Administration of the Access to Allied Psychological Services Program

Department of Health and Ageing

Canberra ACT
21 June 2011

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Department of Health and Ageing with the authority contained in the *Auditor-General Act 1997*. I present the report of this audit and the accompanying brochure to the Parliament. The report is titled *Administration of the Access to Allied Psychological Services Program.*

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

Ian McPhee
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

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Contents

Abbreviations

AGPN	Australian General Practice Network
AMHP	Allied Mental Health Professional
ANAO	Australian National Audit Office
APS	Australian Psychological Society
ATAPS	Access to Allied Psychological Services
BOiMHC	Better Outcomes in Mental Health Care
CGG	Commonwealth Grant Guidelines
COAG	Council of Australian Governments
CSS	Crisis Support Service
DoHA	Department of Health and Ageing
EOI	Expression of Interest
ERC	Expenditure Review Committee
EWG	Evaluation Working Group
Finance	Department of Finance and Deregulation
GP	General Practitioner
MBS	Medicare Benefits Schedule
MDS	Minimum Dataset
MHSRRA	Mental Health Services in Rural and Remote Areas
PBS	Portfolio Budget Statements
PFPS	Program Funding and Procurement Service
PNDI	ATAPS Perinatal National Depression Initiative
T-CBT	Telephone-Cognitive Behavioural Therapy

Glossary

Division of General Practice
Divisions of General Practice provide services and support to general practice at the local level to achieve health outcomes for the community that would not otherwise be achieved on an individual GP basis.[1]

Mental Health
A state of emotional and social wellbeing. It influences how an individual copes with the normal stresses of life and whether he or she can achieve his or her potential. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably with one another and with their environment, in ways that promote subjective wellbeing and optimise opportunities for development and use of mental abilities.[2]

Mental Health Disorder
Is defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder.[3]

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[1] Department of Health and Ageing, 2011, *Overview of the Divisions of General Practice Program*, Canberra. Available from: <http://www.health.gov.au> [accessed 21 February 2011].

[2] Australian Health Ministers, 2003, *National Mental Health Plan 2003–2008*, Canberra, pp. 34–35. Available from: <http://www.health.gov.au> [accessed 21 February 2011].

[3] Department of Health and Ageing, 2010, *2010–11 Guidelines for the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Canberra, p. 34.

Summary and Recommendations

Summary

Introduction

1.   Almost one in two Australians aged 16 to 85 years has experienced a mental health disorder at some point in their life, with anxiety, depression and/or alcohol dependence the most common.[4] In 2008, Australian governments spent $5.1 billion on mental health (see Figure S.1 for the distribution of total recurrent funding on mental health by major funders), which represents 7.5 per cent of total government health spending.[5]

Figure S.1

Distribution of recurrent spending on mental health (2007–08)
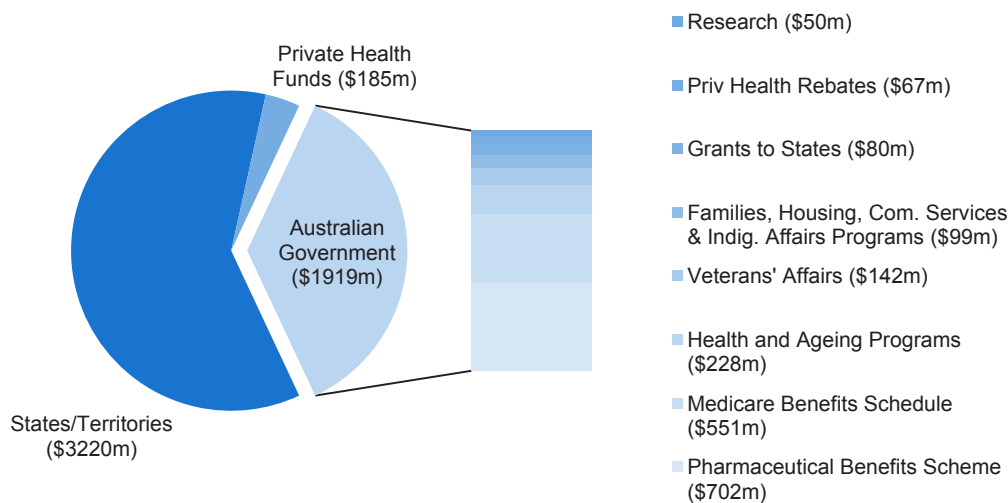
Source: ANAO from the National Mental Health Report 2010.

2.   The impact of mental illness can be profound, with the Mental Health Council of Australia reporting that affected individuals and their carers constitute one of the most disadvantaged and marginalised groups in terms of access to services and complexity of issues. They frequently experience

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4   National Advisory Council on Mental Health, 2009, *Discussion Paper: A Mentally Healthy Future for all Australians*, Canberra, p. 8. Available from: <http://www.health.gov.au> [accessed 22 December 2010].

5   Department of Health and Ageing, 2010, *National Mental Health Report 2010: Summary of 15 Years of Reform in Australia's Mental Health Services Under the National Mental Health Strategy 1993–2008*, Canberra, p. 2. Available from: <http://www.health.gov.au> [accessed 22 December 2010].

financial hardship, housing issues and homelessness, unemployment or underemployment, alcohol and other drug use, and related physical health complaints.[6]

3. Access to treatment remains problematic for many Australians with a mental health disorder. It is estimated that over half the Australians with a mental illness do not access support services. The level of access has gradually improved since 2007, with the improvement attributed primarily to the introduction of additional government funded mental health care programs.[7]

4. The Department of Health and Ageing (DoHA) is the lead agency responsible for advising on, implementing and managing Australian Government mental health care policies and measures. Initiatives and programs administered by DoHA are varied and range from Medicare-based universal mental health programs through to programs designed to provide flexible mental health care services that target hard to reach groups less likely to access Medicare-based services. An example of the latter program type is the Access to Allied Psychological Services (ATAPS) Program.

Access to Allied Psychological Services Program

5. The ATAPS program, which had its origin in a 2001–02 Budget measure, has a current budget of approximately $43 million per year. It is the Australian Government's primary mechanism to address historically poor access to mental health care for specific groups in society, such as people in remote locations including Indigenous communities, youth and the homeless. The program enables General Practitioners (GPs) to refer patients diagnosed as having a mental disorder to an allied mental health professional[8] for a capped number of sessions of focused psychological strategies[9] at low or no cost. Since

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[6] Mental Health Council of Australia, 2011, *ATAPS Flexible Care Packages for People with Severe Mental Illness Discussion Paper*, Canberra, p. 1. Available from: <http://www.mhca.org.au> [accessed 2 May 2011].

[7] University of Melbourne, 2011, *Final Report–Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners Through the Medicare Benefits Schedule Initiative: Summative Evaluation*, Melbourne, pp. 25–27. Available from: <http://www.health.gov.au> [accessed 6 April 2011].

[8] Under the ATAPS program, allied mental health professionals include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications.

[9] The term 'focused psychological strategies' is defined in the 2010–11 ATAPS operational guidelines as the provision of time-limited, evidence-based psychological treatments restricted to psycho-education, cognitive-behavioural therapy, relaxation strategies, skills training, interpersonal therapeutic strategies and narrative therapeutic strategy.

2001–02, over $150 million has been budgeted for the ATAPS program. As part of the 2011–12 Federal Budget, the Government announced a $2.2 billion *National Mental Health Reform* package[10], which included an increase of $206 million over the next five years to double the size of the ATAPS program.

6. The program is administered by a small team within DoHA's Mental Health and Suicide Prevention Branch, which has responsibility for program design, planning, implementation, oversight, and reporting to the Minister and the Parliament. The responsibility for day-to-day delivery of the program rests with the Divisions of General Practice (Divisions), which cover defined geographic areas. Divisions act as fund holders and are allocated an annual budget to broker allied mental health services for consumers referred by GPs.[11] Divisions are afforded flexibility by DoHA to tailor service delivery to suit local circumstances and establish an appropriate system to manage local demand for services within the capped annual budget. Over recent years, these flexible delivery arrangements have been increasingly called upon to deliver the Australian Government's response to the increase in mental health care needs following significant natural disasters, such as the 2009 Victorian bushfires and the 2011 flood and cyclone emergencies in Queensland.

7. Responsibility for day-to-day delivery of the ATAPS program will transition from Divisions to Medicare Locals from mid-2011. Medicare Locals, which are a key component of the Australian Government's National Health Reforms, will be primary health care organisations established to coordinate primary health care delivery to address local health care needs and service gaps.

8. In February 2010, DoHA released a departmental review of the ATAPS program—conducted with oversight from an Expert Advisory Committee— which focused on the outcomes of the program as well as future directions.[12] The department is currently working to implement the areas of enhancement recommended by the review, while also responding to the expansion of the program as a result of substantial new Budget measures over recent years.

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[10]   This package included $1.5 billion over five years in new initiatives.

[11]   Department of Health and Ageing, 2010, *2010–11 Guidelines for the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Canberra, p. 3.

[12]   The review proposed four key future directions around the themes of addressing service gaps, efficiency, innovation and quality.

Audit objective and scope

9.   To examine the effectiveness of the Department of Health and Ageing's administration of the Access to Allied Psychological Services Program.

10.   The focus of the audit was on DoHA's administration of the ATAPS program, including systems and processes that the department employs to: guide its administrative efforts; manage day-to-day delivery of the program through a large number of third-party providers; plan and administer program initiatives; monitor compliance with program requirements; and report on the extent to which the program is achieving the objectives set by government.

Overall conclusion

11.   The ATAPS program, with current annual funding of around $43 million, is a key Australian Government initiative designed to improve access to mental health care, with an increasing focus in recent years on those groups with historically poor access and with low usage of 'mainstream' Medicare-funded services. Since commencing in 2002, the ATAPS program has facilitated greater consumer access, at low or no cost, to Australian Government subsidised treatment in a primary care setting for people experiencing high prevalence mental health disorders, such as depression and anxiety disorders. As at March 2011, more than 900 000 mental health sessions of care had been recorded under the ATAPS program to around 170 000 people with a diagnosed mental health disorder.

12.   Although considered a mature program, ATAPS is at a point of transition, with policy and administrative challenges arising from: a substantial increase in program funding announced in the 2011–12 Budget; the refocusing and targeting of the program following a review released in early 2010 to better complement larger mainstream programs; the implementation of four new ATAPS measures from the 2010–11 Budget; the proposed transfer of responsibility for day-to-day administration from Divisions of General Practice to Medicare Locals; and the implications of broader reforms to the health care system in Australia.

13.   The day-to-day administration of the ATAPS program also presents challenges, requiring departmental engagement with a broad range of program stakeholders—often with competing views on program delivery priorities and approaches—and the oversight of over 100 organisations contracted to implement the program on the Australian Government's behalf. The topical nature of mental health care policy and the clinical aspects of

mental health care service delivery also contribute to the challenges facing DoHA's program administrators. Additionally, the expanded use of the ATAPS service delivery framework to respond to increases in demand for mental health care services following significant natural disasters has called for agility and responsiveness, which the department demonstrated when responding to the 2009 Victorian bushfires and when developing options to respond to the 2011 Queensland flood and cyclone emergencies.

14.   While the ATAPS program is delivering valued services to those able to access mental health care under the capped program, the administrative arrangements established by DoHA have not consistently supported the achievement of program objectives. In particular, there has been variable administrative performance, over the relatively long life of the program, in relation to a number of important program elements including: the allocation of program funding on the basis of identified need; monitoring compliance with program requirements; and the administration of new ATAPS initiatives.

15.   Achieving improvements in access to mental health care services for hard to reach groups is strongly influenced by the extent to which funding for service delivery is matched to those consumers experiencing the greatest need. The allocation of ATAPS funding to Divisions was initially determined using a population-based funding formula. This approach, which reflected the broad eligibility for the program at the time, has not kept pace with demographic changes or changes in the program, such as the increased targeting of services. As DoHA has not historically assessed mental health care needs within Division of General Practice boundaries or regions on a regular basis, or used such information to allocate ATAPS resources, some communities are not receiving an equitable share.

16.   To help ensure that funded organisations deliver the program as intended by government and that eligible consumers receive the appropriate services to which they are entitled, it is necessary to establish clear program requirements. DoHA has established in its program guidelines a broad range of terms, conditions and rules for the delivery of ATAPS services, such as the number of services available to eligible consumers, while relying heavily on self-reporting from Divisions as a means of monitoring compliance. Self-assessment and reporting have inherent limitations with respect to the level of assurance they can provide, but the department has not adequately considered and documented alternatives, such as focusing on those providers presenting the greatest risk of non-compliance. A risk-based approach to monitoring compliance would enable the department to more effectively deploy its limited

resources and to better identify, and if necessary treat, the risk of ATAPS not being used as specified in the program guidelines.

17.   ATAPS has been used regularly as a platform to trial new and innovative service delivery methods with the potential to improve access to mental health care for hard to reach groups. ATAPS initiatives have included trials of telephone-based therapy to address barriers to access for rural and remote consumers and projects to provide greater support for GPs engaged in suicide prevention activities for at risk patients. While certain aspects of DoHA's administration of ATAPS initiatives were well managed, in general, the department had not actively managed initiatives and taken timely corrective action to address identified delivery issues. Furthermore, the absence of success criteria, established at the commencement of each initiative, has meant that the basis on which the department assessed the success or otherwise of initiatives (as a prelude to incorporating them as elements of the core program) was unclear.

18.   The work currently underway within DoHA to implement the areas of enhancement recommended by the ATAPS review provides the department with an opportunity to establish a foundation for future program design decisions and to address identified weaknesses in administration. To assist DoHA to strengthen its administration of the ATAPS program, particularly in light of the substantial expansion of the program announced in the 2011–12 Budget, the ANAO has made five recommendations directed at improving the way in which the department: allocates and manages program funding; supports program administrators; oversees consumer access and the approaches employed by funded organisations to manage demand; administers program initiatives; and monitors compliance with program requirements.

Key findings

Designing the program

19.   The ATAPS program has evolved considerably over the 10 years since it was announced, particularly in response to the introduction of significant new mental health care programs. Most recently, the Government has decided that ATAPS will be complementary to larger mainstream programs through the targeting of hard to reach groups.

20. Across a number of areas, the department was not well placed to make informed program design decisions, primarily due to the lack of: retained information on funding approaches; a complete set of program guidance materials; or evidence on which policy decisions were based. Effectively recording the basis of program changes stemming from the recent review will assist DoHA to make informed decisions regarding future changes in the design of the program and mitigate the risk of program delivery decisions being inconsistent with the policy parameters set by government.

21. DoHA has outlined the key program delivery parameters in its operational guidelines, including: target groups; eligibility criteria; service providers; eligible services; and service delivery models. With the program currently in transition to a more targeted approach, it would be timely for the department to review key ATAPS design elements and guidance materials, including the program guidelines, to ensure that they adequately support the government's new policy settings for the program. The capture of key design elements in an explicit ATAPS program objective, endorsed by government, would also serve to inform future changes to the design of the program, provide a focus for DoHA's performance monitoring activities, and assist the department to convey the intent of the ATAPS program to stakeholders.

Allocating program funding and managing demand

22. As observed by the ATAPS review and as acknowledged by DoHA, ATAPS funding was originally intended to reflect a population-based funding formula, but there has been a drift away from this formula over time, with some communities with higher needs not receiving an equitable share of ATAPS resources. This view is supported by departmental modelling which indicates that, based on a proposed needs-based funding model, around 60 per cent of Divisions would receive more funding while 40 per cent of Divisions would receive less funding. The department has recognised that a move to reallocate program funding presents risks and requires careful management. To support the effective targeting of program funding to those with the greatest need, the department should provide options, for Ministerial consideration, that would allow the ATAPS program to transition to an appropriate needs-based funding model.

23. The use of demand management strategies, such as the establishment of waiting lists, represents a pragmatic response by Divisions to the delivery of mental health care services within a constrained funding envelope. However, some of the approaches adopted by Divisions have the potential to affect

consumers seeking treatment, for example, by further limiting the number of treatments available to consumers within the thresholds set by DoHA for the program. There is scope for DoHA to assess the appropriateness of the demand management strategies employed by Divisions in order to support more consistent and equitable access to treatment for eligible consumers experiencing a mental health disorder.

Supporting program administrators

24. The administration of the ATAPS program is challenging, requiring engagement with a broad range of program stakeholders and the oversight of over 100 organisations contracted to implement the program on the Australian Government's behalf. The effectiveness of program delivery within this environment is heavily dependent on the knowledge, skills and expertise of a small team of program administrators. In order to strengthen day-to-day management of the ATAPS program, there is scope for DoHA to enhance the support that is currently provided for program administrators through the provision of: tailored induction and training; fit-for-purpose policy and procedural materials; and a central record of key program decisions (particularly exemptions and funding levels).

Responding to natural disasters and administering initiatives

25. The ATAPS service delivery framework has been used as a vehicle by the Australian Government to respond to the increased need for mental health care services following natural disasters and to deliver mental health care initiatives.

26. DoHA's oversight of the ATAPS mental health response to the 2009 Victorian bushfires was timely and well designed, with additional flexibilities afforded to Divisions to tailor approaches to local conditions. The department acted quickly to bring forward program payments and provide additional funding to enable Divisions to respond in a timely manner to emerging mental health care needs. The department also demonstrated agility in providing the Government with options to respond to the anticipated increase in mental health care needs following the recent floods across large parts of Queensland.

27. There were also aspects of DoHA's administration of the three recent ATAPS initiatives—Telephone-based Cognitive Behavioural Therapy (T-CBT), Suicide Prevention, and Perinatal National Depression Initiative (PNDI)—that were well managed, such as the use of an international study and experience to

inform the design of the T-CBT trial and the use of relevant data to target PNDI funding to areas of greatest need. However, in general, the department did not actively manage the delivery of initiatives and did not always take timely corrective action to address identified implementation issues. Furthermore, the absence of a set of clearly documented 'success indicators' for ATAPS initiatives made it more difficult for DoHA to effectively monitor the progress of the initiatives and, ultimately, to assess the success or otherwise of the initiatives before incorporating them as elements of the core program.

Monitoring compliance

28.   A balanced approach to the monitoring of compliance with program requirements, involving a mix of education through to the targeted review of a small number of Divisions presenting the greatest risk of non-compliance, would provide DoHA with appropriate assurance while limiting resourcing requirements. The department's current approach to monitoring Divisions' compliance with program requirements relies heavily on self-reporting, complemented by the provision of annual audited financial statements. While the department's use of reports from Divisions to monitor compliance is efficient from a departmental perspective, self-assessment has inherent limitations with respect to the level of assurance it provides on compliance with program requirements. In order to plan and coordinate its compliance activities, DoHA should establish a risk-based compliance approach to direct limited departmental resources to those providers presenting the greatest risk of non-compliance.

Evaluating program performance

29.   The department's focus on evaluation (involving the preparation of two to three evaluation reports each year) throughout the life of the ATAPS program is viewed by many stakeholders as a strength. It would be timely, given the passage of time since the program commenced and the changes to policy and administrative settings arising from the recent review, for the department to re-examine the evaluation needs of the ATAPS program in order to better determine the level and future focus of evaluation activity.

Summary of agency response

30.   DoHA advised that the following summary comment and the responses to each of the recommendations in the body of the report comprised its formal response:

> The Department of Health and Ageing (DoHA) welcomes the comprehensive audit of the *Access to Allied Psychological Services (ATAPS) program*—spanning the complete ten year history of the program—undertaken by the ANAO and agrees to all five recommendations. DoHA notes that the action recommended in Recommendation 1 was taken in 2010; many of the matters covered in the recommendations are currently being addressed; and implementation of the audit recommendations will further enhance the effectiveness of the administration of the program to continue to produce positive consumer outcomes for particularly disadvantaged Australians with mental illness.

> The administrative arrangements put in place by DoHA have enabled ATAPS to become positioned, as the audit points out, as a targeted program that complements other primary care mental health programs, including services funded through Medicare. It has been shaped to become an agile and well respected program which is able to respond quickly and effectively to emerging needs such as disaster recovery and government policy objectives, particularly in better targeting hard to reach groups. The ongoing evaluation of the program has shown it has delivered effective, evidence based services which have improved mental health outcomes for people in hard to reach populations, within the allocated resources.

Recommendations

The ANAO has made the following recommendations aimed at strengthening DoHA's administration of the ATAPS program. Report references and abbreviated departmental responses are included below, with DoHA's full responses to the recommendations included in the body of the report.

Recommendation No. 1

Para 3.16

To support the effective targeting of program funding, the ANAO recommends that DoHA provide options, for Ministerial consideration, that would allow the ATAPS program to transition to an appropriate needs-based funding model.

DoHA response: *Agreed*

Recommendation No. 2

Para 4.27

To strengthen management of the ATAPS program, the ANAO recommends that DoHA enhance support for program administrators through the provision of:

(a)   induction and training tailored to the administration of the ATAPS program;

(b)   fit-for-purpose policy and procedural materials to guide administrators, support consistent administrative practice and retain corporate knowledge; and

(c)   a central repository to provide administrators with ready access to key program decisions that they require to efficiently discharge their responsibilities.

DoHA response: *Agreed*

Recommendation No. 3

Para 4.48

To support equitable access to treatment for eligible consumers experiencing a mental health disorder, the ANAO recommends that DoHA periodically review the demand management strategies employed by Divisions funded under the ATAPS program and provide additional assistance and guidance where necessary.

DoHA response: *Agreed*

Recommendation No. 4

Para 5.53

In order for DoHA to effectively monitor progress and assess the success or otherwise of any future ATAPS initiatives, the ANAO recommends that the department:

(a) establish success indicators at the commencement of each initiative and use these indicators to inform ongoing monitoring and evaluation activities; and

(b) record key implementation and evaluation decisions to support accountable program delivery.

DoHA response: *Agreed*

Recommendation No. 5

Para 6.21

In order to plan and coordinate its compliance activities, the ANAO recommends that DoHA establishes a risk-based compliance strategy, promulgates the strategy to internal and external stakeholders, and periodically reviews the strategy.

DoHA response: *Agreed*

Audit Findings

1. Introduction

This chapter provides an overview of the prevalence of mental illness in Australia and outlines the provision of mental health care services, with a focus on the Access to Allied Psychological Services Program. It also introduces the audit, including the audit objective, scope and approach.

Mental health in Australia

1.1   Almost one in two Australians aged 16 to 85 years has experienced a mental health disorder at some point in their lives, with anxiety, depression and/or alcohol dependence the most common. The prevalence of mental health disorders in Australia is expected to rise, with the World Health Organisation predicting that developed nations will see an increase in the burden of disease and disability attributable to mental illness over the next decade.[13]

1.2   The impact of mental illness can be profound, with the Mental Health Council of Australia reporting that affected individuals and their carers constitute one of the most disadvantaged and marginalised groups in terms of access to services and complexity of issues. They frequently experience financial hardship, housing issues and homelessness, unemployment or underemployment, alcohol and other drug use, and related physical health complaints.[14]

1.3   In 2008, Australian governments spent $5.1 billion on mental health (see Figure 1.1 for the distribution of total recurrent funding on mental health by major funders), which represents 7.5 per cent of total government health spending.[15] Government spending on mental health—in relation to government spending on health generally—has remained stable over the last 15 years.[16]

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[13]   National Advisory Council on Mental Health, 2009, *Discussion Paper: A Mentally Healthy Future for all Australians*, Canberra, p. 8. Available from: <http://www.health.gov.au> [accessed 22 December 2010].

[14]   Mental Health Council of Australia, 2011, *ATAPS Flexible Care Packages for People with Severe Mental Illness Discussion Paper*, Canberra, p. 1. Available from: <http://www.health.gov.au> [accessed 2 May 2011].

[15]   Commonwealth of Australia, 2010, *National Mental Health Report 2010: Summary of 15 Years of Reform in Australia's Mental Health Services Under the National Mental Health Strategy 1993–2008*, Canberra, p. 2. Available from: <http://www.health.gov.au> [accessed 22 December 2010].

[16]   ibid, pp. 25–26.

Figure 1.1

Distribution of recurrent spending on mental health (2007–08)

Private Health Funds ($185m)

Australian Government ($1919m)

States/Territories ($3220m)

- Research ($50m)
- Priv Health Rebates ($67m)
- Grants to States ($80m)
- Families, Housing, Com. Services & Indig. Affairs Programs ($99m)
- Veterans' Affairs ($142m)
- Health and Ageing Programs ($228m)
- Medicare Benefits Schedule ($551m)
- Pharmaceutical Benefits Scheme ($702m)
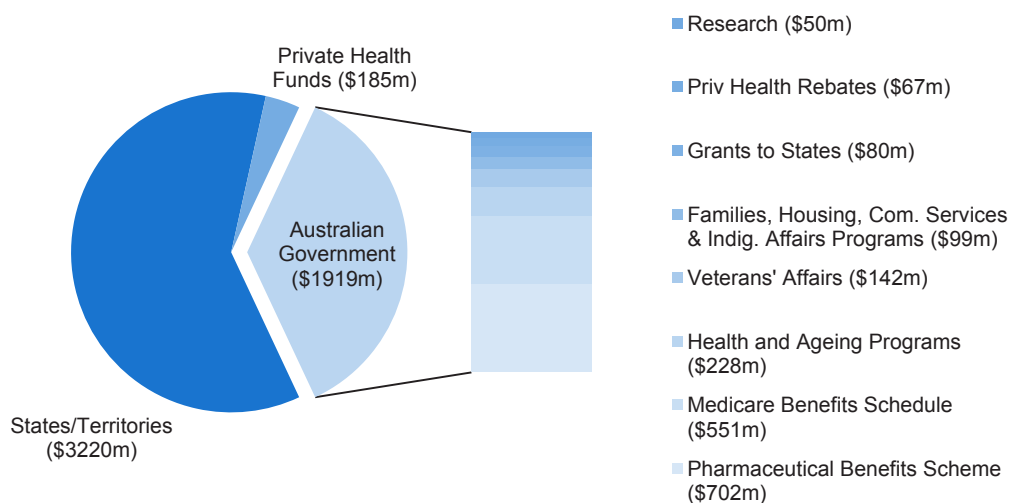
Source: ANAO from the National Mental Health Report 2010.

1.4   Access to treatment remains problematic for many Australians. It is estimated that over half the Australians with a mental illness do not access support services. The level of access remained largely unchanged between 1997 and 2007, with only a third of Australians with a mental illness accessing health services in 2007.[17] A reported gradual improvement in access since 2007 is attributed primarily to the introduction of additional government funded mental health care programs.[18] In relation to levels of access, the Minister for Health and Ageing has stated that not enough people are accessing mental health care services—services that can and should be helping with their mental health problems.[19]

1.5   The National Advisory Council on Mental Health considered that more needs to be done to provide mental health care that meets the needs of specific

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[17]   Australian Bureau of Statistics, 2007, *National Survey of Mental Health and Wellbeing: Summary of Results*, Canberra. Available from: <http://www.health.gov.au> [accessed 22 December 2010].

[18]   University of Melbourne, 2011, *Final Report–Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners Through the Medicare Benefits Schedule Initiative: Summative Evaluation*, Melbourne, pp. 25–27. Available from: <http://www.health.gov.au> [accessed 6 April 2011].

[19]   Slade et al, 2009, *The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing*, Canberra. Available from: <http://www.health.gov.au> [accessed 24 December 2010]. Foreword by the Minister for Health and Ageing.

groups within society with historically poor access to mental health care. These groups include: Indigenous Australians[20]; those who have experienced generational trauma and abuse; people who are homeless; children living in families with severe mental illness; people from culturally and linguistically diverse communities; offenders and their families; youth; the elderly; and people with personality disorders.[21]

Responsibility for mental health care services in Australia

1.6　The responsibility for delivering mental health care services in Australia is shared across government, community and private sector providers.

1.7　The responsibility of governments for the provision of mental health care services is generally aligned with the severity and prevalence of the mental health disorder. The Australian Government is primarily responsible for less severe, high prevalence mental health disorders[22] through the primary health care system. State and Territory governments are primarily responsible for more severe, low prevalence mental health disorders[23] which affect around 2.5 per cent of the Australian population. Treatment is generally delivered through specialised mental health services.

1.8　The Department of Health and Ageing (DoHA) is the lead agency responsible for advising on, implementing, and managing Australian Government mental health care policies and measures. Other Australian Government agencies also play a role in implementing specific initiatives and are responsible for measures which relate to their core responsibilities.[24]

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[20]　The Australian Institute of Health and Welfare reported that, based on 2008 data, almost one-third of young Indigenous people (aged 16–24 years) had high or very high levels of psychological distress—more than twice the rate of young non-Indigenous Australians. Indigenous young people were also hospitalised more commonly for mental and behavioural disorders, at 1.8 times the non-Indigenous rate. Australian Institute of Health and Welfare, 2011, *The health and welfare of Australia's Aboriginal and Torres Strait Islander people, an overview 2011*, Cat. no. IHW 42, Canberra, p. ix. Available from: <http://www.aihw.gov.au> [accessed 5 May 2011].

[21]　National Advisory Council on Mental Health, op cit., p. 9.

[22]　These include: common anxiety and depressive disorders, personality disorders, and eating disorders.

[23]　These include: psychoses, bipolar disorder, severe depression, severe anxiety conditions, and severe eating disorders.

[24]　For example, the Department of Education, Employment and Workplace Relations has primary responsibility for implementing mental health measures related to employment and training.

1.9 The delivery of the Australian Government's mental health initiatives and programs by DoHA primarily occurs under the department's Outcome 11: *Mental Health*. The Outcome 11 objective is: 'Improved mental health and suicide prevention, including through targeted prevention, identification, early intervention and health care services'.[25] These initiatives and programs are varied and range from Medicare-based universal mental health programs through to programs designed to provide flexible mental health care services that target hard to reach groups that are less likely to access Medicare-based services. An example of the latter program type is the Access to Allied Psychological Services (ATAPS) Program.

Access to Allied Psychological Services Program

1.10 The ATAPS program had its origin in a 2001–02 Budget measure. The Australian Government announced the Better Outcomes in Mental Health Care (BOiMHC) initiative in the 2001–02 Budget, with $120.4 million allocated over four years. This initiative consisted of five interrelated components aimed at improving community access to quality primary mental health care. At present, only two components remain comprising the GP Psych Support initiative and the ATAPS program.[26]

1.11 The ATAPS program is the Australian Government's primary mechanism to address historically poor access to mental health care for specific groups in society, such as people in remote locations including Indigenous communities, youth and the homeless, with low usage of 'mainstream' Medicare-funded services. The program enables General Practitioners (GPs) to refer patients diagnosed as having a mental disorder to an allied mental health professional[27] for a capped number of sessions of focused psychological strategies[28] at low or no cost. As at March 2011, more than 900 000 mental

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[25] Department of Health and Ageing, 2010, *Portfolio Budget Statements 2010–11*, Canberra, p. 5. Available from: <http://www.health.gov.au> [accessed 24 December 2010].

[26] The GP Psych Support initiative provides General Practitioners with patient management advice from psychiatrists within 24 hours.

[27] Under the ATAPS program, allied mental health professionals include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications.

[28] The term 'focused psychological strategies' is defined in the 2010–11 ATAPS operational guidelines as the provision of time-limited, evidence-based psychological treatments restricted to psycho-education, cognitive-behavioural therapy, relaxation strategies, skills training, interpersonal therapeutic strategies and narrative therapeutic strategy.

health sessions of care had been recorded under the ATAPS program to around 170 000 people with a diagnosed mental health disorder. Funding for the ATAPS program is capped, with a current annual budget of around $43 million. Since 2001–02, over $150 million has been budgeted for the ATAPS program.

1.12 The program is administered by a small team within DoHA's Mental Health and Suicide Prevention Branch, which has responsibility for program design, planning, implementation, oversight, and reporting to the Minister and the Parliament. The responsibility for day-to-day delivery of the program rests with the Divisions of General Practice (Divisions), which cover defined geographic areas. Divisions act as fund holders and are allocated an annual budget to broker allied mental health services for consumers referred by GPs.[29] Divisions are afforded flexibility by DoHA to tailor service delivery, including the development of innovative approaches, to suit local circumstances according to identified need and establish an appropriate system to manage local demand for services within the capped annual budget. The Centre for Health Policy, Programs and Economics, located at the University of Melbourne, has been commissioned, since the commencement of ATAPS, to prepare regular evaluation reports on various aspects of the program.

1.13 The ATAPS program is one of a broad range of government programs and initiatives aimed at improving access to mental health services for people with a mental health disorder. Related programs include:

- *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative*: enables GPs to refer patients diagnosed with a mental illness to allied mental health professionals for a series of time-limited focused psychological strategies subsidised under the Medicare Benefits Schedule (MBS).[30]

- *Mental Health Services in Rural and Remote Areas (MHSRRA) program*: provides allied and nursing mental health services in rural and remote

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[29] Department of Health and Ageing, 2010, *2010–11 Guidelines for the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Canberra, p. 3.

[30] Allied mental health professionals under the Better Access program include psychiatrists, clinical psychologists, registered psychologists, social workers and occupational therapists.

communities across Australia, with a mental health workforce similar to that of ATAPS.[31]

- *Mental Health Support for Drought Affected Communities initiative*: the majority of funding under this initiative is allocated to 41 eligible rural and remote Divisions to provide community outreach and crisis counselling to communities affected by drought.

Recent ATAPS developments

Program review

1.14 In February 2010, DoHA released a departmental review of the ATAPS program—conducted with oversight from an Expert Advisory Committee—which focused on the outcomes of the program as well as future directions. The review proposed four key future directions around the themes of addressing service gaps, efficiency, innovation and quality. A significant change stemming from the review was the staged introduction of amended funding arrangements from 1 July 2010, which are designed to better target existing funding allocations to hard to reach groups.

New ATAPS elements and program expansion

1.15 The 2010–11 Federal Budget allocated $58.5 million over four years to extend ATAPS to deliver new packages of care for up to 25 000 people with severe mental illness being managed in the community. The packages are designed to provide coordinated, individualised care bringing together clinical and non-clinical services to enable those with severe mental illness to experience better health and social outcomes and prevent unnecessary hospitalisation. Implementation of the flexible care packages commenced on 1 April 2011.

1.16 In late 2010, the Government allocated additional funding for the ATAPS program in the areas of: child mental health ($21.6 million over four years); psychological services in the community for individuals at risk of suicide ($23.5 million over three years); as well as more community-based psychiatry services ($22.5 million over three years).

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[31] Organisations such as Divisions, Aboriginal Medical Services and the Royal Flying Doctor Service receive funding to provide mental health care services.

1.17   As part of the 2011–12 Federal Budget, the Government announced a $2.2 billion *National Mental Health Reform* package[32], which included an increase of $206 million over the next five years to double the size of the ATAPS program. The Government estimates that this additional ATAPS funding will support a further 185 000 people with a mental health disorder.

Transition from Divisions to Medicare Locals

1.18   A key component of the Australian Government's National Health Reforms is the establishment of a new nation-wide network of Medicare Locals. Medicare Locals will be primary health care organisations, established to coordinate primary health care delivery to address local health care needs and service gaps.[33] The implementation of Medicare Locals is planned to occur in three stages from mid-2011. A total of $477 million over four years will be provided to establish the national network of Medicare Locals across Australia. The Government has announced that Medicare Locals, once established, will assume responsibility for the day-to-day delivery of the ATAPS program.[34]

The audit

Audit objective and scope

1.19   To examine the effectiveness of the Department of Health and Ageing's administration of the Access to Allied Psychological Services Program.

1.20   The focus of the audit is on DoHA's administration of the ATAPS program, including systems and processes that the department employs to: guide its administrative efforts; manage day-to-day delivery of the program through a large number of third-party providers; plan and administer program initiatives; monitor compliance with program requirements; and report on the extent to which the program is achieving the objectives set by government.

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[32]   This package included $1.5 billion over five years in new initiatives.

[33]   Medicare Locals are to be established as independent companies limited by guarantee, managed by skills-based boards, and as such will be subject to the *Corporations Act 2001*.

[34]   Commonwealth of Australia, 2010, *A National Health and Hospitals Network for Australia's Future: Delivering Better Health and Better Hospitals*, Canberra, p. 111. Available from: <http://www.yourhealth.gov.au> [accessed 7 April 2011].

Audit criteria

1.21 Our assessment was based on the following criteria:

- DoHA has established robust program governance arrangements;
- DoHA's day-to-day management of the program is sound; and
- DoHA effectively monitors and reports program performance.

Audit approach

1.22 The audit methodology comprised:

- interviewing key administrative and management personnel at DoHA's Central Office;
- interviewing stakeholders, including representatives from peak professional bodies and consumer representative organisations;
- visiting Divisions of General Practice;
- assessing departmental compliance with the provisions of the Commonwealth Grant Guidelines;
- reviewing relevant documentation, including policies, procedures, agreements and correspondence;
- analysing and testing program data holdings; and
- reviewing relevant literature.

1.23 The audit was conducted in accordance with ANAO Auditing Standards at a cost of $325 000.

Report structure

1.24 The audit findings are reported in the following chapters:

Chapter	Chapter Overview
2. Designing the Program	*Examines the way in which DoHA has designed the ATAPS program to support the achievement of the Government's policy objectives.*
3. Planning for Program Delivery	*Examines DoHA's planning arrangements, with a focus on determining needs, funding allocations, and setting performance standards.*

Chapter	Chapter Overview
4. Managing Program Delivery	*Examines DoHA's day-to-day management of ATAPS program delivery, with a focus on guidance for funded organisations, support for program administrators, stakeholder engagement, coordinating mental health programs, and managing consumer demand.*
5. Responding to Natural Disasters and Administering Initiatives	*Examines DoHA's use of the ATAPS service delivery framework to respond to the increased demand for mental health care services following natural disasters and to deliver ATAPS program initiatives.*
6. Monitoring and Reporting Program Performance	*Examines performance monitoring and reporting arrangements established by DoHA for the ATAPS program, with a focus on performance monitoring against established measures, compliance monitoring, reporting program performance to stakeholders, and evaluating the program's achievements.*

2. Designing the Program

This chapter examines the way in which DoHA has designed the ATAPS program to support the achievement of the Government's policy objectives.

Introduction

2.1 In order to meet government and stakeholder expectations regarding the achievement of established policy objectives, it is important for administering agencies to possess a well-developed understanding of the Government's policy intent and to design programs that effectively and efficiently facilitate achievement. Where the delivery of government programs is devolved to third parties, including non-government organisations, it is necessary for administering agencies to clearly explain program objectives and delivery parameters—essentially, 'who' will benefit from the programs and 'what' services they will receive.

2.2 The ANAO's examination of the design decisions for the ATAPS program considered the:

- ATAPS program structure—including the policy foundations for the program and the evolution of the program since it was announced in 2001;

- consumer access to services—focusing on eligibility criteria and targeting of program services; and

- services available to eligible consumers—including approved service providers, available services and models of service delivery.

Program structure

Policy foundation

2.3 The ATAPS program (initially entitled *Access to Allied Health Services*) was established as part of the Better Outcomes in Mental Health Care (BOiMHC) initiative, which was announced in the 2001–02 Federal Budget. The ATAPS program, along with the other four components of the BOiMHC initiative[35], was designed to enhance the capacity of GPs to incorporate

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[35] These were: education and training for GPs; the 3 Step Mental Health Process; focused psychological strategies; and GP access to psychiatrist support.

effective management of mental health problems as a component of their normal practice.

2.4   The 2001–02 Budget measure which established the BOiMHC initiative, entitled *More Options, Better Services*, provided $120.4 million over four years to: address barriers to the early identification and treatment of mental health disorders in Australia; and provide more appropriate remuneration for focused diagnosis and care of patients presenting to GPs with mental health problems.

2.5   When explaining the BOiMHC initiative following the Budget, the then Minister for Health and Aged Care described mental health as a 'silent epidemic in Australia' and provided the following rationale for the initiative:

> Most people use GPs as their entry point for mental health issues. GPs find it uneconomic to consult and they really only have chemical treatment options available. We'll be providing $120 million over the next four years, but rising to $50 million in the fourth year, so it will be a substantial investment. And we will be paying GPs to develop their skills in mental health diagnosis, care and treatment…and for the first time ever, it will also enable GPs to access allied health providers, particularly psychologists, in a way that we've never been able to do before. In mental health, our resources have gone into psychiatry. A great deal of treatment could be provided other than by psychiatrists, and we think it's about time Medicare started focusing on some of these broader issues.[36]

2.6   The ATAPS program is now 10 years old and has evolved since it was announced to accommodate changes in the delivery environment and refinements to the Government's policy settings for the program. Most recently, the Government has decided that ATAPS will be complementary to larger mainstream programs through the targeting of hard to reach groups.

2.7   In this context, it is important for program administrators to have suitable visibility of, and access to, the key policy materials that have shaped the program since its introduction. This provides the basis for understanding current policy and administrative settings and informs deliberations as to the need for, and nature of, potential changes to those settings. The departmental policy advice on which government decisions are based, and program guidelines, are particularly important resources for administrators where

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[36]   Wooldridge, M. Dr, 2001, *Address at the Australian Institute for Political Science Breakfast to Discuss Budget's Health Funding*. Available from: <http://www.health.gov.au> [accessed 28 November 2010].

programs are established under executive authority, that is, those programs where key delivery parameters are not set by legislation. Retention of such materials in an accessible form assists agencies' management of corporate knowledge, and is also a means of managing the risks associated with staff mobility and turnover.

2.8   Across a number of areas, the department was not well placed to make informed program design decisions, primarily due to the lack of: retained information on funding approaches[37]; program guidance materials[38]; or evidence on which policy decisions were based.[39]

Program evolution

2.9   The ATAPS program was initially established as a pilot, with 15 projects[40] funded under Round 1 between June and August 2002. A further 14 supplementary projects were funded under Round 1 between January and March 2003. The program was then significantly expanded under a second funding round in which 41 additional projects were approved in July 2003. A third funding round, in July 2004, resulted in an additional 32 projects receiving program funding, with a further six projects funded from July 2005 (Round 4 projects).

2.10   Over the 10 years since it was announced, the ATAPS program has evolved in response to the introduction of new mental health care programs, primarily the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (Better Access) initiative, and resulting changes to the broader BOiMHC initiative, such as the removal of mandatory GP mental health education and training. In recent years, the program has increasingly targeted specific demographics and mental health disorders

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[37]   The basis on which DoHA originally determined and allocated ATAPS funding to Divisions and subsequently altered funding levels over time has not been clearly recorded by the department (the allocation of funding for Divisions is examined in Chapter 3).

[38]   DoHA was unable to locate copies of ATAPS operational guidelines relating to the period from program announcement in 2001 through to 2005. Further, DoHA was unable to provide evidence of the approval of the 2005, 2008 and 2010 revisions to the ATAPS guidelines (guidance for funded organisations is examined in Chapter 4).

[39]   The department was unable to provide evidence to explain the basis on which policy decisions were taken by government over the life of the ATAPS program, with the ANAO referred initially to overarching, public policies and strategies.

[40]   The term 'project' is used by DoHA to define the ATAPS funded activities delivered by each Division. Some Divisions may deliver projects on behalf of other Divisions.

through a series of initiatives. Additionally, the recent review of the program has seen the introduction of revised delivery and funding arrangements in 2010 with further changes foreshadowed.

Introduction of the Better Access initiative

2.11 In 2006, COAG endorsed a new *National Action Plan on Mental Health*. The Australian Government allocated $1.9 billion for specific initiatives to progress the plan. A key initiative under the COAG package, with most relevance to the ATAPS program, was the commencement in November 2006 of the Better Access initiative.

2.12 Under Better Access, psychiatrists, GPs and psychologists (and appropriately trained social workers and occupational therapists) are able to provide mental health care services on a fee-for-service basis subsidised through Medicare.[41] As is the case for the ATAPS program, the initiative provides access to short-term psychological therapies, but this is done through private providers not through fund holding arrangements.

2.13 While the uptake of ATAPS services decreased briefly when the Better Access initiative was introduced, demand has subsequently returned to previous levels. The Government now views the ATAPS program as an important and necessary program to complement the much larger Better Access initiative, in particular through the targeting of groups with low usage of Medicare-funded services.

Changes in BOiMHC

2.14 In addition to the ATAPS program, BOiMHC originally comprised components to support education and training for GPs, provide GPs with support from psychiatrists, and deliver increased GP remuneration for the delivery of mental health care services. These components were superseded by the Better Access initiative, with mandatory GP education and training no longer a pre-requisite for participation in the ATAPS program. While this change has meant that GPs are no longer required to undertake specified supplementary mental health care training, it has resulted in a larger number of GPs being eligible to refer consumers under the ATAPS program.

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[41] In the period since the introduction of the initiative in November 2006 to 30 June 2010, over 13.7 million Medicare-subsidised psychological services have been provided to around 2.3 million people, including over 620 000 people living in rural and remote areas.

Administration of initiatives

2.15 The Government has also used the ATAPS delivery framework to target mental health care services to specific demographics and mental health disorders through the establishment of a series of ATAPS initiatives. To date, the ATAPS program has been used to deliver: a trial of Telephone-based Cognitive Behavioural Therapy (T-CBT); the Support for Patients at Risk of Suicide and Self Harm project; and an ATAPS component under the National Perinatal Depression Initiative.

2.16 The Government has expanded the ATAPS program to target people experiencing severe mental disorders. The 2010–11 Budget allocated $58.5 million over four years to the delivery of new flexible packages of coordinated care for people with severe mental illness being cared for in a primary care setting through ATAPS program arrangements. The flexible care packages component of the ATAPS program commenced on 1 April 2011.

2.17 The Government has also used the ATAPS delivery framework to provide targeted assistance to areas experiencing severe natural disasters. In particular, additional ATAPS program funding was made available to provide services for people with increased mental health care needs following the 2009 Victorian Bushfires and, more recently, the 2011 Queensland flood and cyclone emergencies.

2.18 DoHA's administration of ATAPS initiatives and responses to natural disasters is covered in Chapter 5: *Responding to Natural Disasters and Administering Initiatives.*

Current focus: ATAPS program review

2.19 DoHA considered that, 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. The Minister for Health and Ageing established a review process to examine how ATAPS could be further developed to capitalise on the service provision of new, complementary programs and better target harder to reach population groups. The review was undertaken by the department, with oversight provided by an expert committee comprising a broad range of mental health care service delivery stakeholders.

2.20   The review, which commenced in April 2008, was finalised in early 2010 with a report released in February 2010.[42] The review identified four key areas of enhancement comprising: better addressing service gaps; increasing efficiency; encouraging innovation; and improving quality. In order to support the transition to new delivery arrangements, the review recommended that DoHA develop an implementation plan in consultation with stakeholders to: 'support realistic and practical *[approaches]* to implementing the directions in the review report'.[43] The review suggested that a stakeholder workshop in early 2010 would be an important opportunity to discuss the implementation plan and other key elements of the proposed new arrangements. Additionally, the review recognised the need for revised ATAPS guidelines, including a requirement for additional guidance on the new funding arrangements.

2.21   The new funding arrangements stemming from the review currently comprise a two-tiered funding model. As of June 2010, Tier 1 (base) funding was available to Divisions of General Practice (Divisions) to continue targeting psychological services within their populations. Tier 2 (special purpose) provides funds to target services for women with perinatal depression, suicide prevention, bushfire victims, people at risk of homelessness, people in remote locations, and children with mental health disorders. As part of the health and hospital reforms announced by the Government in April 2010, additional funding will be available to establish and implement a third tier which will cater for people with severe, persistent and complex mental disorders.

2.22   The department has worked to implement the enhancements outlined in the review report and established new funding agreements with Divisions in May/June 2010 based on the new tiered funding model (Tiers 1 and 2 initially). The ATAPS operational guidelines were revised in June 2010 to reflect the new funding arrangements. DoHA also consulted with stakeholders, with a draft implementation plan forming the basis of consultations, in late 2010 and early 2011. Notwithstanding these activities, Divisions expressed concerns regarding the limited guidance provided by the department covering the introduction of Tier 2 funding and the absence of sufficient information on the introduction of Tier 3 funding. There were

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[42]   Department of Health and Ageing, 2010, *Outcomes and proposed next steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Canberra. Available from: <http://www.health.gov.au> [accessed 6 December 2010].

[43]   ibid, p. 23.

particular concerns raised regarding: delayed consultation; the lack of clarity surrounding the process used to select Tier 2 target groups; and issues surrounding the difficulties encountered when establishing capacity to target a particular group with no certainty regarding ongoing funding.[44]

2.23   The endorsement of an implementation plan and the conduct of stakeholder workshops in early 2010, as recommended by the review, would have better assisted DoHA to communicate its program reforms to stakeholders. It would also have provided Divisions with sufficient understanding of, and allowed them to prepare for, the impending changes to the way in which the ATAPS program was to be funded and delivered.

Consumer access to services

Eligibility criteria and targeting

2.24   Over recent years, the intended focus of the ATAPS program has evolved from delivering mental health care services to the broad population, to delivering services to those segments of the population that experience difficulty in accessing services. The change in focus has resulted from the introduction of additional mental health care programs, primarily the Better Access initiative in 2006. The Better Access initiative is well placed to deliver high volume universal mental health care, but less successful in reaching people in rural and remote areas and people in lower socio-economic groups. The ATAPS program is now viewed as a complementary program to the much larger, uncapped Better Access initiative.

2.25   The Government, in its endorsement of the future directions from the recent review, has supported this complementary role for the ATAPS program. The new approach will be underpinned by a move to focus program resources on hard to reach and disadvantaged groups, and the Government has subsequently agreed to new funding arrangements designed to: 'better target funding to where it is needed'.[45]

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[44]   In a presentation to the Australian General Practice Network's Primary Mental Health Care National Conference, DoHA stated that target groups under Tier 2 are variable, that is: '[*there*] may be different groups next year'.

[45]   Letter from the Minister for Health and Ageing to Divisions of General Practice, April 2010.

2.26 In this context, the establishment of a clear program objective would help frame the new policy settings and inform eligibility and targeting criteria. DoHA has developed a number of descriptive statements, across a variety of program documents, about the intent of the ATAPS program, but is yet to promulgate an endorsed program objective. The various descriptive statements for the program used by DoHA in different program documents touch on a number of common themes, such as the treatment of mental health disorders via focused psychological strategies. However, there are a broad range of differences across the statements relating to targeting, the nature of mental health disorders, and the duration of treatments. The establishment of an explicit ATAPS program objective would inform changes to the design of the program, provide a focus for DoHA's performance monitoring activities, and assist the department to convey the intent of the ATAPS program to stakeholders.

2.27 Following a significant change in the focus of a mature program, it is also particularly important for administering agencies to ensure that program guidance materials incorporate and clearly communicate the new policy settings. This provides a 'line of sight' alignment with government policy, sets the foundations for effective program governance, and places all program stakeholders 'on the same page'.

2.28 DoHA has outlined the changing focus of the program in its current ATAPS operational guidelines, which advise that: 'The role of ATAPS has evolved from providing services to a broad population to focussing on service gaps and populations not well serviced by other mental health programs'. However, while the guidelines indicate that priority should be given to those segments of the population that experience difficulty in accessing mental health treatment, they also advise that eligibility for the program remains open to all people experiencing a mental health disorder. On their face, the guidelines do not reconcile the historic (broad) eligibility for the program and the contemporary (targeted) focus which is intended to direct funding to specific demographics or mental health disorders. As currently drafted, the guidelines suggest that there is tension between the historic and contemporary approaches to eligibility:

> While any consumer with a mental disorder would generally be eligible for ATAPS, it is intended to target services to those individuals requiring primary

mental health care who are not likely to be able to have their needs met through Medicare based mental health services.[46]

2.29 There would be merit in reviewing the program guidelines to avoid any apparent inconsistencies in their wording. There would also be benefit in reviewing certain ATAPS design elements to ensure that they also support the new targeted approach. While the ATAPS program is being positioned as a complementary program to the Better Access initiative, key design elements of the program are shared, including eligibility. At present, both programs include:

- broad eligibility to individuals with a mental health disorder diagnosed by a GP;

- the provision of short-term, focused psychological interventions; and

- interventions provided by appropriately qualified allied mental health professionals.

2.30 As a consequence, ATAPS services are currently being delivered to a similar demographic as the Better Access initiative[47], but skewed to rural areas and low income consumers. A much higher proportion of ATAPS services are delivered in rural areas than the Better Access initiative (45 per cent compared to 18 per cent); with significantly lower average co-payments ($2.79 compared to $19.03 in urban areas and $0.76 compared to $15.31 in rural areas).

2.31 The need for effective articulation of the complementary role of the ATAPS program was identified in the 2010 ATAPS review, which stated:

> Anecdotes of Better Access and ATAPS operating in the same location, provided by the same allied mental health providers, providing an identical service illustrate the risks of duplication if a clearer distinguishing role for ATAPS is not defined.[48]

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[46] Department of Health and Ageing, 2010, *2010–11 Guidelines for the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Canberra, p. 3.

[47] Approximately 72 per cent of consumers of ATAPS services are female, with an average age of 39 years. This compares with the Better Access initiative, where around 66 per cent of consumers are women aged between 35 and 44 years.

[48] Department of Health and Ageing, 2010, *Outcomes and proposed next steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Canberra, p. 18. Available from: <http://www.health.gov.au> [accessed 6 December 2010].

2.32 As noted earlier, ATAPS is a program in transition and DoHA has taken steps to position the program as a complementary, targeted program, including through the introduction of tiered funding. There is, however, scope for the department to take additional steps as part of the transition, by reviewing certain ATAPS design elements and guidance materials, including the program guidelines, to ensure that they adequately support the Government's new policy settings for the program.

Services available to eligible consumers

Service providers

Clinicians who can refer consumers

2.33 Under the ATAPS program, GPs play a central role in the initial diagnosis of a mental health disorder, preparation of a Mental Health Care Plan, referral to an allied mental health professional and subsequent assessment of the outcome of treatment. While DoHA encourages assessment and referral by a GP in most cases, the operational guidelines acknowledge that this will not always be possible. In some circumstances, other clinicians may prepare the Mental Health Care Plan, for example medical officers in non-government organisations. It is, however, the department's preference that consumers access the ATAPS program via a GP referral.

2.34 Program stakeholders informed the ANAO that the requirement for referral by a GP, while generally a 'good thing', presents a potential barrier to program access and is impractical for some groups targeted under the ATAPS program, such as Indigenous people, youth and homeless people. In general, these groups may not have existing links to GPs, and may be unlikely to maintain an ongoing relationship with a GP. The requirement for GP referral may, therefore, make outreach activities more challenging.

2.35 Given the recent introduction of Tier 2 funding, which is designed to accommodate more flexible models of service delivery, it would be timely to provide further guidance to Divisions regarding those circumstances where alternative referral pathways can be used.

Allied mental health professionals who can deliver services

2.36 The operational guidelines developed by DoHA for the ATAPS program include a definition of allied mental health professional, which comprises the following professions: psychology, mental health nursing, occupational therapy, social work and Aboriginal and Torres Strait Islander

health workers. The guidelines also outline the standards and minimum requirements to be met by professionals providing services under the ATAPS program.

2.37 While eligibility to provide mental health services is open to a range of mental health professionals, over 90 per cent of clinicians providing services under ATAPS are psychologists and clinical psychologists. The department informed the ANAO that it is yet to formally explore the reasons contributing to the low participation rate by eligible professions other than psychologists. While the lower rate of participation by other professions may simply be a reflection of the available workforce with specialist mental health training, there is some evidence to indicate a GP preference for certain professions. One Division informed the ANAO that the GPs on the ATAPS Project Reference Group considered that psychologists were 'best trained' and, as a result, participation of allied mental health professionals within the Division was limited to psychologists.

2.38 DoHA is aware that ATAPS has predominantly relied on psychologists to provide services and has previously encouraged Divisions to make greater use of alternate providers. Nevertheless, there is scope for DoHA to undertake further work to build the department's understanding of the factors contributing to lower participation rates by allied health professions other than psychologists, and to work with peak professional bodies to address any identified barriers to participation in the program.

Allied mental health professionals engaged to provide services

2.39 The selection of allied mental health professionals to participate in the program by Divisions involves balancing the quality and experience of allied mental health professionals against cost considerations. The lower the fee negotiated between the Division and the allied mental health professional, the more services that are available to meet high levels of demand. Low fee providers are, however, more likely to be less experienced and less qualified.[49] It is an important balancing act for Divisions—ensuring high quality service provision in the face of tight budgetary conditions resulting from high levels of consumer demand for a capped program.

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[49] This is not always the case, as some very experienced and highly qualified allied health professionals are committed to assisting financially disadvantaged consumers.

2.40 Program stakeholders and several Divisions indicated that, in some instances, cost had dominated selection considerations for allied mental health professionals. As a consequence:

> the cheapest psychologists that they can get [*are employed/engaged*]—usually the youngest. This is particularly concerning in rural and remote areas where these psychologists are more isolated.

2.41 The inclusion of the selection criteria for allied mental health professionals in the suggested review of ATAPS design elements and guidance materials would provide DoHA with an assurance that suitably qualified professionals are engaged to treat the spectrum of mental health disorders now covered by the ATAPS program.

Mental health care services

Service types

2.42 The ATAPS operational guidelines state that: 'Allied health services to be purchased under the ATAPS program are to be restricted to the provision of focused psychological strategies'. The following focused psychological strategies, considered by the department to be evidence-based for the treatment of a number of psychological disorders, are allowed to be purchased under the ATAPS program:

- psycho-education;

- cognitive-behavioural therapeutic strategies;

- relaxation strategies;

- skills training;

- interpersonal therapeutic strategies (especially for depression); and

- narrative therapeutic strategy.

2.43 The approved treatments under the ATAPS program were initially determined following a review of the evidence base for psychological interventions in 2003. Approval for inclusion of psychological interventions was provided by the Better Outcomes Implementation Advisory Group.[50]

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[50]   The Better Outcomes Implementation Advisory Group was established in October 2002 and was formally discontinued by DoHA in October 2006. The group was established to provide advice to the department on the implementation of the Better Outcomes in Mental Health Care initiative.

Subsequent reviews in 2005 and 2010 have reaffirmed the original list of approved psychological interventions under the ATAPS program.

Number of services

2.44   Up to twelve individual allied mental health services are available to consumers, on referral from a GP, in a calendar year. The referring GP may consider that, in exceptional circumstances[51], an additional six individual focused psychological strategies above those already approved may be provided (up to a maximum total of 18 individual services per consumer per calendar year).[52] On average, the number of mental health services provided to each consumer under the ATAPS program is around five services.[53] Session thresholds were last reviewed, and subsequently modified, in late 2004.

2.45   Notwithstanding operational guidelines that allow up to 18 ATAPS funded sessions each year, some Divisions restrict the number of services available to consumers as a means of managing demand.[54] While this approach may assist in the provision of services to a larger number of consumers, there are potential equity and clinical implications, such as ceasing treatment before it would otherwise be appropriate (Divisions' use of demand management strategies is examined further in Chapter 4).

2.46   Given the time that has passed since session thresholds were last reviewed, the potential impact of these thresholds on equity and the clinical outcomes of treatment, and the recent rationalisation of the number of sessions available each year under the Better Access initiative[55], it would be timely for

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[51]   Exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring GP to determine that the patient meets these requirements. In these cases a new referral should be provided, and exceptional circumstances noted on that referral.

[52]   In addition to individual services, up to 12 separate services within a calendar year for group therapy services involving six to ten consumers. These group services are separate from the individual services and do not count towards the 18 individual allied mental health services in a calendar year.

[53]   Department of Health and Ageing, 2010, *Outcomes and proposed next steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program,* Canberra, p. 10. Available from: <http://www.health.gov.au> [accessed 6 December 2010].

[54]   The ANAO's analysis found that 13 Divisions (out of 107 with recorded sessions) had recorded an average number of sessions per consumer of less than four. Individual Division averages ranged from 3.28 to 9.48 sessions per consumer.

[55]   As part of the 2011–12 Budget, the Government announced that the maximum number of subsidised allied mental health services available each year under the Better Access initiative would be reduced from 18 to 10.

the department to confirm the evidence base underpinning current thresholds for the ATAPS program.

Service delivery models

2.47   The ATAPS program provides Divisions with flexibility regarding the engagement and retention of the allied mental health workforce. This flexibility accommodates adaptation to local circumstances and conditions. Some Divisions directly employ allied mental health professionals while others purchase services from private providers on a fee for service basis, or a combination of the two. Divisions considered that flexible program delivery arrangements were critical to the success of their ATAPS projects and, in particular, Divisions' ability to align service provision to consumer needs.

2.48   The Australian Government's funding of direct mental health care service delivery raises a range of issues surrounding clinical governance, particularly in relation to the quality of consumer care.[56] This is especially the case where Divisions directly employ allied mental health professionals and subsequently deliver Australian Government funded mental health care services. It is also a key consideration when administrative staff within Divisions make decisions regarding demand management—such as the use of group therapy as a means of reducing cost, establishing waiting lists, or limiting the number of sessions in an effort to 'ration' available funding. Stakeholders expressed a general concern regarding the absence of adequate guidance surrounding clinical governance, and also indicated a heightened sense of concern given the impending expansion of the ATAPS program to treat low prevalence disorders through the introduction of flexible care packages.

2.49   The need for sound clinical governance for the ATAPS program has been acknowledged by program stakeholders, and has previously been raised directly with DoHA. A draft clinical manual was developed by a peak professional body and provided to the department in 2005. While DoHA acknowledged in 2008 that clinical governance required further attention, the department did not progress work in this area at the time.

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[56]   Clinical governance is the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care (Australian Council on Healthcare Standards).

2.50 DoHA has since informed the ANAO that clinical governance is a critical issue for the ATAPS program and has been 'earmarked' for careful consideration by the department under the area of quality improvement emerging from the recent review. Early discussions about progressing work on clinical governance have already taken place in the context of the ATAPS Expert Advisory Panel's deliberations. The department intends to establish: 'a broader quality framework, with the advice of the Expert Advisory Committee, within which clinical governance would sit before funding specific proposals'.

2.51 DoHA has outlined the key program delivery parameters in its operational guidelines, including target groups, eligibility criteria, service providers, eligible services, and service delivery models. There is, however, given the transitional status of the program, scope for the department to review ATAPS design elements and guidance materials, including the program guidelines, to ensure that they adequately support the government's new policy settings for the program.

3.   Planning Program Delivery

This chapter examines DoHA's planning arrangements, with a focus on determining needs, funding allocations, and setting performance standards.

Introduction

3.1   High quality planning underpins efficient, effective and ethical grants administration.[57] The ANAO's examination of planning processes for the ATAPS program considered DoHA's:

- use of needs-based planning to identify the mental health care needs within Divisions;

- methodology to determine the allocation of program resources to Divisions;

- thresholds for Division administration costs;

- management of funding once allocated to Divisions; and

- identification and treatment of risks to the achievement of program objectives.

3.2   The ANAO also examined the extent to which DoHA established appropriate performance information for the ATAPS program.

Program planning

Identifying need

3.3   Historically, DoHA has not assessed the mental health needs within Division boundaries or regions on a regular basis and then used this information as the basis for the allocation of resources under the ATAPS program. The department informed the ANAO that, as a result, a 'maldistribution' of program funding has arisen over the period of program delivery.[58]

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[57]   Department of Finance and Deregulation, 2009, *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration*, Canberra, p. 15. Available from: <http://www.finance.gov.au> [accessed 4 January 2011].

[58]   DoHA advice provided on 29 March 2011 and 6 April 2011.

3.4 In a limited number of cases, DoHA has sought to determine the level of need within Divisions and has used this information to allocate additional funding through ATAPS initiatives. In the case of the National Perinatal Depression Initiative, the department used birth data and Medicare utilisation rates to inform the allocation of additional funding made available to Divisions under the ATAPS initiative (further information on the administration of the ATAPS component of the National Perinatal Depression Initiative is provided in Chapter 5).

3.5 DoHA has also used Division expenditure as a proxy for need. In the last quarter of each year, the department seeks applications from Divisions for additional 'top-up' funding. These applications underpin the re-distribution of unspent program funding. The application process requires Divisions to demonstrate need and their capacity to spend any additional funding (the re-distribution of funding is discussed further later in this chapter under *Managing funding allocations*).

3.6 The ATAPS review proposed a gradual adjustment to the ATAPS funding model to better target areas not well serviced by Medicare-based allied mental health care services. As part of DoHA's work to implement the proposed directions stemming from the ATAPS review, the department sought Ministerial approval for one of two options to transition the program to better target service gaps:

- *Option 1*—introduction of tiered funding in year 1, with modest targets for efficient funding introduced in the second year; or

- *Option 2*—introduction of tiered funding in year 1, modest targets for efficient funding introduced in the second year, and the reallocation of funding to Divisions using a new funding formula to better target funding to areas of greater need of ATAPS services.

3.7 As DoHA considered that any reduction in funding for a Division would likely mean reduced service delivery and criticism from stakeholders, the department supported a phased and modest approach. In particular, the department considered that the redistribution of funding to Divisions should be deferred pending new funding or the introduction of the anticipated move to new governance and fund holding arrangements in primary care. On this

basis, DoHA advised the Minister that it preferred Option 1.[59] The Minister subsequently endorsed Option 1, which was implemented through the revised funding agreements endorsed in May/June 2010.

Determining funding for Divisions of General Practice

3.8   In order to effectively target areas most in need, administering agencies generally establish and promulgate methodologies or formulae to inform the distribution of available program funding.

3.9   DoHA has reported that the funding allocations under the ATAPS program were initially determined using a population-based formula derived from underpinning Census data. In the ATAPS review report, the department stated that:

> 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 needs 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.[60]

3.10   The basis on which DoHA originally determined and allocated ATAPS funding to Divisions and subsequently altered funding levels over time has not been clearly recorded by the department.[61] The funding levels for Divisions were subsequently revised in 2005–06. DoHA informed the ANAO that these

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[59]   DoHA informed the Minister that departmental modeling indicated that, under the proposed new funding formula, the: 'reallocation would reduce funding <u>by up to 21%</u> for <u>approximately half of all the 106 divisions</u> providing ATAPS in the 2011–12 financial year and as such would present some risks' [*emphasis added*]. The ANAO reviewed the department's modeling and sought clarification regarding the advice provided to the Minister. DoHA subsequently informed the ANAO that an error occurred in finalising the advice to the Minister. The 21 per cent figure used was an average not a maximum, as stated. The department's modeling, which was not provided to the Minister, indicated that around 40 per cent of Divisions would have funding reduced by up to 66 per cent and around 60 per cent of Divisions would have funding increased by up to 169 per cent.

[60]   Department of Health and Ageing, 2010, *Outcomes and proposed next steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program,* Canberra, p. 6. Available from: <http://www.health.gov.au> [accessed 6 December 2010].

[61]   DoHA provided limited evidence—in the form of a draft file note dated 24 November 2000 that outlined components of an outcomes-based formula—to explain the basis on which funding to Divisions was originally calculated. The department has advised that this formula was also used as a basis to determine ATAPS funding in 2003.

revised funding levels for Divisions were submission-based, with funding allocations to Divisions determined using an outcomes-based formula. While DoHA provided several additional documents relating to the submission process, the department was unable to locate documentation detailing the actual formula that was used to modify funding levels in 2005–06.[62]

3.11   The department informed the ANAO that since the introduction of the Better Access initiative in November 2006:

> there was some iterative reallocation of underspent funds associated with the inevitable drift of GPs to refer consumers to Better Access instead of ATAPS. This resulted over the period up to 2008, together with the innovative funding and other calls for extra funds from highly performing Divisions, in a distribution which had moved away from the original OBF [*outcomes based*] population formula but which, importantly, reflected ongoing referral patterns of GPs.

3.12   The department further advised that once additional funding of this nature was provided, it was not a simple matter to reduce funding levels because this would withdraw needed and effective service delivery. The drift away from an outcomes-based population formula occurred even though DoHA was aware of the considerable changes in Divisions' demographics since the ATAPS program commenced. The extent of demographic changes within some Divisions is highlighted by the following comment in a six-monthly report from a Division servicing a remote mining population:

> Fly in Fly out workers (numbering some 18 000 additional population) are accessing our services. It would be important to take this into account in future funding rounds.

3.13   The department has continued to use historic allocations, with some iterative reallocation, as the basis of current funding. Funding allocations to Divisions for the 2010–11 funding agreements, issued in May/June 2010, are based on pre-existing levels. In general, Divisions advised that they were not aware of the basis on which DoHA allocated ATAPS program funding.

3.14   As noted earlier, DoHA has undertaken preliminary work to develop a revised funding methodology, referred to by the department as the 'equitable funding formula', to underpin the transition to a more targeted approach for the ATAPS program. The formula considers factors such as: population; levels

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[62]   DoHA's ability to explain its program design decisions is discussed in Chapter 2.

of disadvantage; 'rurality'; and relative access to MBS mental health services. DoHA's modelling of the impact of the revised funding formula demonstrates the extent of the reported 'maldistribution' of program funds that has occurred over time. Under the new formula, which is designed to target funding to areas experiencing the greatest need, around 60 per cent of Divisions would receive an increase in ATAPS program funding of up to 169 per cent, while around 40 per cent of Divisions would have funding reduced by up to 66 per cent.

3.15   As observed by the ATAPS review and as acknowledged by DoHA, ATAPS funding was originally intended to reflect a population-based funding formula, but there has been a drift away from this formula over time with some communities with higher needs not receiving an equitable share of ATAPS resources.

Recommendation No.1

3.16   To support the effective targeting of program funding, the ANAO recommends that DoHA provide options, for Ministerial consideration, that would allow the ATAPS program to transition to an appropriate needs-based funding model.

Departmental response: Agreed

3.17   However, DoHA notes that the action proposed in this recommendation was taken in 2010. In March 2010, the Minister for Health and Ageing approved transition to a needs-based formula for distribution of additional funding upon the availability of new funding for the program. The Department has actioned this Government decision with all new funding arising from the 2011–12 Budget Mental Health Reform Package to be distributed using a new needs-based formula.

Allocating administrative funding

3.18   Divisions are provided administrative funding by DoHA to deliver the ATAPS program. The ATAPS review provides the following history of administrative funding to Divisions under the program:

> Originally ATAPS funding was utilised by divisions almost solely for service delivery (85 per cent) and only a small component was set aside for administration (15 per cent). 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.[63]

3.19 In its most recent set of operational guidelines, DoHA has sought to clarify its position with regard to the allocation of administrative funding. The department now requires Divisions to: 'ensure that administration costs are cost-effective and the emphasis of funding provided under ATAPS is for service provision to communities'. DoHA has stated that it expects Divisions to keep within the allocated budget split of 85 per cent for service provision and 15 per cent for administration costs, unless the department has approved an alternate split.[64] The allocation for administration costs was determined at the outset of the program (2003), and was based on: 'the standard loading associated with academic funding contracts at the time'.

3.20 All Divisions interviewed by the ANAO commented on the adequacy of administration funding and the implications of the recent increased emphasis on targeting 'hard to reach' consumers through more flexible and innovative models of service delivery. Divisions considered that these developments, coupled with a heavy reporting and data collection workload, warranted a review of the current level of administration funding.

3.21 In the context of reforms following the recent ATAPS review and work to implement the 2010–11 ATAPS-related budget measures, DoHA considers that it is now timely to review the administration cost limitations currently in place.

Managing funding allocations

3.22 Once total funding allocations have been determined by DoHA, funding is distributed to Divisions in the form of milestone payments established in funding agreements. Milestones include the provision of: annual plans and budgets; statements of compliance; and six-monthly progress reports.

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[63] Department of Health and Ageing, 2010, *Outcomes and proposed next steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program,* Canberra, p. 19. Available from: <http://www.health.gov.au> [accessed 6 December 2010].

[64] In general, the department would only consider higher administration costs in conjunction with innovative projects.

3.23 DoHA monitors Divisions' use of funding through its review of the unaudited financial statements that accompany six-monthly progress reports. Prior to releasing additional milestone funding to Divisions, the department reviews the level of unspent funds from the previous period. Where Divisions retain a significant level of unspent program funds, the department seeks confirmation that any unspent funds and the proposed milestone payment will be expended. If Divisions are unable to demonstrate their capacity to expend funding, the department works with Divisions to determine whether a subsequent milestone payment should be wholly or partially relinquished.

3.24 Toward the end of the financial year, DoHA determines the quantum of any remaining, unallocated program funding and also seeks information from Divisions regarding allocated funding that they are unable to spend in the current financial year.[65] Additional 'top-up' funding is offered to Divisions on the basis of an application against set criteria.

3.25 There has been some inconsistency in the application of the criteria. The Minute to the delegate seeking endorsement of the reallocation of $3.9 million in funding for 2007–08 and 2008–09 stated that all applications met the established criteria.[66] However, a large number of applications exceeded the maximum 10 per cent threshold[67] and the $50 000 'cap'.[68] In one case, DoHA administrators, under direction from the departmental delegate, approached a Division to increase its application over and above its initial request for an additional 10 per cent of base funding. The Division was eventually approved to receive an increase that represented 28 per cent of base funding. In another case, a Division applied for $37 937 (10 per cent of base funding), but the department offered the Division $50 000, as it considered the Division was

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[65] Subject to approval from DoHA, Divisions are able to 'roll-over' unspent program funding to the next financial year.

[66] The relevant criteria were:

- submissions must be in accordance with the ATAPS guidelines;
- Divisions must be able to demonstrate current high, unmet demand for services;
- Divisions must be able to demonstrate current unacceptable waiting lists with patients unable to access services within reasonable timeframes;
- Divisions must be able to demonstrate their capacity to spend any additional funds within the 2007–08 financial year; and
- Divisions will only be granted up to an additional 10 per cent of their base 2007–08 funding (capped at $50 000).

[67] Up to 51 per cent of base funding approved for a Division.

[68] Up to $95 000 approved for a Division.

servicing a: 'high needs area'. The inconsistent application of criteria for funding reallocations does cause issues of equity, and may have disadvantaged those Divisions that lodged compliant applications.

3.26 The reallocation of substantial additional funding late in the financial year also brings with it the risk that Divisions will be unable to effectively deploy the funding, or that the expectations of providers and consumers are raised and cannot be sustained once funding returns to 'business as usual' levels. Divisions suggested that a better process was needed to more effectively monitor expenditure throughout the year, with the reallocation of unspent funds occurring sufficiently early to enable Divisions to make considered decisions on expenditure. The equity of access to additional ATAPS program funding was also questioned by several Divisions.

3.27 There would be merit in DoHA examining its current approach to managing Divisions' funding allocations under the ATAPS program. Such an examination could consider: approaches to improve the monitoring and early identification of unspent program funding; the criteria used to allocate additional 'top-up' funding to make sure that it does not disadvantage high performing Divisions; and the establishment of transparent allocation practices in accordance with agreed criteria. The transition to a funding model that targets program funds based on need, as recommended earlier, may also alleviate some of the need to reallocate funds between Divisions during the year.

Managing risk

3.28 The Commonwealth Grant Guidelines state that: 'Risk is part of the environment within which agencies operate, and risk management should be built into an agency's grants administration processes at the planning and design phase'. Specific risks to granting activity could include:

- fraud or misrepresentation;

- use of grant funds for purposes contrary to the terms and conditions of the grant; and

- granting activity not contributing to the achievement of an agency's strategic directions, or to government outcomes.[69]

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[69] Department of Finance and Deregulation, 2009, *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration*, Canberra, p. 15. Available from: <http://www.finance.gov.au> [accessed 4 January 2011].

3.29 The first documented risk assessment for the ATAPS program was prepared in mid-2009, some six years after the program commenced. The assessment identified eight risks to the achievement of the program's objectives. Identified risks include: *Duplicates Better Access services*; *Divisions do not have enough Allied Health Professionals to support the project*; and *Divisions expend funds prior to end of project*. The risk assessment was developed at a relatively high level, and did not include a range of risks that would potentially impact upon the achievement of the program's objectives. These risks include: clinical risks arising from the selection of less qualified allied mental health professionals to deliver ATAPS services due to cost considerations; the risk of non-compliance given the department's heavy reliance on self-reporting; and the risk of inappropriate/unauthorised services being delivered under the program.[70]

3.30 DoHA prepared a subsequent risk assessment for the ATAPS program in 2010, with the 2009 and 2010 risk assessments identical in all material aspects. Despite significant change within the program in 2010 following the review and expanded program coverage announced in the Federal Budget, the department did not identify any change in the program's risk profile. Relevant risks would appear to include: the expansion of the program to include flexible packages of coordinated care for people with severe mental illness; and the implementation of revised funding and delivery arrangements. The risk assessment also indicates that treatments—designed to reduce the chance of the risk occurring or the severity of risks where they do occur—were not expected to be completed until 29 June 2012. Current funding agreements with Divisions expire on 30 June 2011.

3.31 There is considerable scope for DoHA to strengthen the risk management practices that it employs for the ATAPS program in order to effectively identify and treat risks to the achievement of program objectives, particularly in light of significant changes following the program review, the expansion of program coverage, and the subsequent growth in funding.

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[70] Notwithstanding DoHA's efforts to educate and inform program participants through the program guidelines, peak professional bodies and Divisions identified the practical difficulties in 'policing' program parameters, noting that what occurs behind the 'closed doors' of a clinical consultation is impossible to monitor (monitoring compliance with program requirements is examined in Chapter 6).

Establishing performance information

3.32 Performance information assists program administrators and stakeholders to draw well-informed conclusions about performance and take corrective action, where necessary. It contributes to timely and effective decision-making on policy and program delivery issues, and contributes to the accountability of agencies for their performance.[71]

3.33 The ANAO examined the development of public performance information for ATAPS in DoHA's Portfolio Budget Statements (PBS) and also the extent to which the department had developed quality measures for ATAPS services.[72]

3.34 DoHA has established two deliverables and two performance indicators within its PBS that specifically relate to the ATAPS program. Performance information included in the current PBS (2011–12) is categorised under *Strengthening primary mental health care* and comprises:

- *Deliverables:*

    – *Increase primary mental health care services; and*

    – *Number of additional people assisted under the expansion of the Access to Allied Psychological Services program.*

- *Performance indicators:*

    – *Increased uptake of primary mental health care by groups with lower usage such as young people, men and people living in rural and remote locations; and*

    – *Percentage of Divisions of General Practice/Medicare Locals with the capacity to provide perinatal depression services through the Access to Allied Psychological Services initiative.*[73]

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[71] Department of Finance and Deregulation, 2009, *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration*, Canberra, p. 18. Available from: <http://www.finance.gov.au> [accessed 4 January 2011].

[72] Portfolio Budget Statements are presented to Parliament by Commonwealth departments and agencies to inform Senators and members of Parliament of the proposed allocation of resources to government programs and outcomes. They also facilitate understanding of the proposed appropriations in Appropriations Bills (Numbers 1 and 2). Agencies are required to provide sufficient information, explanation and justification in their PBS to enable Parliament to understand the purpose of each program and outcome proposed in these bills.

[73] Department of Health and Ageing, 2011, *Portfolio Budget Statements 2011–12*, Canberra, pp. 317–319. Available from: <http://www.health.gov.au> [accessed 18 May 2011].

3.35 The number of ATAPS specific deliverables and performance indicators is down from seven in the previous year, despite the substantial increase in funding for the program announced in the Budget and the ongoing reforms to the program following the recent review. Furthermore, of the four deliverables and performance indicators outlined in the 2011–12 PBS, only one has been carried over from the previous PBS. As a consequence, it is potentially more difficult for stakeholders to monitor the performance of the ATAPS program over time.

3.36 In addition to the measures outlined above, the department advised the ANAO that:

> A significant indicator of the administration of the program is the annual program spend. Notwithstanding the need to work with Divisions to support their demand management, and to reallocate underspent funds, the program has consistently spent on or close to full annual expenditure.

3.37 The performance information included in DoHA's PBS is, by its nature, relatively high level. It is also focused on activity-based measures, which are quantifiable and, therefore, generally easier to report on. The strong emphasis that the department places on 'program spend' further reinforces a focus on quantifiable, activity-based measures. Measuring the quality of services provided under mental health care programs offers more promise, but is not straightforward, nor easy. It requires good quality pre- and post-treatment data, both from the clinician and the consumer. It does, however, have the potential to provide important information on which the success, or otherwise, of a program can be assessed.

3.38 Well-designed feedback mechanisms can provide a starting point for developing quality measures. DoHA has, to date, not collected feedback directly from consumers regarding the referral process and the services delivered under the ATAPS program.[74] The department, through the data collected from clinicians and entered onto the ATAPS Minimum Dataset (MDS) is, however, progressively building its capability to report on the clinical outcomes of treatment under the ATAPS program. DoHA has previously reported early consumer outcomes from the program:

> ATAPS projects are achieving positive outcomes of medium to large improvements in approximately 86% of cases. Overall there is good evidence

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[74] In a limited number of cases, customer feedback has been sought as part of the monitoring and evaluation of ATAPS initiatives.

that consumers are achieving positive results with regards to alleviating symptoms, improving levels of functioning and impacting on general well being.[75]

3.39   Owing to the low number of consumers for which data is available, outcome data for the program should be interpreted cautiously.[76] The University of Melbourne has previously explained the caveats that apply to ATAPS outcome data: 'the proportion of patients for whom pre- and post-treatment outcome data were available was less than optimal at 15%...It is possible that this may have introduced a systematic bias, such that those for whom no outcome data were available may have had poorer outcomes (if, for example, outcome data were unavailable because they dropped out of treatment)'.[77]

3.40   In an attempt to address the low levels of consumer outcome data provided by Divisions, the University of Melbourne sought approval from DoHA in September 2008 to make the provision of outcome data mandatory. However, DoHA decided that the mandatory provision of consumer outcome data would be overly burdensome to Divisions. The department did, however, agree to review the operational guidelines to encourage Divisions to collect patient outcome data. A revised statement of requirements was included in subsequent guidelines. DoHA informed the ANAO that, while consumer outcome fields in the MDS remain optional, the department is: 'committed to moving towards routine collection of outcomes based data in consultation with Divisions.'

3.41   To some extent, the suggested comprehensive assessment of the evaluation needs of the ATAPS program (outlined in Chapter 6) would provide a platform for DoHA to incorporate balanced performance measures that inform reporting on quality and the impact of the program on improving access to mental health care services.

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[75]   Department of Health and Ageing, 2010, *Outcomes and proposed next steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program,* Canberra, p. 12. Available from: <http://www.health.gov.au> [accessed 6 December 2010].

[76]   The department did not, however, outline these caveats when referring to positive outcomes from the ATAPS program in the review report.

[77]   The University of Melbourne has also reported that: 'The profile of the patients for whom outcome data were available was fairly similar to that of all patients, although they tended to have fewer sessions and be less likely to receive CBT, which may have had an impact on their outcomes. The findings still stand, but they may present a somewhat over-optimistic picture. At the very least, it is possible to say with certainty that the outcomes of care from the ATAPS projects are excellent for the thousands of patients observed here'.

4.   Managing Program Delivery

This chapter examines DoHA's day-to-day management of ATAPS program delivery, with a focus on guidance for funded organisations, support for program administrators, stakeholder engagement, coordinating mental health programs, and managing consumer demand.

Introduction

4.1   Once programs have been designed and are in place, sound day-to-day administration supports the effective and efficient achievement of program objectives. The ANAO examined the:

- provision of guidance by DoHA to Divisions to support compliant program delivery and to broader stakeholders to provide information about the program;

- support provided to departmental administrators to promote consistent, compliant and informed administration;

- engagement with stakeholders to identify unanticipated issues and to help build understanding and support for change;

- coordination of mental health care programs; and

- management of consumer demand within available funding levels.

Guidance for funded organisations

4.2   To inform program delivery, DoHA provides guidance to Divisions and allied mental health professionals via the following methods:

- operational guidelines;

- funding agreements;

- program circulars and emails; and

- supplementary sources of guidance.

Operational guidelines

4.3   DoHA uses guidelines as the primary means of disseminating ATAPS guidance to Divisions, allied mental health professionals and other stakeholders. The operational guidelines, in conjunction with Division funding

agreements, set out the parameters by which the Divisions' ATAPS projects are to be delivered.

4.4   The guidelines have been updated from time to time, as deemed appropriate by the department. Since the program commenced, ATAPS guidelines have been updated at June 2005, October 2008 and July 2010. DoHA was unable to locate copies of ATAPS operational guidelines relating to the period from program announcement in 2001 through to 2005. DoHA was also unable to provide evidence of the approval of the 2005, 2008 and 2010 revisions to the ATAPS guidelines.

4.5   In relation to the clearance of the 2010 revised guidelines, program administrators advised the departmental delegate in May 2010 that: '[*the*] new Program Guidelines will be developed and provided to ERC [*Expenditure Review Committee*] in accordance with the Commonwealth Grants Guidelines'.[78] In the event, DoHA did not consult with the Department of Finance and Deregulation (Finance) on whether the proposed 2010 guideline changes gave rise to the need for ERC consideration. DoHA informed the ANAO that, as the department had treated the guidelines as an 'operational' document rather than program guidelines, there was no need to seek ERC approval or Finance's specific advice on the proposed guidelines.[79] Notwithstanding the department's views on the classification of its program guidance materials, as the revised guidelines covered the introduction of the new Tier 2 funding arrangements and associated changes to the focus of the program and eligibility criteria, it would have been prudent for DoHA to have consulted with Finance at the time on the need for ERC consideration.

4.6   DoHA plans to consult with Finance on whether the next set of guidelines give rise to the need for ERC consideration, as the department considers that the changes arising from adoption of further aspects of the ATAPS review will be significant.

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[78]   The July 2009 Commonwealth Grant Guidelines state (3.22a): Where a change is proposed to the guidelines to an existing grant program, agencies should consult with Finance on whether the proposed change will give rise to the need for ERC consideration of the guidelines.

[79]   DoHA further advised that it had reached this view on the basis of: 'a generic information session provided to the Department about the Commonwealth Grants Guidelines [*by Finance*] and [*the advice*] did not relate to a specific set of guidelines but did relate to specific questions being asked by program managers in the audience about "operational guidelines" that were developed for post selection management of a program by staff or an approved provider'.

4.7 The *2010–11 Operational Guidelines for the ATAPS component of the BOiMHC* took effect from 1 July 2010, and span the period until 30 June 2011 (the current agreement period with Divisions). The 2010–11 guidelines adequately specify key ATAPS program elements, including: the role of Divisions; allied mental health professionals who can deliver services; the focused psychological services allowed to be provided; and aspects of funding and evaluation.

4.8 Divisions considered that the currency and completeness of the guidelines was generally acceptable. However, there was a level of uncertainty regarding aspects of the guidelines, particularly around recently added program elements such as Tier 2 funding and associated target groups, and also the proposed Tier 3 funding. Stakeholder feedback also highlighted scope for DoHA to consider the inclusion of additional information in future operational guidelines, including: the methodology or formula for determining Divisions' funding; the process used by DoHA to manage funding; the arrangements for consideration of new focused psychological strategies; the addition and removal of Tier 2 target groups; and the selection process for Divisions participating in ATAPS initiatives.

Funding agreements

4.9 In setting the terms and conditions of funding for the ATAPS program, funding agreements provide guidance to Divisions, particularly in relation to their role, responsibilities and legal obligations under the agreement. The funding agreements list a broad range of project activities including:

- identifying and supporting GPs who are managing a patient with a mental disorder…to refer people with a mental disorder to allied mental health professions for focused psychological strategies;

- identifying and engaging appropriately qualified allied mental health professionals who are trained in the use of evidence-based psychological strategies, who meet the requirements as set out in the guidelines and who will be available to receive referrals from GPs;

- establishing and/or maintaining a Project Reference Group to guide the project; and

- monitoring co-payments (recommended that they do not exceed $30 per session).

4.10   The funding agreements usefully add to the suite of guidance provided to Divisions, particularly in relation to the purpose of the funding, descriptions of the groups to be targeted under Tier 2 funding, and reporting milestones and deliverables. High-level guidance on additional activities under Tier 2 funding is also provided in the funding agreements.

Program circulars

4.11   DoHA has used information circulars to supplement program guidance available from the operational guidelines and funding agreements. DoHA first used circulars for the ATAPS program in 2008, with 17 circulars disseminated to Divisions between March 2008 and July 2009. These circulars conveyed changed delivery parameters or clarified particular matters between guideline changes or new funding agreements, such as information on ATAPS initiatives. Circulars were also used to clarify operational guideline provisions, specifically, the use of provisional/intern psychologists in the delivery of ATAPS services.

4.12   No circulars were disseminated in 2010 or the first quarter of 2011. The department informed the ANAO that this was partly due to the extended caretaker period for the Federal election in 2010. DoHA intends to recommence its use of circulars in 2011 to supplement information available to Divisions, particularly in relation to program changes stemming from the ATAPS review.

Supplementary sources of guidance

4.13   Other methods utilised by DoHA to provide guidance to Divisions and allied mental health professionals include:

- letters from the Minister for Health and Ageing and DoHA to Divisions, for example, the Minister wrote to Divisions twice in relation to the conduct and completion of the ATAPS review;

- providing high-level presentations to stakeholders at forums and workshops;

- provision of reporting templates, such as for annual plans and budgets, six-month and final reports and reports relating to ATAPS initiatives and the bushfire response (reporting is examined in more detail in Chapter 6);[80]

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[80]   These templates were not, however, always provided in a timely manner and were rarely made available to Divisions prior to the commencement of the reporting period. The preparation and dissemination of reporting templates prior to the commencement of the reporting period would help Divisions to tailor their information collection activities to meet reporting obligations.

- a DoHA contact officer assigned to specific matters raised in the guidelines, funding agreements, circulars, emails and letters, with the department establishing a single email inbox for all ATAPS-related enquiries;

- DoHA's ATAPS website, which offers a brief description of the program and links to ATAPS resources; and

- the dissemination of evaluation reports and the ATAPS review report, which offer program performance information.

4.14   On balance, the various sources of guidance and information made available to Divisions by DoHA provide a solid foundation on which to deliver the program. As noted, however, there is scope to further build on existing guidance materials to better reflect contemporary design settings for the program.

Supporting program administrators

4.15   To support staff in delivering programs, administering agencies generally:

- identify suitably skilled staff to administer the program, or provide training to staff to assist them in developing requisite skills;

- establish policies and procedures to guide staff; and

- provide systems to assist staff to efficiently perform their duties (for example, to store and help analyse program data).

4.16   DoHA has established a small team of around six staff within its Mental Health and Suicide Prevention Branch to administer the ATAPS program. The work of this team is challenging, requiring engagement with a broad range of program stakeholders—often with competing views on program delivery priorities and approaches—and oversight and direction of over 100 organisations contracted to implement the program on the Australian Government's behalf. In addition, the topical nature of mental health care and clinical aspects of mental health service delivery contribute to the challenges facing DoHA's program administrators.

Staff training and skills

4.17   New DoHA staff undergo an induction program and attend mandatory training courses. DoHA informed the ANAO that new staff administering the ATAPS program also receive close supervision, on-the-job training and mentoring. DoHA also advised that, as of October 2010, new program staff are

provided with a copy of the *Mental Health and Chronic Disease Division New Starters Kit*, which includes ATAPS operational guidelines, reporting templates, planning documents and a copy of the ATAPS review. High turnover (such as that experienced in parts of the Mental Health and Suicide Prevention Branch) heightens the importance of sound induction processes.[81]

4.18 DoHA provides training courses for staff, such as program management, procurement, funding and financial management courses.[82] Guidance materials are also provided, including a project manager's toolkit. The department informed the ANAO that it conducts skill set audits as part of the workforce planning component of its annual business planning processes, DoHA could not, however, locate a copy of the relevant workforce plan.

4.19 The general training that DoHA delivers to program administrators provides broad knowledge and understanding of program administration practices within the department. The inclusion of specific training on certain aspects of the ATAPS program delivery, such as the financial treatment of funds committed by Divisions to future patient treatments, would better equip program administrators to deliver the program.[83]

Policies and procedures

4.20 It is important to document internal procedures for new staff and to support procedural consistency, compliant delivery and cost-effective administration. DoHA has not, however, consolidated key policies and procedures for the ATAPS program, instead relying primarily on supervision, on-the-job training and mentoring, as outlined earlier. There is benefit in capturing and consolidating program delivery knowledge, particularly in a small team with relatively high turnover.

4.21 The ANAO noted several inconsistent practices employed by DoHA, such as weaknesses in report monitoring practices (discussed in more detail in Chapter 6) and poor record keeping practices.

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[81] While DoHA informed the ANAO that, in general, turnover within parts of the Mental Health and Suicide Prevention Branch is lower than that of the wider department, the ANAO found that the majority of staff administering the ATAPS program had limited experience in their current role.

[82] DoHA also informed the ANAO that the Mental Health and Chronic Disease Division routinely identifies staff training needs and provides advice to the department's Business Group.

[83] Once a referral from a GP has been accepted by a Division, funding is generally committed for a minimum of six sessions of treatment. Divisions advised that DoHA administrators have, on occasion, considered these funds un-committed and thus subject to relinquishing by the Division.

4.22   The department has, in a limited number of cases, sought to assist program administrators by developing procedural documentation. In December 2009, DoHA prepared a guide on *Commonwealth Mental Health Response to the Natural Disasters*. The document offers guidance on the mental health response to natural disasters, based on the experiences gained from DoHA's response to the 2009 Victorian bushfires. The capture of experiences and lessons learned from past activity in order to inform future program delivery represents sound administrative practice.

4.23   DoHA's Program Funding and Procurement Service (PFPS) provided quality assurance clearance for the 2010 ATAPS funding agreements and related approval documentation, with the department also utilising a series of checklists to support staff in reviewing and recording funding agreements.[84] The use of the PFPS quality assurance services and the extensive use of checklists helped improve the quality and consistency of documentation across over 100 files and agreements.

4.24   There is scope for DoHA to capitalise on work to date to establish and maintain a set of fit-for-purpose policy and procedural materials to support efficient and compliant program administration.

Management information systems–program data capture

4.25   Management information systems play an important role in streamlining the collection, analysis and reporting of program management information. DoHA does not, however, hold a centralised record of key ATAPS program decisions, for example Division funding levels or approved exemptions (such as exemptions from administration funding limits or approved referral flexibilities). Instead, such decisions reside on each Division's hard copy file. Oversights can occur where information required by program administrators to discharge their duties is not readily accessible. The ANAO noted several administrative oversights by DoHA staff, which caused frustration for Divisions when having to explain or provide DoHA with evidence of prior interactions, such as exemption approvals.

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[84]   The key function of the PFPS is to effectively manage the risk associated with procurement and funding by providing advice, quality assurance and support to program managers and delegates in all aspects of tendering, contract management and funding processes.

4.26 A centralised record of key decisions would be more efficient and require less work to collate information in response to requests (for example, to inform policy formulation, track program and initiative budgets, or to respond to parliamentary hearings). Retaining centralised records would also reduce DoHA's reliance on staff knowledge, which is problematic, given the relatively high levels of staff turnover, limited experience of staff in their current roles, and the large number of Divisions (over 100) being funded to provide ATAPS services.

Recommendation No.2

4.27 To strengthen management of the ATAPS program, the ANAO recommends that DoHA enhance support for program administrators through the provision of:

(a)   induction and training tailored to the administration of the ATAPS program;

(b)   fit-for-purpose policy and procedural materials to guide administrators, support consistent administrative practice and retain corporate knowledge; and

(c)   a central repository to provide administrators with ready access to key program decisions that they require to efficiently discharge their responsibilities.

Departmental response: *Agreed*

4.28 DoHA has taken steps to improve records management and accessibility, and to support program staff.

Stakeholder engagement

4.29 Engaging stakeholders in program delivery can provide a useful source of program information, identify unanticipated issues early and help build understanding and support for change. Engagement with stakeholders may be initiated by agencies, such as actively seeking the views of stakeholders through forums and advisory groups, or initiated by stakeholders in the form of feedback about program delivery.

Obtaining stakeholder feedback

4.30 DoHA has assigned a dedicated program officer, based on geographic areas, to liaise with Divisions on a day-to-day basis for reporting and

contractual matters. DoHA has sought stakeholder feedback in relation to the ATAPS program through:

- the ATAPS review. Submissions were sought from stakeholders and an Expert Advisory Committee was established to inform the review. An Expert Advisory Group is now in place for the program;

- a forum involving bushfire-affected Divisions to allow them to discuss their experiences in responding to the 2009 Victorian bushfires;

- a reference group was formed for the Telephone-based Cognitive Behavioural Therapy (T-CBT) trial, which met on one occasion; and

- interim program evaluation reports, with some reports based in part on surveys, interviews and other communications with stakeholders (such as allied mental health professionals and GPs).

Managing stakeholder complaints

4.31 DoHA has not established a formal complaints handling process for the ATAPS program, nor does the department require Divisions to establish complaints handling mechanisms. Divisions may raise matters directly with the department or via the Australian General Practice Network (AGPN).[85] Allied mental health professionals and GPs can also provide feedback through the Division, or through their respective representative bodies. DoHA advised that consumers are able to complain to Divisions as the providers of ATAPS services, or to professional boards/organisations should they wish to complain about an individual provider. In some jurisdictions consumers also have recourse to the state-based Health Complaints Unit.

4.32 DoHA acknowledged that there is a need to clarify and better communicate existing complaints mechanisms for consumers of ATAPS services. The department has indicated that it will consider ways to explicitly promote a complaints mechanism for the ATAPS program. Furthermore, DoHA indicated that, during the negotiation of the next ATAPS funding

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[85] The AGPN represents a network of 111 local Divisions of General Practice along with eight state-based entities. The network is involved in a wide range of activities including health promotion, early intervention and prevention strategies, chronic disease management, medical education and workforce support.

agreements, the department proposes to require Divisions to contractually comply with relevant standards regarding complaints processes.[86]

Coordinating mental health care programs

4.33 As previously discussed, the ATAPS program is one of a broad range of government programs that are aimed at improving access to mental health care services for people with mental illness. DoHA administers three programs in particular that have a number of similarities with the ATAPS program[87], namely the Better Access initiative, the *Mental Health Services in Rural and Remote Areas* (MHSRRA) Program and the *Mental Health Support for Drought Affected Communities initiative.*

4.34 The importance of effective coordination of mental health care programs is evidenced in the following finding from the recent review of the Better Access initiative:

> Paradoxically there is the suggestion from some remote stakeholders that the increased revenue available to AHPs [*allied health professionals*] through the Better Access initiative has reduced the attractiveness of engagement to provide services through the Access to Allied Psychological Services (ATAPS) program and reduced service availability in rural and remote communities.[88]

4.35 Effectively coordinating the delivery and administration of each related program helps to ensure that: funding is targeted to areas most in need; the duplication of services is reduced; the potential for consumer and other stakeholder confusion about services is minimised; and program administration costs both for DoHA and Divisions are reduced.

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[86] As DoHA considers that Divisions are effectively offering a mental health service, the department expects Divisions to comply with the National Standards for Mental Health Services. In particular, the department expects compliance with Criteria 1.16, which upholds the right of the consumer to express compliments, complaints and grievances regarding their care and to have them addressed.

[87] For example, with similar target populations, or that contract Divisions to deliver/broker services, or utilise similar allied mental health professionals to provide mental health services.

[88] Department of Health and Ageing, 2011, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) Initiative. Component D: Consultation with Stakeholders*, Canberra, p. 18. Available from: <http://www.health.gov.au> [accessed 21 March 2011].

4.36   In relation to consumers accessing the ATAPS program and the Better Access initiative, the ATAPS guidelines state the following:

> Patients are not to be referred for treatment under Medicare through Better Access and ATAPS at the same time. Treatment through both Better Access and ATAPS may occur within one calendar year, provided the total number of individual or group services provided under both programs does not exceed the maximum allowable in a calendar year.[89]

4.37   While the ATAPS guidelines set limits on the number of services accessible under both Better Access and ATAPS, these limits are not monitored by DoHA. The requirement for Divisions to de-identify ATAPS patient data (to protect consumer privacy), means that it is very difficult, if not impossible, for DoHA to cross-match consumers accessing both services. DoHA's capacity to monitor the established session limits is, therefore, limited. For the same reason, DoHA is unable to monitor whether consumers are attempting to receive ATAPS services across different Divisions (monitoring compliance is examined in further detail in Chapter 6).

4.38   In an effort to better coordinate program delivery through Divisions, the department has consolidated the majority of Division funding arrangements under a single overarching contractual agreement, with multiple schedules covering different funding activities and programs. This helps to align reporting, coordinate provision of services and establish consistent terms and conditions. ATAPS program funding is currently enacted via separate contractual and reporting arrangements. A number of Divisions commented that separate arrangements, at times, increase their administrative workload due to additional contractual administration and different reporting requirements. The ANAO notes an opportunity, as the department implements reforms following the recent program review, to consider the cost-benefits of consolidating ATAPS within an overarching contractual agreement.

Managing consumer demand

4.39   Unlike some other mental health care programs, such as the Better Access initiative, funding for the ATAPS program is capped. That is, the number of people assisted by the program is limited by the program's overall budget. Consequently, a sound strategy must be employed to distribute

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[89]   Department of Health and Ageing, 2010, *2010–11 Guidelines for the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Canberra, pp. 5–6.

funding on an equitable basis and, once distributed, manage demand so as not to exceed available funding or cease service provision if funds are used more quickly than anticipated.

4.40 There is some variability in the numbers of ATAPS referrals over time. In particular, there are fewer referrals in December (many Divisions close for a certain period around Christmas) and slight increases around the start of financial years (July and August) following the receipt of additional funding (Figure 4.1 shows the number of referrals recorded by all Divisions in 2008, 2009 and 2010).

Figure 4.1

National ATAPS referrals (2008 to 2010)
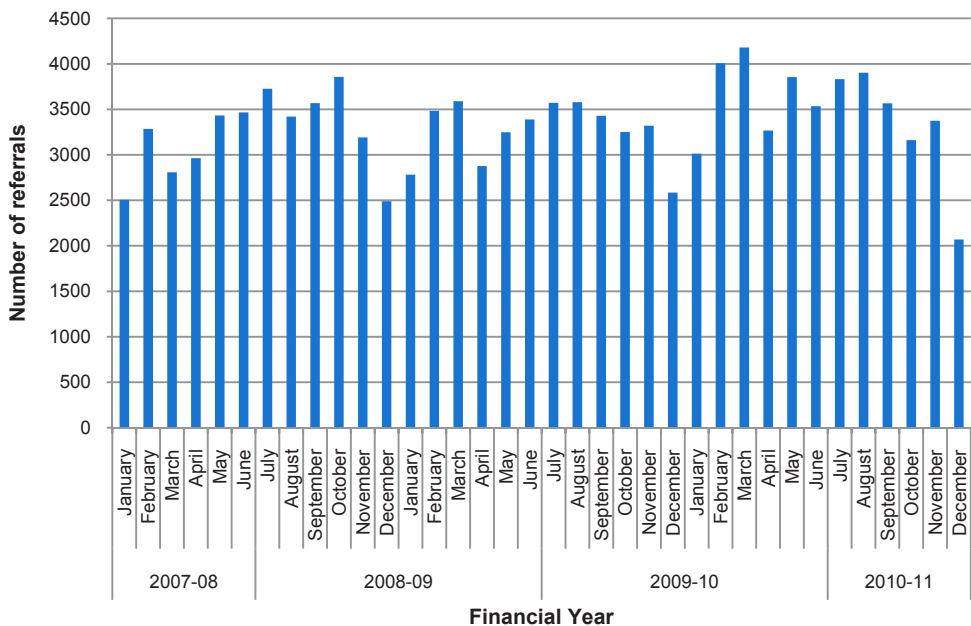
Source: ANAO analysis of MDS data.

4.41 The referral numbers at a national level, illustrated in Figure 4.1, do not demonstrate the more variable access experienced by consumers within individual Divisions. Figure 4.2 shows a rural Division that ceased providing new ATAPS referrals to consumers on two recent occasions—for four months from March 2009 and for two months from March 2010—due to demand exceeding the amount of available funding.

Figure 4.2

Referral numbers for one rural Division (2008 to 2010)
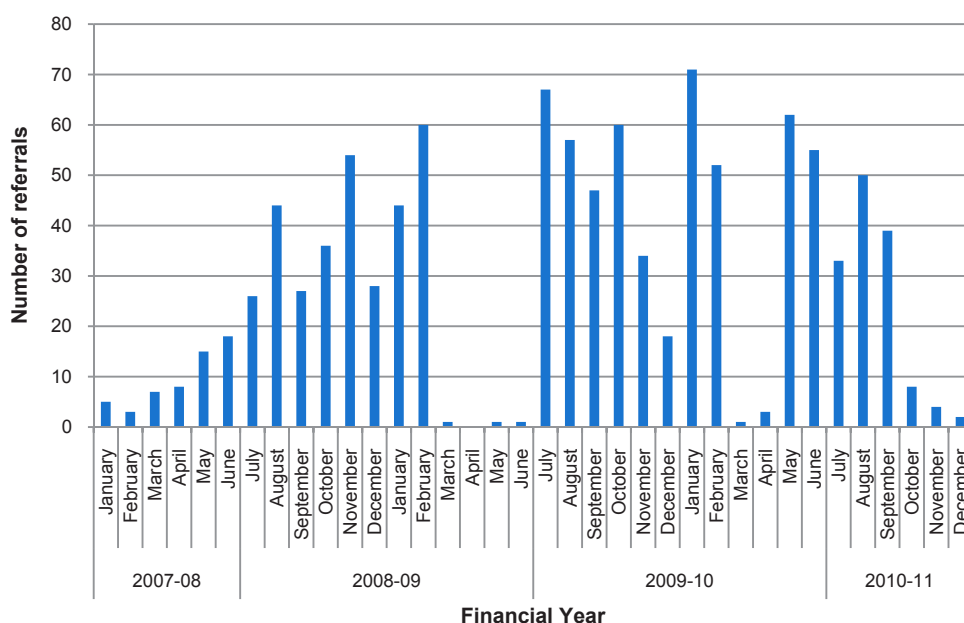
Source: ANAO analysis of MDS data.

4.42   As outlined earlier, effectively managing demand depends upon the allocation of an appropriate amount of funding given the needs of a particular Division, coupled with effective strategies to maintain service delivery over the funding period. The department initially determines the level of funding allocated to each Division—which was covered in Chapter 3. The subsequent management of demand for ATAPS services is the responsibility of Divisions, within the guidelines set by DoHA.

4.43   Divisions have used a wide variety of strategies over the life of the program to manage demand so as to ensure funding is available throughout each financial year. However, as demonstrated in Figure 4.2, Divisions have suspended ATAPS referrals from time to time due to funding shortfalls. This may well affect consumers requiring treatment during these periods.

4.44   The primary means used by Divisions to manage demand are:

- *limiting the number of GP referrals*—such as issuing a set number of vouchers to referring GPs;

- *limiting referring GPs*—in some Divisions, the number of referring GPs is capped. This can be through limiting promotion of the program or the establishment of a maximum number of GPs allowed to participate;

- *limiting the number of services*—some Divisions limit the number of services available to referred consumers, for example setting a six session maximum;[90]

- *limiting services to group therapy*—as group therapy is generally less expensive than individual sessions, the ANAO was informed that some Divisions provide group therapy only 'so as to reach as many consumers as possible with the available funding';[91]

- *consumer co-payments*—Divisions have used high co-payments, within recommended limits, to lower demand;[92]

- *establishing waiting lists*—waiting lists are used where services are unable to be provided at the point of referral; and

- *limiting eligibility for services to particular demographics*—Divisions tend to use targeting to manage demand, such as directing services at low income earners, or at specific geographic sub-areas of the Division, such as specific suburbs or post codes.

4.45   DoHA has sought to better understand the demand management strategies employed within Divisions, through the review of annual plans and six-monthly progress reports, and the commissioning of an interim evaluation report in 2006.[93]

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[90]   As noted earlier, the ANAO's analysis found that 13 Divisions (out of 107 with recorded sessions) had recorded an average number of sessions per consumer of less than four. Individual Division averages ranged from 3.28 to 9.48 sessions per consumer.

[91]   The ANAO's analysis of MDS data found that one Division was responsible for 22.4 per cent of all ATAPS group sessions, with group sessions representing 75.8 per cent of sessions provided by that Division. DoHA also informed the ANAO that it had approved another Division to provide group therapy only.

[92]   The ANAO's analysis of MDS data found that some Divisions may be seeking co-payments above the recommended limit of $30. A total of 6355 sessions (0.68 per cent of the total number of sessions recorded) were recorded as having co-payments greater than $30.

[93]   Naccarella et al, 2006, *Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program—Ninth Interim Evaluation Report: Demand Management Strategies*, Melbourne. Available from: <http://www.health.gov.au> [accessed 5 January 2011]. This report found that 85 per cent of respondents (76 of 89) were using at least one demand management strategy. The survey data suggested that there was considerable activity across Divisions with respect to demand management.

4.46 DoHA informed the ANAO that most demand management strategies are not inconsistent with the ATAPS guidelines. The exception is the strategy limiting sessions of care, with the department stating that: 'This is of concern if it contradicts clinical advice for the patient, as the guidelines indicate that patients are eligible for further services upon review'. DoHA indicated that it has previously identified, through self-reporting, one case in 2010 where a Division was 'capping' ATAPS sessions. The division was instructed to cease the practice as it was in breach of the guidelines.

4.47 While the use of demand management strategies represents a pragmatic response to the delivery of mental health care services within a constrained funding envelope, some of the approaches adopted have the potential to affect consumers seeking treatment. In particular, there is the potential for inequitable service delivery across and within Divisions. Under current arrangements, two people suffering similar mental health disorders from a similar demographic with similar characteristics, such as income status, may experience differing levels of access to treatment and the number of available treatments dependent upon their location. This may also have clinical implications. Furthermore, the level of access may depend upon the point in time at which treatment is sought, as there are various times within the financial year where funding is rationed and new referrals potentially suspended (see Figure 4.2).

Recommendation No.3

4.48 To support equitable access to treatment for eligible consumers experiencing a mental health disorder, the ANAO recommends that DoHA periodically review the demand management strategies employed by Divisions funded under the ATAPS program and provide additional assistance and guidance where necessary.

Departmental response: *Agreed*

4.49 DoHA welcomes this recommendation to continue its improvement in delivery and funding arrangements, most recently through the phased introduction of findings from the 2010 review of the program in respect of quality assurance, efficiency, support for innovation and targeting hard to reach groups. The Operational Guidelines for the program are currently being revised and clinical governance arrangements strengthened in consultation with stakeholder experts. The implementation of this recommendation will

further strengthen administration of the program as it expands through the Australian Government's 2011–12 Budget commitment.

4.50 DoHA notes that as a fund holding program with a capped budget, ATAPS inherently has limits to the extent to which it can be demand driven. Nor should it need to do so, given its complementarity to other programs delivered in primary care, including Medicare-based mental health service delivery. Further, the nature of the purchaser/fundholder model delegates both responsibility and resources to Divisions of General Practice to manage service delivery and enables streamlined administration by DoHA. There will be limits to the extent to which DoHA can and should micromanage decisions and practice at a local level by contracted fundholders.

ANAO comment

4.51 The ANAO notes that there have been cases where the demand management strategies employed by Divisions have been inconsistent with DoHA's operational guidelines. Against this background, it would be prudent for the department to periodically review the strategies employed by Divisions and provide additional support to promote consistency with the guidelines.

5.   Responding to Natural Disasters and Administering Initiatives

This chapter examines DoHA's use of the ATAPS service delivery framework to respond to the increased demand for mental health care services following natural disasters and to deliver ATAPS program initiatives.

Introduction

5.1   Over recent years, DoHA has increasingly used the service delivery arrangements established under the ATAPS program to respond to the increased demand for mental health services following natural disasters and to deliver a range of initiatives, including trials and projects, designed to help achieve the objectives of a number of government policies.

5.2   The ANAO's examination of the department's response to natural disasters and its administration of ATAPS initiatives covered policy development through to outcomes.

Responding to natural disasters

5.3   The ATAPS program was a key element in the department's response to the 2009 Victorian bushfires and the 2011 Queensland flood and cyclone emergencies.

February 2009 Victorian bushfires

5.4   On 7 February 2009, 'Black Saturday', Victoria suffered one of Australia's worst natural disasters when bushfires spread through a large number of towns and communities. In total, 173 people lost their lives, 2100 properties were destroyed or badly damaged, and over 400 000 hectares were burnt.[94]

5.5   In the immediate aftermath of the bushfires, DoHA identified nine Divisions covering areas affected by the bushfires that were expected to experience an increase in demand for mental health care services. To provide urgent assistance, DoHA brought forward the ATAPS payments scheduled to

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[94]   ANAO Audit Report No.36 2009–10, *Emergency Management and Community Recovery Assistance in Centrelink*, Canberra, p. 15. Available from: <http://www.health.gov.au> [accessed 13 April 2011].

be made in April 2009 for those nine Divisions (the payments were approved on 13 February 2009). The nine payments totalled $541 920. The payments, their rationale and the exceptional circumstances in which they were made (before the receipt of deliverables or invoices) were recorded and approved by DoHA. The department also liaised with the Minister's Office during this period.

Policy development

5.6   As part of the Australian Government's response to the bushfires, on 23 February 2009, $7.5 million was allocated to the *Funding for Mental Health Support Services in Bushfire Affected Areas of Victoria* package of assistance. The package (to 30 June 2010) included increased funding of $3.6 million under the ATAPS program to enable Divisions supporting communities affected by the bushfires to provide additional services for people with mental health needs.[95]

Funding allocation

5.7   In the period from April to May 2009, contract variations covering the expanded ATAPS bushfire funding were endorsed for the nine affected Divisions. In 2008–09 and 2009–10, the nine bushfire-affected Divisions received between $320 000 and $650 000 in additional ATAPS funding, totalling $4.39 million. A further Division received $100 000 as a result of fires in its catchment area on the day of the announcement of the Australian Government's package.

5.8   The contract variations provided for: DoHA-developed and funded education and training for allied mental health professionals in bushfire areas; alternative referral pathways and unlimited services for consumers; expansion of support to principals and staff of local schools; and Division participation in an evaluation of the mental health response to the bushfires.

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[95]   Other elements of the *Funding for Mental Health Support Services in Bushfire Affected Areas of Victoria* package included:

- additional funding to organisations providing telephone counselling services to expand their counselling and specialised follow up service, including the provision of support to front line workers and volunteers involved in the bushfire effort;

- community capacity building through locally based mental health promotion initiatives such as 'community sheds', school and youth-focused activities and networking opportunities to help communities support individuals through the recovery and reconstruction process; and

- funding to establish arrangements to provide training, ongoing structured support and supervision and the necessary psychological support and debriefing to health professionals providing bushfire support services, including under the new expanded ATAPS arrangements.

5.9 A notable feature of DoHA's response to the Victorian bushfires was the department's willingness to provide added flexibility to Divisions, in order to better meet the needs of bushfire-affected communities. Flexibilities approved by DoHA (as the need arose) included:

- an allied mental health professional advisory service for staff of local schools;

- the use of funding to remunerate allied mental health professionals to attend essential training; and

- the use of up to 25 per cent of bushfire funds for Division administration.

5.10 In late June 2009, additional funding was provided to six Divisions (all nine bushfire-affected Divisions were offered funding) to boost their capacity to offer appropriate expertise to support and protect individuals at heightened suicide or self harm risk as a result of the bushfires. DoHA had identified unspent funds in the ATAPS program and the National Suicide Prevention Strategy and distributed $66 000 to each of the six Divisions. A second tranche of funding for bushfire-affected Divisions was provided in February 2010—with five of the original six Divisions receiving an additional $66 000.

5.11 On 20 April 2009, a DoHA-funded AGPN forum for bushfire-affected Divisions was held to provide an opportunity for Divisions to discuss their views with DoHA, and other agencies, in relation to:

- strategies for operationalising and integrating the additional ATAPS capacity to support affected individuals, families communities into the future;

- strategies for additional workforce recruitment and support;

- other support and services available; and

- other needs of the Divisions.

Bushfire response outcomes

5.12 DoHA chose not to amend the ATAPS Minimum Dataset (MDS) to specifically record data related to bushfire referrals, given the timeframe to make changes, the work required for Divisions to adapt to the changes, and an anticipated separate ATAPS bushfire response evaluation. DoHA instead contacted bushfire-affected Divisions directly to request their 'best advice' figures.

5.13   DoHA estimates that the number of referrals as at December 2010 (approximate, given the approach to data collection outlined above) made as a result of the additional funding to bushfire-affected Divisions is over 1900 referrals, with 10 000 sessions provided since February 2009. The University of Melbourne was contracted to evaluate the response. It provided its evaluation report in November 2010.

5.14   No additional Victorian bushfire response funds were allocated for the 2010–11 financial year. However, a number of bushfire-affected Divisions have received approval to roll uncommitted funding over into the 2010–11 year. This funding may be used to provide services to bushfire-affected individuals. DoHA was unable to quantify the level of bushfire funds being rolled over because the department accepted a number of rollover reports for general ATAPS that did not separately identify bushfire expenditure. DoHA accepted such reports despite preparing and providing a bushfire-specific rollover reporting template to relevant Divisions, which separately identified roll-over amounts.

5.15   DoHA's response to the 2009 Victorian bushfires was timely and well designed, with additional flexibilities afforded to Divisions to tailor approaches to local conditions. The department acted quickly to bring forward program payments to enable Divisions of General Practice to respond in a timely fashion to emerging mental health care needs. The department also provided additional flexibility and an increase in administrative funding to Divisions to support tailored service delivery models. The provision of departmental funding to bring together bushfire-affected Divisions also provided an opportunity to share experiences, refine service delivery strategies, and identify lessons learned to inform future administrative activity.

2011 Queensland flood and cyclone emergencies

5.16   Devastating flooding occurred in many areas of Queensland during late December 2010 and early January 2011, with three quarters of the state ultimately declared a disaster zone. The impact of the floods on Queensland was compounded by severe Tropical Cyclone Yasi, which crossed the state's north coast around midnight on 2 February 2011. Gale force winds, flooding rain and storm surges caused significant damage to those areas of North

Queensland that were in the cyclone's path.[96] The loss of life and widespread structural and economic damage across Queensland resulting from the floods and Cyclone Yasi is likely to have lasting effects on the mental wellbeing of residents who have experienced trauma and loss.

5.17 DoHA worked quickly to prepare options for consideration by government. On 13 January 2011, the Minister for Mental Health and Ageing announced that, in response to the devastating natural disasters in Queensland, the Australian Government would provide an additional $1.3m to support access to ongoing support from allied health professionals including psychologists and social workers through the ATAPS program.

5.18 As the announcement of Australian Government support and subsequent departmental activity occurred after the completion of audit fieldwork, the ANAO has not examined this aspect of DoHA's administration.

Administering initiatives

5.19 In order to develop innovative, fit-for-purpose ATAPS service delivery approaches that meet the needs of hard to reach groups, it is necessary from time to time to test different approaches through time-limited initiatives. Effectively administering initiatives is important, as those initiatives assessed as successful can be migrated to the general ATAPS program or adopted more broadly in other areas of health service delivery.

5.20 Since 2007, DoHA has administered the following three initiatives under the ATAPS program:

- *Telephone-Based Cognitive Behavioural Therapy (T-CBT) trial*: a mix of face-to-face and telephone-based cognitive behaviour therapy was trialled in rural and remote areas to test ways of overcoming barriers to accessing services, such as distance;

- *Additional Support for Patients at Risk of Suicide and Self Harm project*: which funded a number of demonstration sites around Australia in which Divisions received funding to engage allied mental health providers who are provided with additional specialised training in

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[96] Queensland Government, 2011, *Information about…Queensland Floods*, Brisbane. Available from: <http://www.qld.gov.au/floods> [accessed 13 April 2011].

providing clinical care to people who have attempted suicide and self harm; and

- *National Perinatal Depression Initiative*: the aim of the Initiative is to improve the prevention and early detection of antenatal and postnatal depression, and to provide better care, support and treatment for expectant and new mothers experiencing perinatal depression. Of the $55 million announced for the initiative over five years, $20 million was allocated to the ATAPS program.

5.21 The effective delivery of initiatives requires an appropriate level of administrative oversight, commensurate with the scale of the initiative, including: the establishment of clear objectives and a means to measure achievement; fit-for-purpose planning to support the achievement of established objectives within the set time available; effectively targeting funding to those areas with the greatest need; active day-to-day management to identify sufficiently early any barriers to delivery; and an assessment to determine whether or not the objective was achieved and to determine the future of the initiative.

Telephone-Based Cognitive Behavioural Therapy trial

Policy development

5.22 In late 2007, DoHA commenced planning for a trial of *Telephone-Based Cognitive Behavioural Therapy* (T-CBT) in rural and remote areas.[97] The trial was to involve a mix of face-to-face and telephone-based CBT to test methods of overcoming barriers to accessing services, such as distance, in these areas. Within DoHA, the trial evolved from enquiries from a small number of Divisions wishing to utilise various forms of technology to overcome access barriers in their regions. Studies of a similar rollout of T-CBT in the United Kingdom also informed the department's policy development activities.

5.23 The department sought and obtained approval for the trial from the Minister for Health and Ageing in March 2008, as part of a broader work plan to enhance and refocus the operations of the ATAPS program.[98] Approximately

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[97] Cognitive Behaviour Therapy is a form of psychotherapy that helps a person to change unhelpful or unhealthy thinking habits, feelings and behaviours. CBT involves the use of practical self-help strategies, which are designed to bring about positive and immediate changes in the person's quality of life.

[98] The broader work plan also sought approval for a Suicide Prevention project, discussed later in this chapter, and the instigation of a formal program review.

15 rural and remote Divisions (to be selected via a competitive Expression of Interest [EOI] process) were to take part in the trial lasting 12 months (the work plan timeframe was specified as at May 2008 and approved by the Minister). Funding of $1.1 million was sourced from existing appropriations for the COAG Telephone Counselling, Self-help and Web-Based support program and also from the ATAPS program.

Planning

5.24   In May 2008, DoHA sent EOI requests to 21 rural and remote Divisions, offering up to $11 000 per Division to meet administration costs associated with participation in the trial. DoHA advised that the amount of $11 000 was: 'calculated on the basis of minimal administration costs associated with data collection and reporting on new arrangements for service provision—this was estimated as equating to half a day a week of a project officer within the Division.' In early June 2008, DoHA approved 20 Division EOIs received at that point, with the decision to approve an increased number of Divisions (up from the planned estimate of 15) due to the: 'level of interest and enthusiasm demonstrated by Divisions'.[99]

5.25   In early July 2008, funding agreements for 17 of the 20 approved Divisions were endorsed by DoHA, more than a month after the trial commencement date approved by the Minister.[100] In early September 2008, DoHA approved an additional Division to participate in the trial and approved the funding agreement for that Division. The funding provided by DoHA to each Division was, subsequently, increased to $16 500, as Divisions had expressed concern about meeting the costs of telephone calls from the initial amount offered. One approved Division subsequently withdrew, with 19 Divisions ultimately participating in the trial.

Funding allocation

5.26   The allocation of T-CBT funding and the relative percentage of total funding (as a result of the agreements signed with Divisions, the APS and the University of Melbourne) are provided in Table 5.1.

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[99]   DoHA acknowledged that a reference to 24 participating Divisions in the department's 2007–08 Annual Report was incorrect. As at 6 June 2008, 20 Divisions had been approved to participate in the T-CBT trial.

[100]   DoHA was unable to provide funding agreements for the remaining Divisions.

Table 5.1

T-CBT funding allocation

	Funding 2008–09 ($)	Percentage 2008–09 (%)	Funding 2009–10 ($)	Total Percentage (%)
Divisions [Service Delivery]	313 500	29.9	555 000[1]	53.6
APS [Training and Clinical Support]	253 953	24.3	18 084	16.8
University of Melbourne [Evaluation Services]	479 718	45.8	-	29.6
Total	**1 047 171**	**100.0**	**573 084**	**100.0**

1   As this amount was allocated in June 2010 and the T-CBT trial ended on 30 June 2010, the majority of this funding would have been expended once the T-CBT mode of delivery was approved for delivery under the general ATAPS program (Tier 1) as an innovative service delivery model.

Source: ANAO from departmental information.

5.27   DoHA's initial 2008–09 allocation (the trial was to be for 12 months) of 45 per cent of program funding to evaluation services, as opposed to just under 30 per cent for service delivery, is unusually high. More than half of the $479 718 T-CBT evaluation budget was to rebuild a software tool (originally developed by a contractor[101]), even though the tool was limited to assisting in answering only two out of the nine T-CBT evaluation questions. The University of Melbourne later determined that the tool was not appropriate for use in the T-CBT trial. DoHA agreed to the University altering its MDS system to perform the required functions.

Trial conduct

5.28   In October 2008 and again in November 2008, progress reports from the Australian Psychological Society (largely relating to training numbers) advised DoHA that, of the allied mental health professionals that had completed training (over 90 allied mental health professionals had received training in October), the majority had received very few or no referrals.[102] On 10 December 2008, DoHA disseminated a circular to Divisions, which encouraged Divisions to promote the T-CBT trial to GPs.

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101   Prior to varying its existing evaluation support agreement, DoHA advised the University of Melbourne that it could 'buy-in' the expertise of a particular contractor (known to the department) to provide: 'necessary T-CBT expertise'. The University of Melbourne's successful proposal subsequently included this contractor.

102   The APS was contracted by DoHA to develop and provide training materials for the trial.

5.29   As a further measure to increase the number of T-CBT trial referrals, DoHA revised the T-CBT guidelines on 27 March 2009. The revision allowed for an additional referral pathway, enabling allied mental health professionals to assess a referred consumer's suitability for the trial and offer the T-CBT treatment option instead of the face-to-face treatment for which they were initially referred. While timing was particularly important, as the trial was initially approved for 12 months, it took two months for the circular to be issued and a further four months to create the revised referral pathway. A further notification of changed referral mechanisms was sent to Divisions on 9 April 2009. This notification also alerted Divisions to the extension of the trial until December 2009.

Trial outcomes

5.30   DoHA's actions to improve consumer access to the trial proved ineffective and did not resolve a number of identified implementation issues[103], such as:

- 68 per cent of T-CBT flagged sessions were being provided face-to-face;[104]

- seven (out of 19 T-CBT funded) Divisions had recorded T-CBT referrals;

- 72 referrals had been identified as 'T-CBT' in the two years since the trial commenced, with a further 229 referrals flagged in the MDS as receiving telephone sessions;

- referrals had been recorded before the trial had commenced and training had been developed or provided;

- a number of Divisions flagged sessions as being delivered via telephone, but were not participants in the trial; and

- a number of the telephone sessions were listed as relating to the Suicide Prevention trial—DoHA advised the ANAO that delivery of ATAPS sessions via telephone to this group of patients was not permitted.

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[103] Bassilios et al., 2009, *Interim evaluation report of a trial of telephone-based cognitive behaviour therapy*, University of Melbourne, Melbourne, pp. 26–27.

[104] DoHA had assumed that some T-CBT sessions would be delivered face-to-face (for example, an introductory meeting for the allied mental health professional and consumer to build trust), but did not set an expected level or permitted range to facilitate monitoring.

5.31 DoHA's actions in response to these issues were not recorded on official files. DoHA is yet to investigate the matter, for example by contacting Divisions responsible for the telephone-flagged referrals in the MDS. A summary of comments from the Program Development Section of the Mental Health and Suicide Prevention Branch, after reviewing the final T-CBT evaluation report, stated:

> There is room for further clarification of the findings and there needs to be some comments about what risk mitigation or review processes were in place as reading many of the comments in this report they suggest they were minimal if at all in existence.

5.32 A response to these concerns, or the ongoing issues, was not recorded on official files.

5.33 After an extension to 30 June 2010, the T-CBT mode of counselling was approved for delivery under the general ATAPS program (Tier 1) as an innovative service delivery model, which is allowed under the operational guidelines.

ATAPS Additional Support for Patients at Risk of Suicide and Self-Harm Project

Policy development

5.34 In March 2008, the Minister, as part of the previously discussed broader work plan to enhance and refocus the operations of the ATAPS program, approved the development of strategies to strengthen the emphasis on support for GPs to engage in suicide prevention activities for at risk patients within the ATAPS program.

5.35 The funding for the *ATAPS Additional Support for Patients at Risk of Suicide and Self-Harm Project* (the Suicide Prevention project) was sourced from the National Suicide Prevention Strategy and the ATAPS program. Total funding of $1.7 million was made available in 2007–08 and 2008–09. The one-year project was to commence in June 2008 and conclude in July 2009. Approval for additional funds for the initiative, bringing the total available funds to $2.4 million, was obtained from the Minister in May 2008.

Planning and conduct

5.36 In May 2008, geographic areas for possible demonstration sites were selected by DoHA following consultations with stakeholders, including State and Territory Mental Health Directors. Based on the identified regions, nominations to participate in the project were sought from 21 Divisions on

20 May 2008. DoHA advised Divisions that approximately $100 000 per Division was available for the establishment of demonstration sites.

5.37 In early June 2008, DoHA prepared a funding plan which was endorsed by the departmental delegate, who specified approval for an offer to Divisions of between $80 000–$100 000. DoHA then notified Divisions of their approval to participate in the project and sought brief advice on the amount of funding required (stipulating a range of $80 000–$120 000). Several days later, DoHA advised the AGPN that the department was willing to consider a further three to four Divisions—with EOIs due in four days. DoHA was unable to provide a rationale for the consideration of additional Divisions. Funding agreements with 18 Divisions were signed in June and July 2008.

Funding allocation

5.38 All but two of the 19 participating Divisions initially received between $118 799 and $120 000 (having been offered a range of $80 000 to $120 000). Two Divisions received more than the upper funding range as specified by DoHA—receiving $158 393 and $122 410 respectively. There was no evidence on official files to explain why Divisions were offered $120 000, which exceeded the delegate's approved maximum funding level of $100 000. DoHA was also unable to provide documentation to support the decision to allocate two Divisions funding that exceeded the $120 000 upper range offered to all Divisions.

5.39 One Division expressed its disappointment to DoHA at not being invited to submit an EOI and criticised the selection process. Another Division, also not invited to participate in the project, nevertheless chose to submit an EOI in the hope that DoHA would allow its participation in the project. The Division was subsequently approved in the supplementary funding offer, outlined earlier.

5.40 Due to the poor quality of departmental records it was unclear precisely how much, and when, additional funding was provided by DoHA to extend the initiative. It appears that funding was provided to Divisions on two additional occasions, following extensions of the project:

- $1.1 million was provided to Divisions, the APS and CSS[105] to extend funding arrangements by six months to 31 December 2009; and

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[105] The Crisis Support Service (CSS) was contracted to provide after hours support for consumers.

- a further six-month extension of the project was approved by DoHA to extend the project to 30 June 2010. Eleven Divisions received an additional $66 000 funding, one Division received a further $110 000 (the remaining Divisions rolled over unused funds). Approvals and evidence of the rationale for the extensions of the ATAPS Suicide Prevention project were not recorded on DoHA files.

5.41 As details regarding the allocation of the Suicide Prevention project funding to Divisions, the AGPN, the APS, CSS and the University of Melbourne were not recorded on official project files, the ANAO's information requests were referred to other parts of DoHA. The information on project allocations was eventually sourced from Regulation 9 approvals and the department's financial management system (see Table 5.2).

Table 5.2

Suicide Prevention project funding allocation

Category	Funding 2008–09 ($)	Additional Funding 2009–10 ($)
Divisions [Service Delivery]	2 439 206	2 184 975
AGPN [GP Education][1]	87 538	Nil
APS [AMHP Training][2]	187 647	244 532
CSS [After Hours Patient Support][3]	185 000	206 680[4]
University of Melbourne [Evaluation Services][5]	72 481	Nil
Total	**2 971 872**	**2 636 187**

[1] The AGPN was contracted by DoHA to provide resources and information sessions to GPs.

[2] The APS was contracted by DoHA to develop and deliver training to allied mental health professionals.

[3] The Crisis Support Service (CSS) was contracted to provide after hours support for consumers.

[4] Note: Including $22 090 to extend support to the six 'bushfire suicide prevention' Divisions.

[5] The University of Melbourne had its existing agreement with DoHA varied to provide evaluation support for the project.

Source: DoHA information.

Project outcomes

5.42 The University of Melbourne produced four interim evaluation reports for the Suicide Prevention project, dated July 2009, February 2010, July 2010, and February 2011. The fourth interim report noted that:

- between 1 October 2008 and 24 January 2011, 1401 referrals (399 rural and 1002 urban) had been made under the Suicide Prevention project;

- the majority of referrals were received from GPs (79 per cent), with 18 per cent from emergency departments and 3 per cent from community mental health services;

- the profile of participating consumers differed from that of general ATAPS consumers (for example, project consumers were more likely to be younger, male, and to have a diagnosis of depression); and

- for the 19 per cent of consumers for which outcome data had been recorded, the project was achieving positive outcomes for consumers as evidenced by statistically and clinically significant levels of improvement across all outcome measures examined.

5.43   On 30 March 2010, the Minister approved the use of up to $3 million in funding in 2010–11 from the National Suicide Prevention Strategy to continue and expand the Suicide Prevention project through its inclusion as an ATAPS Tier 2 funding priority.

ATAPS Perinatal Depression Initiative

Policy development

5.44   Announced as part of the 2008–09 Budget, the $85 million National Perinatal Depression Initiative aims to improve prevention and early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression.[106] Of the $85 million funding over five years, $20 million was allocated to the ATAPS program: 'to build the capacity of Divisions to support better treatment for women with perinatal depression'.

5.45   In June 2008, the Minister approved the use of a blended funding model for the entire $85 million plan, based on birth rates and adjusted to correct for inequitable access to MBS funded services. Attached to the Minute to the Minister was a draft implementation plan, which detailed an implementation schedule for the initiative. DoHA did not finalise the implementation plan.

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[106]   Perinatal depression covers antenatal and postnatal depression. For the purposes of the ATAPS program, the perinatal period is defined by DoHA as pregnancy and the first year after child birth.

Planning

5.46   Between June 2008 and January 2009, DoHA developed a formula to allocate funding to Divisions, including drawing on internal data such as Better Access utilisation rates in Divisions (as a measure of relative access to Medicare-based service delivery) and Australian Bureau of Statistics' birth rate data. DoHA utilised the services of a consultant to assist with the development of the formula. The allocation of ATAPS Perinatal National Depression Initiative (PNDI) funding in line with the broader initiative, based on birth rates and adjusted to correct for lower levels of access to MBS-based services, supported the targeting of funding to areas of greatest need.

Funding allocation

5.47   In January 2009, DoHA approved expenditure of $3.6 million of the PNDI funding for the remainder of 2008–09 and the first six months of 2009–10. This included:

- $10 000 to all Divisions to forge linkages with local child and maternal health services and to promote to GPs and other providers the various care pathways available for women experiencing perinatal depression;

- rural and remote Divisions were allocated an additional $5000 each financial year in recognition of the difficulties associated with service delivery in rural and remote regions; and

- funds for Divisions to deliver perinatal depression services. These funds were allocated to individual Divisions based on the number of births in each Division, adjusted for relative access to MBS-funded mental health allied services.

5.48   DoHA recorded the approval of PNDI funds, including the approved Divisions, the basis for that approval, funding amounts by financial year and the methodology used to determine the funding amounts. In total, 98 Divisions received between $15 028 and $102 975 for PNDI for 2008–09 and the first half of 2009–10. The remaining Divisions were to use existing funds for PNDI activities.[107]

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[107]   DoHA allowed a proportion of the PNDI funding to be used for non-PNDI purposes. Unallocated PNDI funds for 2008–09, totalling approximately $312 000, were approved by DoHA for Divisions to use for general ATAPS services in March 2009.

5.49 On 9 February 2009, DoHA notified Divisions that Deeds of Variation were being drafted and were expected to be distributed to Divisions in mid to late February 2009 (about a month after the draft implementation plan listed the funding agreements were to be finalised).

ATAPS PNDI Outcomes

5.50 In February 2011, the University of Melbourne released its third report on PNDI as a supplement to the seventeenth general ATAPS evaluation report. The report stated that 1347 consumers received 6591 sessions of care under PNDI. However, data was only available for 91 Divisions. The report also stated that for the 15 per cent of patients for which outcome data was recorded, outcome indicators demonstrated that improvements were being achieved.

5.51 As at 30 June 2010, women with perinatal depression became a group eligible for Tier 2 ATAPS funding. However, as with the T-CBT trial and the suicide prevention project, DoHA's review of the success or otherwise of the PNDI and the rationale for the inclusion of the perinatal depression group under the Tier 2 stream was not recorded. While PNDI differed from the T-CBT and Suicide Prevention initiatives in that it was designed to span five years, it would have been prudent for DoHA to monitor the initiative's progress, identify enhancements to service delivery, and confirm its suitability for continuation under ATAPS Tier 2 arrangements.

Administration of the three initiatives

5.52 Certain aspects of DoHA's administration of the three recent ATAPS initiatives—Telephone-based Cognitive Behavioural Therapy (T-CBT), Suicide Prevention, and Perinatal National Depression Initiative (PNDI)—were well managed, such as the use of an international study and experience to inform the design of the T-CBT trial and the use of relevant data to target PNDI funding to areas of greatest need. In general, however, the department did not actively manage the delivery of initiatives and did not always take timely corrective action to address identified delivery issues. The absence of a set of clearly documented 'success indicators' for ATAPS initiatives made it difficult for DoHA to effectively monitor the progress of the initiatives and, ultimately, to assess the success or otherwise of the initiatives before incorporating them as elements of the core program. The absence of appropriate documentation on departmental files also meant that the basis of key decisions relating to the initiatives was unclear, including in some cases the number of participating Divisions and the rationale for the level of funding made available.

Recommendation No.4

5.53 In order for DoHA to effectively monitor progress and assess the success or otherwise of any future ATAPS initiatives, the ANAO recommends that the department:

(a)   establish success indicators at the commencement of each initiative and use these indicators to inform ongoing monitoring and evaluation activities; and

(b)   record key implementation and evaluation decisions to support accountable program delivery.

Departmental response: *Agreed*

6. Monitoring and Reporting Program Performance

This chapter examines performance monitoring and reporting arrangements established by DoHA for the ATAPS program, with a focus on performance monitoring against established measures, compliance monitoring, reporting program performance to stakeholders, and evaluating the program's achievements.

Introduction

6.1　Monitoring program performance is important not only to ensure funding recipients are complying with program requirements, but also for administrators to review overall program progress, and where necessary, adjust delivery approaches. Effective performance reporting informs stakeholders of program performance and in doing so, improves public accountability.

6.2　This ANAO examined DoHA's:

- assessment of progress toward the achievement of program objectives;

- monitoring of compliance with agreed terms and conditions and established program rules;

- reporting of program performance to internal and external stakeholders; and

- evaluation of program performance.

Assessing performance

6.3　DoHA's monitoring of program performance is primarily informed by reporting requirements established under Division funding agreements. The current funding agreement template requires Divisions to report on: the aim and objectives of the project; the budget; project activities and deliverables; schedule progress payments against deliverables; and reporting and acquittal requirements. The funding agreement also establishes an obligation on Divisions to comply with the ATAPS operational guidelines.

6.4　The department's monitoring arrangements for Divisions, as outlined in the funding agreements, require Divisions to prepare annual plans and budgets, six-month and final reports and to contribute to the national Minimum Dataset (MDS).

Annual plans and budget

6.5 Funding agreements state that Divisions must prepare an annual plan which includes local objectives and the annual strategies and key activities to be performed. The department requires the annual plan and budget to be a 'living document' that is maintained and updated by Divisions as necessary. As set out in the funding agreement, in developing the associated annual budget Divisions must:

• adopt a service delivery model that suits local arrangements according to identified need;

• establish a system to manage demand for services according to the annual budget; and

• identify innovative approaches, new models of service delivery, and activities to improve help seeking behaviour in the target groups and other hard to reach groups.

6.6 The 2010–11 annual plan template seeks responses across the following areas: information about the Division, its population catchment and their mental health needs; engagement and integration with other mental health programs, services and providers; ATAPS demand management strategies; promotional activities; co-payments; estimated session unit costs; effectiveness of service delivery models; and an action plan describing the targeting of certain groups under Tier 2 funding.

6.7 The annual budget includes a breakdown of anticipated expenditure by tiers (in 2010–11 this included Tiers 1 and 2 and a separate budget for the Suicide Prevention project), specifying components of service delivery and administration costs. In the case of Tier 1 funding, the budget template indicates that administration costs should not exceed 15 per cent of total program funding.

Six-month and final reports

6.8 Six-month and final reports are required to describe the actions taken to support service provision and the activities performed by Divisions for each target group. The funding agreements state that the progress reports must include: a succinct executive summary covering achievements and challenges and key contributing factors and learnings; how community needs are met and in particular those groups who were targeted in order to improve access; and unaudited financial information.

6.9   Progress reports are due three months after the close of the period (31 December and 30 June). An audited financial report is due with the final report. As with annual plans and budgets, progress report templates are supplied by DoHA.[108]

6.10   DoHA routinely reviews the reports provided by Divisions (including annual plans and budgets and six-month and final reports). Program administrators document the review of reports, prepare minutes to the delegate seeking approval, and notify Divisions of approval.

6.11   Divisions considered, however, that DoHA's review of ATAPS reports was cursory, with DoHA primarily interested in the level of administration costs. This perception may be due to the limited feedback provided to Divisions, with DoHA's responses to accepted reports taking the form of a generic notification of acceptance. There is scope for DoHA to more fully capitalise on the information that it receives from progress reports, for example sharing successful delivery models with other Divisions, or to investigate the causes of problems commonly encountered by Divisions. These problems or barriers may also indicate a need for refinement to the administrative policy settings for the program.

6.12   In general, DoHA follows-up identified issues, omissions or gaps in Divisions' reporting (the majority of those issues raised by DoHA related to Divisions exceeding the 15 per cent administration funding threshold). The following examples however, highlight weaknesses in the department's scrutiny of progress reports:

- instances where a Division's file contained a set of DoHA-approved audited general purpose financial statements that made no specific reference to ATAPS revenue and expenditure. DoHA confirmed that these financial statements did not comply with funding agreements;

- DoHA staff completing a financial report on behalf of a Division that was experiencing difficulties;

- an instance where an error was made in transposing funding proportions (administration and service delivery) which meant that the delegate was not aware of a higher (over 15 per cent) administration funding amount when approving an annual plan and budget; and

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[108]   As noted earlier, templates were not always provided by DoHA to Divisions in a timely manner.

- a DoHA reviewer did not identify the absence of a Program Reference Group as advised by a Division in a report, advise the delegate in the approval minute, or follow up with the Division.

MDS contributions

6.13   The ATAPS Minimum Dataset (MDS) was developed by the University of Melbourne to gather de-identified data and information about consumers, GPs and allied mental health professionals from all ATAPS projects. A DoHA payment to Divisions is linked to the provision of MDS data (for example, the 2010–11 funding agreement requires Divisions to provide DoHA with a statement of compliance due at the end of October 2010, covering the period from the start of April to the end of July 2010). In effect, one of the payments for the new funding agreements is tied to the provision of a *Statement of Compliance* from each Division's Chief Executive, or equivalent, which certifies that all available data for the program has been entered into the MDS by the Division for the relevant period. The department does not, however, cross-check data entered into the MDS with data provided in reports submitted by Divisions.

6.14   The University of Melbourne advised the ANAO that Divisions were able to create reports in the MDS system to inform benchmarking against national and state averages. However, most Divisions interviewed by the ANAO were either unaware of this functionality or had not found it useful.

6.15   In reporting on MDS data in its interim evaluation reports, the University of Melbourne provides ATAPS monitoring information to DoHA. These services are provided as part of the Universities' funding agreement for evaluation support (discussed later in this chapter).

Monitoring compliance

6.16   As previously discussed, DoHA has specified requirements for the operation of the ATAPS program, including eligible consumers and target groups, the types and number of services to be provided, the allied health professionals who can provide those services and the operation of Divisions of General Practice (Divisions) ATAPS projects. These requirements are outlined in documents such as the operational guidelines and funding agreements. The setting of program requirements is necessary to support the achievement of program objectives. Once set, departmental monitoring of compliance with program requirements is important to ensure that Divisions' use of funding is appropriate and effective.

6.17 As the ATAPS program funds the delivery of health services, there are a number of additional challenges for DoHA in gaining adequate assurance of compliance, in particular, ensuring that ATAPS program funding is restricted to the agreed list and number of treatments. Notwithstanding DoHA's efforts to educate and inform program participants through the program guidelines, peak professional bodies and Divisions identified the practical difficulties in 'policing' program parameters, noting that what occurs behind the 'closed doors' of a clinical consultation is impossible to monitor. Additionally, the (necessary) use of de-identified consumer data under the program, to protect consumer privacy, means that it is very difficult, if not impossible, for DoHA to accurately monitor the number of services provided to consumers by Divisions. In these circumstances, an ongoing focus on education and guidance targeting both Divisions and providers is necessary.

6.18 A documented approach to monitoring compliance, such as a compliance strategy, helps to define the types of activities to be undertaken to confirm compliance, who will undertake the activities, how frequently they will be conducted, and how they will be reported. The systematic review and regular update of compliance approaches ensures that they reflect the changing delivery environment and remain effective. DoHA has not, however, documented its approach to monitoring compliance with ATAPS program requirements. DoHA primarily relies on self reporting from Divisions (as discussed in the previous section, *Assessing performance*), which has some inherent limitations with respect to the level of assurance it provides on compliance with program parameters.

6.19 DoHA supplements reporting from Divisions with a requirement for Divisions to provide an annual audited financial statement prepared by an approved auditor. The statement must be in compliance with Australian Auditing Standards and must include a definitive statement as to whether the financial accounts are complete and accurate, and a statement of the balance of funds in the Division's ATAPS bank account. While the requirement for audited statements provides additional assurance that reported financial performance is accurate, it does not provide a suitable level of assurance that the program is being delivered in accordance with agreed terms, conditions and rules.

6.20 The requirement for Divisions to provide an annual plan that outlines ATAPS delivery approaches, as discussed earlier, provides DoHA with valuable information on which to build a risk profile for the program. The development of a risk profile would allow the department to effectively deploy

its limited resources to cover off those areas presenting the greatest risk. Effectively managing service delivery risk also helps to avoid disadvantage to consumers which may result from non-compliance within particular Divisions.

Recommendation No.5

6.21 In order to plan and coordinate its compliance activities, the ANAO recommends that DoHA establishes a risk-based compliance strategy, promulgates the strategy to internal and external stakeholders, and periodically reviews the strategy.

Departmental response: Agreed

Reporting program performance

6.22 Effective performance reporting informs internal and external stakeholders of program performance and can strengthen program management and accountability.

Public reporting

DoHA annual reporting

6.23 Agency annual reports are the primary vehicle for reporting program performance, particularly effectiveness, to the Parliament and to the public. DoHA's current Annual Report (2009–10) outlined major ATAPS-related activities including the refocussing of ATAPS to target new groups, the ATAPS contributions to *Improved Services for Women Experiencing Antenatal and Postnatal Depression*, *Support for Individuals at Risk of Suicide* and the mental health response to the Victorian bushfires. The *Deliverables* and *Key Performance Indicators* specific to the ATAPS program, as reported by DoHA in its 2009–10 Annual Report, are provided at Appendix 1.

6.24 The information included in the annual report related to the ATAPS program is based on the performance information in the 2009–10 Portfolio Budget Statements and provides a broad range of predominantly quantitative performance information to stakeholders. In addition to improving the balance of performance information, as suggested earlier, there is scope for DoHA to review the adequacy of the quantitative performance measures established for the ATAPS program. Finance's Portfolio Budget Statements Constructors Kit states:

> When setting performance targets within or beyond the forward estimates period, agencies are to be conscious of previous years' targets and their

progress towards them. Performance targets should not be static, they should grow with improved practices and methods, periodically being evaluated and revised to ensure agencies are achieving the best possible results in contributing towards their outcomes.[109]

6.25 In relation to the quantitative deliverable covering the number of ATAPS sessions delivered (2009–10 target: 70 000, actual: 110 892[110]), the target set by DoHA for 2010–11 (75 000), and future years, was significantly lower than the number of sessions already being delivered.[111] DoHA advised that the target it set was: 'conservative and based on a reasonable increase from the previous year's target'. As DoHA's current and historic performance was clearly well above the proposed targets, the value of these targets in assisting the department to 'achieve the best possible results' was likely to be limited. While the department has not included the number of ATAPS sessions as a deliverable in the current 2011–12 PBS, it has included estimates of numbers of additional people assisted under the expansion of the ATAPS program for each of the next four years. To effectively measure the number of additional people assisted, an appropriate baseline informed by current program performance would need to be established by the department. Once a baseline is established, the ongoing refinement of targets to acknowledge progress in the previous year would help to ensure that performance information is more meaningful to program stakeholders.

6.26 A further issue relates to the measure established by DoHA regarding the percentage of Divisions with the capacity to provide perinatal depression services, which has been carried over to the 2011–12 PBS. DoHA considered that the provision of funding to all Divisions meant that they had the capacity to provide perinatal services. However, some Divisions had previously advised the department that, during 2009–10, they were not in a position to provide services for certain periods of the year, including in one example for more than half of 2009–10.

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[109] Department of Finance and Deregulation, 2009, *2009–10 Portfolio Budget Statements Constructors Kit*, Canberra. Available from: <http://www.finance.gov.au> [accessed 4 January 2011].

[110] DoHA's 2008–09 Annual Report stated that for nine months of 2008–09 (from 1 July 2008 to 31 March 2009), 110 970 sessions of care were provided under ATAPS.

[111] The target was to rise by an additional 5000 sessions in each of the next three financial years to 90 000 by 2013–14.

Other external reporting

6.27 Other external ATAPS program reporting undertaken by DoHA included:

- attendance at Senate Estimates hearings (in 2009, 2010 and 2011 estimates sessions, ATAPS was discussed in relation to mental health issues in rural and remote areas, Victorian bushfire support and the introduction of flexible care packages); and

- public reporting requirements for grants mandated in the Commonwealth Grant Guidelines (CGGs), such as individual grants.

6.28 Overall, recent public reporting of ATAPS program performance by DoHA provides a range of performance information to stakeholders, particularly given the program's relatively small size. An examination of the adequacy of the current set of performance information would provide an assurance that measures and targets are appropriate, for example ensuring future targets for additional sessions provided are informed by DoHA's achievements against previous years' targets.

DoHA internal reporting

6.29 DoHA's internal reporting occurs on an ad hoc basis, primarily relating to current events and issues or recently received feedback. An example is periodic 'Hot Issues' weekly reporting to the Deputy Secretary, with ATAPS program items included as appropriate (for example, advising of upcoming Minutes to the Minister or providing an update on the ATAPS review). DoHA also informed the ANAO that there is a departmental requirement for the notification of major emerging risks and their treatments to be communicated to the Executive on a weekly basis.

Evaluating the program

Evaluation strategy

6.30 Evaluation determines whether, and to what extent, program objectives are being met. The preparation of an evaluation strategy informs the selection of an appropriate evaluation methodology and also informs an administering agency's decisions in relation to an appropriate balance between expenditure on evaluation and service delivery.

6.31 While DoHA is yet to develop an overarching strategy to inform the level and focus of ATAPS evaluation activities, an evaluation framework was

developed by the University of Melbourne (Centre for Health Policy, Programs and Economics) for the broader BOiMHC program in 2003. The framework, which was revised in 2007, was designed to clarify: 'the program logic of the initiative…and uses it to formulate evaluation questions regarding the effectiveness and efficiency of the initiative'.[112] The framework was also developed: 'to provide guidance [*to DoHA*] regarding tendering out of the different evaluation elements'. [113]

6.32   As discussed previously, the Centre for Health Policy, Programs and Economics located at the University of Melbourne has been commissioned by DoHA, since the commencement of ATAPS, to prepare regular evaluation reports on ATAPS.[114] The ANAO examined:

- the initial evaluation support funding agreement; and

- the subsequent 2006 evaluation support funding agreement and associated variations.

Initial funding agreement

6.33   DoHA informed the ANAO that, in September 2002, an Evaluation Working Group (EWG) was established under the Better Outcomes Implementation Advisory Group. Membership of the group was drawn from individuals with relevant evaluation expertise and members were to be coopted as required. The EWG endorsed the need for the development of a continuous process of evaluation of the BOiMHC initiative. DoHA further advised that a tender process was undertaken and the University of Melbourne was selected, although documentation on the conduct of the tender was unable to be located by the department.

6.34   Since being contracted in mid–2003, 17 interim evaluation reports have been completed by the University, with the most recent release in February 2011. The focus and sources of the evaluation reports have varied over time (Appendix 2 provides a list of the interim evaluation reports).

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[112]   University of Melbourne, 2003, *A National Evaluation Framework for the Better Outcomes in Mental Health Care Initiative*, Melbourne, p. 4.

[113]   ibid, p. 20.

[114]   In addition to the provision of evaluation support, DoHA considers that the University of Melbourne's establishment, operation and maintenance of the MDS contributes to ongoing monitoring of the program.

6.35 DoHA informed the ANAO that, initially, the ATAPS program was funded until June 2005 with evaluation services provided by the University of Melbourne until this time. When an extension of the ATAPS program was announced in the 2005 Federal Budget, program administrators sought advice from the department's Procurement Policy and Reporting Centre about options for the ongoing engagement of evaluation support for the initiative. DoHA subsequently retained the University of Melbourne based on the following internal advice that it received:

> if the contractor was changed as a result of a new competitive process, the new services would be inferior to those previously supplied and that projects would be put at risk because of the possible change in contractor. In addition, if a new contractor had different methodology, results would be different and could not be comparable.

6.36 DoHA further advised that, on the basis of Paragraph 8.33(e) of the Commonwealth Procurement Guidelines relating to the extension or continuation of services, the University of Melbourne has been retained to evaluate ATAPS on an ongoing basis.[115]

2006 funding agreement and subsequent variations

6.37 After prolonged agreement negotiations, a new agreement was signed by DoHA and the University of Melbourne in December 2006 for the continued provision of evaluation services for the ATAPS program. The funding agreement also required the University to maintain the MDS for aggregating national data for the ATAPS program.

6.38 The 2006 funding agreement provided $329 749 to the University for the period 1 July 2006 to 30 June 2007. A series of subsequent agreement variations extended the University's role in the evaluation of the ATAPS component for a further four years to 5 March 2011, worth a total of $2.8 million (see Table 6.1).[116]

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[115] Commonwealth Procurement Guidelines, December 2008, Paragraph 8.33 (e): *for additional deliveries of property or services by the original supplier ... that are intended either as replacement parts, extensions or continuing services for existing equipment services... where a change of supplier would compel the agency to procure property or services that do not meet the requirements of compatibility with existing equipment or services,* p. 31. Available from <http://www.finance.gov.au> [accessed 3 February 2011].

[116] The University's 'standard infrastructure fee' also increased from 27 per cent in 2006, to 30 per cent in 2007 and then 35 per cent in 2008.

Table 6.1

Evaluation support agreement: history of variations

Variation	Endorsed	Agreement Term	Value	Additional Information
1	August 2007	2007–09	$737 139	The variation extended evaluation support through to 2009. At the time, DoHA obtained internal legal advice that even though the project period for the agreement had expired, a deliverable was still outstanding and therefore the agreement had not expired and could be varied.
2	June 2008	N/A	$28 600	The variation provided an additional $28 600 for 2008–09 financial year. The University of Melbourne advised DoHA that it had exceeded its first years' travel budget by almost double and requested additional funds. DoHA varied the agreement to provide an additional $14 300 per financial year subject to the approval of a prioritised list of travel.
3	June 2008	N/A	$651 199	The variation added $651 199 to the agreement value for additional evaluation support for the T-CBT and Suicide Prevention initiatives, and an upgrade of the MDS system.
4	June 2009	2009–10	$384 656	The variation extended the evaluation support agreement for a further 12 months.
5	June 2010	2010–11	$676 887	The variation extended the evaluation support agreement until 5 March 2011 and also augmented the agreement scope to include evaluation support for the 2009 Victorian bushfire response.

Source: ANAO from departmental information.

6.39   In signing the new funding agreement in December 2006, the departmental delegate commented that DoHA should: 'assess whether we should go out to market in future years'. No such approach to market occurred, nor was there any evidence to suggest that DoHA further considered such an approach. As previously discussed, DoHA subsequently direct-sourced the University under Paragraph 8.33(e) of the Commonwealth Procurement Guidelines. For the fifth variation, DoHA's Program Funding and Procurement Service area recommended: 'that a new agreement be drafted due to change in pricing scope and the previous number of variations.' A response to this advice was not recorded on official departmental files.

6.40   It would be timely for the department to assess its ATAPS monitoring and evaluation activities, including a comprehensive review of the 2003 evaluation framework. Such an assessment would better position the

department to determine the level and future focus of evaluation activity and to structure evaluations to better inform the department's decision-making, such as the targeting of program funding or the performance of ATAPS initiatives. A strategic assessment of the evaluation needs of the program would also help to balance the amount of data sought to determine program outcomes with the cost to Divisions and the department of collection. It would also be appropriate, given the passage of time since the program commenced and subsequent changes to policy and administrative settings arising from the recent review, for the department to reconsider the need to approach the market for evaluation services. A consideration in any strategic assessment of the evaluation needs of the ATAPS program will be the impact of the establishment of a National Mental Health Commission, which was announced in the 2011–12 Budget.[117]

6.41 DoHA considers that the University of Melbourne has performed well under its contractual requirements. The department also considers that transferability of the MDS to another organisation is not as simple as transferring capacity to evaluate the program to a different party—there is a need to facilitate continuity in terms of the collection and analysis of complex data. However, the department indicated that it will consider the findings of the audit and consider appropriate action in this respect.

Ian McPhee   Canberra ACT

Auditor-General   21 June 2011

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[117] The Government will provide $32 million over five years to establish a National Mental Health Commission. The Commission, which will be established as an Executive Agency within the Prime Minister's portfolio, will independently monitor, assess and report on how the system is performing as well as provide advice on mental health policy and programs. Some functions currently performed by DoHA, including administering the *Annual National Report Card on Mental Health and Suicide Prevention*, will be transferred to the Commission.

Appendices

Appendix 1:   ATAPS Public Performance Reporting

Table A.1

DoHA Annual Report 2009–10: ATAPS-specific performance reporting

Deliverable	Reported Result	Result Description
Deliverables		
Qualitative: The number of services available for women experiencing antenatal and postnatal depression will be monitored on a six monthly basis, through data collected under the ATAPS Initiative.	Deliverable Met	Data on services available through the ATAPS initiative for women experiencing antenatal and postnatal depression is collected from Divisions and reported to the department every six months. 106 Divisions are providing services for the treatment of antenatal and postnatal depression throughout Australia.
Qualitative: The department will work with the Vic. Department of Human Services to develop and implement targeted services to assist in the psychological recovery of individuals and communities recovering from the Vic. bushfire disaster.	Deliverable Met	The success of this program is evident through the high uptake of mental health services in the bushfire affected regions. Since commencement of funding in February 2009, the nine Divisions that receive funding from the department reported more than 1900 bushfire specific referrals and more than 10 000 sessions of care.
Quantitative: Number of patient sessions to be delivered under the ATAPS Initiative. 2009–10 Target: 70 000	Deliverable Met 2009–10 Actual: 110 892	To support the needs of people living with mental illness in the community in 2009–10, the department managed the ATAPS initiative which funds the provision of short-term focused psychological services for people diagnosed with a mild to moderate mental disorder. Services are provided throughout Australia by a range of allied health professionals employed or contracted by Divisions, which have been the fund holders for the ATAPS initiative since it was established. During 2009–10, more than 110 800 sessions of care were delivered. Outcomes of treatment were measured through validated mental health instruments and demonstrate positive outcomes of large or medium magnitude in 86 per cent of cases. The department supported 22 rural and remote Divisions in 2009–10 to participate in a trial of telephone-based cognitive behaviour therapy. It also provided funding to 18 Divisions to establish and operate demonstration sites to help general practitioners with patients at risk of suicide and self-harm.

Deliverable	Reported Result	Result Description
Key Performance Indicators		
Qualitative: A review of the ATAPS initiative to be completed by July 2009.	Indicator substantially met.	The review of the ATAPS initiative was completed in March 2010. The delay was due to a need for detailed modelling to guide future funding arrangements. The aim of the review was to refocus the service to better complement fee for service programs, to better target particular groups, and to address service gaps in locations with limited private Medicare services. As part of the review process, the Australian Government refined the initiative to better meet the emerging needs of communities in accessing mental health services. The enhancements included: • innovative service trials including T-CBT and Suicide Prevention; • updated guidelines to reflect and clarify modifications to ATAPS since its commencement; • mental health support to bushfire affected communities; and • building the capacity to treat women experiencing perinatal depression through the national perinatal initiative. As a result of the review, a new funding model is being implemented to better address gaps, increase efficiency and encourage innovation. Consultation with key stakeholders on efficiency measures, guidelines and quality assurance/ governance is planned for late 2010.
Quantitative: Percentage of Divisions of General Practice with the capacity to provide perinatal depression services through the ATAPS initiative. 2009–10 Target: 100%	Indicator met. 2009–10 Actual: 100%	In 2009–10, the department distributed funding to all Divisions to build capacity and provide perinatal depression services. Funding was distributed according to a formula based on population, rurality and number of births per head of population. In addition to service delivery, the Divisions built on established linkages with local child and maternal health services and primary mental health care services to ensure that women experiencing perinatal depression and their families can access appropriate resources.

Source: DoHA Annual Report 2009–10.

Appendix 2:   List of ATAPS Evaluation Reports

Table A.2

ATAPS interim evaluation reports

Report No.	Date	Focus
1	Dec-03	First Interim Evaluation Report (first 15 pilot Divisions)
2	Jul-04	Second Interim Evaluation Report (first 15 pilot Divisions and 14 supplementary Divisions)
3	Feb-05	Benefits and barriers associated with different models of service delivery
4	Apr-05	Fourth Interim Evaluation Report (achievements of the Round 1 and Round 2 projects [totalling 69 Divisions])
5	Jun-05	Models of service delivery: Profile and association with access
6	Nov-05	Progressive achievements over time
7	Mar-06	Rural and urban projects: Similarities and differences
8	Jun-06	Consumer outcomes: The impact of different models of psychological service provision
9	Oct-06	Demand Management Strategies
10	Nov-07	Progressive achievements over time
11	Oct-07	Utilisation of evaluation findings
12	Apr-08	Making an impact on the Australian mental health care landscape
13	Mar-09	Relationship between ATAPS projects and the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (Better Access) initiative
14	Jun-09	Ongoing gains in improving access to mental health care in Australia
15	Feb-10	Current profile of, and innovations in, service delivery of Access to Psychological Services projects
16	Jul-10	Clinical improvement after treatment provided through the ATAPS projects: Do some patients fare better than others?
17	Feb-11	Evaluating the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care (BOiMHC) program: Update on the achievements of the ATAPS projects

Source: DoHA.

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