Frequently Asked Questions (FAQ) for ATAPS Allied Health Providers

Following Professional Development evenings – 14 and 28 September 2016

Q: How are GPs educated about referring to ATAPS?

A: Eastern Melbourne PHN's (EMPHN) Clinical Intake and Community Engagement Team (CICET) and General Practice Engagement Team (GPET) provide information to GPs over the phone and through face-to-face meetings. The teams are familiar with the mental health services commissioned by EMPHN and the referral processes involved.

EMPHN staff also provide information to GPs about how ATAPS fits into the stepped care model. That is, ATAPS is for the mild to moderate, high prevalence, low intensity cohort for the most part.

Q: What is happening regarding the stepped care model and will there be services for people with more complex needs?

A: A stepped model of care is not something new, and has been delivered in various ways by Medicare Locals and General Practice Networks before them. EMPHN hopes to improve on the systems that currently exist. EMPHN plan to have services in this model that can service the more severe and complex mental health presentations and all other severities of presentation. EMPHN's aim is also to have pathways and well defined processes for people to access the right care at the right time for their presentation. Again, this does not mean that ATAPS cannot provide a service community members with more complex presentations. It is just that interventions for this population will still need to meet to the low intensity psychological services criteria that ATAPS is designed to deliver.

Q: Can more complex clients be referred to ATAPS?

A: Clients with complex presentations can be referred to ATAPS. For example, a client with schizophrenia or an eating disorder can be referred for something specific, such as cognitive behavior therapy to manage anxiety as part of their care. While ATAPS is not designed to treat the schizophrenia or eating disorders, it is designed to deliver session limited, short term, focused psychological strategies.

Other parts of the mental health sector service more complex needs and ATAPS does not duplicate those services. ATAPS is not supposed to take away from tertiary services, for example Community Care Teams (CCT) which comprise psychiatrist registrars, psychiatrists, psychiatric nurses, social workers and psychologists. A client case managed within that system is eligible to receive psychological services. It's much better for that person to get that service in-house so they have wrap around care, with a comprehensive team working together. EMPHN don't want to deny people a service but don't want to duplicate a service that they're already receiving.

Q: The other PHN I'm registered with is auditing files but you haven't done that. Is this something that will occur in the future?

A: There is a lot of pressure from the Commonwealth to increase accountability. There may be a time when EMPHN do conduct a file audit/service audit but there are no immediate plans to do so. Should we do it our goal is more about a positive engagement and learning about the kind of work that you do. We do however hear about some of your work, particularly in the Clinical Intake and Community

Engagement Team (CICET) and some feedback has spoken highly of the services that you deliver.

Q: Is ATAPS considering adding solution focussed group therapy interventions to the focussed psychological strategies?

A: Part of what EMPHN are going to do in system reform is assessing current models in Better Access and ATAPS, and what's worked in both of those programs. EMPHN will collaborate with important stakeholders in our sector and look at an evolution in terms of an improved low intensity therapy model with an aim to fill some of those gaps. ATAPS is an excellent program, but there is certainly room for improvement in low intensity psychological therapies and EMPHN want to work with providers to have some positive sector reform in this space. Therapeutically, there is a list of therapies that fit into the ATAPS framework. EMPHN are committed to reviewing this list in light of emerging research and are open to discussions with clinicians on the use of other evidence based therapies outside of the ATAPS remit, on a case by case basis.

Q: Is there a way to have the GPs' mental health treatment plan on FIXUS?

A: If EMPHN receive a mental health treatment plan from GPs it is saved into FIXUS but EMPHN don't always receive them. Often the GP sends them directly to the clinician and some GPs are reluctant to send through any more information than they absolutely have to, and often will give the treatment plan to the client to take to the clinician. If you believe EMPHN have received a treatment plan and it's not in FIXUS, please call EMPHN and they will follow this up. If you think that there are particular strategies that are helpful in getting GPs to forward treatment plans, please contact Craig Russouw or Rachel Pritchard to discuss this.

Q: What is EMPHN doing regarding the National Disability Insurance Scheme (NDIS) and what might that look like?

A: The NDIS is a relatively new program and although functional in only part of the EMPHN's catchment, EMPHN is taking steps to improve understanding of how this program might best service the community. EMPHN has a role in educating GPs in how they support consumers and carers in accessing the NDIS and have held five consumer and carer events in the north during 2016, including one joint GP event with North West Melbourne PHN. EMPHN have also recently visited Newcastle to look at their NDIS pilot site and improve their knowledge of the scope of NDIS service providers in the system. Appropriate mental health practitioners can register as a service provider on the NDIA portal. The Department has been very clear that the role of PIR will change and their presence in this space will decrease as NDIS becomes more widely active. The good news about the National Disability Insurance Agency is that they seem to be responding very well to service feedback. The feedback from the NDIS pilot site is that it is valued by consumers and carers.

Q: What templates do we use to report back to the doctor?

A: EMPHN has developed a new GP report template and it is one of the last links on the ATAPS web page. A group of GPs in the outer east were consulted to assess what they would like in a feedback template and this information was used to compile the current ATAPS template. EMPHN would kindly request that those general headings in the template remain in combination with the outcome measure data, but ultimately it's the AHPs work and the word document format allows for flexibility in content in line with the general headings.

Q. With the Child Mental Health Service stream of ATAPS, previously clinicians didn't need the mental health treatment plan, just the ATAPS referral. Is that still the same criteria?

Even with the provisional referral, AHPs have always needed to link their client in with the GP after two sessions. A provisional referral does not require a treatment plan because it's not a requirement at that stage, but before your client comes in for session three they are supposed to link in with their GP to get a treatment plan. The Department has given scope to complete a Child Treatment Plan instead, which is the same format, but the GP changes the item number to 2713 which means it's a long mental health consultation. They can put in the Child Treatment Plan that the child is at risk of a mental illness and include some symptoms but they don't have to include a diagnosis.

Q: Does that apply to teenagers as well?

A: As soon as a child turns 12, for General ATAPS, a GP must complete a mental health treatment plan. The only other ATAPS program that's exempt from that is the Aboriginal and Torres Strait Islander program, which is for those aged 12 years and over. Again, the GP can book a consult for this program as a long mental health consult and then they don't need to include a diagnosis.

Q: Recently, an email was sent stipulating different conditions regarding Suicide Prevention. It said the ATAPS clinician is clinically responsible for the client, but sometimes GPs refer clients for the SPS service on a Friday. On the weekend, what does it mean to be clinically responsible for someone?

A: For EMPHN, Suicide Prevention referrals are Monday to Thursday. If EMPHN receive a referral on a Friday, EMPHN may try to facilitate contact with a clinician for a client but this may only occur on Monday. For referrals made after 3pm Monday to Thursday, all day Friday, or over the weekend, GPs are supposed to link the client with the ATAPS after hour's suicide support line. The client can call the support line if they are in crisis and a GP can also organise call backs for Friday and over the weekend. Ideally, GPs will call the support line while the client is in the surgery to make sure they get call backs overnight or over the weekend. Ultimately, ATAPS is not a crisis service for high risk clients and not for people who need tertiary care.

If a clinician agrees to take an SPS referral, there will be agreed upon time frames for a first contact with the client and during that first phone contact the ATAPS clinician must perform a risk assessment and develop a safety plan that the client agrees to. Any risk issues identified through that contact must be managed in a professional and timely manner by the clinician. EMPHN only ask that clinicians perform their role professionally in terms of client management as is clinically appropriate. For referrals on Friday this process is the same, but if a referral is received on Friday, the 24 hour timeframe for first contact is likely to extend to Monday as directed by EMPHN intake. If this the first contact is not required until a time specified on Monday, there is no expectation that a safety plan will be developed prior to Monday. This is why it is important for GPs to perform this role after hours or on Fridays and or GPs to manage this risk.**Q: ATAPS is not for a high risk cohort, yet it seems some clients may be high risk. What happens when you cannot contact a client or they don't get back to you?**

A: If clients present with a suicide risk, a clinician should engage in safety planning and obtain client agreement to adhere to a safety plan between sessions. If you are having trouble contacting a client, EMPHN suggest that you try three times at different times of day during the business week. If there is still no contact, send them a contact by seven day letter. If you don't hear back inform the GP in writing and put a brief note on FIXUS. While trying to contact them it is a good idea to check with the GP that the contact numbers are correct, if the GP has seen them in the last few days and if they have a history

of not following through with services. You can also try contacting the next of kin if their details are on the referral form.

The GP is the centre of care, has seen the client and made the referral for a low to moderate risk service. If we can't contact the client we give the referral back to the GP and have a discussion about how assertively that client needs to be followed up. We're happy to do that with you or to talk you through doing that or to have that contact with the GP and think about different ways to support you if you can't contact a client. Ultimately though, if you believe a client to be at risk, whether they are contactable or not, then you must take appropriate steps to professionally manage that risk within appropriate time frames.

Q. Regarding the Suicide Prevention Service, are there limits on phone conversations with clients? Previously, clinicians were allowed to have a certain number of phone contacts. Is it true that clinicians can't have any unless they've done the APS accredited telephone course and, even then, clinicians may only get paid for one telephone consult?

A. Clinicians are allowed 10% phone therapeutic sessions for any ATAPS program which works out to one consult per person for all clients apart from the Bushfire and Posttraumatic Stress Program. But if you need more than that, contact Craig and EMPHN will put into place an agreement to meet the needs of your client in a clinically appropriate manner. EMPHN included one phone contact as a baseline and you can have as much phone contact as you see fitting as a clinician, but you can only bill for one session unless other arrangements have been formalised with EMPHN. Sessions can only be billed if clinicians have completed the APS T-CBT training. This is a minimum training standard set out by the Department of Health that EMPHN supports. EMPHN acknowledge that there is a lot of unpaid work that clinicians do and this facet of clinical work will be reviewed in the future.

Q: In the case of missed appointments, why is there a differentiation between the first session and any of the other sessions?

A: The main reason is that most missed sessions will be the first session. We prefer if you're going to claim for a missed session that it be a session for a client that you've already engaged with. This is the current contractual rule that was decided on in consultation with a number of EMPHN staff members. In the previous Agreement, a no-show used to be one of the 12 sessions. This year, there has been a change and it's over and above the 12 sessions, but clinicians cannot claim this for that first session. This current process is something that will be under review this reporting period as well.

Q: If a client has had 12 sessions this calendar year but needs ongoing care, what are my options in ATAPS?

A: ATAPS session allocations work in a calendar year and in this circumstance there are two options. If you believe that your client meets exceptional circumstances criteria, then outline these to their GP in your treatment report and request that the GP liaise with intake about an exceptional circumstances referral. There is a form for GPs to complete on the website for exceptional circumstances and the criteria for exceptional circumstances is outlined on the ATAPS webpage. If the client has new symptoms, a referral for a new clinician may be appropriate. A referral for a new condition can only occur in the same calendar year as the previous referral if the maximum session numbers for that year have not been exceeded. This is 12 sessions per client for every program with the exception of bushfire and posttraumatic stress which is 24. These caps do not include SPS sessions. Otherwise, the second referral can only be facilitated in the new calendar year. If clinically appropriate, referral to the Mental

Health Nurse Incentive Program is another option for ongoing care.

Q: What if I suspect a client may be able to afford full fee councelling?

A: There is no specific financial rule about income amount for a client, except that a client must be not be able to afford full fee counselling or gap fee subsided MBS to be eligible for ATAPS. It is up to the client's GP to make that assessment.

If you believe that a particular GP is not referring appropriately to ATAPS then please call intake so that we can assist this GP in our capacity building role within the community.

Q: Can we use another tool other than HoNOS?

A: You can use any outcome measure that you deem appropriate with your clients however EMPHN ask that you use the suite of HoNOS measures for all clients. This is an excellent measure and having consistency of outcome measure for all ATAPS clients means that EMPHN have a body of data that is meaningful and useful for service planning.

Q: There are cases where GPs forget to fax the ATAPS forms. Can we computerise the form?

A: The PHN now has Medical Director and Best Practice templates and are working towards having online forms to submit.

Q: I have been told that I will have to go through a tender process moving forward to provide services in ATAPS, is this true?

A: Currently there is no tender process for EMPHN ATAPS for individual providers. All PHNs are different and this may not be the case for other PHNs across Australia. EMPHN are not certain about the specifics of low intensity face to face services in 2017 – 2018 in terms of delivery specifics, contracting and stepped care models, but are committed to retaining a psychological services program as we move forward.

In the interim we are in a continuous process of needs and gaps analysis and will review new applicant AHPs in light of this information as we consider all applicants in an equitable and transparent manner.

Q: Do I have to send the same information at the end of this financial year?

A: Once you have registered for this first time, the paperwork submission requirements will be reduced for the coming financial year.

Q: Would EMPHN consider a referral period longer than three months?

A: The three month referral length is a standardised operational process put in place to ensure that as much funding as possible is available for client's who require services. This does not mean that referrals cannot be longer than three months and a brief email to Kalisteni Kostas requesting an extension with a rationale will ensure that the referral is kept open on Fixus. If a referral is closed and your client requires ongoing care, please email Kalisteni and she will reopen the case if this request is appropriate.

Q: When does the three months start from?

A: The three months start when the case is allocated to you. It will be between three and four months from this date when the case is formally closed on Fixus.

Q: Will payment processing times reduce in the future?

A: EMPHN acknowledge that it has been frustrating for clinicians when a session delivered early in the month has been paid in the middle of the following month. Ultimately, EMPHN aim to make a payment every four weeks and are in the process of reviewing this as a part of our continuous improvement process.

Q: I am wondering about the Suicide Prevention Service and how to access this for the clients?

A: To register, clinicians must complete the APS ATAPS e-learning course and provide Kallisteni with a copy of your certificate. Clients must see their GP to be referred to the SPS program.

Q: I don't think GPs know about the SPS. What can I do to inform my GP?

A: If you think that a clinic could benefit from some capacity building please inform the intake team and/or direct the GP to our website. The new website is a good resource for stakeholders.