe mental illness, to be delivered through ATAPS arrangements.

### Taking Action to Tackle Suicide Strategy

Building on the existing reforms already underway, on 27 July 2010, the Prime Minister, the Hon Julia Gillard MP, stated that mental health will be an important second term agenda for the Government, announcing the "Taking Action to Tackle Suicide" strategy. Under this strategy, \$274 million will be invested over four years to:

- provide more services to those at greatest risk of suicide including psychology and psychiatry services, as well as non-clinical support to assist people with severe mental illness and their carers with their day-to-day needs;
- invest more in direct suicide prevention and crisis intervention, including through boosting the capacity of counselling services such as Lifeline and providing funding to improve safety at suicide 'hotspots';
- provide more services and support to men – who are at greatest risk of suicide, but least likely to seek help; and

- promote good mental health and resilience in young people, to prevent suicide later in life.

As part of this package \$60 million will be available over three years from 2011-12 to extend funding pools available under the Flexible Care Packages for People with Severe Mental Illness measure to enable access to non-clinical support services, such as structured social activities, psychosocial rehabilitation, vocational support or respite services for carers. This complements clinical services and case management available under the original allocation to Flexible Care Packages, and will enable wrapped around care to be tailored to the needs of the individual.

For the purposes of consultation, Flexible Care Packages are defined as including both the initial \$58.5 million for clinical services and case coordination, and the subsequent \$60 million for non clinical support described above.

#### Flexible Care Packages for People with Severe Mental Illness

People diagnosed with severe mental illness referred to ATAPS by a General Practitioner (GP) or a psychiatrist will be able to access a package of care.

A Flexible Care Package (FCP) is a package of care which is tailored to meet an individual's needs and will comprise of the following components:

- funding to purchase clinical services;
- the capacity of funding case coordinators to work closely with the referring GP or psychiatrist and assist individuals navigate the clinical and social support they need;
- new funding to purchase the required community/social support services; and
- an emphasis on links and flexible pathways to broader clinical and support services, including Commonwealth, State and Territory and NGO services such as specialist mental health services, acute services, crisis support, and broader vocational and community support.

The total number of ATAPS flexible care services provided to an individual (both clinical and case coordination) will depend on the individual's particular needs. It is estimated that an average of 20 clinical services in a calendar year will be provided to each individual, although it is recognised that some clients may need more clinical services in a calendar year depending on the level of severity of their illness and associated disability. In addition non-clinical support will be available to the individual, subject to their needs and care plan.

#### Access to Allied Psychological Services

ATAPS is a component of the Better Outcomes in Mental Health Care (BOiMHC) Program which was introduced in 2003 to:

- produce better outcomes for consumers with common mental disorders of mild to moderate severity through offering evidence based short-term psychological interventions within a primary care setting;
- offer referral pathways for GPs to support their role in primary mental health care;
- offer non-pharmacological approaches to the management of common mental disorders; and
- promote a team approach to the management of mental disorders.

ATAPS enables GPs to refer patients who have been diagnosed as having a mental disorder of mild to moderate severity to an allied health professional to provide short term focussed psychological strategies. ATAPS primarily treats common mental disorders such as anxiety and depression and targets hard to reach groups. Using their annual budget, Divisions of General Practice (Divisions) are able to adopt a model that best suits local

needs and arrangements.

In April 2008, the Minister for Health and Ageing, the Hon Nicola Roxon MP, announced a review of ATAPS with the goal of refocussing ATAPS to better complement the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* (Better Access) initiative and to better target service gaps for people who, for reasons of geographical location or other barriers, are not able to easily access Medicare subsidised services. The Minister also announced the use of ATAPS as a platform for innovative service delivery models including perinatal depression services, telephone based cognitive behaviour therapy and services for people who have self harmed or attempted suicide.

#### Outcomes from the Review of ATAPS

The review was completed in March 2010 and the consultation and research undertaken through the review process identified four key areas for ATAPS to focus upon to better meet the needs of consumers experiencing mental illness. These four key areas are Better Addressing Service Gaps, Increasing Efficiency, Encouraging Innovation and Improving Quality.

To address some of the outcomes of the review, a new tiered funding model was introduced on 1 July 2010.

ATAPS Tier 1 funding, which is the core funding provided to Divisions, is intended to complement Medicare subsidised service provision and provide mental health services to hard to reach groups. ATAPS Tier 2 funding supplements Tier 1 funding and provides an additional, flexible pool of funding for innovative service delivery to specified groups (such as women with perinatal depression, individuals who are or are at risk of homelessness, children, people in more remote locations, individuals who have attempted suicide or are at high risk of suicide or people who are impacted by extreme climatic events) with priority needs which cannot be met through traditional ATAPS service delivery approaches. The priorities for this pool are targeted to address service gaps.

The new FCPs measure will provide an additional tier of funding over and above this structure.

Other review recommendations will be implemented over the next year or so and stakeholders will be consulted in this process.

## Discussion of Key Issues

To inform the design of the FCPs and the program guidelines, the following questions have been developed.

### Definition

There are no simple definitions of mental illness and severe mental illness. However, for the purposes of FCPs, it is proposed to use a broad definition that reflects that people experience different phases and impacts of illness and allows some clinical flexibility. Therefore, the following definition, based on the definition in the Fourth National Mental Health Plan<sup>1</sup>, is proposed:

*To be referred for a FCP, a person is required to be diagnosed by a General Practitioner or Psychiatrist as having a severe mental illness. The severity of the mental disorder is to be judged according to the type of illness (diagnosis), intensity of symptoms, duration of illness (chronicity), and the degree of disability caused*

***Bearing in mind the need for flexibility and the FCPs target population, does this definition of 'severe mental illness' fit the purpose of FCPs?***

### Who can refer people for FCPs? Is a Mental Health Treatment Plan required?

It is intended that GPs and psychiatrists can refer to FCPs. In exceptional circumstances, other providers may be eligible to provisionally refer to FCPs if prior agreement from the Department has been granted.

It is expected that the *Mental Health Treatment Plan* prepared for referral of a patient for the provision of focussed psychological strategies under the FCPs arrangements would be based on the format for the GP *Mental Health Treatment Plan* under the Medicare Benefits Schedule (MBS items 2710 or 2702).

***Are there other clinicians who would be appropriate to provisionally refer people with severe mental illness for FCPs?  
If so, what special conditions should be placed on these referrals?  
What is considered to be a reasonable time period for clients to have a Mental Health Treatment Plan developed if they have been provisionally referred by other than a GP or psychiatrist?***

<sup>1</sup> Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014, page 16

### Integrated referral pathways (intersections) between Commonwealth and State funded mental health services and with Non-Government Services (NGOs)

The FCPs are intended to increase coordination of services for people with severe illness and to help connect people to services. However they will only be one part of the service pathway and need to be connected to other state and Commonwealth health and non health services which people with severe mental illness need.

In particular, these services are not designed to take over the care of people with severe and persistent mental illness from the state and territory specialist mental health care system. The intent is to help the primary care system to better complement this service system and improve outcomes for people with severe mental illness, including minimizing their movement into hospitalisation and optimise their participation in the community.

It is recognised that the support needs of people with severe mental illness may vary with severity of symptoms from time to time, and may move from being supported in the state specialist mental health system when they are very unwell, to being managed through primary care when their symptoms are more under control. Similarly there may be some patients who present to either the specialist system who would be more appropriately managed in primary care and visa versa. In this way close working relationships will be needed to support integrated and flexible pathways between the two service systems.

Arrangements will also be put in place to ensure that should the client's needs change that they have immediate priority access to the required state specialist mental health services such as crisis support services.

Liaison with a broad range of NGOs, including the Commonwealth-funded services such as Day to Day Living and Personal Helpers and Mentors, as well as employment services, housing services and state funded NGO services will also be needed.

***What arrangements should be put in place to facilitate seamless transition between Commonwealth and State funded mental health services to meet the changing needs of individuals?  
How can Divisions (and later Medicare Locals) establish partnerships with local NGOs to ensure integration and coordination of services?***

### Type of Services to be Provided

The FCPs are intended to include clinical care and case coordination for people with severe mental illness being managed in the community and to enable access to non-clinical support services, such as structured social activities, psychosocial rehabilitation, vocational support or respite services for carers.

***What type of clinical and non-clinical services may be needed for individuals receiving FCPs?  
Where could these services be purchased from?  
What arrangements need to be put in place to facilitate access to clinical and non-clinical services?  
What would be the case coordination activities?***

### Quality Assurance

It is important that there be consistency in quality and clinical appropriateness in services provided under FCPs throughout Australia. New linkages and pathways will need to be developed, and additional support to assist Divisions through this process will be required.

The promotion of best practice is important in the delivery of FCPs. This can be achieved through sharing and disseminating information on, and examples of, the standards and competencies that are most critical for effective service delivery. This could include innovative service models, credentialling and scope of practice, triaging and ways to attract and retain staff.

***What quality issues need to be addressed?  
Who should be responsible for implementing any quality framework that may be developed?  
How can we best support interface to allow Divisions to work effectively with state based services?  
What constitutes a best practice model?  
What information would best support service provision?***

### Skills of Allied Health Providers

To ensure consistent quality throughout Australia, allied health professionals engaged under ATAPS to deliver FCPs should be appropriately credentialled and have their scope of clinical practice defined in accordance with both their level of skill and experience and the clinical practice in the ATAPS context.

***What aspects of credentialling should be considered when engaging allied health providers to deliver Flexible Care Packages?  
What information do Divisions need to facilitate credentialling and define the scope of practice for ATAPS service providers?  
What support mechanisms are needed for Divisions?***

### Clinical support for the workforce

With the move into providing services for people with severe mental illness, there is a need for additional clinical support for ATAPS allied health providers delivering FCPs. Models of providing this support will need to be considered and may include models such as the GP Psych Support Service. The Royal Australian College of General Practitioners is currently engaged through a funding agreement with the Department to deliver the GP Psych Support Service. This service provides GPs with phone, fax and internet/email access to patient management advice from a psychiatrist within 24 hours (or 48 hours for specialised drug and alcohol or child and adolescent mental health matters) of their request.

***What specific elements are needed to appropriately support allied health professionals in ATAPS delivering FCPs?  
Would an expansion of the GP Psych Support Service provide this support?  
If a different support mechanism is preferred, how should it be structured?***

## **Next Steps**

The next steps in the implementation of the FCPs include:

- The broad distribution of this discussion paper to a number of key stakeholders and publication on the Department's web site;
- Consultations in each state and territory with clinicians, consumers and carers commencing in early 2011;
- Ongoing consultation with the ATAPS Expert Advisory Committee;
- Peak organisations to consult with their members and provide advice to the Department from their professions (by 11 February 2011);
- Written submissions invited, with a closing date of 11 February 2011.
- Development of guidelines and recommendations on support structures based on feedback from consultations and the discussion paper will be developed for Government consideration in early 2011;
- Support structures will be established through a competitive process in early 2011;
- Funding will be negotiated with Divisions in early 2011; and
- Funding agreements to be executed with Divisions in time for delivery of FCPs to commence from 1 April 2011.

## **AGPN Consultation – ATAPS**

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**Venue: GP VIC Melbourne**

**Date: Thursday, 20 February 2011**

**Time: 10:00 AM – 4:00 PM**

<b>10:00 - 10:10</b>	Welcome and Introductions
<b>10:10 - 11:15</b>	<b>Introduction and Overview (Jennie Parham)</b> <ul style="list-style-type: none"><li>• Overview of the day,</li><li>• Purpose of the consultation</li><li>• Overview of the consultation papers</li><li>• Feedback from participants who attended DoHA consultation</li></ul>
<b>11:15 - 11:30</b>	<b>Morning Tea</b>
<b>11:30 - 12:30</b>	<b>Small group discussion of key themes and issues (all)</b>
<b>12:30 - 1:15</b>	<b>Lunch</b>
<b>1:15 - 2:00</b>	<b>Feedback from small groups and identification of gaps</b>
<b>2:00 - 2:45</b>	<b>Infrastructure Support (Meriel and small groups)</b> <ul style="list-style-type: none"><li>• Summary of themes, processes and issues for effective implementation</li><li>• Identification of support needs</li></ul>
<b>2:45 - 3:00</b>	<b>Afternoon Tea</b>
<b>3:00 - 3:30</b>	<b>Report back from small groups (Meriel)</b>
<b>3:30 - 4:00</b>	<b>Wrap up and Close (Jennie and Meriel)</b> <ul style="list-style-type: none"><li>• Summary of the day</li><li>• Next steps</li></ul>

## **AGPN Consultation – ATAPS**

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**Venue: Grand Chifley Hotel**

**Date: Thursday, 27 January 2011**

**Time: 10:00 AM – 3:00 PM**

<b>10:00 - 10:10</b>	Welcome and Introductions
<b>10:10 - 11:00</b>	<b>Introduction and Overview (Jennie Parham)</b> <ul style="list-style-type: none"><li>• Overview of the day,</li><li>• Purpose of the consultation</li><li>• Overview of the consultation paper</li><li>• Overview of the DoHA consultation process</li></ul>
<b>11:00 - 12:00</b>	<b>Small group discussion of key consultation questions (all)</b>
<b>12:00-12:30</b>	<b>Feedback from small groups</b>
<b>12:30 - 1:15</b>	<b>Lunch</b>
<b>1:15 - 2:00</b>	<b>Infrastructure Support (Meriel and small groups)</b> <ul style="list-style-type: none"><li>• Summary of themes, processes and issues for effective implementation</li><li>• Identification of support needs</li></ul>
<b>2:00 - 2:20</b>	<b>Report back from small groups (Meriel)</b>
<b>2:20 – 2:30</b>	<b>Afternoon Tea</b>
<b>2:30 – 2:50</b>	<b>Summary of today’s themes for feedback to DoHA Consultation</b>
<b>2:50 – 3:00</b>	<b>Wrap up and Close (Jennie and Meriel)</b> <ul style="list-style-type: none"><li>• Summary of the day</li><li>• Next steps</li></ul>

### Appendix 3 Consultation attendee list

#### Adelaide List of Participants

Participant	Division	Position
Andrea Triggs	Flinders and Far North Division of General Practice	Mental Health Program Co-Ordinator
Andrew Moulding	General Practice Network South	
*Cathy Zesers	General Practice SA	Team Leader Network Services
Clare Andrews	Mid North Division of Rural Medicine	Manager
Danie Miller	Yorke Peninsula Division of General Practice	Mental Health Program Co-ordinator
Kim Doecke	Barossa General Practice Network	Program Officer - Mental Health
*Lissa Selga	Adelaide Hills Division of General Practice	Project Development / Allied Health Unit Manager
Maurice Breust	Murray Mallee General Practice Network	Clinical Services Manager
*Reg Harris	Eyre Peninsula Division of General Practice	Mental Health Programs Coordinator
Robyn Size	Riverland Division of General Practice	Clinical Services Leader
*Sarah Murray	General Practice Network South	Mental Health Program Manager
Wendy Hariz	Adelaide North East Division of General Practice	ATAPS Project Coordinator
<i>*indicates those who also attended DoHA consultation</i>		

#### Melbourne List of Participants

Participant	Division	Position
Amanda Irwin	Bayside General Practice Network	Mental Health - ATAPs & Continuing Professional Development
Chris Edmonds	Greater Monash General Practice Network	Program Coordinator
*Debbie Neill	Melbourne East General Practice Network	Mental Health Program Coordinator
Elizabeth Perrin	Dandenong Casey GP Association	Mental Health Program Manager
Judy Tiziani	General Practice Alliance - South Gippsland	Mental Health Program Coordinator
Julie Rogalsky	Central West Gippsland Division of General Practice	Service Development Manager
Karen Cousins	Dandenong Casey GP Association	Mental Health Program Manager
Krestina Oliver	Westgate General Practice Network	Finance Manager
Lee Miller	impetus	Manager Strategic Operations
*Merinda March	Goulburn Valley Division of General Practice	Team Leader – Navigating Life
*Michele Speak	Monash Division	Quality Manager
Monique de Zoete	PivotWest	Program Development Officer- Mental Health
Natalie Orgias	North East Victorian Division of General Practice	Mental Health Program Officer
*Pam Callaly	General Practitioners Association of Geelong	Mental Health, Rural Primary Health Services and Aged Care Access Initiative Program Officer

Paul Canham	impetus	Mental Health Program Manager
*Peter Gartside	General Practice Victoria	Mental Health Program Consultant
Regina Kalb	Central West Gippsland Division of General Practice	Chief Executive Officer
Ron Marshall	Dandenong Casey GP Association	Mental Health Program Co-ordinator
Shareen Pearson	Peninsula GP Network	Mental Health Program Co-ordinator
Slawka Bell	Monash Division	Chief Executive Officer
Sonja Johansen	East Gippsland Division of General Practice	Mental Health Outreach Worker
Stephen Parr	Mallee Health Care Network	Programs Manager
Sukhi Arora	Bayside GP Network	Chief Executive Officer
Zoi Servinis	Northern Division of General Practice	Better Outcomes in Mental Health Care Project Worker
<i>*indicates those who also attended the DoHA consultation</i>		

### Sydney List of Participants

Name	Division	Position
Adam Leahy	South Eastern Sydney Division of General Practice	Practice Support - Mental Health
Alana Kohn	Eastern Sydney Division of General Practice	Mental Health Program Officer
Anne Galloway	North West Slopes (NSW) Division of General Practice	Clinical Team Leader
Anne Harley	Macarthur Division of General Practice	Mental Health Project Officer
Bob Boss Walker	Hastings Macleay General Practice Network	Manager Clinical Services
Callie Moran	Wentwest Limited	Area Services Co-Ordinator
Claudia Grab	Blue Mountains General Practice Network	Senior Program Manager
Eve Craddock	Shoalhaven Division of General Practice	Chief Executive Officer
*Gillian Minto	Sutherland Division of General Practice	Mental Health Program Officer
Helen Correia	Bankstown General Practice Division	Psychologist
*Jane Westley	General Practice NSW	Team Leader: Mental Health and Drug and Alcohol
Janelle Cowin	Hunter Rural Division of General Practice	2IC and Quality Manager
Jennie Campbell	Riverina Division of General Practice and Primary Health	Manager- Adult Mental Health
John Gunn	Hawkesbury-Hills Division of General Practice	Business Manager
Julie Huntington	Southern Highlands Division of General Practice	Program Officer
Julie Redway	Murrumbidgee General Practice Network	Operations Manager
Karen Frost	Central Sydney GP Network	Mental Health Project Officer
Kathleen Ryan	Dubbo/Plains Division of General Practice	Program Manager
*Katrina Delamothe	GP Access	ATAPS Officer

Linden Ross	NSW Central West Division of General Practice	Program Officer
Mano Arumanayagam	Central Sydney GP Network	Project Officer, ATAPS
Mariam Faraj	St George Division of General Practice	Adolescent & Mental Health Program Officer
*Mark Stephens	Riverina Division of General Practice and Primary Health	Director Mental Health Services
*Meg Bennett	General Practice NSW	Coordinator: Mental Health, Divisions Support
Michael Kundukulam	Wentwest Limited	General Manager Division Services
Paul Hussein	GP Network Northside	Executive Manager - Development
Rosemary Agnew	Australian Capital Territory Division of General Practice	Program Officer
Sandhya Gaunder	Mid North Coast (NSW) Division of General Practice	Business Manager
Sara Courtwood	Nepean Division of General Practice	Psychologist - Mental Health Project Officer
Sarah Fenton	Central Coast Division of General Practice (NSW)	Mental Health GPLO
Steve Sant	Australian Capital Territory Division of General Practice	CEO
Susan McCann	Sunshine Coast Division of General Practice	ATAPS Officer
Theresa Korman	Southern Highlands Division of General Practice	Psychologist
<i>* indicates those who also attended DoHA consultation</i>		

### Brisbane List of Participants

Name	Division	Position
Carmel McNeil	Brisbane South Division of General Practice	Program Manager – Mental Health
Cathy Beck	General Practice Queensland	Program Co-ordinator
*Christian Greaves	Mackay Division of General Practice	CEO
Christina Barron	GP Connections	Program Manager - Services
Diane Anderson	Central Queensland Rural Division of General Practice	Allied Health Administration Officer
Erin Tupou	General Practice Gold Coast	Project Officer - PIM
Helaine Friedman	Ipswich and West Moreton Division of General Practice	Team leader – programs and projects
Holly Moloney	Brisbane South Division of General Practice	ATAPS Support Officer
*Jean McRuvie	Moreton Bay General Practice Network	Acting CEO
Jennie Sealy	RHealth	Program Officer – Mental Health
*Jennifer Ryder	RHealth	Development Officer
Jenny Shaw	General Practice Queensland	Program Officer – Mental Health
*Karen Hale-Robertson	General Practice Queensland	Senior Program Leader – Mental Health
Krissy Campbell	Brisbane South Division of General Practice	Indigenous Health Project Officer
Kristie Milloy	SouthEast Primary HealthCare Network	Primary Care Liaison Officer
Lesa Black	South East Alliance of General	Mental Health Program Support Officer

	Practice (Brisbane)	
Louisa Backus	Central Queensland Rural Division of General Practice	Allied Health Team Leader
Marina Whitchurch	Ipswich and West Moreton Division of General Practice	Program Manager
Neil Taylor	Sunshine Coast Division of General Practice	Clinical Psychologist, FOCUS
*Shelly Kleinhans	GP Partners	Manager, Community & Hospital Integration
Tim Wilke	GP Connections	Chief Executive Officer
Traci Bourke	GP Partners	Mental Health Program Manager
Vicki McGowan	South East Alliance of General Practice	Program Officer
<i>* indicates those who also attended DoHA consultation</i>		

### Perth List of Participants

Name	Division	Position
Ally Piper	Great Southern GP Network	
Carolyn Green	Canning Division of General Practice	Program Manager
*Chris Pickett	Pilbara Health Network	Chief Executive Officer
*Deb Chambers	Midwest GP Network	Program Manager
Helen Robinson	Goldfields Esperance GP Network	Chief Executive Officer
Kath Harradine	General Practice Network NT	Mental Health Program Manager
Kerry Menaglio	Perth Primary Care Network	
*Kevin Shanks	Rockingham Kwinana Division of General Practice	Deputy Chief Executive Officer
Lee Luttig	Goldfields Esperance GP Network	Project Officer Better Outcomes in Mental Health - Kalgoorlie
Lisa Tomney	Osborne GP Network Ltd	Mental Health Program Manager
Nicky Smith	Greater Bunbury Division of General Practice	Education Officer
*Paula Braimbridge	Osborne GP Network Ltd	Mental Health Program Manager
Robyn Church	GP Down South	Mental Health Program Coordinator
Rod Redmond	Canning Division of General Practice	Chief Executive Officer
*Sherenne Foale	Fremantle GP Network	Fremantle headspace Coordinator
Trisha Ellis	Wheatbelt GP Network	Allied Health Manager
<i>* indicates those who also attended DoHA consultation</i>		

#### Appendix 4 Small group questions

1. Who will benefit from Tier 3?
2. Who won't it work for?
3. What value will it add to current service provision ?
4. Who should refer?
5. What models of service delivery will work? Describe
6. What services are needed and how will they be co-ordinated and delivered?
7. How will you know they are working?

**ATAPS – Flexible Care Packages (Tier 3)**  
**AGPN consultation – Victoria**  
**20 January 2011**

**Introduction**

DoHA is conducting consultations in each capital city in all States and Territories. Representation from the AGPN (the Network) is restricted to five participants in each location. AGPN is conducting supplementary consultations in the five larger jurisdictions in Victoria, New South Wales, Queensland, Western Australia and South Australia to inform a response to the DoHA ATAPS consultation paper. This paper was circulated on 18<sup>th</sup> January 2011, outlining the proposed introduction to ATAPS Flexible Care Packages (Tier 3) in April 2011.

The AGPN consultations allow for a wider representation from the Network. In some instances the AGPN consultation will be conducted before the DoHA consultation, providing an opportunity for those attending both to take information from the Network to the DoHA consultation. In other instances, the AGPN consultation will occur following the DoHA consultation and provide feedback to the state Network and further consideration of both state and a national Network response to DoHA.

**Victorian consultation**

The first Network meeting was held in Victoria on 18 January 2011, following the DoHA consultation in that state (17 January). 24 people from the Network attended with a good mix of CEOs, ATAPS Program Managers, Finance Managers and administrative and program staff (see Attachment 1). Five of the participants and Jennie Parham had attended the DoHA consultation the previous day.

Participants were provided with the DoHA discussion paper about the introduction of Tier 3 Flexible Care Packages.

The consultation was hosted by Peter Gartside from GP Victoria and facilitated by Jennie Parham, Principal Network Adviser, AGPN and Meriel Schultz, Consultant to AGPN.

***The objectives of the day*** were to:

- Gain feedback on the DoHA consultation from the five Network members who attended
- Discuss themes and issues arising
- Identify the way that Tier 3 can best be introduced and delivered by Victorian Divisions of General Practice
- Outline the infrastructure support needed to allow this to happen in an effective and efficient way.

Jennie Parham provided an overview of the DoHA discussion paper and overview of the Consultation the day before.

## **Key findings**

### *Who will benefit from Tier 3?*

The definition of those who could be included should be by diagnosis and functionality (based on definitions included in the Mental Health Nurse Initiative and the 4th Mental Health Plan) rather than solely on the basis of diagnosis.

### *Inclusion criteria*

- Those who have been serviced under Tier 1 and 2 but have complex needs and are more appropriate for Tier 3
- Population wide
- New clients with severe mental illness and reduced functionality
- Potential to include people with schizophrenia, bipolar, personality disorders, eating disorders, older people (>65).

### *Exclusion criteria*

- Those not eligible include those receiving services through the state system, those with dementia, those who have means to pay for private services.

### *How will Tier 3 add value to current service provision?*

- Enables holistic care to people in most need
- Deals with complex needs through a non-capped model of care
- Provides opportunity for enhanced coordination and continuity of care
- Promotes partnerships between services, especially between community sector and primary health care + other inter sectoral working relationships
- Individually tailored approach
- Streamlines pathways of care and enhanced social support
- Frees up Tier 2 funding

### *Models of Care*

Participants noted that it is essential that there is ability to be flexible with the type of program design and model and use of funds for best result at the local level. One size will not fit all.

The group noted that the level of funding may not allow Tier Three to be applied 'across the board' and some General Practice Networks would want to use a targeted approach – eg funding used for adolescents only and linked into the local headspace program.

The group suggested that referrals to the program be limited to GPs and psychiatrists. Some participants sought to have this widened to include referring health professionals as for Tier 1 and 2. Noted as a demand management issue. At this stage, (if this referral process is opened up to others or to the NGO sector) clinical governance and quality management of the program would be extremely difficult.

Most General Practice Networks also saw synergies between the Mental Health Nurse Initiative and the ATAPS Tier 3, suggesting the MHN initiative could provide the clinical care and the Division then add additional social supports for the clients.

Two basic models were suggested:

- 1) Division led direct employment: Central intake, employ care coordinator, broker services on behalf of the client
- 2) Division as broker: Outsource program to other supplier(s) for all coordination and service provision. Division to maintain input to quality control.

Models need to emphasise integration and connection with other currently funded (locally delivered) programs (eg mental health nurse initiative, headspace, PHaMS)

Phasing was noted as important:

- *Phase One*: funded planning and establishment phase (this phase would include scoping, environmental scan, client need, gaps in current service provision, identification of services in the area, workforce and other resources, especially those for social support. Outcome: Identified client base.
- *Phase Two*: coordination and implementation (to include further development of the model, promotion and negotiation between services, partnership arrangements, trial and delivery of program)
- *Phase Three*: monitoring and evaluation

The models need to accommodate strategies for transfer to Medicare Locals. At best, implementation should be delayed until Medicare locals in place. There was a strong emphasis on flexibility.

**Note:** *There are discrepancies in timing – General Practice Networks are only funded to 2012 and ATAPS Tier 3 contracts may be longer. Legal issues relevant to this mismatch require resolution prior to contracting General Practice Networks.*

#### *Service Coordination and delivery*

Funding needs to cover:

- Establishment costs.
- Coordination and administration of Tier 3
- Program delivery
- Evaluation

This will include at a minimum:

- Mapping and scoping models of care
- Coordination and partnership development (noting this is a time consuming exercise)
- Workforce recruitment, training and ongoing professional development
- Management (of sub contracts etc)
- IT
- Monitoring and evaluation
- Marketing and promotion

#### *Implementation support*

The group suggested the following:

- Draft MOUs for use with other services
- Linkage funding to allow for linkages with existing programs (eg perinatal programs, suicide prevention)
- Planning templates, guidelines, policies and procedures

- Inclusion and discharge criteria
- Information to inform streamlined movement between ATAPS Tiers
- IT support
- Linked health records (in the future)
- Regular information, updates on progress
- Models of best practice (eg via AGPN and GPV)
- Facilitated dialogue between stakeholders (eg with State services, NGOs, community health and other
- Clinical supervision, professional development, training
- Quality control mechanisms
- Agreed minimum data sets
- Monitoring and evaluation guidelines

### **In summary**

While the General Practice Networks welcome the Tier 3 program and could see the potential benefits, *timing* is a major factor. Primary health reform is the first priority at the moment. Adding new programs to General Practice Networks in a transition phase is complex. Some General Practice Networks are ready and some are not. There needs to be an 'opt out' option as well as an 'opt in' option. April 1 is not a viable timeframe for implementation. The group suggested that expressions of interest be sought from interested and prepared General Practice Networks who could then commence the planning phase of ATAPS Tier 3, from April 1 with implementation occurring once the first tranche of Medicare Locals are in place.

**ATAPS – Flexible Care Packages (Tier 3)  
AGPN consultation – Adelaide  
27 January 2011**

**Introduction**

DoHA is conducting consultations in each capital city in all States and Territories. Representation from the AGPN (the Network) is restricted to five participants in each location. AGPN is conducting supplementary consultations in the five larger jurisdictions in Victoria, New South Wales, Queensland, Western Australia and South Australia to inform a response to the DoHA ATAPS consultation paper. This paper was circulated on 18<sup>th</sup> January 2011, outlining the proposed introduction to ATAPS Flexible Care Packages (Tier 3) in April 2011.

The AGPN consultations allow for a wider representation from the Network. In some instances the AGPN consultation will be conducted before the DoHA consultation, providing an opportunity for those attending both to take information from the Network to the DoHA consultation. In other instances, the AGPN consultation will occur following the DoHA consultation and provide feedback to the state Network and further consideration of both state and a national Network response to DoHA.

**South Australian consultation**

The second Network consultation workshop was held in Adelaide on 27 January 2011, prior to the DoHA consultation in that state (28 January). 12 people from the Network attended with representation from both urban and rural General Practice Networks (see Attachment 1). Four of the participants were to attend the DoHA consultation the following day.

Participants were provided with the DoHA discussion paper about the introduction of Tier 3 Flexible Care Packages.

The consultation facilitated by Jennie Parham, Principal Network Advisor, AGPN and Meriel Schultz, Consultant to AGPN.

**The objectives of the day** were to:

- Provide representatives attending the DoHA consultation with information from the Network about requirements for successful implementation of Tier 3.
- Explore lessons learned from the mental health shared care program in South Australia
- Discuss themes and issues relevant to introduction of ATAPS Tier 3
- Identify the way that Tier 3 can best be introduced and delivered by Victorian Divisions of general practice
- Outline the infrastructure support needed to allow this to happen in an effective and efficient way.

## Key findings

### *Lessons learned from mental health, shared care program*

South Australia has a state funded mental health shared care program. This is unique to South Australia and has similarities with the proposed ATAPS Tier 3. Delegates at the meeting noted the lessons learned from this program:

- The importance of engagement, relationships and partnerships between primary health care and State Health.
- Adequate resourcing to develop supporting infrastructure such as clinical governance models, psychiatric service systems, management protocols etc
- A good knowledge of the evidence base that supports the model
- A funded six month establishment phase prior to service provision
- Education of GPs for appropriate referral practices
- Containing referrals only to GPs (at least in the first instance).

### *Who will benefit from Tier 3?*

- The definition of those who could be included should be by diagnosis and functionality (based on definitions included in the Mental Health Nurse Incentive Program and the 4<sup>th</sup> Mental Health Plan) rather than solely on the basis of diagnosis.

### *Inclusion criteria*

General Practice Networks to have discretion re intake/exclusion (based on a planning and intake service like Tier 2).

Inclusion criteria will include:

- Shared care clients who don't have existing health co-morbidities (although it was acknowledged that most would)
- Those who have been serviced under Tier 1 and 2 but have complex needs and are more appropriate for Tier 3
- Population wide + targeting for specific groups (eg CALD, Indigenous, older people)
- New clients with severe mental illness and reduced functionality
- Potential to include people with schizophrenia, bipolar, personality disorders, eating disorders, older people (>65).

### *Exclusion criteria*

- Those not eligible include those receiving services through the state system, those with dementia, those who have means to pay for private services, those who are in an acute phase of mental illness/psychotic episode and those with a chronic illness.

### *How will Tier 3 add value to current service provision?*

- Increases capacity to respond to need.
- Enables holistic care to people in most need
- Deals with complex needs through a non-capped model of care
- Provides opportunity for enhanced coordination and continuity of care
- Provides ability to purchase non clinical services
- Acknowledges the role of triage allocation

- Promotes partnerships between services, especially between community sector and primary health care + other inter sectoral working relationships
- Individually tailored approach
- Streamlines pathways of care and enhanced social support
- Frees up Tier 2 funding
- Increases satisfaction – for workers and clients.

### *Models of Care*

Participants noted that it is essential that there is the ability to be flexible with the type of program design and model and use of funds for best result at the local level. One size will not fit all.

Tier Three was seen as an opportunity to provide a 'step down' service complementing the SA shared care program.

General Practice Networks would prefer a single ATAPS model and funding that allows them (or the shared care program) to 'triage' clients to appropriate Tiers of service

The group noted that the level of funding may not allow Tier Three to be applied 'across the board' and some General Practice Networks would want to use a targeted approach – eg funding used for adolescents only and linked into the local headspace program.

The group suggested that referrals to the program be limited to GPs in the first instance. Some participants sought to have this widened to include self referral (accepted at division's discretion).

Most General Practice Networks also saw synergies between the Mental Health Nurse Incentive Program (MHNIP) and the ATAPS Tier 3, suggesting the MHNIP could provide the clinical care and the division then add additional social supports for the clients.

Another option was to expand and adapt the headspace model.

Models need to be flexible and use a graded approach to referral processes.

The group expressed a preference for adapting current data collection rather than setting up whole new data set.

In rural and remote areas, the preference was to use the state funded rural and remote mental health service statewide and including out of hours, outreach and enhancement for existing service provision.

Phasing was noted as important:

- *Phase One*: funded planning and establishment phase (this phase would include scoping, environmental scan, client need, gaps in current service provision, identification of services in the area, workforce and other resources, especially those for social support. Outcome: Identified client base.
- *Phase Two*: coordination and implementation (to include further development of the model, promotion and negotiation between services, partnership arrangements, trial and delivery of program)

- *Phase Three*: monitoring and evaluation

The models need to accommodate strategies for transfer to Medicare Locals.

**Note:** *There are discrepancies in timing – General Practice Networks are only funded to 2012 and ATAPS Tier 3 seeks a four year commitment. Legal issues relevant to this mismatch require resolution prior to contracting General Practice Networks.*

#### *Service Coordination and delivery*

Funding needs to cover:

- Establishment costs. Coordination and administration of Tier 3
- Program delivery
- Evaluation

This will include at a minimum:

- Discussion and decisions on the synergies between shared care and ATAPS, noting this is a Commonwealth /State responsibility.
- Mapping and scoping models of care, incorporating 'wrap around' multidisciplinary services to ensure holistic client care and exploration about ways to purchase non clinical services.
- Follow up services for clients referred from State Health to GPs
- Client centred approach to care
- Funded phase to allow for coordination and partnership development (noting this is a time consuming exercise)
- Funding for care coordination once service implementation starts
- Better access to psychiatry services (innovative approaches to psychiatric linkages - ? linkages through Medicare items)
- Workforce recruitment, training and ongoing professional development
- Management (of sub contracts etc)
- IT
- Transport issues
- Monitoring and evaluation
- Marketing and promotion

#### *Implementation support*

The group suggested the following:

- Support infrastructure to be funded separately from service delivery.
- Support infrastructure needs to be developed by the Network itself. This could be coordinated by AGPN in collaboration with other key stakeholders
- Infrastructure requirements will include program administration, organisational issues and clinical services.

#### *Organisational:*

- Some decisions need to be made at Commonwealth/State level (eg around synergies between shared care and ATAPS)
- Guidelines, frameworks
- Include a 'centre learning network' for all ATAPS providers
- Clearing house web base for information, models, evidence etc
- Budget template so that ATAPS needs can be reviewed.

## **Program Administration**

- Draft MOU/service agreement templates for use with other services
- Linkage funding to allow for linkages with existing programs (eg perinatal programs, suicide prevention)
- Planning templates, guidelines, policies and procedures
- Guidelines for purchasing services
- Inclusion and discharge criteria
- Information to inform streamlined movement between ATAPS Tiers
- IT support
- Linked health records (in the future)
- Regular information, updates on progress
- Models of best practice (eg via AGPN and GPV)
- Facilitated dialogue between stakeholders (eg with State services, NGOs, community health and other)
- Data entry by designated person in ATAPS workforce not clinicians
- Appropriate evaluation tools

## **Clinical**

- Credentialling
- Clinical supervision, professional development, training
- Contract out ATAPS clinical supervision to a single external body (eg university)
- Quality control mechanisms eg national standards for ATAPS workforce
- Accredited ATAPS workforce development
- Agreed minimum data sets
- Monitoring and evaluation guidelines

## **In summary**

- While the General Practice Networks welcome the Tier 3 program and could see the potential benefits, timing and lack of information about funding is a major factor. A phased approach to introduction of Tier 3 is essential.
- Prior to introducing Tier 3 the Commonwealth and State need to agree program boundaries and responsibilities. This is particularly important in South Australia as mental health shared care program is in place and relationships between state funded programs and ATAPS Tier 3 will need clarification.
- Primary health reform is the first priority at the moment. Adding new programs to General Practice Networks in a transition phase is complex.
- April 1 is not a viable timeframe for implementation. No division is willing to accept Tier 3 until the level of funding is known. Planning is not possible until funding levels are identified.

### **Key messages for DoHA consultation**

- A fully funded phased approach (establishment, program coordination, service delivery, monitoring and evaluation)
- Identification of level of funds available for each division
- The new program should add value to current programs and be integrated where feasible (eg the SA shared care program)
- Flexibility in model design and delivery is essential – one size cannot fit all General Practice Networks requirements.
- Commonwealth /state relationship needs to be clear in each state prior to local level introduction of ATAPS Tier 3, maximising connectedness, streamlined service provision and integration mechanisms and clarifying roles and responsibilities for State services and for PHC

**ATAPS – Flexible Care Packages (Tier 3)  
AGPN consultation – New South Wales  
2 February 2011**

**Introduction**

DoHA is conducting consultations in each capital city in all States and Territories. Representation from AGPN (the Network) is restricted to five participants in each location. AGPN is conducting supplementary consultations in the five larger jurisdictions in Victoria, New South Wales, Queensland, Western Australia and South Australia to inform a response to the DoHA ATAPS consultation paper. This paper was circulated on 18<sup>th</sup> January 2011, outlining the proposed introduction to ATAPS Flexible Care Packages (Tier 3) in April 2011.

The AGPN consultations allow for a wider representation from the Network. In some instances the AGPN consultation will be conducted before the DoHA consultation, providing an opportunity for those attending both to take information from the Network to the DoHA consultation. In other instances, the AGPN consultation will occur following the DoHA consultation and provide feedback to the state Network and further consideration of both state and a national Network response to DoHA.

**New South Wales consultation**

The third Network consultation workshop was held in Sydney on 2 February 2011, following the DoHA consultation in that state in the previous week. 33 people from the Network attended with representation from both urban and rural General Practice Networks. Six of the participants had attended the DoHA consultation and a written summary of the consultation was provided to all participants (see attached).

The consultation was facilitated by Jennie Parham, Principal Network Adviser-Mental Health, AGPN and Meriel Schultz, Consultant to AGPN.

***The objectives of the day*** were to:

- Obtain feedback from the DoHA consultation.
- Discuss themes and issues relevant to introduction of ATAPS Tier 3
- Identify the way that Tier 3 can best be introduced and delivered by NSW General Practice Networks of general practice
- Outline the infrastructure support needed to allow this to happen in an effective and efficient way.

**Key findings**

*Feedback from DoHA consultation*

See attached paper.

### *Who will benefit from Tier 3?*

- The definition of those who could be included should be based on the need for care rather than by diagnosis alone
- Benefits were seen for both service providers – eg GPs and practice nurses, for patients and their carers and families.

### *Inclusion criteria*

The group noted that national eligibility and suitability criteria are required and entry and exit strategies require definition together with guidelines for Tier 3 more broadly. Guidelines should focus more on exclusions, leaving inclusions to discretion of the provider.

Inclusion criteria will include:

- Those with moderate to severe mental disorders
- Those who need both clinical and non clinical services
- Those who have been serviced under Tier 1 and 2 but have complex needs and are more appropriate for Tier 3
- Those currently not being serviced
- Those in transition from state to primary health care
- Population wide + targeting for specific groups (eg CALD, Indigenous, older people)
- New clients with severe mental illness and reduced functionality
- Potential to include people with schizophrenia, bipolar, personality disorders, eating disorders, older people (>65). (Noting that care needs to be identified not just to 'pick up' where the state fails to do so).

### *Exclusion criteria*

- Those not eligible include those on forensic or CTOs (some debate as to whether this is a valid exclusion criteria).
- Those receiving services through the state system, those who have means to pay for private services, those who are in an acute phase of mental illness/psychotic episode (ie this is not a crisis intervention service).

### *How will Tier 3 add value to current service provision?*

- Increases capacity to respond to need.
- Enables holistic care to people in most need
- Provides a voluntary service expanding patient choice
- Provides access to a range of clinical and non-clinical services
- Potential to improve linkages with Area Health Services and NGOs
- Provides support for GPs
- Enhances team based care.

### *Models of Care*

Participants noted that it is essential there is ability to be flexible with the type of program design and model and use of funds for best results at the local level. One size will not fit all.

- General Practice Networks would prefer a single ATAPS model and funding that allows them (or the shared care program) to 'triage' clients to appropriate Tiers of service
- Model will be driven by level of funding available

- There is a need for top down Commonwealth/State consultation and agreement on boundaries and linkages between programs.
- There should be national monitoring and evaluation strategies
- Model should adopt a triage system with a centralised assessment point determined.
- Model should be led through local planning processes and decision making, have clear boundaries set, standards and assessment protocols in place
- Preference for a strengths based, recovery based model.
- Mapping of referral pathways important.
- Include funded case conferencing
- Determine how funds may enhance access to psychiatric services

### *Service Coordination and delivery*

Funding needs to cover:

- Establishment costs. Coordination and administration of Tier 3
- Program delivery
- Evaluation

This will include at a minimum:

- Mapping and scoping models of care, incorporating 'wrap around' multidisciplinary services to ensure holistic client care and exploration about ways to purchase non clinical services.
- Follow up services for clients referred from State Health to GPs
- Client centred, recovery and strengths based approach to care
- Identification of triage capabilities/workforce
- Issues such as employment, vocational training, exercise, advocacy need to be considered within the non-clinical component of the package
- Skilled care coordinators with a knowledge of assessment and knowledge of the NGO sector
- Linkages to wide range of other services (eg counselling, AOD, NGO, other health professional PHC services).
- Education, promotion and support for GPs
- Partnership building at the local level.

### **Quality Assurance – Progress/outcomes**

Issues raised included the need for exploration and clarification of:

- Expected psychosocial outcomes
- Workforce skills, recruitment models, remuneration.
- Consumer requirements
- Carers perspectives
- Medico legal issues – eg duty of care
- Risk management strategies
- Insurance issues
- Number of clients accepted
- Clinical Governance.

### **Implementation support**

The group suggested the following:

- Develop the program as part of Medicare Local remit
- Medicare locals have the capacity to coordinate infrastructure requirements
- Shift thinking from program management to capacity building approach

- Commonwealth to articulate funding levels for program and infrastructure prior to planning at local levels.
- Need to build the evidence base and articulate good practice
- Good practices to be disseminated to network
- Consistency and standardisation developed nationally and adapted locally
- Draft MOUs and templates designed nationally and adapted to suit at local level.
- Clinical Governance framework – may vary depending on model used – ie outsourced services, in house services, brokerage.
- Roles and responsibilities of Commonwealth/States and PHC need clear definition and delineation.
- Support for credentialing of workforce – clinical services and support for interns (maybe AGPN role?)
- Workforce issues need to be addressed at national level between professional organisations and workforce planners.
- Funding models will need to vary region to region based on need (ie socio economic status of population and location)
- Central clearing house for information – a state level function (difficult once SBOs go)
- Funded central coordinator position
- Program itself phased and funded in four stages under a tripartite agreement between Commonwealth, State and PHC – 1) planning and establishment, 2) partnership development, 3) implementation and 4) monitoring.

### **Key messages**

- A fully funded phased approach (establishment, program coordination, service delivery, monitoring and evaluation)
- Current timeframes not viable for most General Practice Networks
- Deliver ATAPS as a single program with increasingly targeted components at Level 1, 2 and 3.
- Identification of level of funds available for each division
- The new program should add value to current programs and be integrated where feasible (eg the Shared Care Program)
- Flexibility in model design and delivery is essential – one size cannot fit all General Practice Networks requirements.
- Commonwealth/state relationship needs to be clear in each state prior to local level introduction of ATAPS Tier 3, maximising connectedness, streamlined service provision and integration mechanisms and clarifying roles and responsibilities for State services and for PHC
- DoHA consultations have not brought together the right mix of people – gaps in information.

**ATAPS – Flexible Care Packages (Tier 3)**  
**AGPN consultation – Queensland**  
**3 February 2011**

**Introduction**

DoHA is conducting consultations in each capital city in all States and Territories. Representation from AGPN (the Network) is restricted to five participants in each location. AGPN is conducting supplementary consultations in the five larger jurisdictions in Victoria, New South Wales, Queensland, Western Australia and South Australia to inform a response to the DoHA ATAPS consultation paper. This paper was circulated on 18<sup>th</sup> January 2011, outlining the proposed introduction to ATAPS Flexible Care Packages (Tier 3) in April 2011.

The AGPN consultations allow for a wider representation from the Network. In some instances the AGPN consultation will be conducted before the DoHA consultation, providing an opportunity for those attending both to take information from the Network to the DoHA consultation. In other instances, the AGPN consultation will occur following the DoHA consultation and provide feedback to the state Network and further consideration of both state and a national Network response to DoHA.

**Queensland consultation**

The fourth Network consultation was held in Brisbane on 3 February 2011, prior to the DoHA consultation (which is to be rescheduled because of the cyclone problems). 22 people from the Network attended with representation from both urban and rural General Practice Networks, many of which have been flood affected. Those from the cyclone areas were unable to attend.

The consultation was facilitated by Jennie Parham, Principal Network Adviser-Mental Health, AGPN and Meriel Schultz, Consultant to AGPN.

**The objectives of the day** were to:

- Discuss themes and issues relevant to introduction of ATAPS Tier 3
- Identify the way that Tier 3 can best be introduced and delivered by Queensland General Practice Networks of general practice
- Outline the infrastructure support needed to allow this to happen in an effective and efficient way.
- Identify key messages for participants to take to the DoHA meeting

The group spent a short time discussing the impact of the floods and the cyclone.

## **Key findings**

Who will benefit from Tier 3?

- The definition of those who could be included should be based on the need and level of functioning rather than by diagnosis alone
- Benefits were seen for both service providers – eg GPs and practice nurses, and for patients and their carers and families.

### *Inclusion criteria*

The group agreed with other States that national eligibility and suitability criteria are required and entry and exit strategies require definition together with guidelines for Tier 3 more broadly.

Inclusion criteria suggested are:

- Those who do not meet criteria for state funded mental health unit, PHAMS etc or who are exiting those services
- Those in areas where there is no state funded service.
- Hard to reach groups (ie homeless, CALD, drug and alcohol affected)
- Could benefit school age children
- People requiring mobile services
- Those with complex needs and in difficult situations
- People with Personality disorder (mixed views in group)
- Those with a chronic mental illness
- Those who choose not to use state funded services
- Could respond to carers mental health needs

### *Exclusion criteria*

- Those managed by other services
- People who don't access a GP
- People in aged care facilities
- Homeless or hard to reach
- Isolated and remote communities
- Those that don't meet ATAPS criteria

*How will Tier 3 add value to current service provision?*

- Legitimises the services currently provided
- Provides new options
- Takes the strain of the public mental health system
- Adds additional community services
- Encourages links with GPs
- Provides a more holistic approach for clients
- Provides care coordination – takes burden off the GP
- Increases capacity to respond to need.
- Enhances current ATAPS services, and other programs like headspace, MHNIP.
- Can provide payment for care coordination
- Improves pathways to mainstream services
- Assist the intermediate recovery phase
- Brings together clinical and non clinical services

### *Models of Care*

Participants noted that it is essential that there is ability to be flexible with the type of program design and model and use of funds for best result at the local level. One size will not fit all. Design of models at local level preferred. Key elements of models include:

- Triage and care coordination role for General Practice Networks/Medicare Locals
- Model driven by level of funding available
- A need for top down Commonwealth/State consultation and agreement on boundaries and linkages between programs.
- Flexible referral pathways
- Risk management strategies
- Demand management strategies
- Shared electronic records across providers
- Referral could be by other agencies but important for patient to have or find a GP
- Referral protocols from sources other than GPs requires negotiation at Commonwealth/State level
- Protocols to deal with DNA clients
- Partnership with State Health
- Funding models to be determined by service model
- Clinical governance
- Brokerage options
- An adapted version of the mental health treatment plan (current one will not fit the program)
- Recognition of shortage of services in rural and remote areas

### *Service Coordination and delivery*

Funding needs to cover:

- Development/Establishment costs.
- Coordination and administration of Tier 3
- Program delivery
- Evaluation

### *Infrastructure support*

The group suggested the following:

- Develop the program as part of Medicare Local remit
- Medicare locals have the capacity to coordinate infrastructure requirements This will include at a minimum:

### *Clinical:*

- Clinical governance
- ? Division of capping between clinical (capped) and non clinical (uncapped)
- Access to workforce
- Supervision
- Long term funding to enable staff retention
- Set levels/rates of funding (using Mental health Nurse as a comparator)
- Guidelines and standards
- Training and staff development
- Funded case conferencing, discussion between clinicians/multidisciplinary meetings

## **Organisational**

- Federal/State partnership agreements
- MOUs with service providers
- Protocols for partnership work
- Workforce incentives (especially for rural and poorly resourced areas) Risk management strategies
- Clarity on cross boundary issues (especially as Medicare Locals develop)

## **Administrative**

- State level support
- No administrative cap
- Breakdown of regional services
- Funded development phase
- Clarification of future and/or changes to Tiers One and two
- Review of current ATAPS patient list – to identify those suitable for Tier Three
- Forms to assist referral pathways
- Procedural protocols
- Identified budget
- Transport models

## **Key messages**

- A fully funded phased approach (establishment, program coordination, service delivery, monitoring and evaluation)
- Current timeframes not viable for most General Practice Networks
- Deliver ATAPS as a single program with increasingly targeted components at Level 1 & 2 and 3
- Identification of level of funds available for each division
- The new program should add value to current programs and be integrated where feasible
- Flexibility in model design and delivery is essential – one size cannot fit all General Practice Networks requirements.
- Commonwealth/state relationship needs to be clear prior to local level introduction of ATAPS Tier 3, maximising connectedness, streamlined service provision and integration mechanisms and clarifying roles and responsibilities for Commonwealth, State and for PHC.

## Appendix 6: GP Structured Interviews performa

1. What is your experience with ATAPS and other Commonwealth funded programs?
2. What do you know about the Flexible Care Packages?
3. What patients of yours could benefit from flexible care packages?
4. Do you think GP's should be the primary referring agent? If not, who else do you think could refer patients for flexible care packages?
5. What support would you want from your Division or Medicare Local?
6. How do you see the flexible care package integrating with the other Commonwealth funded programs. (eg. Mental Health Nurse Incentive Program) and State services
7. Who do you think is best placed to provide the non-clinical services?
8. How would it work in your area?