



**S·A·R·R·A·H**

Services for Australian  
Rural and Remote Allied Health

**Response to the Department of Health  
and Ageing**

**ATAPS discussion paper:  
Flexible care packages for  
people with severe mental  
illness**

**February 2011**

## **Introduction**

Services for Australian Rural and Remote Allied Health (SARRAH), welcomes the opportunity to submit a response to the Access to Allied Psychological Services (ATAPS) discussion paper: Flexible care packages for people with severe mental illness.

SARRAH is nationally recognised as a peak body representing rural and remote Allied Health Professionals working in both the public and private sector.

SARRAH's representation comes from a range of allied health professions including but not limited to: Audiology, Dietetics, Exercise Physiology, Occupational Therapy, Optometry, Oral Health, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology.

These Allied Health Professionals provide a range of clinical and health education services to individuals who live in rural and remote communities. Allied Health Professionals are critical in the management of their clients' health needs, particularly with chronic disease and complex care needs.

Allied Health Professionals work across the Primary and Acute Health Care Services continuum. They have significant roles in health care and health education across the sectors.

The Allied Health Professional, particularly in rural and remote areas, is required to adapt to workforce shortages and is well versed in the interdisciplinary and team approach to health care, especially for management of chronic disease and to improve health behaviour.

It is repeatedly demonstrated that skilled and supported Allied Health Professional services are essential to improving the quality of life and better health outcomes for rural and remote communities.

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that Allied Health Professional services are basic and core to Australians' primary health care and wellbeing.

## **General Comments**

It is deeply concerning that the review of ATAPS found the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative (Better Access Initiative) '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' and will not be as accessible to those in rural and remote areas or Aboriginal and Torres Strait Islander people (Dept Health & Ageing, 2010, p20). At the same time, SARRAH is pleased to note that the Federal Minister for Health and Ageing the Hon Nicola Roxon MP has endorsed the Access to Allied Psychological Services (ATAPS) as an important and necessary program to complement the Better Access Initiative. SARRAH also acknowledges the commitment to strengthen the ATAPS program to better meet the needs of Aboriginal and Torres Strait Island people and those in rural and remote areas as an outcome of the Review of the ATAPS Component of the Better Outcomes in Mental Health Care Program.

While ATAPS is recognised as providing mental health services that may not otherwise be available in rural and remote areas, it must be recognized that ATAPS is a small program compared to Better Access, delivering an average of just 100,000 mental health services per annum, compared to the 3.3 million mental health services delivered under Better Access each year. While it is encouraging to find that approximately 45% of all ATAPS services have been provided in rural Australia it is further noted that this was supplemented with 25% rural and remote uptake of Better Access mental health services. The Fourth Mental Health Plan specifically cites ATAPS as a key service delivery model to ensure primary mental health care is more accessible at a local level, with non-government primary mental health care service providers being charged with managing local workforce recruitment and retention and the targeting of services to address service gaps.

## **Special Needs of Very Remote Communities**

SARRAH believes the flexible service delivery model offered by the ATAPS program has the capacity to address service gaps and to meet unmet needs of Aboriginal and Torres Strait Islander peoples and others in very remote Australia. Since all communities in very remote Australia have populations of 4,000 people or less, they lack the population base required to support a private practice, fee-for-service model on which Better

Access and some ATAPS programs are based. As a result, all communities in very remote Australia meet the criteria of having needs which cannot be met through traditional service delivery approaches and will require ATAPS fund-holding arrangements to support outreach service delivery by mental health practitioners based in larger remote or regional centers. Travel costs associated with providing services in very remote Australia will also need to be taken into account.

### **Equitable Service Provision in Very Remote Australia**

While Aboriginal and Torres Strait Islander people constitute 2.5% of the total Australian population, this proportion increases with geographic remoteness and peaks in very remote areas where 45% of the population is Indigenous (ABS 2007). The nearly equal proportions of Indigenous and non-Indigenous people in very remote Australia allows equity of service provision to be monitored and gaps in service provision to be identified in national data collections. It is therefore noteworthy that delivery of MBS-funded ambulatory mental health services to Indigenous people compared to others is lowest in very remote Australia (SCRGHS, 2011).

In order to overcome inequities in service provision, there needs to be an increased awareness among policy makers that communities in very remote Australia tend to be either overwhelmingly Indigenous or non-Indigenous (Memmott & Moran, 2001; Ellis & Kelly, 2004). While very remote towns with a non-Indigenous population base tend to have access to resident general practitioners and hospitals, those containing a majority Indigenous people do not (Ellis & Kelly, 2004; Kelly & Dade-Smith, 2006) and will therefore be unable to benefit from any program that relies on referrals from fee-for-service general practitioners. Instead, the very remote Indigenous population relies on service delivery by Aboriginal Community Controlled Health Organisations (ACCHO) that provide culturally appropriate comprehensive primary health care services at community and regional levels. Since the Indigenous population lives spatially segregated from the non-Indigenous population in very remote areas, the appropriate fund-holder for ATAPS programs targeting Indigenous people would be Aboriginal Community Controlled Health Services (ACCHS), rather than Divisions of General Practice (NB: Since GPs rarely provide services in Indigenous communities and doctors employed by ACCHOs are not eligible for membership of Divisions, there is a deficit in knowledge and experience about service delivery in very remote Indigenous communities). Since Indigenous

communities tend to be smaller and more remote compared to non-Indigenous localities, funding formulas need to reflect the differences in costs associated with providing goods and services to the two populations in very remote Australia.

SARRAH looks forward to assessing the outcomes of the evaluation of Indigenous-specific and other strategies implemented under the COAG National Action Plan on Mental Health 2006-2011, including the Mental Health Services in Rural and Remote Areas program, and the comparative reach and effectiveness of these strategies across Indigenous and non-Indigenous populations in very remote Australia. SARRAH suspects the failure to invest in a national strategy to increase the cultural competence of the mental health workforce seeking to access MBS items may have resulted in low uptake by Aboriginal and Torres Strait Islander people in regional, rural and remote areas.

### **Immediate Strategies to Close Emerging Gaps in Service Provision and Mental Health Outcomes**

SARRAH is concerned that the large expenditure on Better Access services (\$753.8 million over five years) compared to ATAPS programs (\$80 million over six years), the disproportionate uptake of Better Access in urban areas and the lack of reach of both programs into regional, remote and very remote Aboriginal and Torres Strait Islander communities is creating inequities in mental health outcomes for Indigenous and non-Indigenous Australians. Further investment in Better Access and ATAPS without remedial strategies to ensure Aboriginal and Torres Strait Islander Australians are able to access an equivalent set of mental health services in the primary care sector, is likely to increase this emerging gap and further entrench existing inequities. Indeed, serious consideration should be given to ceasing or capping expenditure on the Better Access initiative unless the metro-centric, mono-cultural nature of mental health services provided under this initiative can be urgently addressed. Without a commitment to ensure equitable service provision within the Better Access program, further investment is likely to deliver a range of inequities across the Australian population.

Outside the Better Access initiative, SARRAH is pleased to note there is a recognition that different service delivery models are required for different populations and advocates that a proportional share of Tier 1 and Tier 2 special purpose ATAPS funding

be quarantined to assist in the development and delivery of Indigenous-specific service models suitable to address high prevalence disorders in regional, remote and very remote Indigenous communities. Primary mental health care services should be universally available through the Aboriginal Community Controlled sector, with funds being held by ACCHO's and services delivered at a local and regional level. There is a need to develop a supporting infrastructure within this sector to raise awareness and to develop culturally appropriate models and benchmarks for service delivery, efficiency and quality; to support information exchange on best practice models; and to provide clinical support for service providers. Service delivery by Aboriginal and Torres Strait Islander counsellors as well as Indigenous members of the mental health workforce (Psychiatrists, Psychologists, Social Workers, Mental Health Nurses and Aboriginal Mental Health Workers) should be considered. It is essential that a component of the funding be allocated for cultural competence training and on-going mentoring for any non-Indigenous mental health practitioners participating in service delivery.

The capacity to support service delivery to address more common mental health disorders needs to be developed within the Aboriginal Community Controlled Health sector before Flexible Care Packages For People With Severe Mental Illness are introduced under ATAPS arrangements. This will allow the Aboriginal Community Controlled Health sector to develop a supporting infrastructure, increase its capacity to deliver primary mental health services for common disorders (such as mild to moderate anxiety and depression) and decrease the stigma associated with these disorders. Service delivery must be supported by the development of connections with state specialist mental health and a range of other services and programs, prior to taking on the more challenging task of delivering services to those with serious mental illnesses with persisting symptoms and associated disability. This is particularly important in very remote Indigenous communities where there is usually just a single health service and a lack of access to hospitals, state funded community mental health services or the range of other agencies available in urban and other settings – including pharmacy services.

### **Response to Questions Posed**

So far in this response, SARRAH has attempted to highlight the special needs of Indigenous and non-Indigenous people in very remote Australia. For the remainder of the document, SARRAH will respond from the broader perspective of regional and

remote Australia.

### **1. Definition.**

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

*Response: Yes.*

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

Are there other clinicians who would be appropriate to provisionally refer people with severe mental illness for FCPs?

*Response: Yes, employed medical practitioners in ACCHOs and mental health service providers/managers providing services under Better Access and ATAPS programs. Referral to Clinical Psychologists should be prioritized under this program.*

If so, what special conditions should be placed on these referrals?

*Response: Completion of an on-line education module about the program and its goals.*

What is considered to be a reasonable time period for clients to have a Mental Health Treatment Plan developed if they have been provisionally referred by other than a GP or Psychiatrist?

*Response: Twelve months.*

### **3. Integrated referral pathways (intersections) between Commonwealth and state funded mental health services and with non-government services (NGOs).**

What arrangements should be put in place to facilitate seamless transition between Commonwealth and state funded mental health services to meet the changing needs of individuals?

*Response: It is likely that criteria will need to be developed to indicate when referral is required; reasons to accept/reject referrals; documentation to indicate whether a referral has been accepted or rejected; and mapping of referral pathways.*

How can Divisions (and later Medicare Locals) establish partnerships with local NGOs to ensure integration and coordination of services?

*Response: Clearly articulate the behavioural elements that constitute a 'collaborative relationship' and require services to report activity against these criteria each quarter. Report number, acceptance/rejection, waiting lists and outcomes of referrals.*

#### **4. Type of services to be provided.**

What type of clinical and non-clinical services may be needed for individuals receiving FCPs?

*Response: Similar to that provided by the Personal Helpers and Mentors Program and Day to Day Living Program, Better Access and ATAPS programs. Clinical services should be provided by Clinical Psychologists.*

Where could these services be purchased from?

*Response: Non-clinical services could be purchased from Personal Helpers and Mentors Program, Day to Day Living in the Community Program and service providers under Better Access and ATAPS programs. Clinical services should be purchased from Clinical Psychologists.*

What arrangements need to be put in place to facilitate access to clinical and non-clinical services?

*Response: Referral by GP or other service providers participating in the delivery of the range of services under Flexible Care Arrangements. Services should conform to the National Standards for Mental Health Services.*

What would be the case coordination activities?

*Response: Coordination of care; appropriate referral; protection of privacy and human rights of consumers; assessment of quality and safety of care provided; management of referrals; payment for services provided; ensure care conforms to the National Standards for Mental Health Services.*

#### **5. Quality assurance.**

What quality issues need to be addressed?

*Response: Similar to those implemented in the Personal Helpers and Mentors Program, Day to Day Living in the Community Program and service provision under Better Access and ATAPS programs. In addition, the National Practice Standards for Mental Health*

*Services would need to be met.*

Who should be responsible for implementing any quality framework that may be developed?

*Response: The contractors, fundholders and consumers as well as those provided by the National Practice Standards for Mental Health Services.*

How can we best support interface to allow Divisions to work effectively with state based services?

*Response: Employ service coordinator(s).*

## **6. Skills of allied health providers.**

What aspects of credentialing should be considered when engaging allied health providers to deliver Flexible Care Packages?

*Response: Similar to those implemented in the Personal Helpers and Mentors, Day to Day Living in the Community and Better Access and ATAPS programs. All service providers should be required to complete cultural competence training in order to gain access to MBS items and to participate in these programs.*

What information do Divisions need to facilitate credentialing and define the scope of practice for ATAPS service providers?

*Response: Similar to those implemented within the Personal Helpers and Mentors, Day to Day Living in the Community and the Better Access and ATAPS programs. The National Practice Standards for the Mental Health Workforce and National Standards for Mental Health Services would also need to be met.*

## **7. Clinical support for the workforce.**

What specific elements are needed to appropriately support Allied Health Professionals in ATAPS delivering FCPs?

*Response: Provide access to supervision, mentoring and continuing professional development; identify career pathways and opportunities; consider staff rotation, work shadowing and site visits.*

Would an expansion of the GP Psych Support Service provide this support?

*Response: Yes.*

If a different support mechanism is preferred, how should it be structured?

*Response: N/A.*

## **Conclusion**

SARRAH as the peak body representing Allied Health Professionals delivering health services to people residing in rural and remote communities across Australia is well positioned to continue to work with the Commonwealth Government and other stakeholders to assist in the establishment and operation of flexible care packages for people with severe mental illness.

## **References**

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