



**Evaluating the Access to Allied Psychological  
Services component of the Better Outcomes in  
Mental Health Care program**

**Second Interim Report for the Evaluation of the Specialist  
Services for Consumers at Risk of Suicide**

**Kylie King, Fay Kohn, Bridget Bassilios, Justine Fletcher,  
Grant Blashki, Philip Burgess, Jane Pirkis**

**Feb 2010**

# Table of contents

---

Executive summary .....	3
Chapter 1: Background .....	7
Chapter 2: Method .....	9
Chapter 3: What are the benefits and disadvantages of the Specialist Services for Consumers at Risk of Suicide, from the perspective of GPs, allied health professionals and emergency departments? .....	11
Chapter 4: What is the level of uptake of Specialist Services for Consumers at Risk of Suicide by GPs, allied health professionals and consumers? .....	15
Chapter 5: What is the profile of consumers at risk of suicide accessing the Specialist Services through the ATAPS projects? .....	20
Chapter 6: What is the precise nature of the services being delivered through the ATAPS projects for consumers at risk of suicide? .....	22
Chapter 7: Discussion and conclusions .....	24
References .....	27
Appendix A: Divisions of General Practice involved in general ATAPS projects.....	30
Appendix B: Divisions of General Practice involved in the Specialist Services for Consumers at Risk of Suicide.....	33
Appendix C: Survey of Allied Health Professionals, Emergency Department Professionals and General Practitioners for the Specialist Suicide Services. ....	34

# Executive summary

---

## **Background**

In July 2001, the Better Outcomes in Mental Health Care program was introduced in an effort to improve consumers' access to high quality primary mental health care. This involves a number of components, key among which is the Access to Allied Psychological Services (ATAPS) component which supports GPs and allied health professionals to work together to provide optimal mental health care. Specifically, this component enables GPs to refer consumers with high prevalence disorders to allied health professionals for twelve sessions of evidence-based mental health care (or 18 in exceptional circumstances). This collaborative approach to mental health care is occurring through 105 ATAPS projects being conducted by 112 Divisions of General Practice and progressively funded through four funding rounds.

In June 2008, the Department of Health and Ageing provided additional funding to 19 Divisions to offer a more intensive, prioritised service for people who are at risk of suicide (e.g., those who have made a recent suicide attempt, have recently self-harmed, or are having severe suicidal thoughts), who may or may not have a mental disorder. These Divisions have been provided with an additional \$100,000-\$150,000 to secure the services of specialised allied health professionals to provide intensive care and follow-up to referred consumers.

In mid-2003, the University of Melbourne's Centre for Health Policy, Programs and Economics (CHPPE) was contracted to evaluate the ATAPS projects. Our ongoing evaluation has drawn on a number of data sources, including information from projects' local evaluation and project implementation reports, a purpose-designed minimum dataset, a Divisional forum, and one-off surveys. In June 2008, our contract was varied to incorporate an evaluation of the new specialist ATAPS services for people at risk of suicide.

The current report considers the achievements of the Specialist Services for Consumers at Risk of Suicide since its implementation in June 2008. It looks at the benefits and disadvantages of the Specialist Services for Consumers at Risk of Suicide from the perspective of general practitioners (GPs), allied health professionals, and emergency departments, the level of uptake by GPs, allied health professionals, and consumers at risk of suicide, the profile (socio-demographic and clinical) of consumers at risk of suicide, and the precise nature of services being delivered.

## **Method**

The report draws on data from a survey of GPs and allied health professionals representing the 19 ATAPS projects providing specialist suicide services, and emergency departments associated with these projects, and from a purpose-designed minimum dataset which collects consumer- and session-based data on the projects. It considers the implementation and the achievements of the Specialist Services via the following evaluation questions:

*Evaluation Question 1:* What are the benefits and disadvantages of the Specialist Services for Consumers at Risk of Suicide, from the perspective of GPs, allied health professionals and emergency departments?

*Evaluation Question 2:* What is the level of uptake of the Specialist Services for Consumers at Risk of Suicide by GPs, allied health professionals, and consumers?

*Evaluation Question 3:* What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing Specialist Services through the ATAPS projects?

*Evaluation Question 4:* What is the precise nature of the services for consumers at risk of suicide being delivered through the ATAPS projects?

Consumer outcomes have not been evaluated in this interim report as there was not sufficient consumer outcome data available. However, the evaluation team will be supporting Divisions to provide further outcome data so that this can be evaluated in the final report to be submitted in mid 2010.

## **Key findings**

### **What are the benefits and disadvantages of the Specialist Services for Consumers at Risk of Suicide, from the perspective of GPs, allied health professionals and emergency departments?**

#### **General Practitioners**

Six general practitioners (GPs) from five different ATAPS projects (two urban, three rural) were interviewed.

Five of the GPs said that the referral process to the Specialist Services was *'good'* and *'easy from the GP perspective'*. They all reported that they felt confident assessing and referring patients to the services. Three of the GPs reported no barriers to the referral process. However, the other three GPs reported having specific issues with the Division (ATAPS project office) which were related to poor communication from the Division to the GP. Most of the GPs reported that communication with the allied health professionals had been good.

All the GPs interviewed relayed that the consumers were pleased with the offer of a referral to the Specialist Services, responded well and were reassured by the *'back up'* provided. In general, the GPs stated that the consumers were *'really relieved to get action quickly'*. Most of the GPs reported that the impact of Specialist Services on themselves had been positive. One GP commented that it had *'decreased a lot of stress with patients that harm themselves'*. Another GP stated that the *'people have got better faster'* and treatment by a GP can *'go on for months'*. Another GP said that the program was an effective way to manage patients, and another commented that access was *'easy'*. Most of the GPs said there were no negative impacts for themselves.

All of the GPs interviewed felt that the Specialist Services had had positive impacts for their consumers. Patients were satisfied as they were seen immediately, someone cared about them, and the service provided *'more than what is otherwise available'*. No negative impacts for consumers were identified by the GPs. GPs further commented that they were supportive of the Specialist Services and highly valued its usefulness and value to patients.

#### **Allied Health Professionals**

Three allied health professionals, two psychologists and a community mental health nurse, from three different rural ATAPS projects were interviewed. Two of the allied health professionals said that they felt that the referrals were appropriate and the consumers presenting were of mild to moderate risk of suicide.

When asked about the overall impact of the Specialist Services on consumers, two of the professionals spoke about the accessibility of the services to consumers who would not normally be able to access services. One professional stated that the early intervention is positive for the consumer and that they could receive a *'good level of expertise'* and not have to *'struggle along with the GP'*. The allied health professionals said that overall the Specialist Services was a good program. Two of the professionals reported that they felt that rural areas faced some difficulties not experienced in urban areas. Two professionals also raised concerns about difficulties in responding to consumers quickly following referral, especially for referrals received after hours.

#### **Emergency Department Professionals**

Three emergency department professionals, all psychiatric nurses, from two different ATAPS projects (one urban, one rural) were interviewed.

The three professionals reported that the specialist service provided a quick response for consumers of mild to moderate risk of suicide who would have previously been referred back to their GP and would have possibly had to wait for a number of weeks to receive an appointment with a psychologist. They all

reported that the referral process had been '*very straightforward and smooth*' and that emergency department staff had felt confident making the referral.

All three professionals commented on the positive impact for the department of being able to refer consumers to the appropriate service quickly. One professional reported that this had resulted in lessened workload for the department.

The three professionals said that consumers had responded positively to the Specialist Services. All three professionals cited positive impacts for consumers including: the consumers are happy because they are able to access an allied health professional quickly, consumers don't have to go back to their GP for a referral as the emergency department does this for them, decreased stigma for consumers, availability of ongoing care, and availability of care with no cost to the consumer. None of the professionals cited any negative impacts for their consumers.

### **What is the level of uptake of Specialist Services for Consumers at Risk of Suicide by GPs, allied health professionals and consumers?**

Uptake data is available for the 17 (of the 19) Divisions who had entered data into the minimum data set as at 4<sup>th</sup> February 2010. For the period October 2008 to January 2010, referrals were made by 196 GPs and sessions were conducted by 101 allied health professionals in the 17 Divisions.

Whilst the majority of referrals to the services were made by GPs (79%), 19% were made by emergency departments and 2% were made by community mental health services. Most of the referrals made by emergency departments were made in urban areas, with few made by emergency departments in rural areas. These trends in referral are consistent with the period October - July 2009 presented in the previous report.

Between October 2008 and January 2010, 17 projects reported that 604 referrals were made to the Specialist Services for Consumers at Risk of Suicide, 196 rural and 407 urban. This is an increase of 322 referrals from the 282 referrals reported in the October 2008-July 2009 period.

Seventeen projects reported delivering 2,821 sessions (924 rural, 1897 urban) between October 2008 and January 2010, representing an increase of 1757 sessions (from 1064 sessions; 387 rural, 677 urban) reported since the October 2008 – July 2009 period. These 2,821 sessions were delivered to 569 consumers to date, making the average number of sessions provided to consumers 5. However, this is likely to be an underestimate as not all consumers will have completed treatment prior to the data being extracted. This represents a slight increase in the number of sessions per consumer when compared to the October 2008 – July 2009 period, wherein 240 consumers received an average of 4.4 sessions.

Overall, there were a greater number of referrals and sessions in urban compared to rural areas. The number of sessions and referrals in urban and rural areas both gradually increased from late 2008 and peaked in July 2009. The tables show a decline in sessions and referrals after August 2009, but this may be due to a data entry lag, and the fact that most ATAPS projects are closed over the Christmas period.

### **What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing Specialist Services through the ATAPS projects?**

Around three-fifths of consumers to Specialist Services are female, and their mean age is approximately 33 years. About one half are on low incomes, as judged by their GP. Slightly less than half of the consumers have a history of previous mental health care. One and one half per cent of consumers were reported to be Aboriginal, and less than 1% Torres Strait Islander. A diagnosis was made by the referring GP in 82.8% (500) of the 604 referrals made. For these 500 referrals, almost all have been diagnosed with depression (89.8%). In the main, the profiles of rural and urban consumers were similar; however there is a trend for rural consumers to be less likely to be on a low income and to be slightly younger than urban consumers. Comparisons are made with the general ATAPS projects.

## **What is the precise nature of the services for consumers at risk of suicide being delivered through the ATAPS projects?**

Sessions of 46-60 minutes account for two thirds of Specialist Services and are less popular than in the national ATAPS projects. More sessions conducted in the Specialist Services are less than 30 minutes when compared with the national ATAPS services. Session interventions differed between urban and rural areas and from the national ATAPS projects. Overall, session interventions were more likely to be diagnostic assessment and CBT-skills training and less likely to be psycho-education and CBT-behavioural interventions in the Specialist Services when compared to the national ATAPS projects. Urban Specialist Services were more often reported to be diagnostic assessment and CBT-cognitive interventions and less likely to be CBT-skills training than rural Specialist Services. No copayment was reported in any of the Specialist Services sessions. Comparisons are made with the general ATAPS projects.

## ***Conclusions***

The current report indicates that Specialist Services for Consumers at Risk of Suicide have been received positively by allied health professionals, emergency departments, and general practitioners who all view it as a welcome service addition that provides a quick and effective service response to consumers of mild to moderate suicide risk. The services have continued to steadily attract referrals from GPs and Emergency Departments. Sessions delivered by allied health professionals to consumers are also steadily rising. The profile of consumers is somewhat different from the general ATAPS projects suggesting that these Specialist Services are reaching a different group of consumers and are complementing the general ATAPS projects. The nature of services being delivered varies from that of general ATAPS and between rural and urban areas. Consumers are receiving a free of cost service, with no co-payments reported in any sessions.

# Chapter 1: Background

---

Since the late 1990s, Australia has seen significant changes in the way in which mental health care is delivered in Australia. There has been increased recognition that disorders such as depression and anxiety are prevalent. The 2007 National Survey of Mental Health and Wellbeing showed that 6% of Australian adults experienced an affective disorder in a given 2007<sup>1</sup>. There has also been increased acknowledgement that many people with these high prevalence disorders receive no treatment or ineffective treatment<sup>2</sup>, and that those who do receive treatment tend to utilise GPs rather than providers like psychologists (29% utilise the former; 7% the latter<sup>3</sup>). GPs are well-placed to assess people with these disorders, who often present with a mix of physical and psychological symptoms, but they have traditionally been under trained to provide effective psychological treatment (particularly non-pharmacological therapies<sup>4</sup>), citing barriers such as lack of training and time constraints<sup>5</sup>. By contrast, psychologists' training and mode of service delivery equips them well to provide treatment for common disorders such as depression and anxiety, but their services tended to be out of the reach of many individuals, due to cost barriers.

Suicide continues to be a major public health issue. There were 1881 deaths from suicide in 2007 in Australia. Males accounted for over three-quarters of these deaths<sup>6</sup>. Many of these people may not have a mental illness or access to specialised mental health care and many may have visited a GP during that time<sup>7</sup>.

In July 2001, the Department of Health and Ageing (DoHA) introduced the Better Outcomes in Mental Health Care (BOiMHC) program. This program aims to improve consumers' access to high quality primary mental health care, through a number of components. Key among these is the Access to allied Psychological Services (ATAPS) component which supports GPs and allied health professionals to work together to provide optimal mental health care. Specifically, this component enables GPs to refer consumers with high prevalence disorders (e.g., depression and anxiety) to allied health professionals for twelve sessions of evidence-based mental health care (predominantly Cognitive Behavioural Therapy, or CBT), delivered in six to twelve time-limited sessions (or up to 18 in exceptional circumstances). One hundred and twelve Divisions of General Practice (Divisions) are facilitating this collaborative approach to mental health care through 111 projects (see Appendix A).

DoHA has now provided funding to 19 Divisions (see Appendix B) to offer a more intensive, prioritised service for people who are at risk of suicide (e.g., those who have made a recent suicide attempt, have recently self-harmed, or are having severe suicidal thoughts), who may or may not have a mental disorder. These Divisions were selected by DoHA on the basis of their capacity to deliver such a service, and in a manner that ensures representation from all states and territories. These Divisions have been provided with an additional \$100,000-\$150,000 to secure the services of specialised allied health professionals who will provide intensive care and follow-up to referred consumers. This project commenced in June 2008.

The project differs from the general ATAPS services in a number of ways. The Specialist Services for Consumers at Risk of Suicide focus on the treatment and care of three groups of individuals;

- People who have been discharged into the care of GPs from hospital, including emergency departments or from a medical ward following an overnight admission after a suicide attempt.
- People who have presented to GPs after an incident of self harm.
- People who have expressed strong suicidal ideation to their GPs.

Unlike general ATAPS, consumers are not required to have a mental health diagnosis.

The project is intended to provide priority access to the allied health professional. The allied health professional is required to speak to the consumer within 24 hours of referral and to see the consumer for the first treatment session within 72 hours of referral or earlier if necessary. As part of the Specialist Services the Department provided an after hours support phone service for consumers.

Unlike ATAPS, there is no limit on the number of sessions. However, it is anticipated that support provided under these services will be more intense than general ATAPS' support and that sessions would be conducted in a condensed time period of up to two months.

A provisional referral can be made by designated Emergency Department personnel to allow immediate contact with an allied health professional which would be followed up within one week by a GP referral to the ATAPS suicide prevention service in order to be eligible. Local protocols were to be developed by Divisions for these referral pathways.

Training is mandatory for allied health professionals participating in this service and is delivered via DVD training modules developed by the Australian Psychological Society. Probationary allied health professional providers are not eligible to provide these services.

The University of Melbourne's Centre for Health Policy, Programs and Economics (CHPPE) has been evaluating the ATAPS projects since mid 2003. To date, 14 interim evaluation reports have been produced drawing on a number of data sources, including information from projects' local evaluation and project implementation reports, a purpose-designed minimum dataset, a Divisional forum, and one-off surveys<sup>8-24</sup>. Our ongoing evaluation continues to draw on a number of data sources, including information from projects' local evaluation and project implementation reports, a purpose-designed Minimum Dataset, a Divisional forum, and one-off surveys. In June 2008, our contract was varied to incorporate an evaluation of the new specialist ATAPS services for people at risk of suicide.

The current report is the third to document the progress of the evaluation of the Specialist Services. It represents an update of the second interim report which was submitted to the Department of Health and Ageing in July 2009 and the progress report which was submitted in November 2008<sup>25</sup>. The current report considers the achievements of the Specialist Services for Consumers at Risk of Suicide component of the ATAPS projects since its introduction in June 2008. It looks at the benefits and disadvantages of the Specialist Services for Consumers at Risk of Suicide, from the perspective of GPs, allied health professionals and emergency departments, the level of uptake by GPs, allied health professionals and consumers at risk of suicide, the profile (socio-demographic and clinical) of consumers at risk of suicide, and the precise nature of services for consumers.

# Chapter 2: Method

---

## ***Evaluation questions***

This report considers the progressive achievements of the Specialist Services for Consumers at Risk of Suicide component of the Access to allied Psychological Services (ATAPS) projects, via the following evaluation questions:

*Evaluation Question 1:* What are the benefits and disadvantages of the Specialist Services for Consumers at Risk of Suicide, from the perspective of GPs, allied health professionals and emergency departments?

*Evaluation Question 2:* What is the level of uptake of Specialist Services for Consumers at Risk of Suicide by GPs, allied health professionals, and consumers?

*Evaluation Question 3:* What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing Specialist Services through the ATAPS projects?

*Evaluation Question 4:* What is the precise nature of the services for consumers at risk of suicide being delivered through the ATAPS projects?

Consumer outcomes have not been evaluated in this interim report as there was not sufficient consumer outcome data available.

## ***Data sources***

Evaluation question one was addressed through phone surveys with GPs, allied health professionals and emergency departments involved in the Specialist Services (see Appendix C). Of the 19 Divisions participating in the Specialist Services ten are represented in these surveys. The survey focussed on the perceived benefits and disadvantages of the Specialist Services for consumers.

Each ATAPS project involved in the Specialist Services for Consumers at Risk of Suicide was asked to email an invitation to participate in an interview regarding the Specialist Services on behalf of the evaluators to either two general practitioners, two allied health professionals or two emergency department professionals. Professionals then returned a consent forms directly to the evaluators if they wished to take part in the interview.

Three allied health professionals, three emergency department professionals, and six general practitioners, took part in the 15 minute phone interview which aimed to glean a better understanding of their views and the impact on themselves and their consumers of the Specialist Services for Consumers at Risk of Suicide. These 12 professionals represented ten different ATAPS projects (seven rural, three urban).

Evaluation questions two, three, and four were addressed using data from the previously-mentioned minimum dataset, which captures de-identified, consumer-level and session-level information. Data from the minimum dataset was analysed for the period from October 2008 to January 2010, and therefore includes data previously reported in the interim report submitted in July 2009.

Of the 19 Divisions involved in the Specialist Services for Consumers at Risk of Suicide, 17 submitted data to the minimum dataset during this period (9 urban, 8 rural).

Data was downloaded on the 4<sup>th</sup> of February 2010 from the MDS in relation to evaluation questions two, three, and four.

## ***Data analysis***

Qualitative analyses of surveys of GPs, allied health professionals and emergency departments were used to answer evaluation question one. Simple frequencies and percentages were calculated in order to answer evaluation questions two, three, and four.

## Chapter 3: What are the benefits and disadvantages of the Specialist Services for Consumers at Risk of Suicide, from the perspective of GPs, allied health professionals and emergency departments?

---

The benefits and disadvantages of the Specialist Services for Consumers at Risk of Suicide, from the perspective of general practitioners, allied health professionals and emergency departments were explored via phone interviews with general practitioners, allied health professionals and emergency department staff.

### **General Practitioners**

Six general practitioners (GPs) from five different ATAPS projects (two urban, three rural) were interviewed.

All five of the GPs reported that they referred consumers to psychologists on a weekly basis, and that they had referred ten or less consumers specifically to the Specialist Services for Consumers at Risk of Suicide (22 referrals in total).

GPs were asked how they would have managed these consumers at risk of suicide prior to the availability of the Specialist Services. Most of the GPs reported that they would have seen the consumer more frequently themselves, and supported them while they attempted to gain a referral to a psychologist, which could take up to six weeks. One of the GPs commented that the care of the consumer would have been undertaken *'with great difficulty'*.

The GPs were asked how the availability of the Specialist Services had impacted on their consultations with consumers. Four of the GPs stated that their consults with consumers had been impacted. One GP commented that the availability of the Specialist Services meant that the consumers are not counselled in depth by the GP. One GP said that he/she was keener to assess consumers' suicide risk because they were confident that they could be referred to a psychologist. Two of the interviewees said that the availability of the Specialist Services had not significantly impacted on their consultations.

Five of the GPs said that the referral process was *'good'* and *'easy from the GP perspective'*. They all reported that they felt confident assessing and referring patients to the services. In all cases the GPs were happy with the way the client risk was managed during the referral process. However, one commented that the after hours referral process was *'difficult'*, and another GP said the referral process in general was *'cumbersome'* and that they weren't happy with the extra administration required to make the referral (i.e. the separate referral form).

Three of the GPs reported no barriers to the referral process. However, the other three GPs reported having specific issues with the Division (ATAPS project office) which were related to poor communication from the Division to the GP. Most of the GPs reported that communication with the allied health professionals had been good.

All the GPs interviewed relayed that the consumers were pleased with the offer of a referral to the Specialist Services, responded well and were reassured by the *'back up'* provided. In general, the GPs stated that the consumers were *'really relieved to get action quickly'*.

When asked about the overall impact of Specialist Services on the GPs, most reported that the impacts had been positive. One GP commented that it had *'decreased a lot of stress with patients that harm themselves'*. Another GP stated that the *'people have got better faster'* and treatment by a GP can *'go on for months'*. Another GP said that the program is an effective way to manage patients, and another

commented that access was 'easy'. Most of the GPs said there were no negative impacts for themselves. One GP commented that it was concerning for GPs when consumers did not return to them after the referral had been made.

All of the GPs interviewed felt that the Specialist Services had had positive impacts for their consumers. Patients were satisfied as they were seen immediately, someone cared about them, and the service provided '*more than what is otherwise available*'. No negative impacts for consumers were identified by the GPs.

The GPs were asked about the support they had received from their local Division for the Specialist Services. Most of the GPs reported that they had been visited by a project officer from the Division who gave a brief introduction to the Specialist Services, and some had received a package of information from the Division which included information of risk assessment and referral forms. Four of the GPs said that support from the Division had been '*appropriate*' and '*good*'. The other two GPs said they felt they did not need training or support as they felt confident with consumers at risk of suicide. All of the GPs said that they now felt comfortable dealing with these consumers and did not feel they needed any further support or training from the Division.

When asked for further comments about the Specialist Services, all the GPs commented that they were supportive of the Specialist Services and highly valued its usefulness and value to patients. As one GP commented, '*the patients who have come back from the psychologist really improved*' and another commented, '*I would be at a loss of how to handle patients if it wasn't for the pilot*'.

### **Allied Health Professionals**

Three allied health professionals; two psychologists and a community mental health nurse, from three different rural ATAPS projects were interviewed.

The allied health professionals reported that they had seen 9, 4 and 2 consumers respectively via the Specialist Services. The two psychologists reported that they also deliver general ATAPS services. All three professionals reported previous experience providing services to consumers at risk of suicide.

None of the professionals reported any significant concerns about seeing clients at risk of suicide. Two of the professionals expressed some concern about access to a '*back up*' service for consumers at higher risk of suicide. One of the professionals said that as they were in a rural location consumers could be approximately one hour away, which was of some concern.

The allied health professionals reported receiving referrals from both general practitioners and mental health services. Two of the allied health professionals said that they felt that the referrals were appropriate and the consumers presenting were of mild to moderate risk of suicide. The professionals interviewed felt that GPs still found the referral process '*onerous*' and were not always sure if a consumer was eligible for the service. As a result, one professional commented that the referrals have not always been appropriate in that the consumer was not a suicide risk. One professional commented that the service can be a bit of a '*dumping ground*' from other mental health services.

Two of the allied health professionals reported that they were satisfied with the way consumer risk was managed during the referral process. However one of the professionals complained that there were time delays in the referral process via the Mental Health Service. This occurs when staff do not fax referrals but send them in the mail delaying consultations for up to a week.

Two of the three professionals reported that providing services via the Specialist Services for Consumers at Risk of Suicide had not made any significant difference to the way in which they consult with consumers. One professional commented that being part of the services had reinforced the need to do a risk assessment with other consumers and this has become '*more foremost in your mind when seeing them*'. The two professionals who also provided general ATAPS services said that their Specialist Services did not differ markedly to the services they provide other consumers. One of the professionals commented that they are more likely to follow up consumers at risk of suicide more closely than consumers seen via general ATAPS. One of the professionals commented that '*general ATAPS is more a therapy, whereas suicide is more a risk management*'.

In general the Australian Psychological Society training provided to the allied health professionals for the Specialist Services was found to be *'fairly good'* with special acknowledgment that there were good practical hints for consulting younger consumers. The professionals commented that the training *'makes you feel confident'* and was *'good preparation'*.

Support from the Divisions was reported variably. One professional said that the support from the Division had been good in terms of the referral process and someone to call if needed. The other two professionals stated the Divisions were only concerned about the roll out of the services.

When asked about the overall impact of Specialist Services on the professionals, all three stated that the impacts had been positive. One allied health professional felt that they have been able to be *'more of a link in the community'* and through this program the allied health professional had been able to support some of the GPs, commenting that: *'this pilot has improved those links'*. Another professional reinforced that the service is very worthwhile and useful, and that the rationale and patient referrals are appropriate.

When asked about negative impacts for the professionals, one professional said that *'getting the [referral] process right took some time'*. There was some frustration according to one professional because they *'got stuck with longer term patients referred from other agencies with nowhere to refer to as there are limited services'* for this consumer group. Another professional noted that the presence of this service had reinforced to her that general practitioners want to hand over the care of these consumers, but that he/she felt that there needs to be continued GP involvement.

When asked about the overall impact of the Specialist Services on consumers, two of the professionals spoke about the accessibility of the services to consumers who would not normally be able to access services. One professional stated that the early intervention is positive for the consumer and that they could receive a *'good level of expertise'* and not have to *'struggle along with the GP'*. One professional commented on the benefits in a rural community for the consumer who can have a *'neutral outlet'* because the service is provided in another town and the consumer is not seen by other locals.

Negative impacts for clients cited by the three professionals were potential inappropriate referrals that could mean that consumers felt forced to attend a session when it was not necessary, and conversely that for the consumer with chronic suicidal thoughts the treatment was too limited.

When asked for other comments about the Specialist Services, the allied health professionals said that overall, the Specialist Services was a good program. Two of the professionals reported that they felt that rural areas faced some difficulties not experienced in urban areas. For example, one professional described a location where a clinic only operates once a week and there can be a lengthy wait depending on when the referral comes through. Two professionals also raised concerns about difficulties in responding to consumers quickly following referral, especially for referrals received after hours.

### ***Emergency Department Professionals***

Three emergency department professionals, all psychiatric nurses, from two different ATAPS projects (one urban, one rural) were interviewed.

All three professionals reported that their department had referred consumers, who were not at high risk of suicide, to the Specialist Services for Consumers at Risk of Suicide. They all noted that the specialist service provided a quick response (within 72 hours) for these consumers who would have previously been referred back to their general practitioner and would have possibly had to wait for a number of weeks to receive an appointment with a psychologist. They all reported that the referral process had been *'very straightforward'* and smooth and that emergency department staff had felt confident making the referral. Two of the professionals reported no barriers to the referral process. One professional commented that there were not enough clinicians providing the Specialist Services. The Divisions (ATAPS projects) were praised by the professionals for being involved, having developed the necessary forms and in one case worked closely with the Emergency Department in developing the

process. Two of the professionals reported that the implementation of the services had been facilitated by a staff member from the local Division coming and meeting with them.

All three professionals said that consumers had responded positively to the Specialist Services. Consumers were pleased with the speed at which they were seen by a psychologist and felt that there were fewer stigmas for them than being referred through their general practitioner or accessing psychiatric services. All of the professionals also said that communication between the emergency department and the division had been 'excellent'. Two of the professionals said that communication with the allied health professional providing the Specialist Services had also been good.

All three professionals reported that the impact of the availability of the Specialist Services on the emergency department had been positive. All three commented on the positive impact of being able to refer consumers to the appropriate service quickly, one professional reported that this had resulted in lessened workload for the department. None of the interviewed professionals reported any negative impacts for their departments. One of the professionals commented that there had been no feedback from the allied health professional providing the Specialist Services.

When asked about the perceived overall impact on consumers, all three professionals cited positive impacts including: the consumer is happy because they are able to access an allied health professional quickly, the consumer doesn't have to go back to their general practitioner for a referral as the emergency department does this for them, decreased stigma for consumers, availability of ongoing care, and availability of care with no cost to the consumer. None of the professionals cited any negative impacts for their consumers. One professional commented that they were concerned that consumers might '*feel fobbed off*' by the department, but also reported that they had not seen this reaction in any of their consumers.

When asked for other comments about the Specialist Services and what they felt could make it work better, all highlighted the need for the Specialist Services to continue. One professional commented that they '*would like to see it continue because there have been good outcomes for the patients*', another commented; '*please keep it going, it's so needed*' and another said; '*I can't speak highly enough about it*'. One professional said that they felt the Specialist Services needed more resources to ensure that allied health professionals could continue to be retained and that they could see consumers at short notice.

# Chapter 4: What is the level of uptake of Specialist Services for Consumers at Risk of Suicide by GPs, allied health professionals and consumers?

Uptake data is available for the 17 (of the 19) Divisions who had entered data into the minimum data set as at 4<sup>th</sup> February 2010.

## Uptake by GPs, allied health professionals, and emergency departments

For the period October 2008 to January 2010, referrals were made by 196 GPs and sessions were conducted by 101 allied health professionals in the 17 Divisions. This is an increase of 46 participating GPs from the 150 participating in the October 2008-July 2009 period, and an increase of 52 (from 49) in the number of allied health professionals.

### New referrers

Table 4 shows a summary of referral sources, this data were available for 341 of the 608 referrals made. Emergency Departments were responsible for a significant proportion of referrals in urban areas. The majority of referrals came from GPs, especially in rural areas. This trend has remained relatively consistent over the 17 months of the services, the only notable difference being a decrease in the proportion of referrals received from emergency departments in urban areas over time, this may be due to the increased participation by GPs.

**Table 4: Summary of referral sources for the Specialist Services for Consumers at Risk of Suicide.**

	Oct 2008 – July 2009			Oct 2008 – Feb 2010		
	National	Rural	Urban	National	Rural	Urban
Community Mental Health Services	1%	0%	1%	2%	2%	2%
Emergency Department	24%	1%	39%	19%	3%	25%
GPs	75%	99%	60%	79%	95%	73%

### Uptake by consumers

Between October 2008 and January 2010, 17 projects reported that 604 referrals were made to the Specialist Services for Consumers at Risk of Suicide, 196 rural and 407 urban. This is an increase of 322 referrals from the 282 referrals reported in the October 2008-July 2009 period.

Seventeen projects reported delivering 2,821 sessions (924 rural, 1897 urban) between October 2008 and January 2010, representing an increase of 1,757 sessions (from 1,064 sessions; 387 rural, 677 urban) reported since the October 2008 – July 2009 period. These 2,821 sessions were delivered to 569 consumers, making the average number of sessions provided to consumers 5. This represents a slight increase in the number of sessions per consumer when compared to the October 2008 – July 2009 period, wherein 240 consumers received an average of 4.4 sessions.

Figure 1 shows referrals and sessions by month for the 17 participating projects from October 2008 to January 2009. Figures 2 and 3 show these referrals and sessions by month broken down into rural and urban projects between October 2008 and January 2010. Note that in the time period October 2008 to July 2009 only fifteen projects had provided data to the minimum data set regarding the Specialist Services, and by January 2010 an additional two projects had provided data.

Overall, there were a greater number of referrals and sessions in urban compared to rural areas. The number of sessions and referrals in urban and rural areas both gradually increased from late 2008 and peaked in July 2009. The tables show a decline in sessions and referrals after August 2009, but this

may be due to a data entry lag, and the fact that most ATAPS projects are closed over the Christmas period.

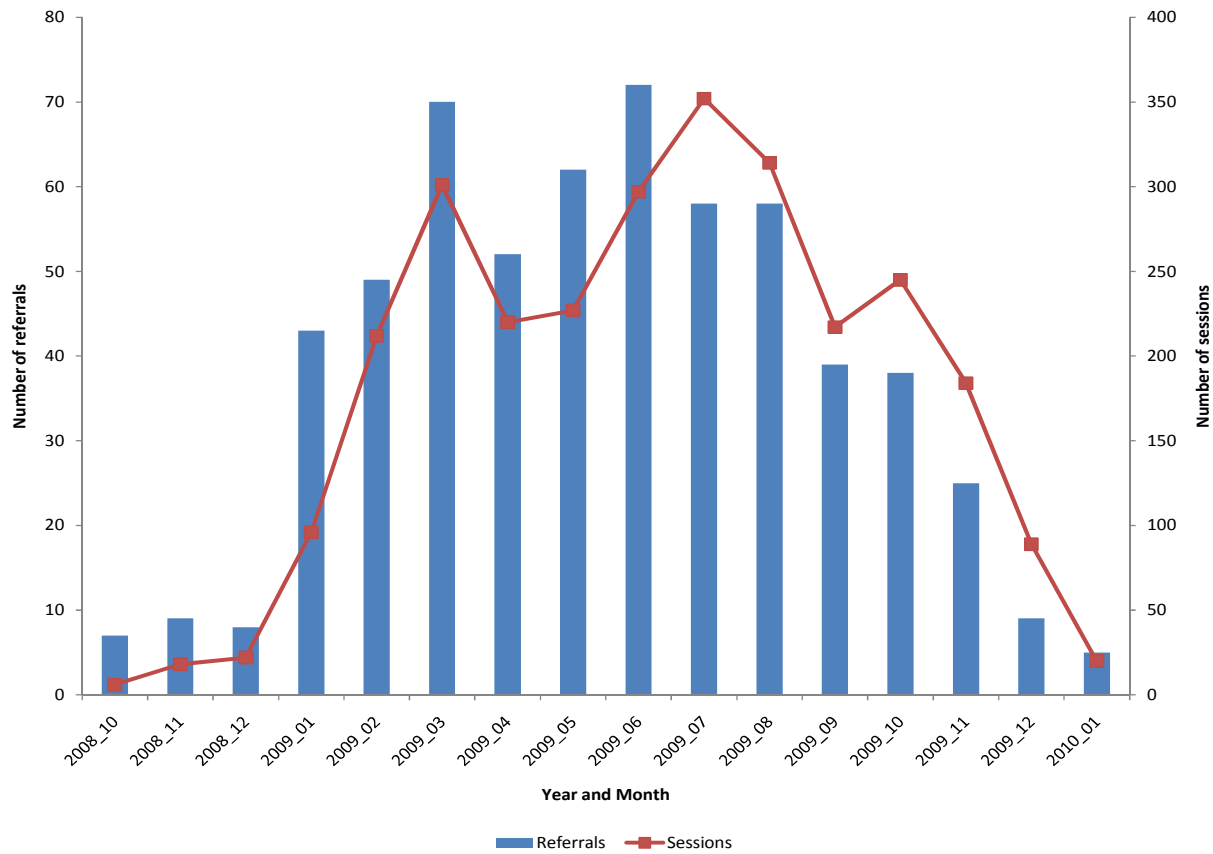


Figure 1: Referrals for sessions of care through the Specialist Services for Consumers at Risk of Suicide ATAPS projects, by month (all participating Divisions).

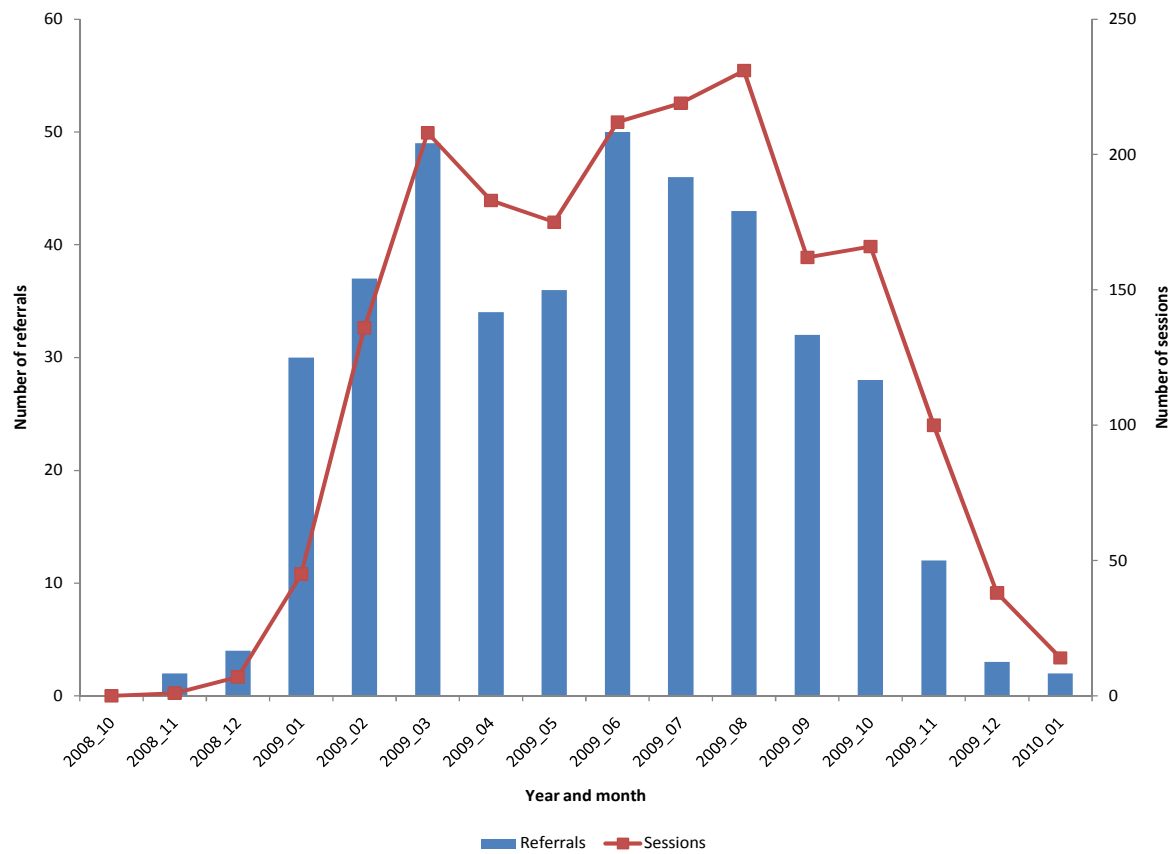


Figure 2: Referrals for sessions of care through the Specialist Services for Consumers at Risk of Suicide ATAPS projects, by month (urban Divisions).

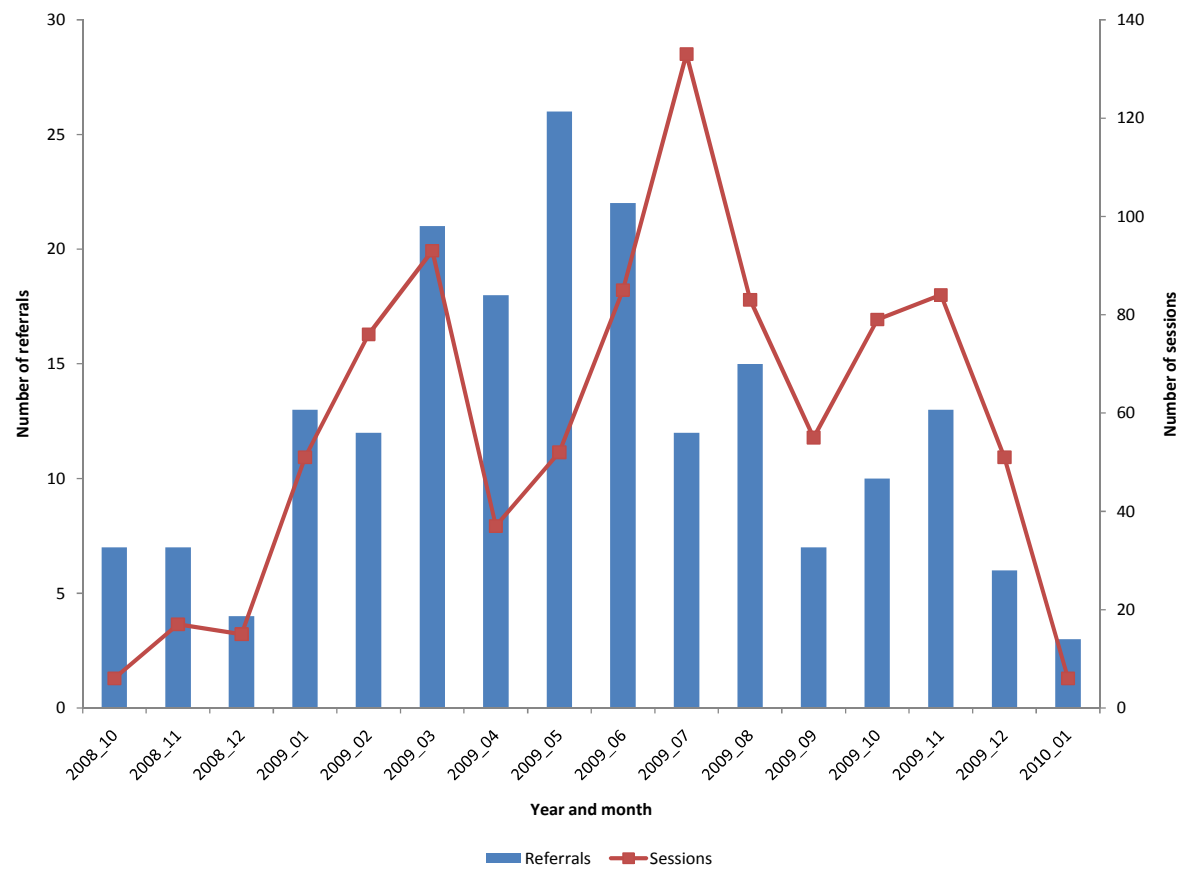


Figure 3: Referrals for sessions of care through the Specialist Services for Consumers at Risk of Suicide ATAPS projects, by month (rural Divisions).

# Chapter 5: What is the profile of consumers at risk of suicide accessing the Specialist Services through the ATAPS projects?

---

Table 5 summarises some of the key characteristics of the consumers receiving care through the Specialist Services between October 2008 and January 2010 compared to aggregated general ATAPS consumers<sup>8-23</sup>, displaying data at the national, rural, and urban level. Note that whilst consumers of the Specialist Services are described in urban and rural areas, the comparison is made with national (both urban and rural) general ATAPS consumers.

Around three-fifths of consumers to Specialist Services are female, and their mean age is approximately 33 years. About one half are on low incomes, as judged by their GP. Slightly less than half of the consumers have a history of previous mental health care. One and one half per cent of consumers were reported to be Aboriginal, and less than 1% Torres Strait Islander. A diagnosis was made by the referring GP in 82.8% (500) of the 604 referrals made. For these 500 referrals, almost all have been diagnosed with depression (89.8%). In the main, the profiles of rural and urban consumers were similar; however there is a trend for rural consumers to be less likely to be on a low income and to be slightly younger than urban consumers.

In comparison to aggregated national general ATAPS consumers, the consumers at risk of suicide continue to tend to be younger, are more likely to be male, are less likely to be on a low income, and are more likely to have used psychiatric services before. If diagnosed, consumers at risk of suicide were more likely to have a diagnosis of depression and less likely to be diagnosed with an anxiety disorder than national general ATAPS consumers. Although a relatively small number of consumers have been diagnosed with psychotic disorders and alcohol or drug use disorders, there is a smaller proportion of these diagnoses in rural specialist service projects.

The profile of consumers in the Specialist Services in the October 2008 to January 2010 period is relatively consistent with that of the October 2008 – July 2009 period with only a slight decrease in the reported previous use of psychiatric services (51.5% vs. 44.5%) and in the prevalence of a diagnosis of depression (94% vs. 89.8%).

**Table 5: Summary characteristics of consumers receiving care through the Specialist Services for Consumers at Risk of Suicide compared to National General ATAPS consumers.**

	October 2008 – July 2009		October 2008 – January 2010		
	National General ATAPS	National Specialist Services	National Specialist Services	Rural Specialist Services	Urban Specialist Services
<b>Gender</b>					
• Female	71.5%	59.5%	60%	63.2%	58.3%
• Male	28.5%	40.5%	40%	36.8%	41.7%
<b>Mean age</b>	39	32.9	32.9	31	33.8
<b>Low income</b>					
• Yes	63.9%	54.1%	53.7%	43.3%	58.8%
• No	21.4%	26.2%	26.8%	36.4%	22.1%
• Unknown	14.7%	19.7%	19.5%	20.3%	19.1%
<b>Aboriginal</b>					
• Yes	2.4%	1.3%	1.5%	2.1%	1.1%
• No	74.7%	80.2%	76.1%	61.5%	83.8%
• Unknown	22.9%	18.5%	22.4%	36.4%	15.1%
<b>Torres Strait Island</b>					
• Yes	0.3%	1%	0.4%	0.5%	0.3%
• No	75.5%	80%	76.6%	62.9%	83.9%
• Unknown	24.7%	19%	23%	36.6%	15.8%
<b>Previous psychiatric service use</b>					
• Yes	39.7%	51.5%	44.5%	46.3%	43.6%
• No	44.6%	29.9%	38.7%	32.1%	42%
• Unknown	15.7%	18.6%	16.8%	21.6%	14.4%
<b>Diagnosis</b> (Multiple responses permitted)					
• Alcohol and drug use disorders	7.2%	10.6%	8.2%	6.1%	9.1%
• Psychotic disorders	2.0%	5.0%	3.8%	2.3%	4.6%
• Depression	75.5%	94.0%	89.8%	89.5%	90%
• Anxiety disorders	56.9%	31.7%	34%	36.3%	32.8%
• Unexplained somatic disorders	2.6%	0.5%	1%	1.8%	0.6%
• Unknown	2.0%	1.5%	1.2%	1.8%	0.9%

## **Chapter 6: What is the precise nature of the services being delivered through the ATAPS projects for consumers at risk of suicide?**

---

In total 2,821 sessions of care were provided through the Specialist Services to 569 consumers, making the average number of sessions provided to consumers 5. The profile of these sessions is shown in Table 6 detailing national, rural, and urban data compared to aggregated data for the general national ATAPS projects<sup>3-24</sup>. Note that whilst consumers of the Specialist Services are described in urban and rural areas, the comparison is made with national (both urban and rural) general ATAPS consumers.

Sessions of 46-60 minutes account for two thirds of Specialist Services and are less common than in the national ATAPS projects. More sessions conducted in the Specialist Services are less than 30 minutes when compared with the national ATAPS services. Session interventions differed between urban and rural areas and from the national ATAPS projects. Overall, session interventions were more likely to be diagnostic assessment and CBT-skills training and less likely to be psycho-education and CBT-behavioural interventions in the Specialist Services when compared to the national ATAPS projects. Urban Specialist Services were reported to more often be diagnostic assessment and CBT-cognitive interventions and less likely to be CBT-skills training than rural Specialist Services.

No copayment was reported in any of the Specialist Services sessions. This varies considerably from the general ATAPS projects where since July-September 2007 copayments have been charged in between 19% - 24% of sessions for urban projects and in 3 - 4% of sessions for rural projects<sup>24</sup>.

**Table 6: Summary characteristics of sessions provided to consumers through the Specialist Services for Consumers at Risk of Suicide compared to General ATAPS consumers.**

		October 2008 – July 2009		October 2008 – January 2010		
		General National ATAPS	National Specialist Services	National Specialist Services	Rural Specialist Services	Urban Specialist Services
<b>Duration</b>	• 0-30 mins	1.9%	18.8%	17%	23.3%	13.9%
	• 31-45 mins	4.5%	0.6%	1.7%	2.8%	1.2%
	• 46-60 mins	82.0%	60.2%	62.6%	52.5%	67.5%
	• Over 60 mins	11.6 %	20.4%	18.7%	21.4%	17.4%
<b>Type</b>	• Group	2.2%	0.4%	0.4%	0.1%	0.5%
	• Individual	97.8%	99.6%	99.6%	99.9%	99.5%
<b>Interventions<sup>a</sup></b>	• Diagnostic assessment	16.1%	35.8%	27.8%	10.4%	37.3%
	• Psycho-education	23.6%	18.0%	15.6%	14.3%	16.3%
	• CBT-Behavioural interventions	35.5%	31.0%	29.4%	29.1%	29.6%
	• CBT-Cognitive interventions	46.9%	35.1%	44.9%	32.5%	51.7%
	• CBT-Relaxations strategies	18.6%	12.5%	15.1%	17.6%	13.7%
	• CBT-Skills training	18%	26.5%	24.9%	48.4%	11.9%
	• Interpersonal Therapy	22.7%	22.5%	25.4%	25.8%	25.2%

a. Multiple responses permitted

## Chapter 7: Discussion and conclusions

---

### ***Summary of the achievements of the Specialist Services for Consumers at Risk of Suicide component of the Access to allied Psychological Services projects***

The current report considers the achievements of the Specialist Services for Consumers at Risk of Suicide component of the ATAPS projects since its introduction in June 2008. It looks at the benefits and disadvantages of the Specialist Services for Consumers at Risk of Suicide, from the perspective of GPs, allied health professionals and emergency departments, the level of uptake by GPs, allied health professionals and consumers at risk of suicide, the profile (socio-demographic and clinical) of consumers at risk of suicide, and the precise nature of services for consumers. Specifically, it set out to investigate four evaluation questions, the answers to each of which are summarised below.

### ***Key findings***

#### **What are the benefits and disadvantages of the Specialist Services for Consumers at Risk of Suicide, from the perspective of GPs, allied health professionals and emergency departments?**

##### **General Practitioners**

Six general practitioners (GPs) from five different ATAPS projects (two urban, three rural) were interviewed.

Five of the GPs said that the referral process to the Specialist Services was *'good'* and *'easy from the GP perspective'*. They all reported that they felt confident assessing and referring patients to the services. Three of the GPs reported no barriers to the referral process. However, the other three GPs reported having specific issues with the Division (ATAPS project office) which were related to poor communication from the Division to the GP. Most of the GPs reported that communication with the allied health professionals had been good.

All the GPs interviewed relayed that the consumers were pleased with the offer of a referral to the Specialist Services, responded well and were reassured by the *'back up'* provided. In general, the GPs stated that the consumers were *'really relieved to get action quickly'*. Most of the GPs reported that the impact of Specialist Services on themselves had been positive. One GP commented that it had *'decreased a lot of stress with patients that harm themselves'*. Another GP stated that the *'people have got better faster'* and treatment by a GP can *'go on for months'*. Another GP said that the program was an effective way to manage patients, and another commented that access was *'easy'*. Most of the GPs said there were no negative impacts for themselves.

All of the GPs interviewed felt that the Specialist Services had had positive impacts for their consumers. Patients were satisfied as they were seen immediately, someone cared about them, and the service provided *'more than what is otherwise available'*. No negative impacts for consumers were identified by the GPs. GPs further commented that they were supportive of the Specialist Services and highly valued its usefulness and value to patients.

##### **Allied Health Professionals**

Three allied health professionals, two psychologists and a community mental health nurse, from three different rural ATAPS projects were interviewed. Two of the allied health professionals said that they felt that the referrals were appropriate and the consumers presenting were of mild to moderate risk of suicide.

When asked about the overall impact of the Specialist Services on consumers, two of the professionals spoke about the accessibility of the services to consumers who would not normally be able to access services. One professional stated that the early intervention is positive for the consumer and that they could receive a *'good level of expertise'* and not have to *'struggle along with the GP'*. The allied health

professionals said that overall the Specialist Services was a good program. Two of the professionals reported that they felt that rural areas faced some difficulties not experienced in urban areas. Two professionals also raised concerns about difficulties in responding to consumers quickly following referral, especially for referrals received after hours.

### **Emergency Department Professionals**

Three emergency department professionals, all psychiatric nurses, from two different ATAPS projects (one urban, one rural) were interviewed.

The three professionals reported that the specialist service provided a quick response for consumers of mild to moderate risk of suicide who would have previously been referred back to their GP and would have possibly had to wait for a number of weeks to receive an appointment with a psychologist. They all reported that the referral process had been '*very straightforward and smooth*' and that emergency department staff had felt confident making the referral.

All three professionals commented on the positive impact for the department of being able to refer consumers to the appropriate service quickly. One professional reported that this had resulted in lessened workload for the department.

The three professionals said that consumers had responded positively to the Specialist Services. All three professionals cited positive impacts for consumers including: the consumers are happy because they are able to access an allied health professional quickly, consumers don't have to go back to their GP for a referral as the emergency department does this for them, decreased stigma for consumers, availability of ongoing care, and availability of care with no cost to the consumer. None of the professionals cited any negative impacts for their consumers.

### **What is the level of uptake of Specialist Services for Consumers at Risk of Suicide by GPs, allied health professionals and consumers?**

Uptake data is available for the 17 (of the 19) Divisions who had entered data into the minimum data set as at 4<sup>th</sup> February 2010. For the period October 2008 to January 2010, referrals were made by 196 GPs and sessions were conducted by 101 allied health professionals in the 17 Divisions.

Whilst the majority of referrals to the services were made by GPs (79%), 19% were made by emergency departments and 2% were made by community mental health services. Most of the referrals made by emergency departments were made in urban areas, with few made by emergency departments in rural areas. These trends in referral are consistent with the period October - July 2009 presented in the previous report.

Between October 2008 and January 2010, 17 projects reported that 604 referrals were made to the Specialist Services for Consumers at Risk of Suicide, 196 rural and 407 urban. This is an increase of 322 referrals from the 282 referrals reported in the October 2008-July 2009 period.

Seventeen projects reported delivering 2,821 sessions (924 rural, 1897 urban) between October 2008 and January 2010, representing an increase of 1757 sessions (from 1064 sessions; 387 rural, 677 urban) reported since the October 2008 – July 2009 period. These 2,821 sessions were delivered to 569 consumers to date, making the average number of sessions provided to consumers 5. However, this is likely to be an underestimate as not all consumers will have completed treatment prior to the data being extracted. This represents a slight increase in the number of sessions per consumer when compared to the October 2008 – July 2009 period, wherein 240 consumers received an average of 4.4 sessions.

Overall, there were a greater number of referrals and sessions in urban compared to rural areas. The number of sessions and referrals in urban and rural areas both gradually increased from late 2008 and peaked in July 2009. The tables show a decline in sessions and referrals after August 2009, but this may be due to a data entry lag, and the fact that most ATAPS projects are closed over the Christmas period.

### **What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing Specialist Services through the ATAPS projects?**

Around three-fifths of consumers to Specialist Services are female, and their mean age is approximately 33 years. About one half are on low incomes, as judged by their GP. Slightly less than half of the consumers have a history of previous mental health care. One and one half per cent of consumers were reported to be Aboriginal, and less than 1% Torres Strait Islander. A diagnosis was made by the referring GP in 82.8% (500) of the 604 referrals made. For these 500 referrals, almost all have been diagnosed with depression (89.8%). In the main, the profiles of rural and urban consumers were similar; however there is a trend for rural consumers to be less likely to be on a low income and to be slightly younger than urban consumers. Comparisons are made with the general ATAPS projects.

### **What is the precise nature of the services for consumers at risk of suicide being delivered through the ATAPS projects?**

Sessions of 46-60 minutes account for two thirds of Specialist Services and are less popular than in the national ATAPS projects. More sessions conducted in the Specialist Services are less than 30 minutes when compared with the national ATAPS services. Session interventions differed between urban and rural areas and from the national ATAPS projects. Overall, session interventions were more likely to be diagnostic assessment and CBT-skills training and less likely to be psycho-education and CBT-behavioural interventions in the Specialist Services when compared to the national ATAPS projects. Urban Specialist Services were more often reported to be diagnostic assessment and CBT-cognitive interventions and less likely to be CBT-skills training than rural Specialist Services. No copayment was reported in any of the Specialist Services sessions. Comparisons are made with the general ATAPS projects.

### ***Some caveats***

Some caution should be exercised in interpreting the above findings, because the minimum dataset has two limitations. Firstly, there are lags in data entry because some Divisions do not enter session data into the minimum dataset until treatment has been completed for a given consumer. This is likely to have the greatest impact on recent data. The qualitative findings based on the interviews with professionals involved in the Specialist Services are limited by the small sample of participants, it is unknown therefore whether these findings are representative of Specialist Services professionals overall. For example, it is possible that allied health professionals, GPs and emergency department professionals working in participating ATAPS projects, but who are not personally engaged in the Specialist Services, may view the Specialist Services less positively than those who are engaged in the services and who took part in the interviews.

### ***Conclusions***

The current report indicates that Specialist Services for Consumers at Risk of Suicide have been received positively by allied health professionals, emergency departments, and general practitioners who all view it as a welcome service addition that provides a quick and effective service response to consumers of mild to moderate suicide risk. The services have continued to steadily attract referrals from GPs and Emergency Departments. Sessions delivered by allied health professionals to consumers are also steadily rising. The profile of consumers is somewhat different from the general ATAPS projects suggesting that these Specialist Services are reaching a different group of consumers and are complementing the general ATAPS projects. The nature of services being delivered varies from that of general ATAPS and between rural and urban areas. Consumers are receiving a free of cost service, with no co-payments reported in any sessions.

# References

---

1. Australian Bureau of Statistics (2007). National Survey of Mental Health and Wellbeing: Summary of Results. ABS Cat No. 4326.0. Canberra: ABS
2. Bassilios B, Fletcher J, Pirkis J, King K, Kohn F, Blashki G, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Thirteenth Interim Evaluation Report - Relationship between ATAPS projects and the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (Better Access) initiative. Melbourne: Centre for Health Policy, Programs and Economics, The University of Melbourne, 2009.
3. Andrews G, Hall W, Teesson M, Henderson S. The Mental Health of Australians. Canberra: Commonwealth Department of Health and Aged Care, 1999.
4. Australian Bureau of Statistics. 3303.0. Causes of Death, Australia 2007. Australian Bureau of Statistics, 2007.
5. Suicide Prevention Section and Community Services Section, Mental Health and Workforce Division, Australian Government Department of Health and Ageing. Guidelines for the ATAPS Additional Support for Patients at Risk of Suicide and Self Harm: Demonstration Project. May 2008.
6. Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: Summary of Results. Canberra: Australian Bureau of Statistics, 2007.
7. Andrews G, Sanderson K, Slade T, Issakidis C. Why does the burden of disease persist? Relating the burden of anxiety and depression to effectiveness of treatment. *Bulletin of the World Health Organization* 2000;78(4):446-454.
8. Fletcher, J., Bassilios, B., King, K., Pirkis, J., Kohn, F., Blashki, G. & Burgess, P. (June 2009). Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program. Fourteenth Interim Evaluation Report. Making an impact on the Australian mental health care landscape.
9. Hickie I, Groom G. Primary care-led mental health service reform: An outline of the Better Outcomes in Mental Health Care initiative. *Australasian Psychiatry* 2002;10:376-382.
10. Pirkis J, Blashki G, Headey A, Morley B, Kohn F. Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: First Interim Evaluation Report. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2003.
11. Morley B, Kohn F, Pirkis J, Blashki G, Burgess P. Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: Second Interim Evaluation Report. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2004.
12. Morley B, Kohn F, Pirkis J, Blashki G, Burgess P. Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: Third Interim Evaluation Report: Benefits and Barriers Associated with Different Models of Service Delivery. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2005.
13. Kohn F, Morley B, Pirkis J, Blashki G, Burgess P. Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: Fourth Interim Evaluation Report. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2005.

14. Pirkis J, Morley B, Kohn F, Blashki G, Burgess P. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Fifth Interim Evaluation Report - Models of Service Delivery: Profile and Association with Access. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2005.
15. Kohn F, Morley B, Pirkis J, Shandley K, Naccarella L, Blashki G, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Sixth Interim Evaluation Report: Progressive Achievements over Time. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2005.
16. Morley B, Kohn F, Naccarella L, Pirkis J, Blashki G, Burgess P. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Seventh Interim Evaluation Report - Rural and Urban Projects: Similarities and Differences. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2006.
17. Morley B, Pirkis J, Sanderson K, Burgess P, Kohn F, Naccarella L, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Eighth Interim Evaluation Report - Consumer Outcomes: The Impact of Different Models of Psychological Service Provision. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2006.
18. Naccarella L, Morley B, Pirkis J, Kohn F, Blashki G, Burgess P. 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: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2006.
19. Fletcher J, Pirkis J, Kohn F, Bassilios B, Blashki G, Burgess P. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Tenth Interim Evaluation Report - Progressive Achievements Over Time. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2007.
20. Kohn F, Pirkis J, Bassilios B, Fletcher J, Morley B, Naccarella L, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Eleventh Interim Evaluation Report - Utilisation of Evaluation Findings. Melbourne: Centre for Health Policy, Programs and Economics, School of Population Health, The University of Melbourne, 2007.
21. Fletcher J, Bassilios B, Pirkis J, Kohn F, Blashki G, Burgess P. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Twelfth Interim Evaluation Report - Making an Impact on the Australian Mental Health Care Landscape. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2008.
22. Bassilios B, Fletcher J, Pirkis J, King K, Kohn F, Blashki G, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Thirteenth Interim Evaluation Report - Relationship between ATAPS projects and the Better Access to {psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (Better Access) initiative. Melbourne: Centre for Health Policy, Programs and Economics, The University of Melbourne, 2009.
23. Fletcher J, Bassilios B, King K, Kohn F, Blashki G, Burgess P, et al. Evaluation of the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program: Fourteenth Interim Evaluation Report - Ongoing gains in improving access to mental health care in Australia. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2009.
24. Fletcher J, Bassilios B, King K, Kohn F, Blashki G, Burgess P, et al. Evaluation of the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program:

Fourteenth Interim Evaluation Report Supplement - Preliminary findings of the National Perinatal Depression Initiative. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2009.

25. King, K., Kohn, F., Bassilios, B., Fletcher, J., Blashki, G., Burgess, P & Pirkis, J. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program : Interim Report for the Evaluation of the Specialist Services for Consumers at Risk of Suicide. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, July 2009.

## Appendix A: Divisions of General Practice involved in general ATAPS projects

---

Round	Division(s)	State	Urban/Rural
1 (pilot)	Central Coast	NSW	Urban
1 (pilot)	NSW Central West	NSW	Rural
1 (pilot)	NSW Outback	NSW	Rural
1 (pilot)	General Practice Network Northern Territory (formerly Top End DGP, now amalgamated with Central Australia DGP)	NT	Rural
1 (pilot)	Logan Area	QLD	Urban
1 (pilot)	SE Alliance of GP Bris (Ass of Bayside)	QLD	Urban
1 (pilot)	Sunshine Coast	QLD	Rural
1 (pilot)	GP Connections (formerly Toowoomba & District)	QLD	Rural
1 (pilot)	Adelaide Nth Div of GP	SA	Urban
1 (pilot)	Central Victorian General Practice Network (formerly Bendigo & District)	Vic	Rural
1 (pilot)	Dandenong Casey DGP (formerly Dandenong DGP & is a fund holder for Greater Monash DGP))	Vic	Urban
1 (pilot)	East Gippsland Div of GP (fund holder for Sth Gipp & Central West Div)	Vic	Urban
1 (pilot)	General Practice Alliance - South Gippsland Limited	Vic	Rural
1 (pilot)	Greater Monash (formerly known as Greater South Eastern DGP, Funds now held by Dandenong Casey DGP)	Vic	Urban
1 (pilot)	Knox	Vic	Urban
1 (pilot)	Impetus (formerly North West Melbourne)	Vic	Urban
1 (pilot)	Central West Gippsland	Vic	Rural
1 (pilot)	Fremantle	WA	Urban
1 (pilot)	Perth & Hills (now amalgamated with Perth Central Coast and known as Perth Primary Care Network)	WA	Urban
1 (supplementary)	ACT Division of GP	ACT	Urban
1 (supplementary)	Hastings Macleay	NSW	Rural
1 (supplementary)	Mid North Coast	NSW	Rural
1 (supplementary)	Riverina (now a fund holder for Barrier)	NSW	Rural
1 (supplementary)	Nth & West QLD Primary Health Care	QLD	Rural
1 (supplementary)	General Practice Network South (formerly Southern Division of GP SA or Adelaide Southern)	SA	Urban
1 (supplementary)	Ballarat & District	Vic	Rural
1 (supplementary)	Central Highlands	Vic	Urban
1 (supplementary)	General Practice Association of Geelong	Vic	Urban
1 (supplementary)	Mornington Peninsula	Vic	Urban
1 (supplementary)	North East Victoria	Vic	Rural
1 (supplementary)	Otway	Vic	Rural
1 (supplementary)	GP Down South (Peel SW)	WA	Rural
1 (supplementary)	Greater Bunbury (split from Peel SW 01.07.04)	WA	Rural
2	Blue Mountains	NSW	Urban
2	Canterbury (no longer providing ATAPS)	NSW	Urban

Round	Division(s)	State	Urban/Rural
2	Dubbo / Plains	NSW	Rural
2	Illawara	NSW	Urban
2	Murrumbidgee	NSW	Rural
2	Nepean Div of GP	NSW	Urban
2	New England	NSW	Rural
2	North West NSW Slopes	NSW	Rural
2	Southern Highlands	NSW	Rural
2	Sutherland	NSW	Urban
2	Sydney South West GP Network Ltd (formerly Fairfield and no longer operating)	NSW	Urban
2	Brisbane South	QLD	Urban
2	Capricornia	QLD	Rural
2	Central QLD Rural	QLD	Rural
2	Far Nth QLD Rural	Qld	Rural
2	General Practice Gold Coast/Tweed Valley Div of GP	QLD	Urban
2	Ipswich/West Moreton	QLD	Urban
2	Mackay	QLD	Rural
2	Townsville	QLD	Rural
2	GP Partners Adelaide (formerly Adelaide Central and Eastern Div of GP)	SA	Urban
2	Adelaide Hills Div of GP	SA	Rural
2	Adelaide NE Div of GP	SA	Urban
2	Adelaide Western General Practice Network (formerly Adelaide Western Div of GP)	SA	Urban
2	Limestone Coast Div of GP	SA	Rural
2	Murray Mallee Div of GP	SA	Rural
2	General Practice Northern Tasmania (formerly North Tasmania)	Tas	Rural
2	NW Tasmania	Tas	Rural
2	General Practice South (formerly Southern Tasmania)	Tas	Urban
2	Central Bayside	Vic	Urban
2	Monash DGP Moorabbin	Vic	Urban
2	Melbourne Eastern (formerly Inner Eastern Melbourne DGP)	Vic	Urban
2	Melbourne DGP	Vic	Urban
2	Murray Plains	Vic	Rural
2	NE Valley	Vic	Urban
2	Southcity GP Services (Inner SE Melb)	Vic	Urban
2	Pivot West (formerly Western Melbourne)	Vic	Urban
2	Westgate	Vic	Urban
2	Whitehorse Div of GP (formerly Inner East Melbourne, now amalgamated with Inner East Melbourne and known as Melbourne Eastern GPN)	Vic	Urban
2	Canning	WA	Urban
2	GP Coastal (formerly Perth Central Coast, now amalgamated with Perth Hills, now known as Perth Primary Care Network)	WA	Urban
2	Great Southern	WA	Rural
2	Osborne	WA	Urban

Round	Division(s)	State	Urban/Rural
3	Adelaide Southern DGP	SA	Urban
3	Barrier (funds held by Riverina)	NSW	Rural
3	Barwon	NSW	Rural
3	Central Sydney	NSW	Urban
3	East Sydney Div of GP (Includes SE Sydney Div)	NSW	Urban
3	GP Network Northside (Hornsby Ku-ring-gai Ryde) (fund holder for Northern Sydney)	NSW	Urban
3	Hunter Rural	NSW	Rural
3	Hunter Urban	NSW	Urban
3	Macarthur	NSW	Urban
3	Northern Rivers	NSW	Rural
3	Northern Sydney (funds held by GP Network Northside)	NSW	Urban
3	SE NSW	NSW	Rural
3	Shoalhaven	NSW	Rural
3	St George	NSW	Urban
3	Went West	NSW	Urban
3	GP Partners (Bris Nth)	QLD	Urban
3	Southern QLD Rural	QLD	Rural
3	Wide Bay	QLD	Rural
3	Barossa DGP	SA	Rural
3	Eyre Peninsula DGP	SA	Rural
3	Flinders and Far Nth	SA	Rural
3	Mid Nth Rural Div of GP	SA	Rural
3	Riverland Div of GP	SA	Rural
3	Yorke Peninsula Div of GP	SA	Rural
3	Albury-Wodonga Regional GP network (formerly known as Border DGP)	Vic	Rural
3	Central West Victoria	Vic	Rural
3	Eastern Ranges GP Association	Vic	Urban
3	Goulburn Valley	Vic	Urban
3	Mallee	Vic	Rural
3	Northern	Vic	Urban
3	Central Wheatbelt (formerly Wheatbelt GP Network)	WA	Rural
3	Eastern Goldfields Medical DGP	WA	Rural
3	Mid West	WA	Rural
3	Rockingham Kwinana	WA	Urban
4	Bankstown	NSW	Urban
4	Hawkesbury Hills	NSW	Urban
4	Liverpool (no longer operational)	NSW	Urban
4	Central Aust Div of Primary Health (amalgamated with Top End DGP, Now known as General Practice Network Northern Territory)	NT	Rural
4	General Practice Cairns	QLD	Rural
4	Redcliffe Bribie Caboolture	QLD	Urban
	Pilbara	WA	Rural
	Kimberley DGP	WA	Rural

## Appendix B: Divisions of General Practice involved in the Specialist Services for Consumers at Risk of Suicide

---

Division(s)	State	Urban/Rural
NSW Central West DGP	NSW	Rural
GP Access	NSW	Urban
NSW Central Coast DGP	NSW	Urban
Central Sydney DGP	NSW	Urban
Dandenong Casey DGP	VIC	Urban
Mornington Peninsula DGP	VIC	Rural
Otway DGP	VIC	Urban
Logan Area DGP	QLD	Urban
Gold Coast DGP	QLD	Urban
Sunshine Coast DGP	QLD	Rural
RHealth (Southern QLD Rural)	QLD	Rural
Adelaide Northern DGP	SA	Urban
Adelaide Hills DGP (SAH)	SA	Rural
Flinders and Far North DGP	SA	Rural
Canning DGP	WA	Urban
Rockingham Kwinana DGP	WA	Urban
General Practice Network NT	NT	Rural
GPSouth – Tasmania -Southern Region	TAS	Urban
DGP Northern Tasmania	TAS	Rural

---

# **Appendix C: Survey of Allied Health Professionals, Emergency Department Professionals and General Practitioners for the Specialist Suicide Services.**

---

## **Interview questions for Allied Health Professionals participating in the Suicide Prevention Pilot**

---

Thank you for agreeing to participate in this interview about the new Suicide Prevention Pilot. The interview will take about 15 minutes. Your responses are confidential, and you are free to withdraw from the interview at any stage.

---

**For which Division have you provided most of your Suicide Prevention Pilot services?**  
This will be confidential and not identified in the report.

**What is your mental health profession?**

**1. Approximately how many clients have you seen who have been referred under the Suicide Prevention Pilot?** [    ]

**1a. Are there clients who were referred and not provided with services via the Suicide Prevention Pilot?**

**How many?**

**Why?**

**2. Approximately how many sessions have you delivered under the Suicide Prevention Pilot?**  
[    ]

**3. Do you also deliver general ATAPS services?**

[    ] Yes, if yes;

**a)How long have you been providing general ATAPS services?** [    ]

[    ] No, if no;

a) **Were you recruited specifically for the suicide prevention pilot?**

**4. Have you had experience providing services to clients at risk of suicide prior to your participation in the ATAPS Suicide Prevention Pilot?**

Yes

No

**5. Did you have concerns about seeing clients at risk of suicide?**

**6a. Who has been the source of referrals for the clients that you have seen under the Suicide Prevention Pilot? (i.e. GP, the Division, Emergency Department, Mental Health Services)**

[PROMPT: If you have had referrals from sources other than GPs (e.g. Emergency Departments) how have these differed from referrals from GPs?]

**6b. How have you found the referral process?**

[PROMPT: How **appropriate** have you found the **referrals**?]

[PROMPT: How **appropriate** have the clients been in terms of their level of suicidal risk?]

[PROMPT: How satisfied have you been with the way in which client risk has been managed during the referral process?]

**7. Has the Suicide Prevention Pilot made any difference to the way in which you consult with individual clients?**

[PROMPT: How has the clients' risk of suicide impacted on the way in which you consult?]

[PROMPT: If you also provide general ATAPS services, how does it differ from providing services under general ATAPS?]

**8. How did you find the APS training for the Suicide Prevention Pilot?**

[PROMPTS: Has it helped you in delivering services under the Suicide Prevention Pilot?]

**9. Did the Division offer any other support or training?**

[PROMPTS: Was this helpful?]

**10. Overall have you found that being able to provide services under the Suicide Prevention Pilot has had positive or negative impacts for you?**

[PROMPTS: What were the positive impacts for you?]

[PROMPTS: What were the negative impacts for you?]

**11. Overall have you found that being able to provide services under the Suicide Prevention Pilot has had positive or negative impacts for your clients?**

[PROMPTS: What were the positive impacts for your clients?]

[PROMPTS: What were the negative impacts for your clients?]

**12. Are there any comments you'd like to make about the Suicide Prevention Pilot?**

---

Thank you for participating in the interview.

## **Interview questions for Emergency Department/Mental Health Services health professionals who have participated in the Suicide Prevention Pilot**

---

Thank you for agreeing to participate in this interview about the new Suicide Prevention Pilot. The interview will take about 15 minutes. Your responses are confidential, and you are free to withdraw from the interview at any stage. **We are interested in the views of health professionals working in emergency departments or mental health services who have referred patients via the Suicide Prevention Pilot.**

---

I'd like to start by asking you some questions about your services use of the Suicide Prevention Pilot.

**1. What type of service are you working in?**

**2. What is your profession and what is your role in the Department/service?**

**3. Can you tell me about how the Suicide Prevention Pilot has been operationalised in your Department and the process whereby referrals have been made?**

**4. Which Division have you been referring to for the Suicide Prevention Pilot?**

This will be confidential and not identified in the report.

**6. On average, how many patients per week does your department refer to an allied health professional or other mental health service? (excluding the Suicide Prevention Pilot)**

**7. Approximately how many patients has your department referred to an allied health professional via the Suicide Prevention Pilot? [   ]**

**8. If the Suicide Prevention Pilot was not available, how would you have managed these patients?**

[PROMPTS: Would you refer them elsewhere or manage them yourself?]

**9. Has the availability of the Suicide Prevention Pilot had an impact on consultations with patients?**

**10. How have you found the referral process?**

[PROMPTS: Have there been any barriers to making referrals?]

[PROMPTS: How did patients respond to the referral?]

[PROMPTS: How confident have staff been in their ability to make appropriate referrals via the Suicide Prevention Pilot?]

[PROMPTS: How have you found the process of communicating with the allied health professional and the Division under the Suicide Prevention Pilot?]

**11. Overall, have you found that the ability to refer patients via the Suicide Prevention Pilot has had positive or negative impacts for your Department/service?**

[PROMPTS: What are the positive impacts?]

[PROMPTS: What are the negative impacts?]

**12. Overall, would you say that the ability to refer to allied health professionals via the Suicide Prevention Pilot had positive or negative impacts for your patients?**

[PROMPTS: What were the positive impacts?]

[PROMPTS: What were the negative impacts?]

**13. What was your Department's/service's experience of working with your local Division of General Practice on this pilot?**

[PROMPTS: What was your working relationship like with the Division before this pilot?]

**14. What support did your local Division of General Practice provide to assist you to refer patients under the Suicide Prevention Pilot?**

[PROMPTS: What support or training would you have liked to have received?]

**15. Are there any comments you'd like to make about the Suicide Prevention Pilot?**

[PROMPTS: What would make the pilot work better?]

---

**Thank you for participating in the interview.**

## **Interview questions for GPs who have taken part in the Suicide Prevention Pilot**

---

Thank you for agreeing to participate in this interview about the new Suicide Prevention Pilot. The interview will take about 15 minutes. Your responses are confidential, and you are free to withdraw from the interview at any stage. **We are interested in the views of GPs who have referred patients via the Suicide Prevention Pilot.**

---

### **With which Division are you associated?**

This will be confidential and not identified in the report.

I'd like to start by asking you some questions about your use of the Suicide Prevention Pilot.

**1. Approximately how many patients have you referred to an allied health professional via the Suicide Prevention Pilot? [ ]**

**1a. If the Suicide Prevention Pilot was not available, how would you have managed these patients?**

[PROMPTS: Would you refer them elsewhere or manage them yourself?]

**2. On average, how many patients per week do you refer to an allied health professional and other mental health services?**

[ ]

**3. Has the availability of the Suicide Prevention Pilot influenced how you consult with patients?**

**4. How have you found the referral process?**

[PROMPTS: Have there been any barriers to making referrals?]

[PROMPTS: How did patients respond to the referral?]

[PROMPTS: How confident have you felt assessing and referring patients via the Suicide Prevention Pilot?]

[PROMPTS: How satisfied have you been with the way in which client risk has been managed during the referral process?]

[PROMPTS: How have you found the process of communicating with the allied health professional under the Suicide Prevention Pilot?]

- 5. Overall have you found that being able to provide services under the Suicide Prevention Pilot has had positive or negative impacts for you?**

[PROMPTS: What were the positive impacts for you?]

[PROMPTS: What were the negative impacts for you?]

- 6. Overall have you found that being able to provide services under the Suicide Prevention Pilot has had positive or negative impacts for your patients?**

[PROMPTS: What were the positive impacts for your patients?]

[PROMPTS: What were the negative impacts for your patients?]

- 7. What support or training did you receive to assist you to refer patients under the Suicide Prevention Pilot? Did you access it?**

[PROMPTS: How useful and appropriate was the support or training?]

[PROMPTS: What other support or training would you have liked to have received?]

**8. Are there any comments you'd like to make about the Suicide Prevention Pilot?**

[PROMPTS: What would make the pilot work better?]

---

Thank you for participating in the interview.