

ATAPS REVIEW DISCUSSION PAPER

Comments from General Practice South Australia (SBO)

March 2009

General comments

The Discussion Paper has provided a very useful summary of the development of the ATAPS program, current challenges and future direction. We are however concerned about some aspects of the discussion:

- The paper notes the significant differences between ATAPS and Better Access goes on to make comparisons of unit costs
- The assertions regarding some very high unit costs appear to have focussed on some extreme examples – how many instances of very high costs have occurred and such exceptions should be addressed with the individual Division(s)
- The issue of “duplication” of ATAPS and BA services needs further exploration and clarification – particularly in regard to evidence of up to 70% of BA services requiring a gap payment
- Reference is made to quality issues in selection and training of allied health professionals, however the 15% cap on program administration does not provide resources to address these needs

Issue 1- targetting unmet needs

The Paper correctly acknowledges the populations in need of improved access to mental health services. GPSA believes a comprehensive review of the program could include approval for broader therapeutic approaches relevant to specific populations, for example couple or family counselling for women with perinatal depression and motivational interviewing for people with substance use disorders.

While it is important to acknowledge the lack of access to ATAPS related to populations not using GP services we believe there are contributing factors that need to be considered carefully. Clearly there is an issue of GP shortages; this is not always because of remoteness – many people in outer metropolitan areas cannot access busy GP practices.

The suggestions of different patient pathways, partnerships and outreach have merit. However, Divisions and other service providers will require resources to

enable to undertake this work, above current funding allocated for program administration.

Issue 2 – ensuring a sustainable workforce for ATAPS

A general comment can be made that the achievements and continuity of the ATAPS program have relied in large part upon the goodwill of Divisions and their allied health workforce. In a field where clinicians can consider secure government employment or lucrative private practice, Divisions cannot generally offer either job security or a high level of remuneration.

It is laudable that the Discussion Paper acknowledges the need for appropriately qualified clinicians and health workers. It is less clear how continuing professional development and credentialing would be supported. At present many Divisions struggle with even being able to fund face to face meeting between clinicians to provide coordination, professional supervision and peer support.

Issue 3 – selecting fundholder organisations to provide ATAPS

GPSA asserts that the ATAPS program has consistently been run very well by Divisions in South Australia. The reallocation of additional resources in 2008 to six Divisions is, we believe, a testament to the demand for quality services and the meeting of local community needs.

We already have examples of effective partnerships, such as where contracted clinicians are working from indigenous health organisations in metropolitan Adelaide and a regional centre. Services are provided in an appropriate setting with the additional benefits of access to culturally appropriate clinical and support services.

GPSA would not assert that Divisions of General Practice would be the only option for service delivery, however some questions arise regarding opening services to contestability:

- What is the net cost of “competition” in regard to tendering, preparing funding submissions?
- Could regional health services really be more efficient conduits for service? – our experience in SA is that community mental health service cannot meet existing demand for services
- How would other organisations be able to demonstrate strong and credible links with GPs?
- If Divisions became part of consortia how would the coordination of this be funded?

Issue 4 – efficiency and effectiveness

The Paper refers to unit cost as the ratio of administrative costs to service delivery. This may not completely represent particular challenges for Divisions in providing services, particularly in rural areas – for example, clinicians' time including travel, transport and accommodation costs.

GPSA supports any move towards simplified accounting and reporting systems for MH programs. Consideration could then be given to establishing interdisciplinary teams at the Divisional level which would have the capacity to deliver flexible and culturally appropriate services to local communities.

It is not clear what measure(s) might be used for performance-based funding. We suggest work could be done to explore this, particularly in regard to individual patient outcomes. Measures could include overall improvement in well-being, social and economic participation and improved management of chronic disease or comorbidity.

Issue 5 – a universal program?

There may be widely differing views on this, but it has always been our understanding that ATAPS is not a universal program. This is because Divisions providing the service have always been required to demonstrate how they will target services to more disadvantaged clients. Where there is high demand for ATPAS services Divisions will generally attempt to offer other referral options including Better Access and community-based programs.

However, as we have noted above ATAPS and Better Access are not the same type of service, especially in respect of costs to patients. Any adjustments to ATAPS funding on the basis of availability of BA services should satisfy the criterion that the latter services are equally and readily available to patients.

Issue 6 – innovative services

Four Divisions in South Australia are participating in the Telephone-CBT trials. We understand that initial take up of services has been low across sites nationally.

GPSA support any innovation in service delivery including computer-based modules. We suggest that GP and clinician use of different modes of counselling may require greater exposure and training. This may be addressed by resourcing education and demonstration of the use of different approaches.

Conclusion

GPSA welcomes the opportunity to provide initial input to this review and we are aware that many Divisions will be providing submissions and comments to the Department.

We hope that key issues identified across the network can be addressed in the formulation of suggested models of service provision and funding.

We would like the opportunity for further structured consultations. The National Primary Mental Health Care Forum in May presents such an opportunity.

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