Private Mental Health
Consumer Carer Network (Australia)
engage, empower, enable choice in private mental health

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RESPONSE TO DISCUSSION PAPER

ACCESS TO ALLIED PSYCHOLOGICAL SERVICES REVIEW

The *Private Mental Health Consumer Carer Network (Australia)* (hereafter Network) represents Australians who have private health insurance and/or who receive their treatment and care, and those that care for them, from private sector settings for their *mental illnesses or disorders.* As our title implies, the Network is the authoritative voice for consumers and carers of private mental health settings.

Mental health brings with it many challenges. As a consumer and carer organisation we are in a unique position to provide direct lived experiences and would welcome the opportunity to engage in further consultations, either independently or with other relevant organisations.

The Network is committed to working with Government and welcomes the opportunity to comment hereunder.

1. How do we better target unmet need through ATAPS?

a) Are there geographic areas or population groups whom ATAPS should be targeting?

The Network understands that to date, the 2006 Better Access '*Medicare*' initiative has catered primarily to those living in the major cities. The uptake of the medicare item numbers in the rural and remote areas has been limited because of a number of issues.

Rural and Remote

The Network strongly supports ATAPS as a means of developing and providing services to rural and remote communities in particular, as it provides opportunities to reimburse health professionals via the distribution of funds from the area Division of General Practice (Division). This allows greater opportunities for innovation which is confined under strict criteria of the Better Access *'Medicare'* initiative.

Stigma plays a huge part in rural and regional areas. Both men and women in small communities seek assistance from health professionals outside of their local community, especially for mental health issues, for fear of the reaction of others. Recognition by young males to a potential health issue such as depression is concerning. It is well known that the suicide rate in young males especially in rural communities is higher than in the cities. Young people turn often to drugs and alcohol in order to self medicate. The Network is also concerned that many single vehicle deaths in the road toll may not always be accidents, rather acts of suicide.

b) How can ATAPS facilitate outreach to individuals who are unlikely to present to GPs?

This always presents problems. How can people who are homeless, indigenous or unconnected become connected?

It is the Network's belief that Emergency Departments, shelters, hostels, and some specific NGOs play an important role in this particular area. Other than Emergency Departments, clients of these entities with no formal connection to GPs, are their core business.

The Network would strongly support **mobile outreach services** under ATAPS be developed to identify and support the mental health needs of these people.

c) Should other medical practitioners, such as paediatricians, psychiatrists and medical officers in Non-Government Organisations, be allowed to refer to ATAPS as long as there is a clinical diagnosis of a common mental disorder?

The Network strongly supports the opportunities for referral by medical officers in NGOs to be allowed to refer to ATAPS. The question for us here is what is the definition of, and criteria for *medical officers*?

Under the current Better Access '*Medicare*' initiative, paediatricians and psychiatrists can refer to allied health professionals. The Network notes the duplication of pathways for referrals, and the funding of those services, ie Medicare or Divisions.

The Network does support the referral by paediatricians and psychiatrists to ATAPS as this provides access via direct referrals to services of nurse practitioners and indigenous mental health workers, which cannot be done, or is complicated currently under the Better Access *'Medicare'* initiative in terms of medicare item numbers.

The Network believes this is an essential link which must be retained, unless Medicare item numbers are raised for these two health professions. In noting this, we are aware of the Mental Nurse Incentive Program. We are also aware of the constraints around the issue of organisation provider numbers rather than access to a mental health nurse practitioner provider number.

2. Ensuring a sustainable well qualified workforce for ATAPS?

a) What are the barriers to attracting workforce for ATAPS?

The Network is not aware of the remuneration amounts for allied health professionals who treat consumers under ATAPS, but if the fee for services is not consistent with the Medicare rebate, this would present difficulties.

The Network also considers that the Divisions play a key role in the sustainability of the workforce, in both attracting and retaining professionals.

b) Are there effective workforce recruitment and retention models that work in the current ATAPS projects, especially in Indigenous and rural and remote communities?

The Network would like to raise the issue of financial incentives. Currently we understand that financial incentives are paid to **teachers** for instance, to travel and work in rural and remote communities. These comprise an initial upfront payment, followed by a secondary payment upon completion of a 3 year period in these areas. Whether we like it or not, financial incentives are mostly the prompts to sustain workforces of whatever capacity, in these areas.

c) Further, how may we ensure continuity of service and retention within the current ATAPS workforce, especially in Indigenous and remote communities?

See above

d) What are the challenges to ATAPS due to workforce issues?

The ability to provide quality mental health care is at the forefront of concerns for those with mental health issues. The limited services particularly in rural, remote and indigenous communities are already a critical issue, and we cannot see the challenges to be any different.

3. Selecting a fundholder organisation to provide ATAPS

a) Should Divisions of General Practice continue to be sole fundholders for ATAPS projects?

The Divisions already have established professional links with the GPs in their defined area, and it makes good sense to continue this link.

b) Are there other entities that may be better placed to meet service gaps in particular regions or for particular target groups, such as Indigenous communities?

The Network is unable to address this point because of lack of knowledge in this area.
However, we do wonder if a suitable alternative fund holder for the Indigenous communities could be the management corporation overseeing the governance of the community.

c) Should the funded organisation be required to apply for funding through demonstrating links to target populations, capacity to work with GPs and a history of operational efficiency?

The Network considers these criteria to be crucial.

4. How can ATAPS become more efficient and effective?

a) Should funding formulas for ATAPS move to a mixture of performance based funding and activity based funding?

The Network is always conscious of funding formulas as we strive to ensure that the Australian private sector does not duplicate the USA health system of managed care. This essentially represents a financial decision to provide a particular service over the clinical imperative.

As long as this does not occur, (ie deference to a financial rather than a clinical decision) the Network considers that performance and activity based funding formulas would be consistent.

b) How can we ensure a high quality service is delivered through ATAPS?

We consider that to ensure a high quality service, the elements of sufficient, well qualified, good mix of health professions is essential. To retain these professionals, adequate remuneration and incentive based models of remuneration needs to be considered.

c) Would efficiencies be created through the streamlining and rationalisation of potentially duplicative programs such as the Mental Health Services in Rural and Remote Areas measure, the Mental Health Support for Drought Affected Communities initiative and ATAPS programs?

Duplication is always an issue with ATAPS and other existing initiatives, however we believe the opportunities for greater flexibility, innovative service delivery is the key to

ATAPS. We also believe that ATAPS is most useful in the rural and remote areas which data suggests the Better Access *'Medicare'* initiative is not reaching.

It would make sense to streamline and rationalise programs in these specific areas.

5. Should ATAPS continue to be a universal program?

a) Where should ATAPS be provided?

Throughout this response, the Network has predominantly focussed on the rural, remote and indigenous communities. We believe this is the major strength of ATAPS. We do note that the uptake is especially relevant to low socio-economic communities and this also need to be retained.

b) If a more selective approach to funding ATAPS is pursued, what criteria should be applied to develop an equitable funding formula and to select areas or organisations for funding?

The discussion paper outlines clear ways forward. If ATAPS were to be focussed specifically to the rural, remote, indigenous and particularly low socio-economic communities, it would make good sense to appropriate funds to these areas that ATAPS specifically addresses. Given the huge uptake of the Better Access *'Medicare'* initiative in the cities, it would make sense to develop a more equitable funding formula.

6. Should ATAPS be a platform for the provision of telephone and web based psychological services to help promote access in rural areas?

a) Is there a role under a future ATAPS for 'virtual' services provided by professionals through telephone or web to supplement face to face services under ATAPS in rural areas?

The Network considers that urgent consideration needs to be given to allow these type of services to be accessed.

We consider more work needs to be undertaken as a matter of urgency to develop new, and refine existing web-based and IT technological alternatives. Additional to these alternatives, the incorporation of tele-medicine or tele-psychiatry services in designated GP practices with accompanying payment incentives should be considered as a matter of urgency.

The Network also considers greater use could and should be made of an individual's computer – ie face to face connections with a health professional via the web-cam technology.

b) What would be the risks and benefits of such models?

Perhaps the risks would be via telephone based services where face to face contact is not possible. The health professional would therefore be unable to see if someone was disturbed.

In terms of benefits, as we have mentioned previously, stigma is a real issue and the great use of innovation via IT models, virtual clinics and e-therapies under ATAPS is strongly supported by the Network.

c) What other innovative service models could be explored through ATAPS?

Greater role of GPs in terms of recalls for health checks.

Greater role and education of GPs in being aware of depression as an association to cancer diagnoses.

d) What other evidence based psychological therapies could be explored through ATAPS?

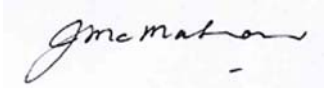
The Network considers that the issue of child trauma and neglect is a particular focus for the health care of indigenous communities. Psychological therapies need to be explored as a matter of urgency around the best evidence based models of treatment and care for children including early intervention and early detection.

Conclusion

The Network has been pleased to provide commentary to this Discussion Paper.
To summarise:

i) The Network strongly supports the continuance of ATAPS under the issues raised herein.
ii) We especially support the ongoing appropriation of ATAPS to rural, remote, indigenous and low socio-economic communities where the uptake has been particularly significant.
iii) Medicare data suggests these areas have the lowest uptake under the Better Access *'Medicare'* initiative.
iv) We believe ATAPS is filling a significant gap in service delivery to the areas specified in (ii) above and providing services to people who would not otherwise receive mental health care.
v) We believe that under the current funding arrangements through the Divisions of General Practice, this offers the ability to provide innovative services without the constraints of the Better Access *'Medicare'* initiative criteria.
vi) We believe ATAPS offers greater service delivery options which can be delivered by mental health nurses and indigenous workers.
vii) We consider ATAPS offers the opportunities for innovation in service delivery which encompasses IT, web-cam, telemedicine and other e-health options, which the Better Access *'Medicare'* initiative does not.
viii) We consider the use of mobile outreach services to deliver mental health care to the homeless is something which could be considered under ATAPS.
ix) We believe ATAPS offer greater opportunities for the delivery of group therapy than the Better Access *'Medicare'* initiative.
x) As GPs are the first port of call for health issues, it seems appropriate that where there is a significant presence, they continue to be the fund holders, however in appropriate areas such as remote and indigenous communities, it makes good sense to appoint other more appropriate entities.
xi) We believe additional financial incentives must be considered to attract and retain a highly qualified workforce in rural, remote and indigenous communities.

Whilst a number of the more complex aspects of the Discussion Paper are outside of our area of expertise, nonetheless we have responded from the 'lived experience' consumer and carer perspective, and would welcome the opportunity of further discussions with the Department.



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Independent Chair
25 February, 2009