Outcomes and proposed next steps:

Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program

February 2010
Foreword

The Australian Government has made and continues to make a significant commitment to the provision of a comprehensive primary mental health care system to support the needs of people living with mental illness in the community.

The Access to Allied Psychological Services (ATAPS) initiative forms an important part of this system, as it provides access for consumers to evidence based psychological services delivered by allied health professionals. ATAPS complements Medicare based mental health services provided under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medical Benefits Schedule (Better Access) program.

In April 2008, I announced that ATAPS would be refocused through a review process to better complement Better Access and to target service gaps for people who cannot easily access Medicare based programs. The review process, which included significant consultation with key stakeholders and input from the ATAPS Review Expert Advisory Committee, is now complete, and I would like to take this opportunity to thank all those who participated in the review process.

The review reflects the Government’s commitment to more efficiently provide primary health care services to consumers, to address service gaps, particularly for Aboriginal and Torres Strait Island people, individuals in rural and remote areas and those experiencing or at risk of homelessness, and will allow ATAPS to be strengthened to produce better mental health outcomes for disadvantaged Australians.

I am pleased that submissions to the review showed strong support for the program, and feel confident that the outcomes of the review will further strengthen a valuable and highly respected service.

Hon Nicola Roxon MP

Minister for Health and Ageing
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1. EXECUTIVE SUMMARY

Established in 2003, the Access to Allied Psychological Services (ATAPS) initiative is a Commonwealth mental health program that funds the provision of short term psychology services for people with mental disorders through fundholding arrangements, administered by Divisions of General Practice. Over 153,000 Australians with a mental health disorder have received services through the ATAPS initiative.

In April 2008, the Minister for Health and Ageing, the Hon Nicola Roxon MP, announced that there would be a review of ATAPS to ensure that the initiative is efficient, sustainable and quality assured into the future and to look at ways through ATAPS to improve access to mental health interventions for hard to reach groups, improve services for people experiencing mental illness in the community and better complement Medicare funded services.

This report has been prepared by the Australian Government Department of Health and Ageing. An ATAPS Review Expert Advisory Committee was established to oversee the review. It summarises the success of the ATAPS program to date, the outcomes of the review process and identifies initial improvements to ATAPS which have already commenced as a result of early review findings. It also proposes additional key directions to refine and further improve the initiative.

Policy Context
This report has been prepared following the publication of the National Health and Hospital Reform Commission Report A Healthier Future for All Australians, and the release of the Australian Government’s report on Primary Health Care Building a 21st Century Primary Health Care System. The content and recommendations of these reports have formed the basis of an extensive national consultation, and are currently being considered by the Australian Government. Any response to this broader health system reform agenda will necessarily inform the broad policy context under which the ATAPS initiative will continue to operate.

Review Process
The process for the review was:

- Establishment of an external ATAPS Review Expert Advisory Committee to provide expert advice to the review, including development of a discussion paper for consultation;
- A formal consultation process including targeted stakeholder consultations and a written submission process in response to the discussion paper developed through the Committee. Over 100 stakeholder submissions were received and analysed;
- Analysis of data collected through the ongoing monitoring and reporting on the ATAPS initiative undertaken by the Centre for Health Policy, Programs and Economics, University of Melbourne. The University of Melbourne has provided regular reports on the ATAPS initiative since its commencement in 2003 including valuable data on referrals to and usage of services;
- Consideration of contemporary policy and plans, including the new National Mental Health Policy and the Fourth National Mental Health Plan in the context of the ATAPS initiative; and
- Assessment of performance in day to day management of the initiative, informed by both the Department’s experience in administering the program and anecdotal feedback from stakeholders.

The success of ATAPS to date
ATAPS has provided over 600,000 mental health sessions of care to people with a diagnosed mental health disorder, predominantly high prevalence disorders such as depression and anxiety type disorders, since its inception in 2003. It is an important and necessary program to complement the Better Access Initiative. ATAPS is very successful, achieving improved consumer outcomes in more than 86% of cases.

ATAPS is also providing a high number of services to low income earners, who represent 68% of the total number of people receiving ATAPS services. Further, approximately 45% of services are provided in rural Australia. The potential for ATAPS to reach marginal groups is high given these findings.
**Proposed Key Directions**
The consultation and associated research undertaken through the review process has indicated that there are four key areas that an enhanced ATAPS initiative could 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.

**Better Addressing Service Gaps**
- Service provision should be supplemented for consumers in areas where access to private Medicare services is limited due to geography or locality, such as in rural, remote and some outer metropolitan areas.
- Appropriate service models should be provided for hard to reach groups in all areas of Australia who are currently not accessing, or cannot afford, psychological services (including Aboriginal and Torres Strait Islander people, children and young people, services for parents when children are identified as having a mental health problem, people at high risk of suicide and people experiencing or at risk of homelessness) and for whom more flexible models of care are needed.

**Increasing Efficiency**
- A shift towards new funding arrangements should be phased in gradually from 1 July 2010. Funding arrangements to be introduced should recognise through-put, and promote efficiency but also encourage and reward innovative approaches to outreach and targeting of hard to reach individuals and population groups.

The proposed funding arrangements could involve moving from the existing ATAPS funding model to a two tiered funding model, which gradually introduces a level of funding that recognises through-put and targets funding to where it is most needed.

- Tier 1 base funding would provide for the supplementation of service delivery provided through Medicare and would enable all Divisions to continue to target psychological services within their population.

- In the medium to long term, where Divisions are not able to demonstrate efficient service delivery or where Divisions indicate that they do not want to administer ATAPS, an alternative NGO or another Division may be contracted to provide ATAPS in the region.

**Encouraging Innovation**
- Tier 2 special purpose funding should supplement Tier 1 funding and provide additional funding for innovative service delivery to particular groups with needs which cannot be met through traditional service delivery approaches.

Tier 2 funding would be a small pool of funding available to Divisions with a track record in providing services for these groups, and on the basis of their demonstration of the needs and size of the population of individuals to be supported. Allocation of the funds in future would be subject to a new planning process to be developed in consultation with stakeholders. Tier 2 funding will simplify the current complex arrangements for special purpose funding which have variously covered suicide prevention, perinatal depression, bushfire support and telephone based cognitive behaviour therapy, but will extend to enable the provision of services to other groups. This could eventually include Aboriginal and Torres Strait Islander communities or mobile outreach services for young people or people at risk of homelessness.

- Approaches that support and encourage innovative and effective ways of accessing hard to reach groups should be further supported and rewarded through Tier 2 funding arrangements, including further consideration of flexible referral models.
Improving Quality

- A requirement for a level of continuing professional development for allied health professionals engaged to deliver ATAPS should be introduced.

- The supporting infrastructure should be refreshed and refocussed to promote benchmarking on efficiency and targeting issues, quality and information exchange on best practice, as well as improved clinical support.

Next Steps

The next step in the Review process, the Australian Government’s consideration of these future directions, should involve preparation of an Implementation Plan by the Department in consultation with stakeholders including Divisions of General Practice and the Australian Psychological Society to support a realistic and practical approach to gradually implementing the directions proposed in this report. A stakeholder workshop would be important for early 2010 to progress discussions on an implementation plan and to consult on other key elements of the proposed new arrangements.

2. Background to the Access to Allied Psychological Services (ATAPS) initiative

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<th>Key Facts and Figures</th>
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<tr>
<td>ATAPS funds the provision of short term psychology services for people with mental disorders through fundholding arrangements.</td>
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<td>Approximately $27 million per year is allocated by the Australian Government to the ATAPS program with a total of $80.7 million allocated since 2003.</td>
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<td>For the period 1 July 2003 to 31 March 2009 ATAPS has provided over 600,000 mental health sessions of care to people with a diagnosed mental health disorder.</td>
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<td>ATAPS projects are achieving positive outcomes of medium to large improvements in approximately 86% of cases.</td>
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<td>ATAPS provides services primarily to people with high prevalence disorders, including depression (76%) and anxiety (59%), indicating high rates of more than one disorder.</td>
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<td>ATAPS is providing a high number of services to low income earners, representing 68% of the total number of people receiving ATAPS services.</td>
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ATAPS is an Australian Government mental health program which funds the provision of short term psychology services for people with mental disorders through fundholding arrangements administered by Divisions of General Practice.

ATAPS is a component of the Better Outcomes in Mental Health Care (BOiMHC) Program which was introduced commencing in July 2001 in an effort to:
• produce better outcomes for consumers with common mental health disorders through offering evidence based short-term psychological interventions within a primary care setting;
• offer referral pathways for General Practitioners (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.

In addition to ATAPS, BOIMHC originally comprised components to support education and training for GPs, support from psychiatrists for GPs and GP remuneration. These components were superseded by the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative (Better Access) initiative, which was introduced in November 2006. Accordingly, almost all BOIMHC spending (over 95%) is now allocated to the Access to Allied Psychological Services (ATAPS) initiative.

ATAPS enables GPs to refer consumers with high prevalence mental health disorders to allied health professionals for six sessions of evidence based mental health care. An option for a further six sessions exists (and up to an additional six sessions in exceptional circumstances), pending a mental health review by the referring GP.

Funding is provided by the Australian Government to all Divisions of General Practice to broker psychological services for consumers. Using their annual budget, Divisions are able to adopt a model that best suits their local arrangements.

3. RATIONALE FOR THE REVIEW

ATAPS has been in operation since 2003. It was introduced gradually, following the implementation of new remuneration and training programs for GPs to promote better support to patients with mental health disorders.

The formula used to distribute funding for ATAPS in 2003 was based on population figures derived from the 1996 Census with a small adjustment for rurality. However, there has been a drift away from this formula over the years due to variations in demand, changes in the boundaries of divisions and changing need of some communities. This has been compounded by the changes to populations in divisions since the 1996 Census, the growth of urban areas to absorb areas once classified as rural and refinements to classification formulae. Inequity and imbalances have developed where some communities with high needs are not receiving an equitable share of ATAPS resources.

With the introduction and establishment of new primary mental health care services and initial refinements of ATAPS already underway, it was timely to consider the role of ATAPS in the primary mental health sector, including how ATAPS could further develop to capitalise on the service provision of the new programs and better target harder to reach population groups.

Mental Health Reform
Since the commencement of ATAPS there has been significant new investment and reform in the area of mental health from both the Australian Government and State and Territory Governments.

The Council of Australian Governments endorsed a new National Action Plan on Mental Health (the Plan) in 2006. The Australian Government allocated $1.9 billion for specific initiatives to progress the Plan. The Plan emphasised a whole of government approach and the importance of primary mental health care.

The Commonwealth contribution to the plan included the Mental Health Services in Rural and Remote Areas measure ($51.7 million over five years), which was designed to complement Better Access by increasing access to mental health services in rural and remote areas. An additional $20.6 million was
allocated under the 2007/08 Budget specifically for drought-affected areas, giving a total of $72.3 million for the Program.

A new focus on youth mental health was introduced through the 2005 Promoting Better Mental Health - Youth Mental Health Initiative, resulting in the establishment of headspace. This provides young people with shopfront access to a range of youth oriented mental health and other support services including primary mental health care.

**Better Access initiative**

One of the most significant initiatives in the COAG package, and with most relevance to ATAPS, was the commencement in November 2006 of the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* initiative (Better Access).

Under Better Access, psychiatrists, GPs and psychologists (and appropriately trained social workers and occupational therapists) are able to provide mental health services on a fee-for-service basis subsidised through Medicare. These services parallel the original program design of ATAPS, offering access to short term psychological therapies but provided through private providers, rather than through fundholding arrangements.

Better Access has significantly increased access to psychological services in Australia. Medicare data indicate that since the introduction of the Better Access initiative in November 2006, over 11.2 million Medicare subsidised mental health services have been provided to around 2 million people (as at 31 December 2009).

This includes over 1.7 million rebates for development of a GP Mental Health Treatment Plan, and over 6.7 million subsidised services provided by clinical psychologists, registered psychologists and appropriately trained social workers and occupational therapists. As at 31 December 2009, around 16,450 allied mental health professionals were registered with Medicare Australia to provide Better Access services. Around 24,000 GPs and 1,700 psychiatrists were using the Medicare items.

**Fourth National Mental Health Plan**

A revision of the National Mental Health Policy, endorsed by the Australian Health Ministers Conference (AMHC) in 2008, further solidified the Commonwealth and state and territories’ commitment to a whole of government approach and a central role of primary mental health care.


The Fourth Plan is consistent with the draft Primary Health Care Strategy and the NHHRC Report in its support for better targeting of services through innovative service delivery models – particularly to provide services to consumers unable to access Medicare services.

The Fourth Plan specifically cites ATAPS as a key service delivery model to ensure that primary mental health care is more accessible. The Plan states that service models such as ATAPS may offer needed flexibility at the local level, enabling non-government primary mental health care service providers to manage local workforce recruitment and retention issues, and provide targeted services that address service gaps.
Broader health policy context
During the period of the ATAPS review, a number of key national reports on the possible future of the health system have been released:

- The National Health and Hospital Reform Commission (NHHRC) Report *A Healthier Future for All Australians* was released in June 2009 and makes 123 recommendations for health reform in Australia;
- A Draft of Australian’s First National Primary Health Care Strategy – *Building a 21st Century Primary Care System* (Primary Health Care Strategy); and

The Australian Government is undertaking extensive consultations before formally responding to these reports. Some of the key findings and recommendations, if progressed, would have particular relevance to the role and future of ATAPS. Key common themes within these reports include:

- The Australian Government has an important role in primary health care including primary mental health care;
- There is a continuing need to ensure Medicare based universal services are provided in addition to blended funding models which utilise fundholding arrangements to target services to particular local and population needs, including episodic care;
- Service gaps need to be better identified and targeted through planned and coordinated approaches;
- Key groups within the community such as children and youth and Aboriginal and Torres Strait Islander people, remain a significant priority and require care sensitive to their needs and which they are more likely to access;
- Collaborative partnerships engaging non-government organisations can play an important local and regional role in providing integrated treatment; and
- There is potential to better utilise new technology including web based modes of care in the provision of health services.

The draft Primary Health Care Strategy acknowledges the value of a balance between universal Medicare based services and targeted fundholding arrangements in targeting particular groups and needs. The Primary Health Care Strategy has also suggested the possible shift to regional primary health care organisations to receive the ‘capped’ funding to proactively target and address primary care requirements for those people not accessing Medicare funded health services.

The NHHRC Report details the importance of youth-friendly community based mental health services provided through a range of modalities – face-to-face, telephone and internet based. In some Divisions, ATAPS projects already focus on the provision services to young people and a number of Divisions have embraced non-face-to-face modalities of service delivery.

4. **ATAPS DATA & ANALYSIS**

Ongoing collection of data and associated reporting on the ATAPS initiative is undertaken by the Centre for Health Policy, Programs and Economics, University of Melbourne. The University of Melbourne has developed regular reports on the ATAPS initiative using data collected by Divisions since the commencement of the initiative in 2003, including data on referrals to and usage of services.
The University of Melbourne collects data from Divisions of General Practice using a purpose designed minimum data set which collects de-identified consumer and session-based data on a quarterly basis. The University uses this data to develop evaluation reports on the ATAPS initiative for the Department of Health and Ageing. These are publicly available on the BOiMHC website – http://www.boimhc.org

In June 2009, the Fourteenth Interim Evaluation Report was released, Ongoing gains in improving access to mental health care in Australia. Key findings of this report included:

- Between 1 July 2003 and 31 March 2009 a total of 10,296 GPs referred consumers to allied health professionals through ATAPS. The Report found that despite a decrease of GPs participating in the 2006-07 period corresponding with the introduction of the Better Access initiative, there has been a subsequent increase so that since the January-March 2008 quarter the number of GPs has increased steadily to an all time peak in April-June 2008. A similar increase has also been seen with allied health professionals, with 1218 professionals providing services by December 2008.

- The profile of referred consumers has remained relatively constant throughout the initiative, with approximately 75% of consumers being female, and over 60% of consumers accessing services are on low incomes. On average, about half have no previous history of mental health care; and

- Using pre and post treatment scores against defined outcome measures, ATAPS has shown that it is achieving positive results of a medium to large impact for 86% of consumers.

**Consumer demographics**

Between July 2003 and March 2009 over 153,000 consumers were referred by GPs to ATAPS services. Of these referrals, over 116,000 consumers accessed services.

Most people accessing ATAPS are experiencing high prevalence mental health disorders such as anxiety and depression. Approximately 71.5% of consumers are female and mean age is 39 years.

![Diagram 1 - ATAPS consumers by gender](image)

About 2% of consumers are of Aboriginal or Torres Strait Islander descent. Around two thirds of consumers are low income earners (as judged by the referring GP) and about half have no previous history of mental health care.
Between 2% and 6% of ATAPS referrals include a diagnosis of severe mental illness. This indicates that whilst ATAPS does not focus upon this population that consumers with severe mental illness are not excluded from receiving services. However, ATAPS may not be the most appropriate service for consumers experiencing severe mental illness and other more intensive service delivery alternatives are usually considered. These include appropriate Australian Government programs (for example the Mental Health Nurse Incentive Program) and State and Territory Government specialist mental health services.

Diagram 2 - Prevalence of mental health disorders among consumers receiving ATAPS services

Episodes and duration of care
Between 1 July 2003 and 31 March 2009, there have been over 602,400 mental health sessions of care provided to consumers. The average number of allied mental health services provided to each consumer under ATAPS is almost exactly the same as the average under Better Access. This is approximately 5 services per consumer.

Over 80% of mental health care sessions provided by allied health professionals are 46-60 minutes in length reflecting the complexity of care provided. Over 97% of sessions are provided to individuals rather than groups and the majority focus upon cognitive behaviour therapy.

ATAPS is a small program in comparison to Better Access both in terms of its funding and in terms of the services provided. Over 600,000 sessions of care have been provided by ATAPS services over a six year period (between July 2003 and March 2009), compared to over 10,000,000 provided by Better Access over a three year period (between November 2006 when Better Access commenced, and November 2009).

As indicated in Diagram 3, the number of ATAPS sessions has increased over time, recognising an initial decrease in the number of sessions coinciding with the introduction of the Better Access initiative in November 2006. It is evident from data provided by the University of Melbourne that the introduction of Better Access decreased the uptake of ATAPS more in those areas which were well serviced by private providers, particularly in urban areas.
Diagram 3: Referrals for sessions of care, by quarter

Cost of service
The average co-payment amount for each session of care for consumers is small. Approximately 75% of ATAPS sessions delivered did not include a co-payment. Co-payments are more common in urban areas than in rural or remote areas, with the average incurred co-payment ranging from $5 to $20. For the 2008/09 period, the cost of delivery of service to each person, calculated for individual Divisions of General Practice, for ATAPS ranged from $57 to as high as $631 per session. Care needs to be taken in interpreting the cost of ATAPS, as these figures do not always fairly encapsulate the cost of providing an episode of care in a way which produces effective health outcomes. The variation can also be attributed to the often significantly higher cost of providing services to remote parts of Australia as well as to the additional costs incurred targeting groups of people who are difficult to reach and may not otherwise access mental health services.

Rural/Urban
Every region in Australia is covered by a Division of General Practice or partnership of Divisions delivering ATAPS services. There are a high number of consumers receiving ATAPS services in rural Australia, with the number of sessions delivered in rural areas reaching a new peak in July-September 2008 of 17,373 sessions. On average, ATAPS is providing approximately 45% of its services to people in rural and remote Australia. Diagram 4 shows the number of urban and rural sessions over time since the commencement of ATAPS in July 2003.

Better Access achieves a rural and remote service rate comparable to other MBS items of approximately 25%, possibly reflecting that the uptake of the Better Access initiative has been considerably less in rural areas than in urban. This suggests that ATAPS and Better Access are operating in a complementary fashion to meet the mental health service needs of Australians.
Diagram 4: Urban and Rural Sessions Over Time (January 2009)

**ATAPS Workforce**
Under the ATAPS Guidelines, allied health professionals have been defined to include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers.

ATAPS has strengthened in terms of allied health professionals’ participation in both urban and rural areas. Further, data provided by the University of Melbourne suggests that, whilst some rural and remote areas have limited access to Better Access services, ATAPS remains available and well utilised. In rural and remote areas ATAPS provides a key mental health service that may not otherwise be available.

The majority (over 90%) of clinicians under ATAPS are psychologists and clinical psychologists.

**Consumer Outcomes**
The key outcome for consumers since the commencement of ATAPS is improved access to high quality, evidence-based primary mental health care. This primary mental health care has been provided at either no or a very low cost to the consumer.

ATAPS projects are achieving positive outcomes of medium to large improvements in approximately 86% of cases. Overall there is good evidence that consumers are achieving positive results with regards to alleviating symptoms, improving levels of functioning and impacting on general well being.

**Summary**
Overall, the data collected by the University of Melbourne demonstrate that ATAPS:

- has become a crucial part of the mental health care service system in Australia;
- is reaching more people who may previously have had difficulty accessing services, particularly those in rural areas, low income earners and Aboriginal and Torres Strait Islander peoples;
- is providing high quality care resulting in consistently strong positive consumer outcomes; and
- is complementing universal Medicare services provided under the Better Access program.

**5. CONSULTATION FINDINGS**

At an early stage of the review process, an Expert Advisory Committee was established to guide the review (a membership list is provided at Appendix A). One of its first tasks was to assist the Australian Government Department of Health and Ageing to develop a discussion paper on the ATAPS review (provided at Appendix B), which was distributed to a large number of key stakeholders in February 2009. The discussion paper provided background information about ATAPS and questions to stimulate input to
the review process and was prepared following initial consultation by the Department with the Expert Advisory Committee.

The Department received over 100 responses to the paper. Responses were provided by a range of organisations including: Divisions of General Practice, the Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian General Practice Network (AGPN), the National Advisory Council on Mental Health, and the Association of Relatives and Friends of the Mentally Ill.

Responses were generally very positive about ATAPS, viewing it as an important primary mental health initiative and a complementary service to the Better Access initiative. The value of ATAPS as a flexible service delivery model with the capacity to address unmet need both geographically and for sub-populations was highlighted throughout the responses.

The responses focussed on the following key areas of the discussion paper and are summarised below.

**What services should be provided through ATAPS, and to whom?**

There was a recurring view that ATAPS should continue to focus on providing short term, evidence based psychological services targeted to the needs of people with mental illness. This view was supported by concern that there remains a high level of unmet need for services among people with mental illness, and funding under programs such as ATAPS needs to continue to focus on psychological therapy to address this need. It was noted that other programs and activities are available to support people with temporary needs for counselling and/or for mental health promotion and prevention.

Responses strongly supported that a refinement of ATAPS should enable better targeting of ATAPS to disadvantaged groups in the community not currently accessing services to address unmet needs. The key groups commonly identified were people in rural and remote areas, Aboriginal and Torres Strait Islander peoples, children and youth, services for parents when children are identified as having a mental health problem and people who are experiencing or at risk of disadvantage such as homelessness. Responses recognised the importance but inherent difficulty in providing services to people with mental illness who were not currently accessing services. Suggestions were made around facilitating outreach to these consumers through stronger linkages with other key organisations including Royal Flying Doctor Service (RFDS) and Aboriginal Medical Services (AMS). The majority of Divisions supported allowing referrals from health professionals other than GPs in certain circumstances (for example, very remote areas without GPs, homeless people, or some Aboriginal and Torres Strait Islander communities).

**Where should ATAPS services be provided?**

All responses agreed with the continued broad geographic availability of ATAPS, while supporting increased targeting to specified populations. Specifically there was not a view that ATAPS should be restricted to rural areas, although there was recognition that the need for ATAPS was greater in some areas than others.

**By whom should services be provided?**

In general there was a view that the ATAPS workforce as set out in the current ATAPS guidelines (psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers) is appropriate to continue delivery of evidence based psychological therapies under ATAPS.

Respondents noted there were a number of challenges to recruiting and retaining the ATAPS workforce including competing with other Government programs and providers preferring to work under the Medicare system through Better Access. In rural and remote areas there is often difficulty attracting providers due to social and professional isolation. It was noted that there is a tension between workforce
recruitment and retention and any move to raise the bar on quality assurance or competencies of providers.

All Divisions which responded indicated that Divisions should continue as fundholders for ATAPS. Other responses were supportive of Divisions as fundholders in most circumstances but suggested provision be made for other appropriate non-government organisations to be fundholders under certain circumstances. For example, where there are cultural sensitivities, appropriate fundholders could be organisations such as Aboriginal Community Controlled Health Services or non-government organisations dealing with people from culturally and linguistically diverse backgrounds. There was consensus that the appointment of fundholders should be based on capability and placement in the community, including knowledge of and links with mental health services, and demonstrated links with target populations.

How should ATAPS services be provided – how can better efficiency and effectiveness be achieved?
There was a general recognition that the current funding model did not offer incentives for efficiency. There was also recognition that the flexibility of funding enabled provision of care to hard to reach individuals, and that it was important that a shift to more efficient models of funding did not jeopardise this flexibility. The majority of responses recommended consideration should be given to a funding model which recognised both the volume of services delivered in addition to rewarding efficient as well as innovative service delivery.

Quality assurance and innovation for ATAPS
A small number of respondents raised concern about increasing safeguards and supports for assuring the quality of the services provided through ATAPS. Suggestions included:

- refocussing national infrastructure to better support Divisions with recruitment and retention of ATAPS providers, and to provide clinical support to service providers;
- introducing benchmarking for divisions; and
- continuing professional development requirements for ATAPS providers akin to the requirement under Better Access.

Respondents pointed to various examples through which ATAPS had already enabled innovative approaches to service delivery – such as mobile outreach services, partnerships with other organisations and flexible approaches to delivery of services to Aboriginal and Torres Strait Island people. Telephone and web based service delivery modalities were seen as providing important alternatives and adjuncts to face-to-face treatment. The further development of service delivery utilising these modalities received strong support.

Advice of the Expert Advisory Committee
The ATAPS Review Expert Advisory Committee (EAC) met in July 2009 to discuss the responses to the discussion paper and propose a way forward for ATAPS. In considering the common themes arising from responses, the EAC identified and provided advice on the following tensions:

- While quality control of the services provided is an important issue, setting the competencies and professional qualifications of providers at too high a level could reduce significantly the available workforce to provide services, and reduce service access particularly in rural areas. The emphasis should be on capacity to provide a service. However, it is vital to ensure that ATAPS remains an initiative that provides high quality mental health services.

- Given ATAPS is a capped program, all enhancements to ATAPS would need to be considered and implemented within the current financial constraints. Any additional funding for one element of ATAPS will need to be mindful that less funding will be available for other elements.

- A related tension is that between the role for ATAPS in providing flexible models of care to hard to reach individuals, and the need for increased efficiency. There is a risk that a dramatic shift to
funding more efficient services could undermine the ability to provide innovative and appropriate services such as outreach to those would not otherwise access care.

The EAC was supportive of a continuing role for Divisions noting overall that Divisions had embraced the role of fundholders under the ATAPS program. In addition, the EAC suggested consideration of regional fundholding arrangements in the future whereby one of a group of Divisions would act as the fundholder for ATAPS for the region. Whilst this concept would potentially improve administrative efficiency (and thus enable a greater portion of funding to be focussed on service delivery) it could also result in strong collaborations with other organisations in the area, and better planning and coordination of care.

The EAC also strongly supported the role of ATAPS in promoting collaborative care between clinicians who formed part of a multidisciplinary care team as well as between ATAPS providers and other non-government organisations delivering care to people with mental illness, particularly those from hard to reach groups.

Another specific issue explored by the EAC was the ability of ATAPS to provide service to consumers with severe or complex mental health issues (including psychosis and post-traumatic stress disorder). The EAC acknowledged that, whilst ATAPS did not exclude these consumers, the short term psychological therapy available through ATAPS would not meet the need for the ongoing support and management that may be required in these instances, particularly where people have persistent symptoms. Given the relatively small scope of the program, there would be limits to the extent to which ATAPS could be adapted to better meet these ongoing needs.

However, the EAC thought that to better provide service to consumers with severe and persistent mental health issues, ATAPS could strengthen linkages with appropriate Australian Government programs (for example the Mental Health Nurse Incentive Program) and State and Territory Government services. It was also suggested that some innovative services targeting short term primary care services to people with severe illness might be appropriate, particularly in areas with low service coverage, as long as these services were well connected to state specialist mental health services.

The EAC considered there was considerable scope to review and refresh governance and infrastructure to better support clinicians providing ATAPS services to particular groups of clients and to promote quality assurance. The EAC noted that many Divisions have consumer representatives on their governing structures and that strengthening consumer involvement at all levels would be in the interests of quality improvement for the program.

6. INITIAL REFINEMENTS TO THE INITIATIVE RESULTING FROM THE REVIEW PROCESS

The ATAPS review process commenced in July 2008 and has comprised a number of stages. As part of the review process, the Australian Government has already made some refinements to ATAPS to enable the initiative to better meet the emerging needs of communities in accessing mental health services. These recent enhancements of ATAPS have included:

ATAPS innovative service trials

**Telephone Based Cognitive Behavioural Therapy**

The engagement of 22 rural and remote Divisions of General Practice to participate in a trial of telephone based therapy commenced in July 2008. This enhancement of ATAPS recognised the value of services being provided via non-face-to-face modalities particularly in rural and remote areas where it is often difficult for patients to travel vast distances to access health services. Additional funding was provided to participating Divisions to develop the infrastructure to enable ATAPS to be provided to patients via telephone. Training in providing services via the telephone was available for ATAPS providers. The trial is based upon a similar successful project undertaken in Doncaster, UK, which also utilised telephone based
services and demonstrated very similar outcome results for patients receiving services via the telephone as compared to face-to-face.

Initially there was some difficulty in attracting GPs and patients to the trial. However, there is evidence that the uptake of the pilot has been underestimated because of data entry and a time lag for entry of data. Evidence from the trial suggests that the value of this mode of service delivery is recognised, despite an overall preference for face-to-face service. There may be merit in considering the permanent integration of the option for delivery of therapy sessions by telephone across the ATAPS projects rather than as a segregated initiative. The trial is being evaluated by the University of Melbourne, with final results expected in mid 2010.

**Suicide Prevention**

This trial has engaged 19 Divisions of General Practice as demonstration sites to receive funding to better support GPs to manage patients who have presented following deliberate self harm or a suicide attempt commenced in July 2008. This trial was established in response to the substantial human and economic cost of suicide and self-harming behaviour. It also recognised the additional support that GPs may require in caring for these patients, including priority access to specialist allied mental health services. People who have attempted suicide are particularly at-risk of further attempts or completed suicide and thus require immediate and intensive management, as offered by this trial.

Divisions were selected to participate in the trial in consultation with State and Territory Governments primarily on the basis of higher suicide rates. Additional funding was provided to the selected Divisions to purchase additional ATAPS services so that GPs could have priority referrals for suicidal patients. Additional training was also provided to the ATAPS providers participating in the trial.

Despite some initial challenges in the establishment of this trial – particularly around clarifying the target population (patients presenting to GPs or emergency departments of hospitals following a suicide attempt or deliberate self harming incident) – this enhancement to ATAPS was met with great enthusiasm from participating Divisions. A number of non-participating Divisions have expressed their desire to also focus on this target population.

Information provided by the University of Melbourne states that between October 2008 and July 2009 there were 282 referrals (181 urban, 101 rural) made to services. The profile of consumers is somewhat different from the general ATAPS projects suggesting that these specialist services are reaching a different group of consumers and are complementing the general ATAPS projects. Consumers are receiving a free of cost service, with no co-payments reported in any sessions.

**Updated Guidelines**

In October 2008 the ATAPS Guidelines were updated to reflect and clarify modifications to the initiative since its commencement in 2001. This process was undertaken in consultation with Divisions of General Practice and other key stakeholders.

**Mental Health Support to Bushfire Affected Communities**

Following the February 2009 Victorian bushfires, additional ATAPS funding has been provided from March 2009 to nine Divisions of General Practice to increase mental health services in affected communities. Some additional funding has also been provided to another Division which experienced increased demand for ATAPS as a result of fires later in February 2009.

The funding has enabled Divisions to engage additional allied health professionals and purchase additional services for people experiencing persistent psychological symptoms. The nine Divisions of General Practice in the bushfire affected regions have directed funding to provide over 1,000 new referrals for services in bushfire affected communities.
In recognition of the impact of the bushfires on young people, funding was also provided for an allied health professional advisory service to support staff of local schools to assist children and staff in coping with trauma and loss. Specialised training in the management of trauma and grief was also made available to all mental health service providers.

ATAPS offered a flexible funding model to allow individual Divisions to direct funding in local areas to consumers most in need of services. Being able to use ATAPS as a funding mechanism facilitated swift action by the Australian Government to a devastating event where a practical response and corresponding resources were required immediately.

On a smaller scale, ATAPS has previously been responsive in providing additional funding for mental health services to Divisions affected by flood, earthquakes and other community tragedy.

National Perinatal Depression Initiative
In addition to these enhancements, ATAPS was extended in February 2009 to provide services as part of the National Perinatal Depression Initiative. Funding was allocated to Divisions to build the capacity to treat women experiencing perinatal depression, based on population, rurality and relative access to Medicare funded mental health services.

This was the first time that the level of ATAPS funding to Divisions had taken into consideration the relative accessibility of services for consumers. This funding method was supported by Divisions and key national stakeholders and provides a useful model for consideration in the shaping of further ATAPS reforms.

7. SUPPORT INFRASTRUCTURE

Prior to the commencement of ATAPS in 2003, the Australian Government Department of Health and Ageing with the assistance of the AGPN (then the Australian Divisions of General Practice) established the National Primary Mental Health Network. This Network, funded by the Australian Government, has membership from each State Based Organisation of the Divisions Network (Development Liaison Officers) and is overseen by the AGPN.

Initially the role of the Network was to promote information exchange on primary mental health care issues between Australian Government and state funded primary mental health care services. When the program which originally funded the Network lapsed, its funding was provided through ATAPS. The Network, in addition to continuing its liaison role, helped to support Divisions to establish ATAPS projects in their local communities, and staff with professional experience in mental health were generally recruited to the positions of Development Liaison Officers (DLOs). Since the inception of the Network, the number of state funded primary mental health care services has diminished and other vehicles are available for liaison on mental health issues.

It is envisaged that as the ATAPS initiative is well established and other vehicles are available for liaison on mental health issues, the supporting infrastructure can now be refocussed and refined to play a pivotal role in quality assurance activities. This may involve advice on staff recruitment and retention, clinical support for ATAPS providers on the management of potential groups of patients, eg children with mental health issues, services for parents when children are identified as having a mental health problem and professional development activities for ATAPS providers.

8. PROPOSED KEY REFORM FOCUS AREAS

The consultation and research undertaken throughout the ATAPS review process have found that future reform of ATAPS should focus on four key areas of enhancement:
— Better addressing service gaps;
— Increasing efficiency;
— Encouraging innovation; and
— Improving quality.

**Better addressing service gaps**

Since the commencement of ATAPS in 2003, services have been available to individuals in the broader population with a diagnosis of mental illness. In the consultation process there was strong support for a continuing role for ATAPS as a capped program with finite resources in targeting people with mental illness who have a need for short term interventions.

There was recognition that the reach of the program would be diluted if the program was extended to the broader population, and that preventive programs and broader counselling programs such as Lifeline offer assistance to people undergoing temporary emotional distress. Instead the shared view was that ATAPS needs to become more targeted on those people with a mental illness who are not accessing services.

Prior to November 2006, when Better Access was introduced, ATAPS was the primary initiative through which consumers could be referred by their GPs to access subsidised psychological services for high prevalence mental health disorders such as depression and anxiety. ATAPS has always had a finite budget - and therefore Divisions had to operate within the allocated funding. In some instances, this meant that Divisions had to determine how to prioritise access to ATAPS services. A number of Divisions prioritised consumers classified as on low income.

The introduction of Better Access provided an alternative service pathway for consumers experiencing mental illness who had previously relied on ATAPS services. In fact, due to the nature of Medicare based funding, the Better Access program provided greater access to services due to a significantly larger (consumer referral driven) program budget. Better Access operates very successfully in the majority of communities and geographic areas as a universal program aimed at improving access to treatment for high prevalence disorders. However in some instances, providing services through Medicare may not be the best approach – for example in rural and remote areas where the number of providers is limited and to Aboriginal and Torres Strait Islander communities and people who are experiencing or at risk of homelessness. ATAPS has shown its ability to deliver high quality services to these populations. Indeed, without ATAPS, these populations would have limited to no access to mental health services.

Prior to Better Access the majority of Divisions provided ATAPS services to the broad population in the local community. Since its introduction in November 2006, many Divisions have already reoriented their ATAPS initiatives to focus on those consumers who do not or cannot access Medicare, including youth, people who are experiencing or at risk of homelessness and Aboriginal and Torres Strait Islander people.

This reorientation process seeks to establish some balance or equity in the relative accessibility of mental health services. It makes sense that ATAPS, with its defined budget, is an adjunct to Better Access. That is, that Better Access remains the service to provide the majority of mental health services to the broader population and that ATAPS operates in a complementary manner to provide mental health services to those consumers who do not or cannot access Better Access services. Anecdotes of Better Access and ATAPS operating in the same location, provided by the same allied health providers, providing an identical service illustrate the risks of duplication if a clearer distinguishing role for ATAPS is not defined.

Accordingly, it is proposed that ATAPS should progressively shift its focus to hard to reach populations and areas where consumers have limited access to Medicare services - either due to geography or locality as well as for those people who currently are not accessing psychological services (including Aboriginal and Torres Strait Islander people, children and young people, services for parents when children are identified as having a mental health problem, services for parents when children are identified as having a mental health problem, people experiencing or at risk of homelessness and people at high risk of suicide).
This would result in some further modest reduction in funding for some areas which are well serviced by Better Access private providers, particularly where there has been a pattern of declining referrals since the introduction of Medicare based mental health services. However, it would also result in a redistribution of funding towards those areas where there is limited per capita access to Medicare services, including outer metropolitan and rural areas. It should also result in strengthening and rewarding of efforts to target hard to reach groups, including those in urban, outer metropolitan and rural areas.

In effect it is anticipated that this will formalise a process which has already commenced over the last few years through retrospectively reallocating unspent funds from divisions which are well serviced by Medicare to other divisions with unmet need and to special purpose activities. It will however enable better planning and targeting of future funding.

These changes could be introduced from 1 July 2010, at the conclusion of current ATAPS funding agreements with Divisions.

**Better Addressing Service Gaps – Proposed Directions**

- ATAPS should be refocused (following a suitable adjustment period for service providers) to target:
  - Supplementing service provision for consumers in areas where access to private Medicare services is limited due to geography or locality, such as in rural, remote and some outer metropolitan areas; and
  - Providing appropriate service models for hard to reach groups in all areas of Australia who are currently not accessing, or cannot afford, psychological services (including Aboriginal and Torres Strait Islander people, children and young people, services for parents when children are identified as having a mental health problem, people at high risk of suicide and people experiencing or at risk of homelessness) and for whom more flexible models of care are needed.

- The funding model should be gradually adjusted to reflect this focus and to better target areas not well serviced by Medicare based allied mental health services.

**Increasing efficiency.**

At the commencement of the ATAPS initiative, the Australian Government has provided funding to Divisions of General Practice based on the size of the population serviced by the division, with minor adjustments for rurality. However, there has been a drift away from this formula over the years due to variations in demand, changes in the boundaries of divisions and changing needs of some communities. This has been compounded by changes to population and classification of rural/urban areas. It is an opportune and appropriate time to consider the funding formula and adjust it to reflect the needs of the population and ensure that divisions are provided with the appropriate share of ATAPS funding.

Originally ATAPS funding was utilised by divisions almost solely for service delivery (85%) and only a small component was set aside for administration (15%). Over the previous three years, the proportion of funding quarantined by divisions for administering the initiative has substantially increased. Now many Divisions use a ratio of 75% service delivery to 25% administration. Whilst it is recognised that administrative costs have increased over the previous nine years since ATAPS commenced, redirecting funding to administration results in less capacity to provide mental health services. Some funding must be utilised for the administration of the initiative within Divisions, however it is important to minimise this cost.
The majority of divisions manage the funding effectively, ensuring that quality services are provided to consumers in the most efficient manner. However, the cost per service for ATAPS varies widely across divisions. For the 2008-09 period, unit costs ranged from $53 to as high as $631 per session. It is recognised that unit cost (defined as total ATAPS funding to the division divided by the number of services provided by the Division) fluctuates based on a number of variables outside the control of the division (for example few referrals, ATAPS providers being unable to provide services due to illness, clients not attending appointments). However, unit costs are also influenced by the proportion of funding utilised for non-service delivery activities (i.e. administrative arrangements, travel costs, costs of office facilities).

Given that ATAPS in many instances already provides services to a population that does not or cannot access Better Access, it is understandable and acceptable that costs may be higher under ATAPS – particularly in recognition of the additional costs in providing services in rural and remote areas. However, to ensure that ATAPS funding is utilised in the most effective manner it is vital to provide services in the most efficient way possible.

To date there has been no financial incentive to divisions for efficiency in the administration of ATAPS. It is proposed that there be a gradual shift to a new approach to funding through which the Department will provide funding for ATAPS with a weighting for number of services provided (through-put). The funding model will be gradually adjusted to reflect the focus on hard to reach groups and to better target areas not well serviced by Medicare based allied mental health services (i.e. Better Access). Divisions which can demonstrate high levels of efficiency will be financially rewarded. This arrangement could be gradually phased in from 1 July 2010.

**Increasing Efficiency – Proposed Directions**

- Funding arrangements to be gradually introduced will recognise through-put, and promote efficiency but will also encourage and reward innovative approaches to outreach and targeting of hard to reach individuals and population groups.

- The proposed funding arrangements involve moving from the existing ATAPS funding model to a two tiered funding model, which gradually introduces a level of funding that recognises through-put and which better targets funding to where it is needed.

- Tier 1 base funding will provide for the supplementation of service delivery provided through Medicare and will enable all Divisions to continue to target psychological services within their population. It is anticipated that an offer of Tier 1 funding would be made to all Divisions currently providing ATAPS services for the 2010-11 financial year.

- In the medium to long term, where Divisions are not able to demonstrate efficient service delivery or where Divisions indicate that they do not want to administer ATAPS, an alternative NGO or another Division may be contracted to provide ATAPS in the region.

**Encouraging Innovation**

The current ATAPS initiative enables Divisions to utilise a model of service delivery that meets local needs.

Better Access, as with all Medicare subsidised services, offers a universal model (that is the same model for the entire Australian population) and does not have the flexibility to be modified to meet the needs of sub-populations. It is recognised that Better Access mental health services are not always accessible to all consumers (for example in rural and remote areas or for Aboriginal and Torres Strait Islander people).

Further, in some instances, face-to-face service provided in the allied health providers consultation rooms does not meet the needs of some consumers.
As a fundholding model, ATAPS recognises that different service delivery models work for different populations. Further, ATAPS has the capacity to support innovative and effective ways of accessing hard to reach groups. ATAPS has already been utilised to trial non-face-to-face modalities of service delivery for example via the telephone as well as some web-based treatment.

Some Divisions have also used ATAPS to provide mobile outreach services to Aboriginal and Torres Strait Islander communities, to young people or for people who are people who are experiencing or at risk of homelessness. These innovative service delivery models enable access for consumers who may not otherwise have been able to access mental health services. They also decrease pressure on waiting lists and may reduce some of the costs of face-to-face delivery particularly in rural and remote areas (such as travel costs and time associated with this).

The proposed concept of innovation is to encourage Divisions to adopt alternative service delivery models to access hard to reach groups within their local communities. This may include group therapy for particular groups (eg women experiencing perinatal depression), e-therapy for remote areas which are impossible to access especially during seasonal times, outreach or mobile clinics to reach groups such as young people, and developing partnership arrangements with other local NGOs with specialist knowledge of the target population (eg Aboriginal Medical Service, Homeless shelters etc).

It is recognised that in some instances it may be restrictive to require a patient to be referred by a GP in order to access ATAPS services. This requirement is intended to ensure that the GP remains the central point for the ongoing day-to-day care of patients. In some instances it may be appropriate for referrals to be made by other medical providers and in exceptional circumstances for no initial referral to be required. The recent ATAPS bushfire funding and the suicide prevention ATAPS project have both trialled provisional referrals to ATAPS where there is an urgent need for psychological support pending a visit at some stage to a medical professional for a formal diagnosis and care plan.

Currently there is a range of special purpose funding arrangements which result in complexity for divisions to administer under ATAPS. This includes ‘add on’ funding for bushfires, for suicide prevention, for perinatal depression, and for telephone cognitive behaviour therapy. Overall this comprises as much as 25% of total funding under ATAPS.

It is proposed that the development of innovative approaches be further supported and rewarded, including further consideration of flexible referral models. It is also recognised that activity of this nature doesn’t fit the traditional ATAPS funding approaches – in some cases funding is required for additional service related outlays such as translation services. In others more expensive care is necessarily required to extend mobile services, such as those involved in some outreach services to Aboriginal and Torres Strait Islander communities.

To address innovative and flexible services, but to simplify current arrangements for ATAPS additional funding for groups with additional needs, a block sum of additional special purpose funding could be provided to those Divisions assessed as having these populations. Given the funding pool for ATAPS as a capped program, there will need to be a careful planning and prioritisation process associated with special purpose funding. Funding for special purpose funding would also need to be capped at a percentage of overall funding.

New ATAPS guidelines will also provide for and encourage innovative service delivery.
Encouraging Innovation – Proposed Directions

- Tier 2 special purpose funding will supplement Tier 1 funding and provide additional funding for innovative service delivery to particular groups with needs which can’t be met through traditional ATAPS service delivery approaches. Tier 2 funding will be available to Divisions with a track record in providing services for these groups, and on the basis of their demonstration of the needs and size of the population of individuals to be supported.

Allocation of the funds will in future be subject to a new planning process to be developed in consultation with stakeholders. Tier 2 funding will simplify the current complex arrangements for special purpose funding which have variously covered suicide prevention, perinatal depression, bushfire support and telephone based cognitive behaviour therapy, but could in future extend to enable the provision of services to other groups such as Aboriginal and Torres Strait Islander communities or mobile outreach services for young people or people at risk of homelessness.

- Approaches that support and encourage innovative and effective ways of accessing hard to reach groups to be further supported and rewarded through Tier 2 funding arrangements, including further consideration of flexible referral models.

Improving Quality

The quality of the mental health services provided under the ATAPS initiative varies enormously between providers and Divisions. This is not to say that the services provided are not valued by consumers or that some providers are below standard. What it does indicate is varying quality around the availability and recruitment of providers, differing levels of experience and qualifications of providers and even the skills and experience of the staff who administer ATAPS within Divisions. It also indicates the need for better clinical support for ATAPS providers, particularly in the management of particular population groups and needs such as child mental health issues or perinatal depression.

It is vital to ensure that ATAPS remains an initiative that provides high quality mental health services.

Under ATAPS – with a capped budget – it is understandable that Divisions may be attracted to recruiting allied mental health providers who attract a lower salary and thus the available funding to stretch to provide a greater number of services. Divisions have reported difficulty, in attracting and retaining ATAPS providers, particularly in rural and remote areas. Whilst the inherent difficulty of persuading people to relocate away from cities is recognised, providing the appropriate levels of clinical support and supervision may go some way in improving the attractiveness of these positions. This would also ensure that ATAPS providers had the opportunity to form networks with other providers in the local area.

Under Better Access, allied health providers are required to undertake continuing professional development to ensure that their skills and qualifications remain current. To ensure parity of service quality with Better Access it is proposed that ATAPS providers should also undertake a level of continuing professional development.

Enhancing infrastructure and supporting a skilled workforce are critical to the quality of service provision for ATAPS. Considerable funds are currently spent on the National Primary Mental Health Care Network to support information sharing between the AGPN, State Based Organisations and Divisions. It is proposed that a supporting infrastructure for ATAPS be refreshed and refocussed, to better promote benchmarking, quality, information exchange on best practice and clinical support, including centralised phone based advice on management of particular client needs.
The quality improvement enhancements would include the introduction of continuing professional development for allied health professionals engaged to deliver ATAPS as well as clinical support arrangements.

**Improving Quality – Proposed Directions**

- A requirement for a level of continuing professional development for allied health professionals engaged to deliver ATAPS will be introduced.

- The supporting infrastructure will be refreshed and refocussed to promote benchmarking on efficiency and targeting issues, quality and information exchange on best practice, as well as improved clinical support.

### 9. NEXT STEPS

In the interests of continuing quality care for consumers that Divisions have time to adapt to any changed funding or administrative arrangements, and that Divisions and other stakeholders have a chance to help shape the guidelines and implementation plan for any new arrangements. A phased-in roll out is therefore recommended, that could commence from 1 July 2010 to allow for a staged rollout of the actions outlined in this Report.

It is recommended that an Implementation Plan should be prepared by the Department in consultation with stakeholders including Divisions of General Practice the Australian Psychological Society to support a realistic and practical approach to implementing the directions in this report.

A stakeholder workshop would be important for early 2010 to progress discussions on an implementation plan and to consult on other key elements of the proposed new arrangements. New ATAPS guidelines will also need to be developed in consultation with key stakeholders including guidelines for the management of new Tier 2 funding.
# Access to Allied Psychological Services (ATAPS) Review

## Expert Committee Membership

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