



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

*Seventeenth Interim Evaluation Report*

**Update on the achievements of the ATAPS projects**

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# Executive summary

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## **Background**

The Access to Allied Psychological Services (ATAPS) projects are a key component of the Better Outcomes in Mental Health Care program, which was introduced by the Australian Government in July 2001 in response to low treatment rates for common mental disorders. These projects, implemented by Divisions of General Practice (Divisions), enable GPs to refer patients with high prevalence disorders (e.g., depression and anxiety) to allied health professionals for low-cost evidence-based mental health care (most commonly cognitive behavioural therapy, or CBT). This care is typically delivered in six individualised sessions, with an additional six (or sometimes 12) sessions made available if this is considered warranted after a review by the referring GP. Up to 12 group sessions are also available.<sup>1</sup>

There are now three Tiers of ATAPS services; the original ATAPS services are referred to as Tier 1, Tier 2 target specific hard to reach groups and/or offer flexibilities in the delivery of psychological strategies and Tier 3 (currently under development) will offer flexible care packages to consumers with severe mental illness. This report relates to Tier 1 only and examines the current: participation rates by GPs, allied health professionals and consumers; the sociodemographic and clinical profiles of consumers; the precise nature of the care they are receiving; and the outcomes of this care for consumers.

## **Method**

Drawing on data from a purpose-designed minimum dataset, the report considers the current achievements of the ATAPS projects over time, via the following evaluation questions:

*Evaluation Question 1:* What is the level of uptake of the ATAPS projects by GPs, allied health professionals and consumers?

*Evaluation Question 2:* What are the sociodemographic and clinical profiles of consumers of the ATAPS projects, and what is the nature of the care they are receiving?

*Evaluation Question 3:* Are the ATAPS projects achieving positive outcomes for consumers?

## **Key findings**

### **What is the level of uptake of the ATAPS projects by GPs, allied health professionals and consumers?**

Between 1 July 2003 and 31 December 2010, 18,545 (10,979, 59.2% urban; 7,566, 40.8% rural) GPs referred consumers to 4,695 (3,324, 70.8% urban; 1,371, 29.2% rural) allied health professionals through the ATAPS projects. This represents a continued increase in the number of GPs and allied health professionals over the life of the ATAPS projects.

Between 1 July 2003 and 31 December 2010, 223,851 consumers were referred to the ATAPS projects, 171,894 (76.9%) of whom took up the referrals provided.

In total, 879,331 sessions of care were provided through the projects, making the average number of sessions provided to consumers 5.1. This average is likely to be an underestimate as projects differ in their ability to identify re-referrals because some have systems which preclude a consumer carrying the same identifier across referrals.

The number of sessions delivered in both urban and rural areas has remained fairly steady over the past two years, with the lags apparent in the last quarter again likely to be attributable to lags in data entry.

**What are the sociodemographic and clinical profiles of consumers of the ATAPS projects, and what is the nature of the care they are receiving?**

The profile of referred consumers has remained relatively consistent over time, and, in the main, is similar across urban and rural projects. Approximately 70% of all consumers are female, and their mean age is 39 years. About 3.5% of consumers are of Aboriginal or Torres Strait Islander descent. The majority (around two thirds) are on low incomes, as judged by their GP. About half have no previous history of mental health care. Of those for whom a diagnosis was made by the referring GP (n=160,201 or 72%), most have been diagnosed with depression (76%) or anxiety disorders (57%).

The profile of sessions has also remained fairly consistent since the ATAPS projects began. Sessions of 46-60 minutes have consistently been the most popular format over time, accounting for around 83% of all sessions, and reflecting the complexity of care provided in these sessions. Almost all of these sessions have been delivered to individuals, rather than groups. The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 55% and 41% of sessions, respectively. These interventions are evidence-based, and widely regarded as appropriate for treating the types of high prevalence disorders with which consumers are presenting. In the main, the profiles of sessions in rural and urban projects mirror the profile for all projects, but there are some nuances.

Nationally, for the 759,508 (86%) sessions where this information was available, 79% of sessions did not incur a copayment. For the 21% of sessions where a copayment was incurred, the average amount was \$15.70. The national average cost per session was \$3.22 (S.D. = \$9.72), with a lower average in rural (\$1.19, S.D. = \$6.13) and a higher average in urban (\$4.48, S.D. = \$11.21) areas.

Finally, while the vast majority of sessions were delivered face-to-face, a few sessions have been delivered using other modalities including, in order of popularity, via telephone, video conference and web-based sessions.

**Are the ATAPS projects achieving positive outcomes for consumers?**

Pre- and post-treatment outcome data were available for 23,536 patients (10.5% of the 223,851). Across all of the nine most commonly used standardised outcome measures, the mean difference was statistically significant and indicative of clinical improvement.

***Conclusions***

The current report indicates that the ATAPS projects continue to be an integral part of the primary mental health care system in Australia. New GPs and allied health professionals continue to provide services to a substantial number of consumers. The number of referrals and sessions has remained fairly steady over the past couple of years. The profile of consumers and the care they are receiving is very consistent overtime. The majority are women with high prevalence disorders. Strategies usually involve CBT-based cognitive and behavioural interventions, which are typically delivered to individuals in sessions of one hour duration. Most importantly, the ATAPS projects are continuing to achieve considerable positive clinical outcomes for consumers.

# Chapter 1: Background

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The Access to Allied Psychological Services (ATAPS) projects are a key component of the Better Outcomes in Mental Health Care program, which was introduced by the Australian Government in July 2001 in response to low treatment rates for common mental disorders. These projects, implemented by Divisions of General Practice (Divisions), enable GPs to refer patients with high prevalence disorders (e.g., depression and anxiety) to allied health professionals for low-cost evidence-based mental health care (most commonly cognitive behavioural therapy, or CBT). This care is typically delivered in six individualised sessions, with an additional six (or sometimes 12) sessions made available if this is considered warranted after a review by the referring GP. Up to 12 group sessions are also available.<sup>1</sup>

Various policy changes have occurred during the life of the ATAPS projects which have had an impact on their nature and direction. In 2006, the Australian Government introduced the Better Access program, which facilitates equivalent access to mental health care from similar providers, but does so via a series of Medicare Benefits Schedule (MBS) item numbers rather than through Divisional projects. In response to these policy changes, since 2008 several sub-programs have been or are being introduced that focus on particular at-risk populations (e.g., women with perinatal depression, people at risk of suicide, people at risk of homelessness, people affected by the Victorian February 2009 bushfires, people in remote locations, children with mental disorders) and/or use specific modalities of service delivery (e.g., telephone-based or web-based CBT). The original ATAPS arrangements are now called Tier 1 services, and the sub-programs are called Tier 2 services. Tier 3 services, which will provide flexible care packages to people with severe mental illness, are currently being developed.<sup>2</sup>

Tier 1 services remain the 'core business' of the ATAPS program. Currently, 110 Divisions are running ATAPS projects which are delivering these services. The University of Melbourne's Centre for Health Policy, Programs and Economics (CHPPE) has been evaluating the Tier 1 ATAPS projects since their introduction. The evaluation has confirmed that the projects are being delivered in the way that was originally intended, under a range of models.<sup>3,4</sup> It has also shown that their uptake has been high in both urban and rural areas, and that the projects have reached a broad range of patients.<sup>3,5-9</sup> In addition, the evaluation has demonstrated that the projects have produced positive outcomes both for providers<sup>10</sup> and for patients<sup>7,11</sup> and that a range of socio-demographic, clinical and treatment-based variables are associated with the levels of outcomes achieved, but improvements are still substantial even for those in the relatively disadvantaged groups.<sup>12</sup>

Drawing on data from a purpose-designed web-based minimum dataset, this report examines the current: participation rates by GPs, allied health professionals and consumers; the sociodemographic and clinical profiles of consumers; the precise nature of the care they are receiving; and the outcomes of this care for consumers. The current report is the 17<sup>th</sup> in the series (including two supplements) evaluating the Tier 1 ATAPS projects.<sup>12-29</sup> Appendix A presents a summary of the findings of the previous reports.

## Chapter 2: Method

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### ***Evaluation questions***

This report considers the progressive achievements of the Tier 1 ATAPS projects over time, via the following evaluation questions:

*Evaluation Question 1:* What is the level of uptake of the ATAPS projects by GPs, allied health professionals and consumers?

*Evaluation Question 2:* What are the sociodemographic and clinical profiles of consumers of the ATAPS projects, and what is the nature of the care they are receiving?

*Evaluation Question 3:* Are the ATAPS projects achieving positive outcomes for consumers?

### ***Data sources***

All three evaluation questions 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 available for the period from 1 July 2003 (when the minimum dataset was first 'rolled out') to 31 December 2010 and was extracted on 7 February 2011.

In total, 120 Divisions of General Practice have been involved over the life of the ATAPS projects and data is included for all of them relevant to the period of time they were involved. Currently there are 110 Divisions involved which were funded in four funding rounds: 18 from June 2002 (Round 1 pilot projects); 15 from January 2003 (Round 1 supplementary projects); 42 from July 2003 (Round 2 projects); 33 from July 2004 (Round 3 projects); six from July 2005 (Round 4 projects). Over the life of the ATAPS projects, some Divisions have ceased operation, amalgamated with other Divisions, or been funded outside of the four rounds described.

Data related to Tier 1 ATAPS projects were extracted from the minimum dataset on the numbers of GPs and allied health professionals providing services through the projects (Evaluation Question 1), the number and profile of consumers accessing these services (Evaluation Questions 1 and 2, respectively), the number and nature of these services (Evaluations Question 1 and 2, respectively), and consumer outcomes (Evaluation Question 3).

### ***Data analysis***

Simple frequencies and percentages were calculated from the Tier 1 ATAPS projects' data in order to answer Evaluation Questions 1 and 2.

Evaluation Question 3 was analysed using paired t-tests to examine the difference between mean pre- and post-treatment scores on the range of outcome measures. Patients who did not have a 'matched pair' of pre- and post-treatment scores were excluded, as were outcome measures for which there were fewer than 150 observations.

## Chapter 3: What is the level of uptake of the ATAPS projects by GPs, allied health professionals and consumers?

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### *Uptake of ATAPS projects by General Practitioners and allied health professionals*

Between 1 July 2003 and 31 December 2010, 18,545 (10,979, 59.2% urban; 7,566, 40.8% rural) GPs referred consumers to 4,695 (3,324, 70.8% urban; 1,371, 29.2% rural) allied health professionals through the ATAPS projects. This represents a continued increase in the number of GPs and allied health professionals from December 2009 when the figures were 15,251 (9,032, 59.2% urban; 6,219, 40.8% rural) GPs and 4,042 (2,933, 72.9% urban; 1,109, 27.4% rural) allied health professionals.<sup>28</sup>

### *Overview of referrals and sessions overtime*

Between 1 July 2003 and 31 December 2010, 223,851 consumers were referred to the ATAPS projects, 171,894 (76.9%) of whom took up the referrals provided. In total, 879,331 sessions of care were provided through the projects, making the average number of sessions provided to consumers 5.1. This average is likely to be an underestimate as projects differ in their ability to identify re-referrals because some have systems which preclude a consumer carrying the same identifier across referrals.

Figure 1 shows that the number of consumers referred on a quarterly basis to the projects rose from 1,344 in July-September 2003 to a peak of 11,150 in July-September 2006. Figures 2 and 3 provide a breakdown of this increase by urban and rural projects, where the figures for the same period were 671 to 6,428 and 673 to 4,722, respectively. After the introduction of the Better Access program (November 2006) there was a temporary reduction in the number of referrals overall and in urban and rural areas, perhaps indicating something of a shift to the newer initiative. After the October-December 2007 quarter the number of referrals steadily increased, however after July-September 2008 there was another drop in the number of referrals, which remained consistent throughout 2009. In urban areas referral numbers were variable during 2007, but rose consistently in 2008. It should be noted that the significant drop in the final quarter (October-December 2010) can probably be explained by lags in data entry.

Figures 1, 2 and 3 also provide a quarter-by-quarter picture of the numbers of sessions overall and in urban and rural areas. Overall, the number of sessions has increased over time from 3,821 in July-September 2003 to a peak of 41,781 in July-September 2006. The same pattern was apparent for urban and rural projects; the equivalent figures were 2,059 and 25,013 for urban projects and 1,762 and 16,768 for rural projects. Again, there was a drop in the number of sessions provided overall and in urban and rural areas after the introduction of the Better Access program. The number of sessions delivered in rural areas reached a new peak in July-September 2008 with 16,768 sessions, possibly reflecting the fact that the uptake of the Better Access program has been considerably lower in rural than in urban areas.<sup>25</sup> The number of sessions in urban areas has steadily increased since October-December 2007, with a new peak of 26,432 reached in July-September 2009. The number of sessions delivered in both urban and rural areas has remained fairly steady over the past two years, with the drops apparent in the last quarter again likely to be attributable to lags in data entry.

Figure 1: Referrals for sessions of care through the ATAPS projects, by quarter (all projects)

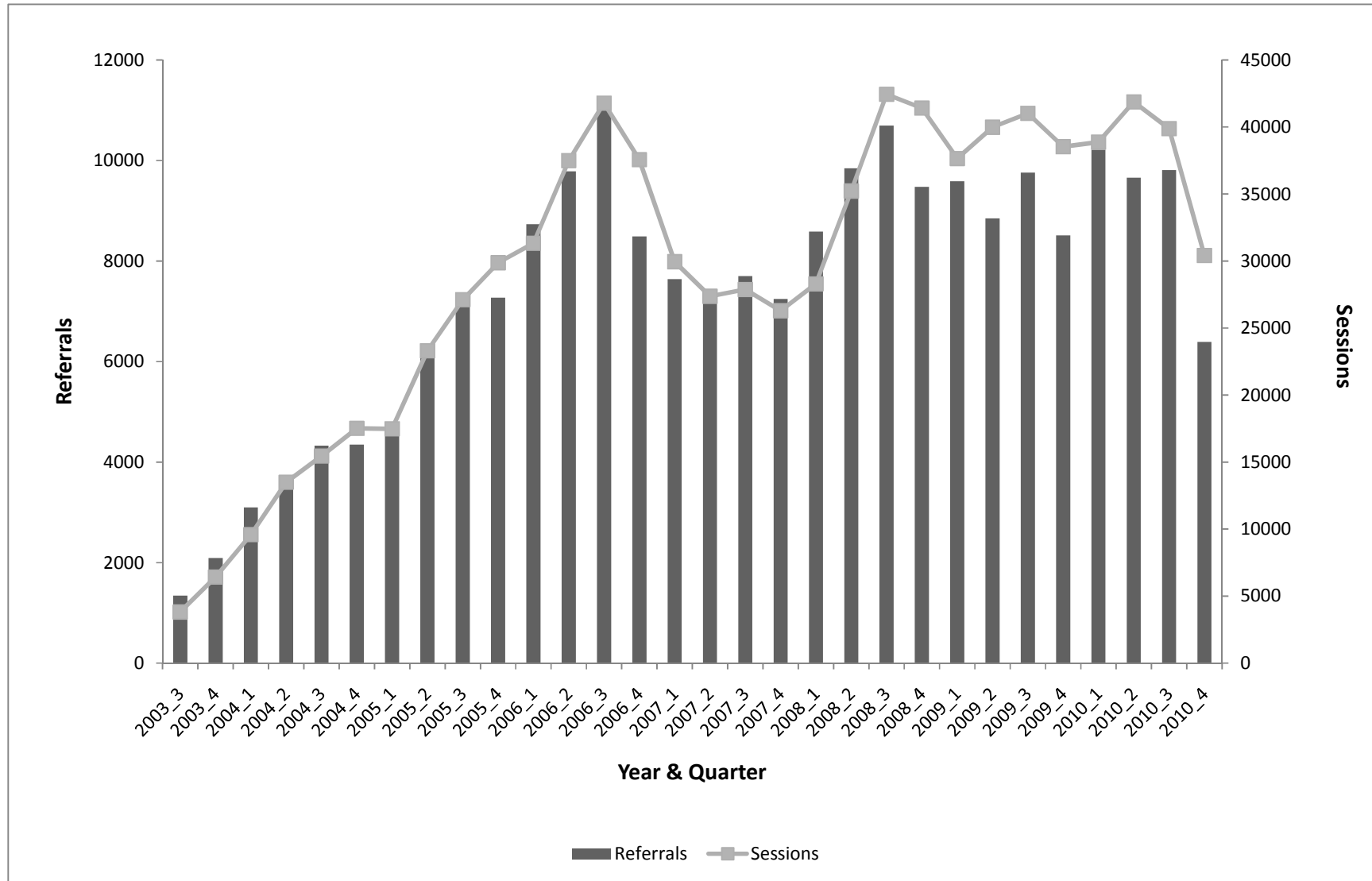


Figure 2: Referrals for sessions of care through the ATAPS projects, by quarter (urban projects)

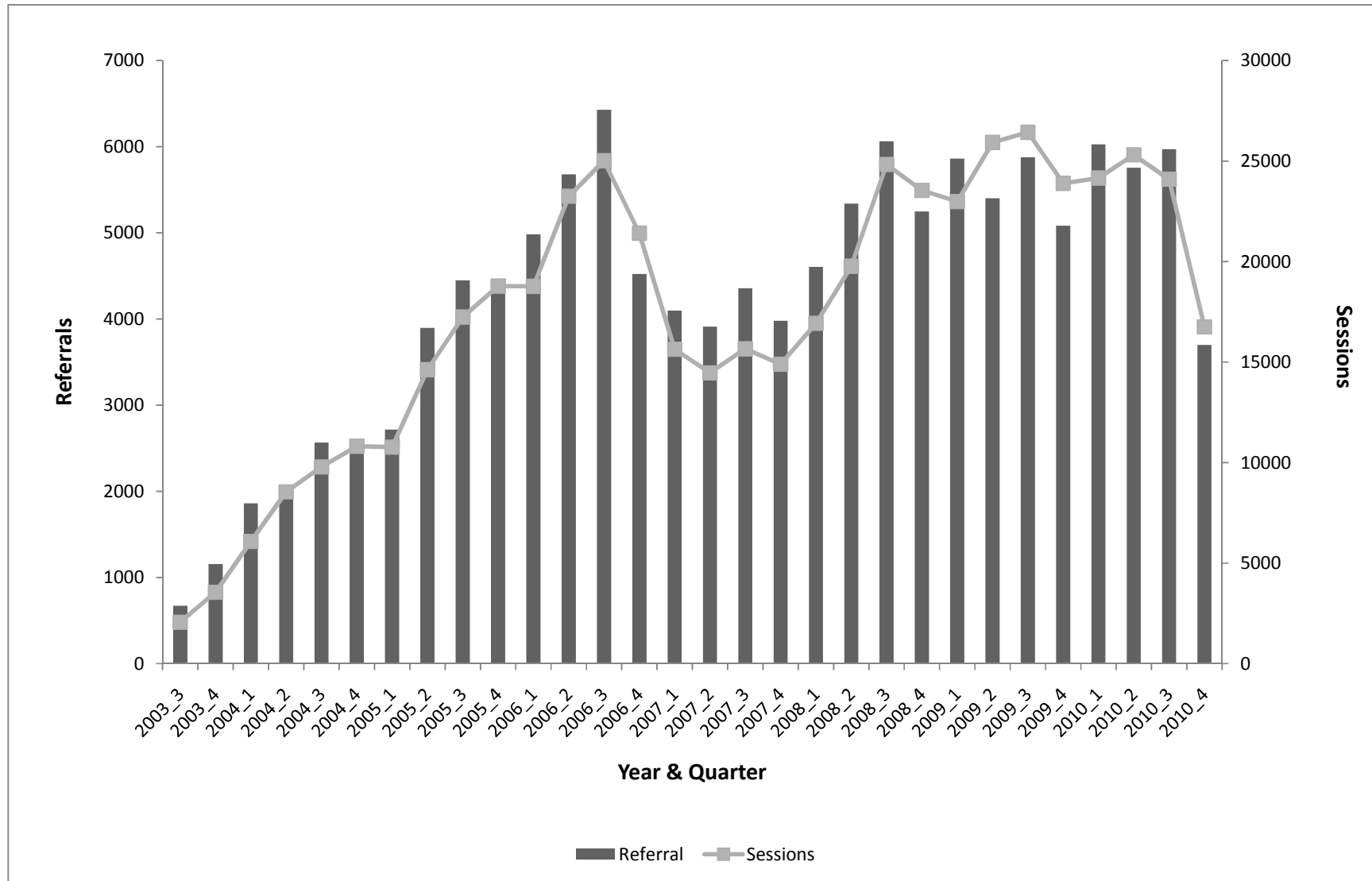
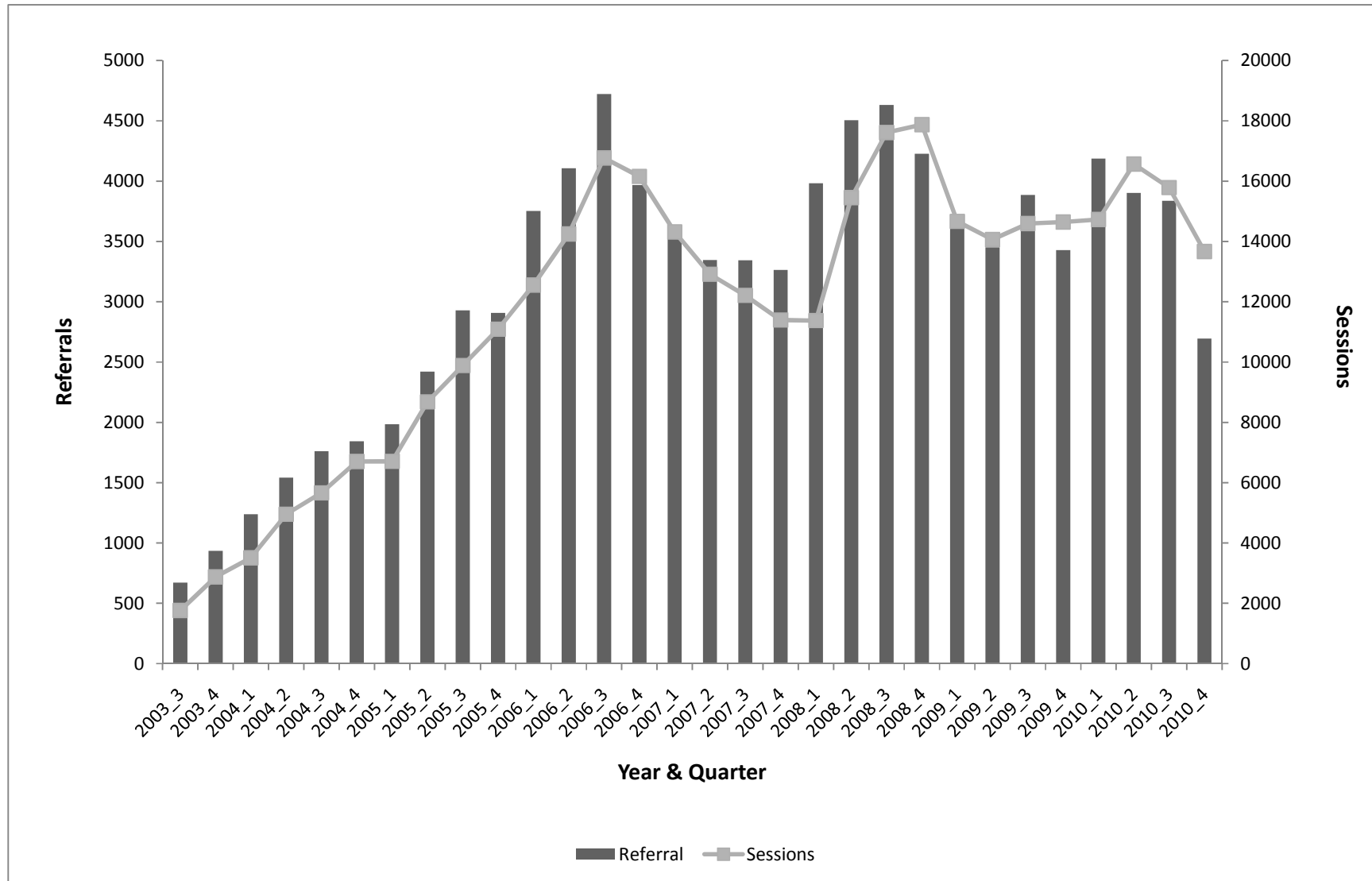


Figure 3: Referrals for sessions of care through the ATAPS projects, by quarter (rural projects)



## **Chapter 4: What are the sociodemographic and clinical profiles of consumers of the ATAPS projects, and what is the nature of the care they are receiving?**

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### ***Profile of consumers***

Table 1 summarises some of the key characteristics of the consumers receiving care through the projects, displaying data at the national level and for urban and rural projects. For simplicity, cumulative percentages are presented, rather than quarterly, because the demographic profile of consumers has remained fairly consistent over time. Approximately 70% of all consumers are female, and their mean age is 39 years. About 3.5% of consumers are of Aboriginal or Torres Strait Islander descent. The majority (around two thirds) are on low incomes, as judged by their GP. About half have no previous history of mental health care. Of those for whom a diagnosis was made by the referring GP (n=160,201 or 72%), most have been diagnosed with depression (76%) or anxiety disorders (57%). In the main, the profiles of rural and urban consumers are similar. The exceptions to this are that rural consumers are somewhat less likely to be on low incomes and to be diagnosed with anxiety disorder and more likely to be Aboriginal.

**Table 1: Summary characteristics of consumers receiving care through the ATAPS projects**

	National	Urban	Rural
<b>Gender</b>			
Female	70.4%	70.8%	69.8%
Male	29.6%	29.2%	30.2%
<b>Mean age</b>			
	39	39	39
<b>Low income</b>			
Yes	64.0%	67.0%	59.8%
No	21.8%	20.3%	23.9%
Unknown	14.2%	12.7%	16.2%
<b>Previous psychiatric service use</b>			
Yes	40.1%	40.8%	39.0%
No	44.9%	45.2%	44.5%
Unknown	15.0%	14.0%	16.4%
<b>Aboriginal</b>			
Yes	3.1%	2.3%	4.2%
No	86.2%	87.9%	83.7%
Unknown	10.7%	9.8%	12.1%
<b>Torres Strait Islander</b>			
Yes	0.4%	0.4%	0.3%
No	88.3%	89.1%	87.1%
Unknown	11.3%	10.5%	12.5%
<b>Diagnosis<sup>a</sup></b>			
Alcohol and drug use disorders	7.5%	8.1%	6.6%
Psychotic disorders	2.2%	2.3%	2.0%
Depression	75.8%	76.1%	75.3%
Anxiety disorders	57.0%	59.3%	53.7%
Unexplained somatic disorders	2.4%	2.7%	2.1%
Unknown	1.9%	1.3%	2.7%

a. Multiple responses permitted

### ***Profile of sessions***

Table 2 summarises some of the key features of the sessions of care provided to consumers, detailing national, rural and urban data. Again, for the sake of simplicity, aggregated percentages over the life of the projects are presented because the profile of these sessions has not changed greatly since the ATAPS projects began. Sessions of 46-60 minutes have consistently been the most popular format over time, accounting for around 83% of all sessions. Almost all of these sessions have been delivered to individuals, rather than groups. The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 55% and 41% of sessions, respectively. In the main, the profiles of sessions in rural and urban projects mirror the profile for all projects, but there are some nuances. For example, although the majority of both rural and urban sessions have consistently been 46-60 minutes in length, a slightly higher proportion of rural sessions have been either less than 45 minutes or over 60 minutes.

Nationally, for the 759,508 (86%) sessions where this information was available, 79% of sessions did not incur a copayment. For the 21% of sessions where a copayment was incurred, the average amount was \$15.70. The national average cost per session was \$3.22 (S.D. = \$9.72), with a lower average in rural (\$1.19, S.D. = \$6.13) and a higher average in urban (\$4.48, S.D. = \$11.21) areas.

Finally, while the vast majority of sessions were delivered face-to-face (n = 863,228), a few sessions have been delivered using other modalities (1,836 by telephone, 129 by video conference and 5 were web-based).

**Table 2: Summary characteristics of sessions provided to consumers through the ATAPS projects**

	National	Urban	Rural
<b>Duration</b>			
0-30 mins	2.2%	1.4%	3.4%
31-45 mins	3.7%	2.9%	4.9%
46-60 mins	83.0%	85.9%	78.5%
Over 60 mins	11.1%	9.7%	13.2%
<b>Type</b>			
Group	2.1%	2.4%	1.6%
Individual	97.9%	97.6%	98.4%
<b>Interventions<sup>a</sup></b>			
Diagnostic assessment	18.7%	19.6%	17.3%
Psycho-education	27.9%	27.6%	28.4%
CBT-Behavioural interventions	41.0%	42.2%	39.2%
CBT-Cognitive interventions	54.6%	55.7%	53.0%
CBT-Relaxations strategies	21.6%	21.5%	20.9%
CBT-Skills training	20.5%	21.1%	19.8%
Interpersonal therapy	27.3%	27.6%	26.9%
Copayment	20.6%	28.2%	8.4%
Average copayment amount	\$15.70	\$15.90	\$14.59

a. Multiple responses permitted

## Chapter 5: Are the ATAPS projects achieving positive outcomes for consumers?

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Pre- and post-treatment outcome data were available for 23,536 patients (10.5% of the 223,851). The majority of these patients (63%) had outcome data from one measure only, but 11.8% had data from two, 19.7% from three, 5.1% from four and 0.4% from five.

### ***Changes on outcome measures from pre- to post-treatment***

Table 3 shows the mean difference in scores on the nine most commonly-used outcome measures: the Beck Anxiety Inventory (BAI),<sup>30</sup> the Behaviour and Symptom Identification Scale 32 (BASIS-32),<sup>31</sup> the Beck Depression Inventory (BDI),<sup>32</sup> the Depression Anxiety Stress Scales (DASS),<sup>33</sup> the Global Assessment of Functioning (GAF),<sup>34</sup> the General Well-Being Index (GWBI),<sup>35</sup> the Hospital Anxiety and Depression Scale (HADS),<sup>36</sup> the Health of the Nation Outcome Scales (HoNOS),<sup>37</sup> and the Kessler 10 (K-10).<sup>38</sup> With the exception of the DASS, the mean differences were based on total scores; in the case of the DASS, the mean differences were based on scores for each of the three sub-scales because a total score on this instrument is not regarded as meaningful.<sup>33</sup> Across all measures, the mean difference was statistically significant and indicative of clinical improvement.

**Table 3: Pre- and post-treatment outcome scores on available outcome measures for patients receiving care through the ATAPS projects**

		n	Pre-treatment mean (s.d.)	Post-treatment mean (s.d.)	Mean difference (s.d.)
<b>BAI</b>	Patient-rated measure designed to measure anxiety. Consists of 21 items, each of which describes a common symptom of anxiety. Patients are asked to rate how much they have been bothered by each symptom over the past week on a 4-point scale ranging from 0 (Not at all) to 3 (Severely – it bothered me a lot). The total score can range from 0 to 63. A positive difference between pre- and post-treatment scores indicates improvement.	508	22.78 (12.52)	14.07 (11.63)	8.71 (10.42)*
<b>BASIS-32</b>	Patient-rated measure comprising 32 items which collectively measure symptoms and behavioural distress in people with a mental illness over the previous week. Each item is rated from 0 (No difficulty) to 4 (Extreme difficulty). The total score is an average of the item scores, and therefore also ranges from 0 to 4. A positive difference between pre- and post-treatment scores indicates improvement.	4,642	0.69 (0.78)	0.12 (0.33)	0.57 (0.72)*
<b>BDI</b>	Patient-rated measure comprising 21 items which assess depressive symptoms over the previous two weeks. Each item has a set of four possible answers, ranging from 0 to 3 where 0 is low intensity (e.g., I do not feel sad) and 3 is high intensity (e.g., I am so sad or unhappy that I can't stand it). The lowest total score is 0 and the highest is 63. A positive difference between pre- and post-treatment scores indicates improvement.	703	27.23 (12.00)	15.42 (11.81)	11.81 (11.26)*
<b>DASS_Anxiety</b>	Patient-rated sub-scale of the DASS designed to measure anxiety. Consists of 14 items on the DASS-42 or 7 items on the DASS-21, each of which consists of a statement relating to a symptom of anxiety. The patient is asked to consider how much each statement applied to him or her in the past week. Each item is scored from 0 ('Did not apply to me at all') to 3 (Applied to me very much, or most of the time'). The sub-scale score on the DASS-42 ranges from 0 to 42; the raw sub-scale score on the DASS-21 ranges from 0 to 21 but is then doubled so that it also ranges from 0 to 42. A positive difference between pre- and post-treatment scores indicates improvement.	5,978	15.78 (10.08)	9.60 (8.66)	6.18 (8.73)*
<b>DASS_Depression</b>	Patient-rated sub-scale of the DASS designed to measure depression. Consists of 14 items on the DASS-42 or 7 items on the DASS-21, each of which consists of a statement relating to a symptom of depression. The patient is asked to consider how much each statement applied to him or her in the past week. Each item is scored from 0 ('Did not apply to me at all') to 3 (Applied to me very much, or most of the time'). The sub-scale score on the DASS-42 ranges from 0 to 42; the raw sub-scale score on the DASS-21 ranges from 0 to 21 but is then doubled so that it also ranges from 0 to 42. A positive difference between pre- and post-treatment scores indicates improvement.	5,989	20.62 (11.22)	11.75 (10.06)	8.67 (10.58)*

<b>DASS_Stress</b>	Patient-rated sub-scale of the DASS designed to measure stress. Consists of 14 items on the DASS-42 or 7 items on the DASS-21, each of which consists of a statement relating to a symptom of stress. The patient is asked to consider how much each statement applied to him or her in the past week. Each item is scored from 0 ('Did not apply to me at all') to 3 (Applied to me very much, or most of the time'). The sub-scale score on the DASS-42 ranges from 0 to 42; the raw sub-scale score on the DASS-21 ranges from 0 to 21 but is then doubled so that it also ranges from 0 to 42. A positive difference between pre- and post-treatment scores indicates improvement.	5,890	22.39 (10.04)	14.35 (9.57)	8.05 (9.80)*
<b>GAF</b>	Clinician-rated measure of functioning which seeks a single rating from 1 (Persistent danger of severely hurting self or others OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death) to 100 (Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his/her many positive qualities. No symptoms). A negative difference between pre- and post-treatment scores indicates improvement.	1,132	58.25 (9.15)	69.78 (11.15)	-11.53 (8.38)*
<b>GWBI</b>	Patient-rated measure comprising 22 items designed to establish how he or she has been feeling during the past 2 weeks. Each item is scored from 0 to 5, with 0 indicating low general well being and 5 indicating high general well being. The total score ranges from 0 to 88. A negative difference between pre- and post-treatment scores indicates improvement.	318	39.87 (15.03)	53.82 (16.22)	-14.95 (16.97)*
<b>HADS</b>	Patient-rated measure developed to detect anxiety and depression in a non-psychiatric hospital setting. Comprises 14 items, seven of which are concerned with anxiety and seven of which are concerned with depression. Each item is scored from 0 to 3, where 0 indicates low levels of symptomatology in the previous week and 3 indicates high levels. The total score ranges from 0 to 42. A positive difference between pre- and post-treatment scores indicates improvement.	406	18.96 (6.76)	9.36 (5.89)	9.62 (6.77)*
<b>HoNOS</b>	Clinician-rated measure of severity of symptoms in people with a mental illness which covers the previous two weeks. Comprises 12 items that collectively cover the sorts of problems that may be experienced by people with a mental illness. Each item is rated from 0 (No problem) to 4 (Very severe problem), resulting in a total score that can range from 0 to 48. A positive difference between pre- and post-treatment scores indicates improvement.	2,694	11.76 (5.03)	6.45 (4.72)	5.31 (4.13)*
<b>K-10</b>	Patient-rated measure developed to assess non-specific psychological distress. Comprises 10 items which ask the patient about symptoms of depression and anxiety in the past four weeks. Each item is rated from 1 (None of the time) to 5 (All of the time), resulting in a total score that ranges from 10 to 50. A positive difference between pre- and post-treatment scores indicates improvement.	11,293	31.22 (7.92)	22.76 (8.46)	8.46 (8.39)*

\* p <0.001

## Chapter 6: Discussion

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### **What is the level of uptake of the ATAPS projects by GPs, allied health professionals and consumers?**

Between 1 July 2003 and 31 December 2010, 18,545 (10,979, 59.2% urban; 7,566, 40.8% rural) GPs referred consumers to 4,695 (3,324, 70.8% urban; 1,371, 29.2% rural) allied health professionals through the ATAPS projects. This represents a continued increase in the number of GPs and allied health professionals over the life of the ATAPS projects.

Between 1 July 2003 and 31 December 2010, 223,851 consumers were referred to the ATAPS projects, 171,894 (76.9%) of whom took up the referrals provided.

In total, 879,331 sessions of care were provided through the projects, making the average number of sessions provided to consumers 5.1. This average is likely to be an underestimate as projects differ in their ability to identify re-referrals because some have systems which preclude a consumer carrying the same identifier across referrals.

The number of sessions delivered in both urban and rural areas has remained fairly steady over the past two years, with the lags apparent in the last quarter again likely to be attributable to lags in data entry.

### **What are the sociodemographic and clinical profiles of consumers of the ATAPS projects, and what is the nature of the care they are receiving?**

The profile of referred consumers has remained relatively consistent over time, and, in the main, is similar across urban and rural projects. Approximately 70% of all consumers are female, and their mean age is 39 years. About 3.5% of consumers are of Aboriginal or Torres Strait Islander descent. The majority (around two thirds) are on low incomes, as judged by their GP. About half have no previous history of mental health care. Of those for whom a diagnosis was made by the referring GP (n=160,201 or 72%), most have been diagnosed with depression (76%) or anxiety disorders (57%).

The profile of sessions has also remained fairly consistent since the ATAPS projects began. Sessions of 46-60 minutes have consistently been the most popular format over time, accounting for around 83% of all sessions, and reflecting the complexity of care provided in these sessions. Almost all of these sessions have been delivered to individuals, rather than groups. The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 55% and 41% of sessions, respectively. These interventions are evidence-based, and widely regarded as appropriate for treating the types of high prevalence disorders with which consumers are presenting. In the main, the profiles of sessions in rural and urban projects mirror the profile for all projects, but there are some nuances.

Nationally, for the 759,508 (86%) sessions where this information was available, 79% of sessions did not incur a copayment. For the 21% of sessions where a copayment was incurred, the average amount was \$15.70. The national average cost per session was \$3.22 (S.D. = \$9.72), with a lower average in rural (\$1.19, S.D. = \$6.13) and a higher average in urban (\$4.48, S.D. = \$11.21) areas.

Finally, while the vast majority of sessions were delivered face-to-face, a few sessions have been delivered using other modalities including, in order of popularity, via telephone, video conference and web-based sessions.

### **Are the ATAPS projects achieving positive outcomes for consumers?**

Pre- and post-treatment outcome data were available for 23,536 patients (10.5% of the 223,851). Across all of the nine most commonly used standardised outcome measures, the mean difference was statistically significant and indicative of clinical improvement.

#### **Caveat**

Some caution should be exercised in interpreting the above findings. There are lags in data entry into the minimum dataset, with some Divisions not entering session data until all sessions for a given consumer are complete. This specifically affects the more recent uptake figures.

#### **Conclusions**

The current report indicates that the ATAPS projects continue to be an integral part of the primary mental health care system in Australia. New GPs and allied health professionals continue to provide services to a substantial number of consumers. The number of referrals and sessions has remained fairly steady over the past couple of years. The profile of consumers and the care they are receiving is very consistent overtime. The majority are women with high prevalence disorders. Strategies usually involve CBT-based cognitive and behavioural interventions, which are typically delivered to individuals in sessions of one hour duration. Most importantly, the ATAPS projects are continuing to achieve considerable positive clinical outcomes for consumers.

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## Appendix A: Summary of focus of evaluation reports

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
First Interim Evaluation Report  Dec 2003	Round 1 pilot projects—Australia	<ul style="list-style-type: none"> <li>Local evaluation reports</li> </ul>	<ul style="list-style-type: none"> <li>What models of service delivery are being used by the pilots?</li> <li>What is the uptake of the pilots?</li> <li>What are the advantages and disadvantages of the pilots?</li> </ul>	<ul style="list-style-type: none"> <li>The pilots are operating under a range of models. The models differ in terms of referral mechanisms (ranging from simple voucher systems to more complex brokerage systems), means of retaining allied health professionals (with most retaining them under some sort of contract and some employing them directly), and location of allied health professionals (with most providing services in GPs' rooms but some providing them in their own rooms or in a third location).</li> <li>The pilots have recruited 136 individual allied health professionals (primarily psychologists) and 10 agencies. In total, 387 GPs have referred 2036 patients to these allied health professionals.</li> <li>Advantages for GPs included: savings in terms of time and cost and feedback from allied health professionals, and disadvantages included opportunity costs and other risks. Advantages for allied health professionals included an increased referral base and improved relationships with GPs, and disadvantages included payment anomalies and communication difficulties. Advantages for patients included access to psychological services although some noted barriers to attendance.</li> </ul>
Second Interim Evaluation Report  July 2004	Round 1 pilot and supplementary projects—Australia	<ul style="list-style-type: none"> <li>Local evaluation reports</li> <li>Minimum dataset</li> </ul>	<ul style="list-style-type: none"> <li>What models of service delivery are being used by the projects?</li> <li>What is the level of uptake of the projects?</li> <li>Who is accessing services through the projects?</li> <li>What services are patients receiving through the projects?</li> <li>What are the advantages and disadvantages of the projects?</li> </ul>	<ul style="list-style-type: none"> <li>A range of models is being used from simple voucher systems to more complex brokerage models. Intermediate models are now available which provide GPs with registers that profile allied health professionals in terms of their skills and competencies, thereby enabling GPs to make informed referral decisions.</li> <li>The projects have involved between 710 and 926 GPs and between 160 and 229 allied health professionals. Together, these providers have enabled between 3476 and 3656 patients to access mental health care, which would otherwise have been out of their reach.</li> <li>The majority (58%) of patients are on low incomes (58%) and have not completed secondary education (56%), most have been diagnosed with depression (77%) and/or anxiety (55%) by their GP, and 40% have no previous history of specialist mental health care, indicating that their access may have previously been problematic.</li> <li>The number of sessions of therapy received to date is 8678. Most sessions tend to be close to an hour in length (71%), and involve individual treatment (99%). The most common interventions are cognitive and behavioural interventions (55% and 41%, respectively). In 76% of all sessions, no co-payment is required; in the remainder of sessions a co-payment of not more than \$10 is charged.</li> <li>GPs and allied health professionals involved in projects are now feeling more satisfied that the initiative is viable and ongoing. Benefits observed by GPs include new skills and knowledge in the area of mental health and new referral options. Benefits observed by allied health professionals include improved relationships with GPs and an increased referral base. Patients are benefiting from ready access to high quality care. Despite these positives, GPs and allied health professionals have experienced some attitudinal and logistical barriers, and patients have experienced some inequities in referral.</li> </ul>

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Third Interim Evaluation Report Feb 2005	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—Victoria and Tasmania	<ul style="list-style-type: none"> <li>▪ Evaluation forum</li> </ul>	<ul style="list-style-type: none"> <li>• Do models of service delivery differ from the conceptualisation outlined in the First and Second Interim Evaluation Reports?</li> <li>• What are the benefits and barriers associated with the means of retaining allied health professionals?</li> <li>• What are the benefits and barriers associated with the various locations from which allied health professionals deliver services?</li> <li>• What are the benefits and barriers associated with the different referral mechanisms?</li> </ul>	<ul style="list-style-type: none"> <li>• The evaluation forum provided support for the validity of the conceptualisation of the different models of service delivery put forward in the early evaluation reports.</li> <li>• The major focus of the evaluation forum was in determining the benefits and barriers associated with the dimensions of the models. Often, the benefits of one model address barriers to another, and vice versa. So, for example, projects in which the allied health professionals operate from their own rooms may have benefits for GPs in terms of access to a range of providers, but may present problems associated with reduced opportunities to collaborate. Conversely, projects in which the allied health professionals are co-located with GPs may have advantages for GPs in terms of communication, collaboration and potential for knowledge transfer, but the downside may be a reduced range of providers to whom referrals can be made.</li> </ul>
Fourth Interim Evaluation Report April 2005	Round 1 pilot and supplementary projects, Round 2 projects—Australia	<ul style="list-style-type: none"> <li>• Local evaluation reports</li> <li>• Minimum dataset</li> </ul>	<ul style="list-style-type: none"> <li>• What models of service delivery are being used by the projects?</li> <li>• What is the level of uptake of the projects?</li> <li>• Who is accessing services through the projects?</li> <li>• What services are patients receiving through the projects?</li> <li>• What are the benefits and barriers associated with the projects?</li> <li>• What lessons have been learned from the early experiences of the projects?</li> </ul>	<ul style="list-style-type: none"> <li>• The projects are operating under a range of different models that vary in terms of means of retaining allied health professionals, location of allied health professionals, and referral mechanisms.</li> <li>• The uptake of the Round 1 and 2 projects is high. Using the minimum dataset as the gold standard, 1771 GPs had referred 12 758 patients to 569 allied health professionals by 31 December 2004. There has been significant growth as time has passed and the Round 2 projects have developed.</li> <li>• The majority (62%) of patients are on low incomes, most have been diagnosed with depression (76%) and/or anxiety disorders (56%) by their GP, and 46% have no previous history of specialist mental health care, indicating that access may previously have been problematic for them.</li> <li>• There are good indications that the Round 1 and 2 projects are providing free or low-cost evidence-based mental health care to patients through structured sessions. In total, the number of sessions of therapy received to date by patients in the Round 1 and 2 projects is 45 823. Most sessions (75%) are an hour in length, and 98% involve individual, rather than group-based, treatment. The most common interventions delivered through these sessions are CBT-based cognitive (61%) and behavioural (45%) interventions. In 63% of all sessions, patients are not required to contribute to the cost of care; in the remainder of cases they are asked to make a co-payment, usually of not more than \$20.</li> <li>• Participating GPs, allied health professionals and patients are very satisfied with the Round 1 and 2 projects. GPs, allied health professionals and patients appreciate upskilling opportunities, the increased referral base and the high quality of care, respectively. There have been some barriers to participation—e.g., paperwork hurdles for GPs, frustration at a perceived lack of decision-making power for allied health professionals, and equity issues for patients.</li> <li>• GPs are now less likely to experience confusion about how the projects operate, allied health professionals seem to be less concerned about the uncertainty of guaranteed work, and problems with inappropriate referrals have generally been 'ironed out'.</li> </ul>

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Fifth Interim Evaluation Report June 2005	Round 1 pilot and supplementary projects, Round 2 projects—Australia	<ul style="list-style-type: none"> <li>Survey of models of service delivery</li> </ul>	<ul style="list-style-type: none"> <li>What is the profile of models of service delivery across the ATAPS projects?</li> <li>Are particular models associated with differential levels of patient access to services?</li> </ul>	<ul style="list-style-type: none"> <li>In 76% of projects, allied health professionals are retained under contractual arrangements; in 28% through direct employment; and in 7% by other means (e.g. arrangements with supervised postgraduate psychology students); in 63%, allied health professionals provide services from GPs' rooms; in 63% they do so from their own rooms; and in 42% they do so from some other location (e.g. Divisional rooms, community health centres, hospitals and other general health and mental health facilities, other community agencies, and universities); and in 27%, voucher systems are used; in 24% brokerage systems are used; in 25% register systems are used; and in 51% direct referral systems are used.</li> <li>All models appear to be performing equally well in terms of enabling patients to receive free (or low-cost), evidence-based mental health care.</li> </ul>
Sixth Evaluation Report Nov 2005	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—Australia	<ul style="list-style-type: none"> <li>Local evaluation reports</li> <li>Minimum dataset</li> </ul>	<ul style="list-style-type: none"> <li>Has participation in the projects by GPs and allied health professionals changed over time?</li> <li>Have access to and the nature of mental health care for patients changed over time?</li> <li>Have the experiences of GPs, allied health professionals and patients changed over time?</li> <li>Are the projects achieving positive outcomes for patients?</li> </ul>	<ul style="list-style-type: none"> <li>2980 GPs have made referrals to 1040 allied health professionals since the projects began. There has been a dramatic increase in participation rates by both GPs and allied health professionals over the life of the projects.</li> <li>The total number of patients receiving care through the projects is 26 444. The total number of sessions provided to these patients is 102 120. Both the number of patients and the number of sessions have increased substantially over time. The profile of sessions has not changed over time, with the majority being individually based, an hour in length, and consisting of CBT-based cognitive and behavioural therapies. Early sessions rarely incurred a co-payment, and where they did it was usually \$10 or less; subsequent sessions more commonly involved a co-payment, sometimes of as much as \$20 or more; and more recent sessions have been less commonly associated with a co-payment although the situation has not returned to the original low.</li> <li>Some experiences for stakeholders have remained constant over time, while others have changed.</li> <li>In 88% of cases, patients who have contact with allied health professionals through the ATAPS projects get better.</li> </ul>
Seventh Interim Evaluation Report March 2006	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—Australia	<ul style="list-style-type: none"> <li>Minimum dataset</li> <li>Survey of models of service delivery</li> <li>Project case studies</li> </ul>	<ul style="list-style-type: none"> <li>What models of service delivery are being used by the rural and urban projects?</li> <li>What is the level of uptake of the rural and urban projects?</li> <li>Who is accessing services through the rural and urban projects?</li> <li>What services are patients receiving through the rural and urban projects?</li> <li>What are the outcomes for patients through the rural and urban projects?</li> <li>What are the issues associated with the rural and urban projects?</li> </ul>	<ul style="list-style-type: none"> <li>Both rural and urban projects are using a mix of models. However, there are some notable differences. Rural projects are more likely than urban projects to directly employ allied health professionals (37% versus 21%). Rural projects are less likely to have allied health professionals providing services from their own rooms (53% versus 72%). Rural projects are more likely to implement direct referral systems (64% versus 38%), and less likely to use register systems (17% versus 32%).</li> <li>As at 31 December 2005, 1587 GPs had referred 14 137 patients to 359 allied health professionals via the rural projects. The equivalent figures for the urban projects are 1639, 16 649 and 770, respectively.</li> <li>The majority of patients in both rural and urban locations are female, however, there are proportionally more male patients in rural settings (28% versus 26%). The majority of rural and urban patients have depression and/or anxiety disorders, a lower proportion of rural patients have the latter (55% versus 60%).</li> <li>The majority of sessions in both rural and urban settings are 46–60 minutes in length, although a smaller proportion are of this duration in rural settings (75% versus 80%). No co-payment is charged in 82% of rural sessions, compared with only 68% of urban sessions.</li> <li>Both rural and urban projects are achieving positive patient outcomes.</li> <li>Rural projects have struck problems to do with: distance; attracting qualified staff; lack of training and support for GPs; limited services; large Indigenous populations; high levels of</li> </ul>

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
				unemployment; and stigma. The issues for urban projects have related more to: uptake and demand; workforce shortages; and availability of and coordination with other services.
Eighth Interim Evaluation Report June 2006	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—Australia	<ul style="list-style-type: none"> <li>• Minimum dataset</li> <li>• Survey of models of service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• What is the level of patient outcomes within and across projects?</li> <li>• Does the level of patient outcomes vary depending on the model of service delivery?</li> </ul>	<ul style="list-style-type: none"> <li>• The projects are achieving positive effects, mostly of large or medium magnitude. This suggests that the projects are effective in improving the mental health of patients who are receiving psychological services.</li> <li>• Projects do not differ markedly in terms of the patient outcomes they are achieving, despite their differences in models of service delivery. Only one variable emerged as significant: projects implementing direct referral systems are tending to achieve greater levels of patient outcomes. In addition, there were non-significant trends toward employment of allied health professionals being predictive of greater patient outcomes and delivery of services from allied health professionals' own rooms being predictive of lesser patient outcomes.</li> </ul>
Ninth Interim Evaluation Report October 2006	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects—Australia	<ul style="list-style-type: none"> <li>• Survey of demand management strategies</li> </ul>	<ul style="list-style-type: none"> <li>• How many projects are using demand management strategies?</li> <li>• What demand management strategies are being used within projects?</li> <li>• Which demand management strategies have been found to be most useful?</li> <li>• What features of any demand management strategy have worked well and not worked well?</li> </ul>	<ul style="list-style-type: none"> <li>• 85% of projects are using at least one demand management strategy.</li> <li>• The most commonly used demand management strategies are: informing/training GPs (used in 82% of projects); putting in place systems and/or administrative procedures (used in 76%); and monitoring and limiting referrals (used in 61%). The majority of projects are using a combination of broad demand management strategies (5.6 per project, on average). They are also employing a range of approaches within each demand management strategy. Monitoring and limiting referrals and putting in place systems and/or administrative procedures are ranked as the most useful demand management strategies, with 29% of project officers endorsing the former and 24% the latter.</li> <li>• Different features of these demand strategies appear to work well for different projects, but a common theme is that they need to be underpinned by strong partnerships and solid infrastructure. There is concern that the need for demand management reflects the fact that projects are insufficiently resourced, and that as a consequence demand management strategies such as limiting referrals can have a negative effect on stakeholder perceptions.</li> </ul>
Tenth Evaluation Report Nov 2007	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects—Australia	<ul style="list-style-type: none"> <li>• Minimum dataset</li> <li>• Medicare Benefits Schedule data</li> </ul>	<ul style="list-style-type: none"> <li>• Has participation in the projects by GPs and allied health professionals changed over time?</li> <li>• Has the profile of consumers varied over time and has the care they are receiving changed?</li> <li>• Are the projects achieving positive outcomes for consumers?</li> <li>• Have there been changes in the level of uptake of services provided by the projects following the introduction of the Better Access program?</li> </ul>	<ul style="list-style-type: none"> <li>• The ATAPS projects have gained considerable momentum over time. Collectively, they are attracting far more GPs and allied health professionals and are providing access to high quality mental health care than was the case originally. The numbers of referring GPs rose steadily from 449 in the July-September 2003 quarter to a peak of 2,451 in the July-September 2006 quarter. 135 allied health professionals, provided services in the July-September 2003 quarter, and 1,225 doing so in the July-September 2006 quarter</li> <li>• In the main, the profile of consumers they are treating and the nature of sessions they are providing have both reached a point of consistency.</li> <li>• The projects are achieving positive outcomes for consumers.</li> <li>• Overall, the introduction of the Better Access program does not seem to have reduced the demand for psychological services provided through the ATAPS projects, although there has been a slight shift to Better Access in urban Divisions.</li> </ul>

<b>Report</b>	<b>Projects included</b>	<b>Data sources</b>	<b>Evaluation questions</b>	<b>Evaluation findings</b>
Eleventh Evaluation Report  October 2007	Not applicable	<ul style="list-style-type: none"> <li>Semi structured Interviews</li> </ul>	<ul style="list-style-type: none"> <li>What have the reports been used for?</li> <li>What have the reports confirmed?</li> <li>What aspects of the reports have been the most useful?</li> <li>Have the reports affected any decisions or led to any changes?</li> <li>Was new knowledge regarding the program produced in the evaluation reports?</li> </ul>	<ul style="list-style-type: none"> <li>Most commonly the reports have been used in describing what was occurring in the field. They have also been used with documentation related to the projects. In some cases they have led to program modification. As well the reports have been used for lobbying and advocacy purposes.</li> <li>The reports have confirmed that the original thinking behind the BOiMHC program in general and the ATAPS projects is appropriate.</li> <li>The uptake data and the data that profiled socio-demographic and clinical characteristic of consumers as well as the services provided were very valuable. Others also valued project impact data, process oriented information and data interpretation.</li> <li>The reports have guided program modification or non modification. The reports have influenced decisions about the ATAPS program for example co payments. Some respondents thought that the reports may have influenced changes at the policy level.</li> <li>The reports furthered understanding about 'what works, for whom, and in what circumstances.'</li> </ul>
Twelfth Evaluation Report  April 2008	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects— Australia	<ul style="list-style-type: none"> <li>Minimum dataset</li> </ul>	<ul style="list-style-type: none"> <li>Has participation in the projects by GPs and allied health professionals changed over time?</li> <li>Has the profile of consumers varied over time, and has the care they are receiving changed?</li> <li>Are the projects achieving positive outcomes for consumers?</li> </ul>	<ul style="list-style-type: none"> <li>The uptake of projects continues to be are substantial, with 7,776 GPs referring 100,854 consumers to 2,665 allied health professionals between 1 July 2003 and 31 December 2007 Uptake steadily rose from 2003, with a drop in late 2006 following introduction of Better Access, and continues to be substantial since then.</li> <li>The profile of referred consumers has remained consistent over time, with the majority being females diagnosed with depression or anxiety, on low incomes, and with a mean age of 39 years. About half have no previous history of mental health care.</li> <li>The projects are achieving positive outcomes of large or medium magnitude in 65% of cases.</li> </ul>
Thirteenth Evaluation Report  March 2009	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects – Australia	<ul style="list-style-type: none"> <li>Minimum dataset</li> <li>Medicare Benefits Schedule data</li> </ul>	<ul style="list-style-type: none"> <li>Have there been changes in the level of uptake of services provided by the projects following the introduction of the Better Access Program?</li> </ul>	<ul style="list-style-type: none"> <li>In the twenty- one months since the introduction of the Better Access program (1 November 2006), a dramatic uptake of Better Access sessions in urban areas coincided with a temporary reduction in sessions provided in urban areas under ATAPS.</li> <li>Similarly, sessions through rural ATAPS projects temporarily decreased but to a lesser extent.</li> <li>Currently the uptake of sessions through both programs is steadily increasing, suggesting that the two programs are complementary in terms of addressing significant community need.</li> </ul>

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
<p>Fourteenth Evaluation Report</p> <p>June 2009</p> <p>Including Preliminary findings of the Perinatal Depression Initiative</p>	<p>Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects – Australia</p>	<ul style="list-style-type: none"> <li>• Minimum dataset</li> <li>• Minimum dataset</li> </ul>	<ul style="list-style-type: none"> <li>• Has participation in the general Access to Allied Psychological Services projects by GPs and allied health professionals changed over time?</li> <li>• Has the profile of consumers of general Access to Allied Psychological Services projects varied over time, and has the care they are receiving changed?</li> <li>• Are the projects achieving positive outcomes for general Access to Allied Psychological Services consumers?</li> <li>• What is the uptake of the Perinatal Depression Initiative by GPs and allied health professionals?</li> <li>• What is the profile of consumers and the care they are receiving?</li> </ul>	<ul style="list-style-type: none"> <li>• Since the January-March 2008 quarter the number of GPs has increased steadily to an all time peak in April-June 2008 to 2,616 (1,116 rural; 1,500 urban).</li> <li>• Similarly, since October-December 2007 the number of participating allied health professionals also steadily increased to 1218 (390 rural; 891 urban) in the October-December 2008 quarter.</li> <li>• The number of GPs and allied health professionals in urban and rural areas has followed a similar pattern to that of the national figures although the impact of Better Access appears to have been much less pronounced in rural areas.</li> <li>• The profile of referred consumers has remained relatively consistent over time, and is similar across urban and rural projects.</li> <li>• The profile of these sessions has not changed greatly since the Access to Allied Psychological Services projects began.</li> <li>• The only notable change over time with respect to the sessions of care provided has been in the charging of a copayment. Relatively small proportions of sessions were associated with copayments</li> <li>• The projects were shown to be achieving positive outcomes of large or medium magnitude in 86% of cases.</li> <li>• 23 divisions have entered data in the minimum-dataset. The majority of referrals and sessions have been in rural areas consistent with the intent of the initiative to target rural and remote locations.</li> <li>• Almost all consumers referred have been female with an average age of 31 years. Eighty-two percent have been diagnosed with depressive disorders and 37% with anxiety disorders. Almost all sessions were individual and an hour in length.</li> </ul>
<p>Fifteenth Evaluation Report</p> <p>February 2010</p>	<p>Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects – Australia</p>	<ul style="list-style-type: none"> <li>• Minimum dataset</li> <li>• Survey of models of service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• What is the level of uptake of the general Access to Allied Psychological Services projects by GPs, allied health professionals and consumers?</li> <li>• What is the sociodemographic and clinical profile of consumers of general Access to Allied Psychological Services projects and what is the nature of the care they are receiving?</li> <li>• Have the models of service delivery being utilised by the general Access to Allied Psychological Services</li> </ul>	<ul style="list-style-type: none"> <li>• Between 1 July 2003 and 31 December 2009, 15,251 (9,032, 59% urban; 6,219, 41% rural) GPs referred consumers to 4,042 (2,933, 73% urban; 1,109, 27% rural) allied health professionals.</li> <li>• During this period, 135,033 (or 77%) of the 174,675 consumers referred to projects took up the referral receiving a total of 709,684 sessions of care.</li> <li>• The profile of referred consumers has remained relatively consistent over time, and is similar across urban and rural projects. Around three quarters of consumers are female with a mean age of 39 years. Two thirds are on low incomes and about half have no previous history of mental health care. 75% of diagnoses relate to depression and 57% to anxiety disorders.</li> <li>• The profile of sessions has not changed greatly since the Access to Allied Psychological Services projects began. Four fifths of all sessions were 46-60 minutes in duration. Almost all sessions were delivered to individuals, 79% did not incur a co-payment and most common intervention types involved CBT-based cognitive (44%) and behavioural interventions (58%).</li> <li>• Some significant changes to service delivery models used by projects since 2005 included increases in the use of: direct employment arrangements; other locations (most notably Divisions' rooms); the brokerage system, as well as a decrease in the use of the voucher system.</li> </ul>

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
			projects changed over time?	<ul style="list-style-type: none"> <li>There continues to be considerable variability across projects in terms of the models of service delivery utilised. This indicated that there is not a 'one model fits all' approach to the services being delivered and that projects continue to flexibly adapt models to local needs.</li> </ul>
<p>Sixteenth Evaluation Report</p> <p>July 2010</p> <p>Including Second report of the Perinatal Depression Initiative</p>	<p>Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects – Australia</p>	<ul style="list-style-type: none"> <li>Minimum dataset</li> <li>Minimum dataset</li> </ul>	<ul style="list-style-type: none"> <li>What are the clinical improvements after treatment provided through the ATAPS projects?</li> <li>Do some patients fare better than others?</li> <li>What is the uptake of the Perinatal Depression Initiative by GPs, allied health professionals, and consumers?</li> <li>What is the profile of consumers and the care they are receiving?</li> <li>What are the outcomes for consumers of the Perinatal Depression Initiative?</li> </ul>	<ul style="list-style-type: none"> <li>Patients are benefiting from the ATAPS projects, and the gains they are making are considerable. A range of socio-demographic, clinical and treatment-based variables are associated with the levels of outcomes achieved, but improvements are still substantial even for those in the relatively disadvantaged groups.</li> <li>More specifically, pre- and post-treatment outcome data were available for 16,700 patients from nine different outcome measures. Across all measures, the mean difference was statistically significant and indicative of clinical improvement. The most commonly-used measure was the Kessler-10 (K-10), and pre- and post-treatment K-10 data were available for 7,747 patients. After adjusting for clustering by Division, outcome on the K-10 was associated with age, levels of income and education, previous receipt of mental health care, number of sessions, treatment received and pre-treatment K-10 score. The benchmark was sufficiently high, however, that even the groups that fared relatively less well still showed strong improvement in absolute terms.</li> <li>Since March 2008, 764 (345 urban; 419 rural) consumers have been referred by 505 (264 urban; 241 rural) GPs to 208 (98 urban 110 rural) allied health professionals for 2,708 (1289 urban; 1419 rural) sessions of care.</li> <li>Almost all consumers were female with an average age of 31 years. Eighty-seven percent were diagnosed with depressive disorders and 40% with anxiety disorders. Half of all consumers were identified as having a low income. Consumers in urban areas were more likely, than rural consumers, to be charged a copayment. Almost all sessions were individual and an hour in length in rural areas. Whereas in urban areas 17% of sessions were delivered to groups and almost a quarter of sessions were over 60 minutes in length.</li> <li>Consumer outcomes as measured by the EDPS, DASS subscales and the K10 all indicate a significant improvement in consumers from the start to the end of treatment.</li> </ul>

