



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

**Final report for the evaluation of the
Specialist Services for Consumers at Risk of Suicide Pilot**

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Executive summary

Background

Introduced in 2001, the Access to Allied Psychological Services (ATAPS) projects, a key component of the Better Outcomes in Mental Health Care program, supports GPs and allied health professionals to collaborate to provide optimal mental health care. Specifically, the ATAPS component enables GPs to refer consumers with high prevalence disorders to allied health professionals for up to 12 (or 18 in exceptional circumstances) sessions of evidence-based mental health care. ATAPS projects are operating in all 110 Divisions of General Practice (Divisions), several via fund holding arrangements.

In June 2008, the Australian Commonwealth Department of Health and Ageing provided additional funding to 19 Divisions to pilot the Specialist Service for Consumers at Risk of Suicide (Specialist Services) as a sub-program of the ATAPS projects. The pilot facilitated a more intensive, prioritised service for people 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 had a mental disorder. The pilot concluded in June 2011, however the Specialist Services have now been extended and expanded nationally to all Divisions under new Tier 2 ATAPS funding aimed at a range of at-risk populations and/or use specific modalities of service delivery.¹

The University of Melbourne's Centre for Health Policy, Programs and Economics (CHPPE) has been evaluating the general ATAPS projects and its sub-programs since their respective introductions.

The current report is the fifth and final in a series evaluating the ongoing achievements of the Specialist Services pilot. It considers the level of uptake by GPs, emergency departments, allied health professionals and consumers at risk of suicide; the socio-demographic and clinical profile of these consumers; the precise nature of services being delivered; the consumer outcomes, and the experiences of Divisions in implementing and maintaining the Specialist Services.

Method

The report draws on data from a purpose-designed minimum dataset which collects consumer- and session-based data on the projects and from a structured interview with Divisions. It considers the achievements of the Specialist Services pilot via the following evaluation questions:

Evaluation Question 1: What is the level of uptake of the Specialist Services pilot by GPs, emergency departments, allied health professionals, and consumers?

Evaluation Question 2: What are the socio-demographic and clinical profiles of consumers accessing the Specialist Services pilot?

Evaluation Question 3: What is the precise nature of the care being delivered via the Specialist Services pilot?

Evaluation Question 4: What are the consumer outcomes being achieved by the Specialist Services pilot?

Evaluation Question 5: How have Divisions experienced the Specialist Services pilot?

Key findings

What is the level of uptake of the Specialist Services pilot by GPs, emergency departments, allied health professionals and consumers?

Between 1 October 2008 and 30 June 2011, 2,312 referrals (857 rural and 1,455 urban) were made to the Specialist Services pilot. Referral source data were available for 2,054 (753 rural and 1301 urban) of these referrals. The majority of referrals came from GPs, especially in rural areas. Referrals were made by 826 GPs and sessions were conducted by 266 allied health professionals. A substantial number of emergency departments and a small number of community mental health services also referred consumers to the Specialist Services pilot. Emergency departments were responsible for one fifth of referrals in urban areas.

11,192 sessions (4,545 rural, 6,647 urban) were delivered between 1 October 2008 and 30 June 2011, representing an increase of 4,282 sessions (from 6,910 sessions; 2,184 rural and 4,726 urban) reported since the October 2008 to January 2011 period. This makes the average number of session per referral 5.4. Overall, there were a greater proportion of referrals (63%) and sessions (59%) in urban compared to rural areas. Since starting to rise in late 2008, the number of sessions and referrals has been relatively stable with some fluctuation. The number of referrals and sessions peaked in January 2011, with the decline nationally in the last quarter likely to be attributable to data entry lags.

In 60% of cases a session was received by a consumer within three days of the referral being made. The first session of care was delivered face to face in 72% of cases.

What are the socio-demographic and clinical profiles of consumers accessing the Specialist Services pilot?

Nationally, 62% of consumers of the Specialist Services pilot were female, and their mean age was approximately 33 years. Over half were on low incomes, as judged by their GP. About one third of the consumers had not previously accessed mental health care. Two percent of consumers were reported to be Aboriginal, and less than 1% Torres Strait Islander. Rural and urban consumers were similar in the main, with low income and Aboriginal status being reported slightly more frequently in rural compared to urban areas (60% vs. 54% and 3.6% vs. 1.2%), and previous psychiatric service use reported slightly more frequently in urban compared to rural areas (43% vs. 39%)

The diagnostic field was completed for 64.4% (1,490) of the 2,312 referrals made. For these 1,490 referrals, the vast majority had been diagnosed with depression (87%) and about one third had been diagnosed with anxiety. The reported diagnoses varied little between rural and urban areas. The profile of Specialist Services' consumers differed somewhat from that of the Tier 1 ATAPS projects' consumers in that they are more likely to be younger and have a diagnosis of depression, and less likely to be female or have a diagnosis of anxiety.

What is the precise nature of the care being delivered via the Specialist Services pilot?

Almost all sessions comprising the Specialist Services pilot were delivered to individuals. Nationally sessions of 46–60 minutes accounted for 70% of Specialist Services delivered and approximately 17% of sessions were of over one hour in duration. More Specialist Services sessions conducted in rural areas were 30 minutes or less when compared with urban areas. Nationally, while the vast majority of sessions were delivered face-to-face, around 9% of all sessions were delivered via telephone and videoconferencing was also infrequently used in rural areas.

Overall CBT-cognitive interventions were most commonly delivered in the Specialist Services pilot. The next most commonly used interventions in rural areas were CBT-skills training and in urban areas diagnostic assessment. No copayment was charged for almost all sessions. The profile of the Specialist Services pilot's sessions differed from that of the Tier 1 ATAPS projects' consumers.

What are the consumer outcomes being achieved by the Specialist Services pilot?

Investigation of all the available outcome data indicated that 328 (14%) consumers had pre and post scores on at least one outcome measure. Of the 328 consumers, 245 had been assessed with the Modified Scale for Suicidal Ideation (MSSI), 128 with either the Depression, Anxiety and Stress Scales (DASS) 21 or 42 item version, and 102 with the Kessler 10 (K10). The Specialist Services pilot achieved positive outcomes for consumers as evidenced by statistically and clinically significant levels of improvement across all outcome measures examined.

How have Divisions experienced the Specialist Services pilot?

How were the Specialist Services operationalised?

The service delivery models used by Divisions varied in terms of how allied health professionals (AHPs) were engaged and how referrals were received and managed. Eight Divisions contracted AHPs. Eight Divisions employed AHPs. Three Divisions had contracted agencies to manage their Specialist Services.

Four Divisions decided to only receive GP referrals, and did not promote the ability of other professionals to refer to the Specialist Services. Four Divisions used a service model that involved direct referral from GPs, or other referrers, to AHPs. Eleven Divisions managed referrals through a centralised, Division-based, intake system which was either staffed by an administration person or by an AHP. Only two Divisions reported that they had received after hours referrals, with most Divisions advising GPs and other referrers to make referrals during business hours and to direct consumers to the relevant state mental health services or to the after hours telephone support line provided by the Specialist Services.

What were the key achievements of the Specialist Services as seen by Divisions?

Divisions reported a number of key achievements of their Specialist Services projects which largely focused on the benefits provided to consumers, the support provided to GPs, links with mental health services, and the development of policies and a service framework.

How did Divisions overcome any initial challenges and barriers to the Specialist Services?

Many of the Divisions reported that they had been able to successfully overcome the initial 'teething problems' associated with the implementation of the new Specialist Services. All of the Divisions reported that the administrative barrier of establishing policy and procedures was no longer an issue and nearly all had settled on a service delivery model that they felt was working well for the Division, AHPs and consumers.

Eight of the Divisions reported that engaging GPs in the Specialist Services had been an initial barrier to the success of the Specialist Services. Some Divisions reported that this was still an ongoing issue due to the high turnover of GPs or the tendency of busy GPs to forget about the service in amongst the large amount

of information they receive. Many Divisions reported that they overcame this through regular and continued promotion of the Specialist Services to GPs.

Six Divisions reported that engagement of AHPs was an initial barrier, with AHPs reluctant to do the training or work with this particular consumer group. Four Divisions reported that the quality of the training continued to be an issue for their AHPs, with one reporting that some of their AHPs had ceased their involvement in the Specialist Services due to this. Divisions had dealt with AHPs' hesitancy to work with the consumer group in a number of ways.

Relationships with the new mental health referrers

Three Divisions reported that linking with the mental health services had been challenging, and that not all mental health services had been receptive to their efforts. Divisions reported that they had found more success in developing individual relationships between staff members rather than through working on policies or service agreements between the services. Seven of the 19 Divisions now reported that they had a close effective working relationship with at least one of their local state mental health services.

Other barriers and challenges

One Division spoke of the challenge in delivering services in a rural area. They had overcome this barrier by implementing a service delivery model which enabled their AHP to travel to GP clinics to deliver services to consumers in different areas. However, they reported that the use of this model had led to increased session costs.

Do Divisions have arrangements in place to refer people at acute and immediate risk to themselves or others to crisis services?

Eleven of the 19 Divisions reported that there was a Division created policy about referring people at acute or immediate risk to themselves or others to the relevant crisis service. For other Divisions the arrangement to refer people at acute and immediate risk to themselves or others was entirely dependent on GP and/or AHP clinical judgement.

How have Divisions developed and maintained linkages and referral pathways with emergency departments and mental health services?

Divisions reported varying successes in developing linkages and referral pathways with emergency departments and mental health services. A number of Divisions had found that emergency departments and mental health services were not receptive to their attempts to develop their relationships. Successful working relationships seemed to be based on a combination of formal meetings, co-attendance at various mental health meetings and committees, regular formal and informal contact between managers, as well as individual relationships between clinicians.

What were the responses from GPs who had been asked by the Division to formally refer consumers who had been provisionally referred by an emergency department?

None of the Divisions reported any negative feedback from GPs who had been asked to formally refer consumers who had been provisionally referred by an emergency department. Twelve of the 19 Divisions reported that the response of GPs to the Specialist Services, and their role in referring, was positive.

What were Divisions' experiences with the APS training for allied health professionals?

All of the Divisions reported that their AHPs had completed the mandatory training for the Specialist Services. Five Divisions reported that the feedback from AHPs had been positive. Nine Divisions reported that they had received negative feedback.

What factors facilitated the effective operation of the Specialist Services?

Divisions spoke about a range of factors that had facilitated the effective operation of the Specialist Services. Six Divisions talked about the relationships between the Division, allied health professionals, GPs, and state mental health services. Five Divisions also spoke about the flexibility of the Specialist Services

and how this was of great benefit to the consumer and also allowed Divisions to more easily integrate the services with their other mental health services. Two Divisions spoke about the pivotal role of the AHP in the success of the Specialist Services. Three Divisions commented on the role of the GP in the success of the Specialist Services. Having GPs who were willing to be involved and who took the service on board were seen as important facilitating factors.

What factors posed a barrier to the effective operation of the specialist suicide services?

Seven Divisions spoke about continued difficulties in the relationship between the Division and the local state mental health services. Divisions commented on the continued need to work to establish trust with them and to educate them, which was made especially difficult by staff turnover within the mental health services.

Five Divisions commented on ongoing issues related to GPs that had posed a barrier to the operation of the Specialist Services. They spoke of the continued need to educate GPs to ensure appropriate referrals.

Five Divisions commented on the limited ability of the Specialist Services to reach all consumers in need such as those with chronic suicidality and indigenous people. Four Divisions commented on the difficulties related to receiving inappropriate referrals from mental health services and GPs. Four Divisions reported that issues related to service funding had posed a barrier to the success of the Specialist Services. They each commented that they felt the funding was not enough.

Suggestions for other data collection for the evaluation

Eight of the Divisions were interested in gaining more information about the broader and longer term impact of the services on individual consumers, suicide rates and presentations to emergency departments.

Use of the outcome tool: the Modified Scale for Suicide Ideation (MSSI)

Twelve of the 19 Divisions reported that their AHPs were using the MSSI with consumers. Eleven Divisions reported that they had received feedback from their AHPs about the tool, of these ten said that the feedback was negative.

Other comments by Divisions

Other comments made by Divisions were overwhelmingly positive. One of the Divisions who had received over 300 referrals to the specialist suicide services made the following comment: *'It is a valuable addition to the suite of services already offered. We were already getting suicide referrals in wider general ATAPS, this allowed us to properly service these people and expand our services. Suicide money allows you to put in a much more comprehensive service. Now there is dedicated time'*.

Conclusions

As with the previous four evaluation reports of the Specialist Services for Consumers at Risk of Suicide pilot, the current report confirms the status of the Specialist Services as a valuable and complementary sub-program of the general ATAPS projects. The Specialist Services have continued to attract referrals from GPs and emergency departments, with a peak in referrals and sessions in early 2011. Correspondingly, allied health professionals have delivered increasing numbers of sessions to a significant number of consumers. The profile of consumers continues to be fairly consistent over time and somewhat different from the general ATAPS projects. The consumer profile suggests that these Specialist Services are reaching a different group of consumers who are more likely to be younger and have a diagnosis of depression, and less likely to be female or have a diagnosis of anxiety. The nature of services being delivered remains at a point of relative consistency, which varies from that of general ATAPS and between rural and urban areas. The vast majority of consumers are receiving a free of cost service. There is good evidence that the pilot is achieving positive outcomes for consumers in terms of alleviating symptoms and improving levels of functioning.

Divisions generally reported that they had overcome any initial teething problems with the Specialist Services and they had for the most part settled on a service delivery model that was successfully fitting within their local context. Divisions reported that they had learnt a great deal through the implementation of the Specialist Services. They commented on the ongoing importance of: building and maintaining relationships with state mental health services, promotion and education of GPs, and the need to support their allied health professionals with this clinically demanding consumer group. Many Divisions reported that they had put considerable effort into developing a sound clinical governance framework for working with this new consumer group which had not only facilitated the implementation of these Specialist Services but also likely placed them in good stead to more seamlessly integrate new ATAPS programs in the future.

Chapter 1: Background

The Access to Allied Psychological Services projects

The Better Outcomes in Mental Health Care (BOiMHC) program, which was introduced by the Australian Commonwealth Department of Health and Ageing (DoHA) in response to low treatment rates for common mental disorders, has been operating since July 2001. The Access to Allied Psychological Services (ATAPS) projects, a key component of the BOiMHC program, supports GPs and allied health professionals to collaborate to provide optimal primary mental health care. Specifically, the ATAPS component enables GPs to refer consumers with high prevalence disorders (e.g., depression and anxiety) to allied health professionals for up to 12 (or 18 in exceptional circumstances) individual and/or group sessions of evidence-based mental health care (predominantly Cognitive Behavioural Therapy, or CBT). Review by the referring GP is essential particularly if more than six (or 12 in exceptional circumstances) sessions are required. The ATAPS projects are operating in all 110 Divisions of General Practice (Divisions, also known as General Practice Networks), several via fund holding arrangements.

During the life of the ATAPS projects, several sub-programs have been 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 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). Flexible Care Packages for people with severe mental illness are also being implemented via ATAPS in 2011. These additional sub-programs aim to enhance capacity to address the needs of these groups and provide increased service flexibility. The original ATAPS arrangements are now called Tier 1 services, and the sub-programs are called Tier 2 services.¹

The Specialist Services for Consumers at Risk of Suicide pilot

Suicide continues to be a major public health issue. There were 1,881 deaths from suicide in 2007 in Australia. Males accounted for over three-quarters of these deaths.² Many of these people may not have had a mental illness or access to specialised mental health care and many may have visited a GP during that time.³ In response to these issues, in mid-2008, DoHA provided funding to 19 Divisions (see Appendix A) to pilot the Specialist Services for Consumers at Risk of Suicide (Specialist Services), as a pilot project within the ATAPS projects. The pilot offered 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 were provided with additional funds to secure the services of specialised allied health professionals to provide intensive care and follow-up to referred consumers. The Specialist Services pilot projects differ from the general ATAPS projects in a number of ways. The unique features of the Specialist Services pilot are summarised in Table 1. The pilot concluded in June 2011, however the Specialist Services were extended and expanded nationally in July 2010 as part of the new 'Tier 2' funding provided by the Department of Health and Ageing for Divisions to focus on particular at-risk populations and/or use specific modalities of service delivery.

Table 1: Unique features of the Specialist Services pilot

Unique features of Specialist Services pilot

- 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; and
 - People who have expressed strong suicidal ideation to their GPs.
 - Consumers are not required to have a mental health diagnosis.
 - The treating 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.
 - Provision by Department of Health and Ageing of an afterhours support phone service for consumers.
 - No limit on the number of sessions.
 - Specialist Services' support is expected to be more intense than general ATAPS' support and sessions are to be conducted in a condensed time period of up to two months.
 - A provisional referral can be made to the Specialist Services projects by designated emergency department personnel to allow immediate contact with an allied health professional, followed by a GP referral within one week.
 - Local protocols were developed by Divisions for the referral pathways via emergency departments.
 - Training is mandatory for allied health professionals participating in the Specialist Services pilot 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.
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Evaluation of the ATAPS projects and the Specialist Services for Consumers at Risk of Suicide pilot

The University of Melbourne's Centre for Health Policy, Programs and Economics (CHPPE) has been evaluating the Tier 1 and Tier 2 ATAPS projects since their respective introductions. To date, 18 interim reports^{4-13 14-19} have evaluated the Tier 1 ATAPS projects and nine have evaluated Tier 2 ATAPS projects,²⁰⁻²⁷ four of which have specifically reported on the Specialist Services pilot (see Appendix B for a summary of reports).^{20-22 28}

The Specialist Services pilot has steadily attracted referrals from GPs and emergency departments and allied health professionals have provided psychological services to an increasing number of consumers. Consumers of the Specialist Services pilot have differed to those of the Tier 1 ATAPS projects in that they have been younger and are less likely to be female, on a low income, and to be diagnosed with anxiety, and more likely to be diagnosed with depression and to have previously used psychiatric services. Similarly, the care provided under the Specialist Services pilot has differed to that of the Tier 1 ATAPS projects in that more sessions have been conducted in less than 30 minutes and have involved diagnostic assessment and CBT-skills training, and no copayment has been associated with any sessions.

During the implementation of the Specialist Services pilot projects phone interviews were conducted at various points in time to ascertain the models of service delivery being utilised by each Division and to understand the experiences of the professionals involved in delivering the Specialist Services. Divisions commenced service delivery between October 2008 and July 2009. In the first interview, conducted between late 2008 and early 2009, Divisions reported on issues associated with the implementation of the Specialist Services. Many Divisions emphasised the need to establish operating policies and procedures around this new client group; they said this was time consuming and had delayed service delivery. Management of consumer risk was a key issue. Issues related to the engagement of GPs, allied health

professionals, and new external referrers (i.e., emergency departments and local mental health services) in the Specialist Services were also identified. Despite these challenges, most Divisions reported positive impacts related to the expansion of ATAPS services to fill a previously existing gap in services for those consumers of medium suicide risk.²⁰

It was reported by Divisions that the models of service delivery for the Specialist Services differed slightly from those of Tier 1 ATAPS. To deliver Specialist Services, project officers reported that allied health professionals were contracted in 68% of cases and directly employed 53% of the time. Allied health professionals delivered services most often from GP rooms and their own rooms (42% and 32%, respectively). The favoured referral mechanism was direct referral from the GP to the allied health professional.²⁰

When professionals (i.e., GPs, AHPs and emergency departments) were interviewed in late 2009 about the benefits and disadvantages of the Specialist services pilot, they were generally positive about the projects from their own perspective and the perspective of their clients. Specifically, GPs and emergency department staff were happy with the referral process, they were confident in conducting the assessments and found the process simple to follow. The allied health professionals receiving the referrals reported that generally the referrals were for consumers of mild to moderate suicide risk, which they found to be appropriate. All interviewed professionals indicated that the Specialist Services were a positive new initiative filling a previously unmet need. They highlighted that consumers were receiving an appropriate service in a more timely fashion than was previously available and all without cost to the consumer. It was generally reported that consumers were happy to be offered the service and that they could receive the services very quickly and were happy to be receiving ongoing care.²¹

The current report

The current report is the fifth and final in a series evaluating the achievements of the Specialist Services pilot. It considers not only the level of uptake by GPs, emergency departments, allied health professionals and consumers at risk of suicide; the socio-demographic and clinical profile of these consumers; and the precise nature of services for consumers, but also the outcomes achieved for consumers. The report also reviews the experiences of Divisions with the Specialist Services through a structured interview with Divisions that focussed on the challenges and benefits experienced by Divisions in implementing and maintaining the Specialist Services Pilot.

Chapter 2: Method

Evaluation questions

This report considers the progressive achievements of the Specialist Services for Consumers at Risk of Suicide pilot component of the ATAPS projects, via the following evaluation questions:

Evaluation Question 1: What is the level of uptake of the Specialist Services pilot by GPs, emergency departments, allied health professionals, and consumers?

Evaluation Question 2: What are the socio-demographic and clinical profiles of consumers accessing the Specialist Services pilot?

Evaluation Question 3: What is the precise nature of care being delivered via the Specialist Services pilot?

Evaluation Question 4: What are the consumer outcomes being achieved by the Specialist Services pilot?

Evaluation Question 5: How have Divisions experienced the Specialist Services pilot?

Data sources

Evaluation questions one to four were addressed using data from a purpose-designed web-based minimum dataset, which captures de-identified, consumer-level and session-level information, as well as pre- and post-treatment scores on standardised outcome measures.

Data from the minimum dataset was downloaded from the minimum dataset on 1 August 2011. The analysis period was from 1 October 2008 to 30 June 2011.

Of the 19 Divisions involved in the Specialist Services pilot, 19 submitted data to the minimum dataset during this period (8 rural, 11 urban).

Evaluation question five was addressed via a structured telephone interview with Division project officers or service managers. The interview was designed to recap findings from a survey with Divisions conducted near the beginning of the pilot in July 2009. The interview focussed on: how the pilot had been operationalised within Divisions, key achievements, how any barriers or challenges had been managed, relationships with emergency departments and mental health services, the mandatory allied health professional (AHP) training, factors that facilitated and acted as a barrier to the services, suggestions for the ongoing evaluation of the services and the use of the outcome tool (the MSSI) (see Appendix C for a copy of the interview). The interviews were conducted between July and August 2011. All 19 Divisions took part in the interview.

Data analysis

In order to answer evaluation questions one to three, descriptive analyses of the uptake of the Specialist Services and consumer- and session-profiles were conducted, with the results presented as simple frequencies and percentages.

In order to answer evaluation question four, paired t-tests were used to examine the difference between mean pre- and post-treatment scores on selected outcome measures. Consumers who did not have a 'matched pair' of pre- and post-treatment scores were excluded.

In order to answer evaluation question five, Template Analysis techniques were utilised to analyse qualitative data from telephone surveys of Division project officers and service managers.²⁹

It should be noted that each field (i.e. each variable) in the minimum dataset has an amount of 'missing' data. 'Missing' data is data that has not been entered into the minimum dataset. For example, a consumer's level of income or language spoken at home may not have been provided. 'Missing' data is likely due either to the data not being collected from the consumer or data entry error. 'Missing' data has been omitted from all analyses in this report. This is consistent with previous ATAPS evaluation reports. However, the most recent ATAPS report, *'The Eighteenth Interim Evaluation Report: An overview of the achievements of Tier 1 and Tier 2 ATAPS'*³⁰ includes 'missing' data in the analyses. 'Missing' data was included in the recent 18th report as it became clear to the evaluators that the 'missing' data was having a significant effect on the representation of some of the variables, especially when considering some of the newer Tier 2 programs where there had been smaller numbers of referrals and sessions. Thus, throughout this report wherever there are comparisons made to 'Tier 1 ATAPS' this is made to the 17th report in the evaluation series³¹ which does not include missing data and is therefore a more appropriate point of comparison for the Specialist Services. This is referenced accordingly throughout the current report.

Chapter 3: What is the level of uptake of Specialist Services pilot by GPs, emergency departments, allied health professionals and consumers?

Uptake data was available for 19 Divisions which had entered data into the minimum data set as at 1 August 2011.

Uptake by GPs, allied health professionals, and emergency departments

Table 2 presents the number of referrers (by profession or organisation) and allied health professionals participating in the Specialist Services pilot nationally and in rural and urban Divisions. Nationally, for the period from 1 October 2008 to 30 June 2011, there were 898 referrers to the Specialist Services. Referrals were made by 826 GPs and sessions were conducted by 266 allied health professionals. This represents an increase by 30% of participating GPs and 60% of allied health professionals, respectively, since January 2011.²⁸ A substantial number of emergency departments and a small number of community mental health services also referred consumers to the Specialist Services pilot.

Table 2: Number of GPs and allied health professionals participating in the Specialist Services

	National	Rural	Urban
GPs	826	336	490
Emergency departments	51	5	46
Community mental health services	18	5	13
Psychiatrist	3	2	1
Allied health professionals	266	104	162

Referral sources

Table 3 shows a summary of referral sources; these data were available for 2,054 (753 rural and 1301 urban) of the 2,312 referrals made. Emergency departments were responsible for one fifth of referrals in urban areas. The majority of referrals came from GPs, especially in rural areas. This trend has remained relatively consistent over the life of the pilot.^{20-22 28}

Table 3: Summary of referral sources for the Specialist Services

	National n (%)	Rural n (%)	Urban n (%)
GPs	1,717 (83.6%)	696 (92.4%)	1,021 (78.5%)
Emergency departments	271 (13.2%)	8 (1.1%)	263 (20.2%)
Community mental health services	61 (3.0%)	46 (6.1%)	15 (1.2%)
Psychiatrists	5 (0.2%)	3 (0.4%)	2 (0.1%)

Uptake by consumers

Between 1 October 2008 and 30 June 2011, 2,312 referrals (857 rural and 1,455 urban) were made to Specialist Services, this represents a substantial increase in referrals since January 2011 (1,401 referrals nationally, 399 rural and 1,002 urban).²⁸

Specialist Services pilot projects reported delivering 11,192 sessions (4,531 rural, 6,647 urban) between 1 October 2008 and 30 June 2011, representing an increase of 4,282 sessions (from 6,910 sessions; 2,184 rural and 4,726 urban) reported since the October 2008 to January 2011 period.²⁸ 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, by January 2010 an additional two projects had provided data, and by June 2010 one more project provided data. By the time of this current report, all 19 Divisions had provided data to the minimum data set.

Figure 1 shows referrals and sessions by month for the 19 participating Divisions from 1 October 2008 to 30 June 2011. Figures 2 and 3 show these referrals and sessions by month broken down into rural and urban projects.

After a slow start in late 2008 the number of sessions and referrals nationally has been relatively stable with some fluctuation, and a peak of referrals and sessions in early 2011. Urban referrals and sessions mirror this pattern. However, projects in rural areas continued to fluctuate throughout 2009 and then steadily increased in the number of referrals and sessions to a peak in January 2011. Overall, there were a greater proportion of referrals (63%) and sessions (59%) in urban compared to rural areas. The decline in all areas in the last quarter is likely to be attributable to data entry lags.

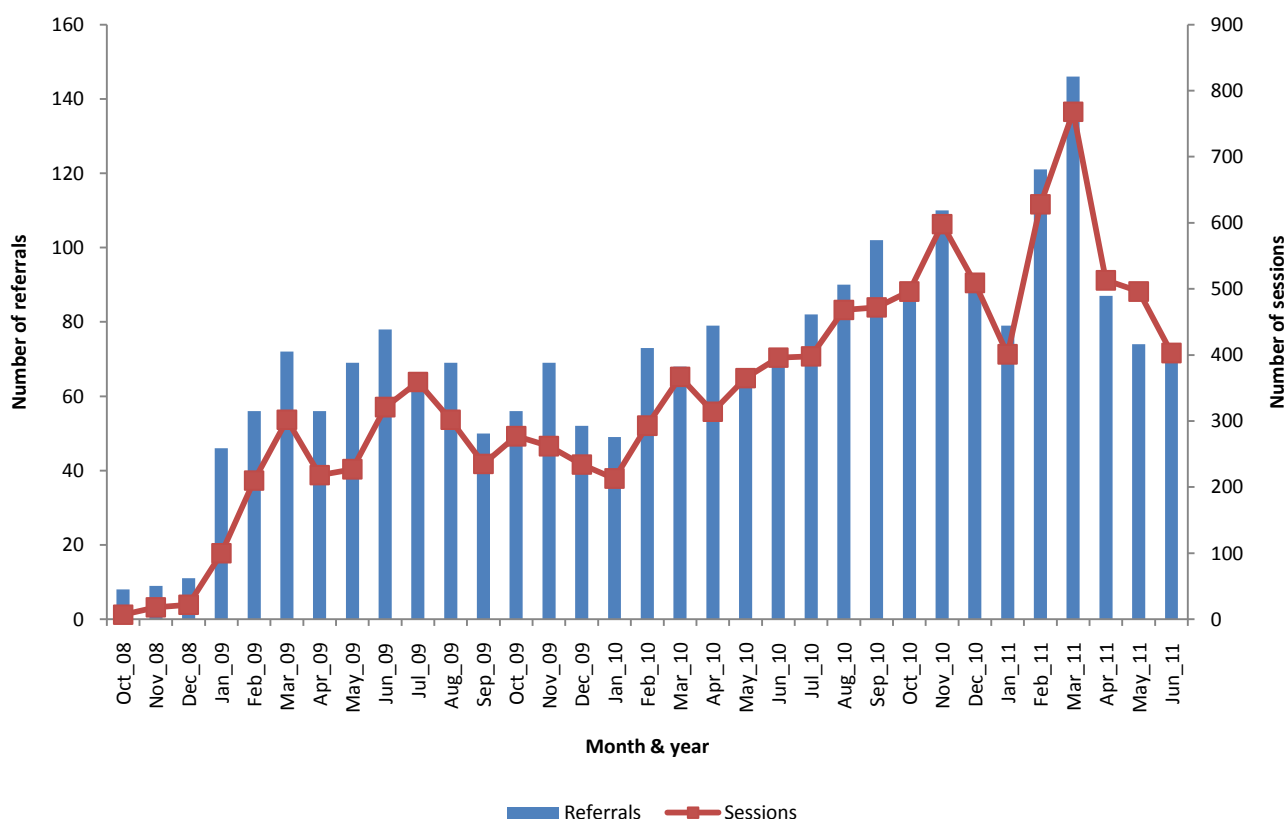


Figure 1: Referrals for sessions of care through the Specialist Services, by month (all participating Divisions).

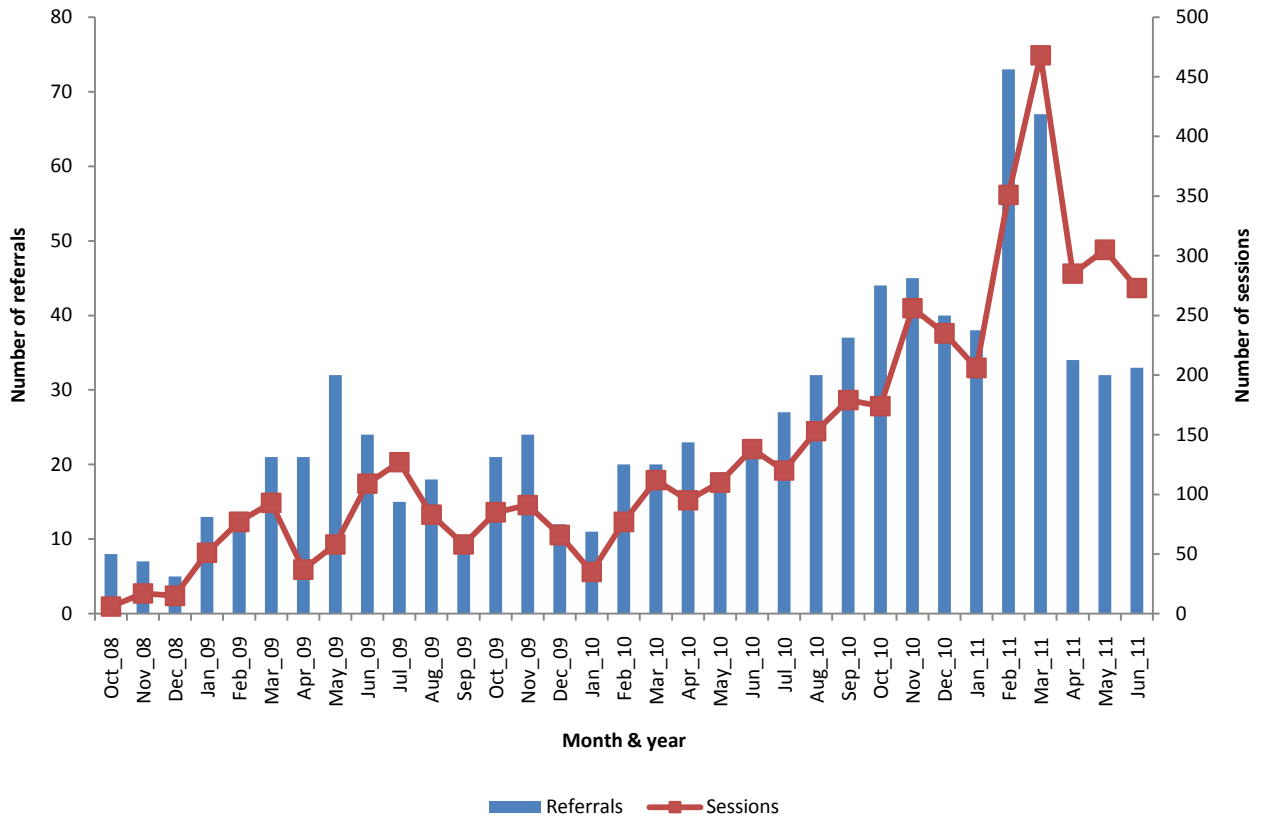


Figure 2: Referrals for sessions of care through the Specialist Services, by month (rural Divisions).

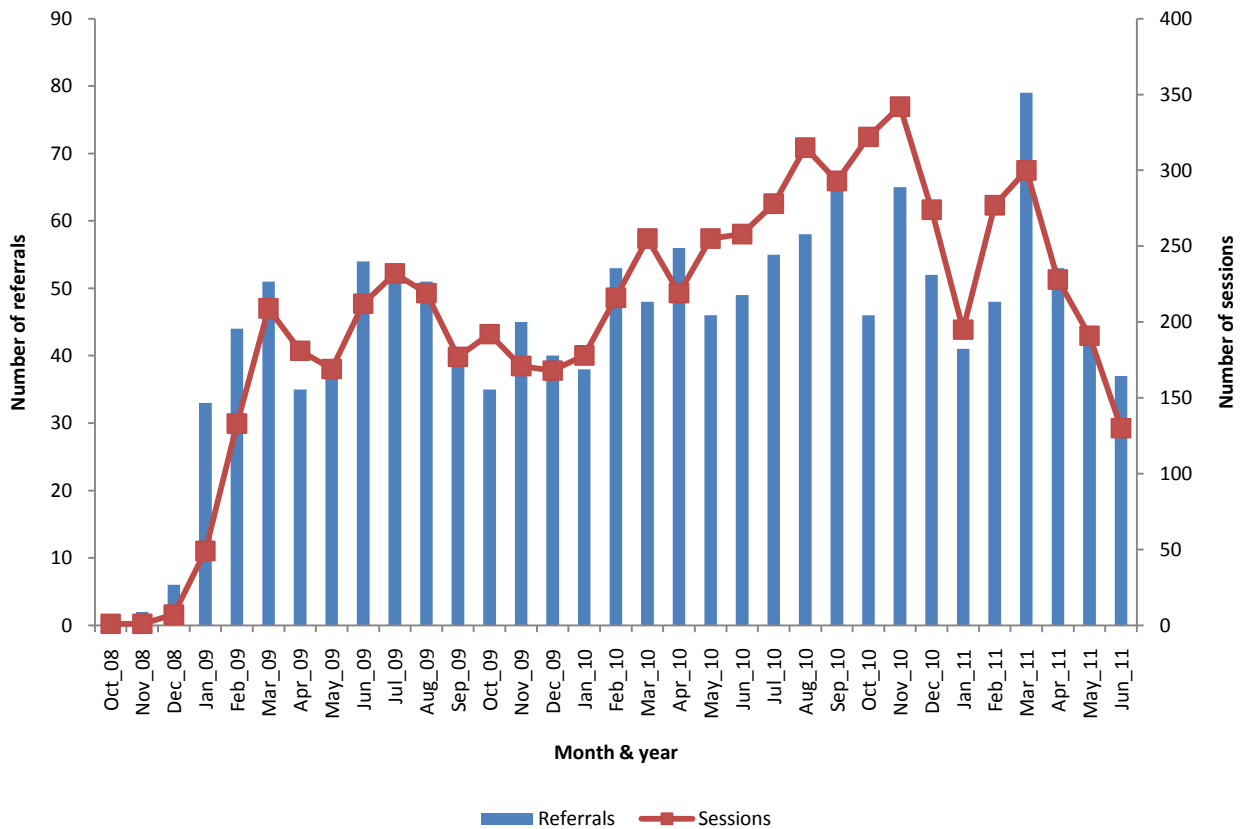


Figure 3: Referrals for sessions of care through the Specialist Services, by month (urban Divisions).

Length of time between referral and first session

A stipulation of the Specialist Services is that the treating 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 (see Table 1). The time lapsed between referral and first session was examined using the MDS data. It is important to note that, unlike general ATAPS, it is possible for consumers to receive their first session prior to having a formal GP referral.

There were 2,805 first sessions entered onto the MDS during the Specialist Services pilot projects. Seventy five percent of these first sessions occurred between 7 days prior to a formal referral being made and 21 days after the formal referral was made. Data indicated that 3% of first sessions took place up to seven days prior to a formal referral being made. Consumers were seen on the day of their referral in 23% of cases and 37% were seen between 1 and 3 days after the referral was made. A further 18% of consumers were seen four to seven days after the referral was made and 18% eight to 21 days after the referral was made. Overall these figures account for 75% of first sessions, the remaining 25% of first sessions are very scattered over time (i.e. up to 365 days prior to a formal referral and 365 days after a formal referral was made) and it is almost impossible to explain the reasons for this, other than to say that a certain number of these would seem to have longer timeframes between the initial referral and first session than was stipulated by the guidelines and are most likely due to data entry error.

Modality of first session

An analysis of the modality of these first sessions shows that 72% (2,009) of sessions were face to face, 15.4% (433) were delivered via the telephone, a small number were delivered via video conferencing or the web (17 and 4 sessions respectively), 342 sessions did not have the modality of the session entered into the MDS.

Thus in summary, according to the MDS data, 63% of consumers were either seen or telephoned by the AHP prior to the formal referral or within 3 days (72 hours) of the referral.

Chapter 4: What are the socio-demographic and clinical profiles of consumers accessing the Specialist Services pilot?

Table 4 summarises some of the key characteristics of the consumers receiving care through the Specialist Services pilot between 1 October 2008 and 30 June 2011, displaying data at the national, rural, and urban levels. Please note that as mentioned previously data that was 'missing' (i.e. not supplied) in the minimum dataset has been omitted from these and all other analyses in this report.

Nationally, around three-fifths of consumers of the Specialist Services were female, and their mean age was approximately 33 years, with a standard deviation of 14 years and a range of between 6 and 88 years. Over half were on low incomes, as judged by their GP. About one third of the consumers had not previously accessed mental health care. Two percent of consumers were reported to be Aboriginal, and less than 1% Torres Strait Islander. Rural and urban consumers were similar in the main, with low income and Aboriginal status being reported slightly more frequently in rural compared to urban areas (60% vs. 54% and 3.6% vs. 1.2%), and previous psychiatric service use reported slightly more frequently in urban compared to rural areas (43% vs. 39%)

The diagnostic field was completed, according to one of the six categories on the minimum dataset (including 'unknown' and 'no formal diagnosis'), for 64.4% (n = 1,490) of the 2,312 referrals made. For these 1,490 referrals, the vast majority had been diagnosed with depression (87%) and about one third had been diagnosed with anxiety. There were very few reporting of 'no formal diagnosis' (0.2%), despite this being a unique feature of the suicide pilot service. 'Other diagnosis' was selected for 444 (19%) referrals, with many but not all of the free-text descriptors being indicative of variants of suicidal ideation or behaviour or self-harm. The reported diagnoses varied little between rural and urban areas.

In comparison to national Tier 1 ATAPS consumers,³¹ overall the consumers at risk of suicide were younger (33 vs. 39) and less likely to be female (62% vs. 70%). Specialist services consumers were also less likely to be on a low income (56% vs. 64%) or to be Aboriginal (2% vs. 3.1%) than Tier 1 consumers. Previous use of psychiatric services is more ambiguous for Specialist Services compared to Tier 1 consumers. If diagnosed, consumers at risk of suicide were more likely to have a diagnosis of depression (87% vs. 76%) and less likely to be diagnosed with an anxiety disorder (37% vs. 57%) than Tier 1 ATAPS consumers. Although a relatively small number of consumers of both Tier 1 ATAPS and of the Specialist Services had been diagnosed with psychotic disorders, the proportion of Specialist Services consumers with a psychotic disorder was twice that of the Tier 1 ATAPS consumers (4% vs. 2%).³¹

Table 4: Summary characteristics of consumers receiving care through the Specialist Services pilot

	National	Rural	Urban
Gender			
Female	62.2%	60.7%	63.1%
Male	37.8%	39.3%	36.9%
Mean age	33.2	32.6	33.6
Low income			
Yes	56.2%	59.8%	54.0%
No	17.1%	15.5%	18.1%
Unknown	26.7%	24.7%	27.9%
Previous psychiatric service use			
Yes	41.8%	39.1%	43.4%
No	33.1%	30.7%	34.5%
Unknown	25.1%	30.2%	22.1%
Aboriginal			
Yes	2.0%	3.6%	1.2%
No	75.0%	68.8%	78.3%
Unknown	23.0%	27.6%	20.5%
Torres Strait Islander			
Yes	0.4%	0.6%	0.3%
No	75.8%	71.6%	78.1%
Unknown	23.8%	27.8%	21.6%
Diagnosis^a			
Alcohol and drug use disorders	7.7%	6.6%	8.1%
Psychotic disorders	4.1%	2.8%	4.7%
Depression	86.6%	84.9%	87.4%
Anxiety disorders	36.7%	36.5%	36.7%
Unexplained somatic disorders	0.9%	1.1%	0.8%
Unknown	3.2%	4.4%	2.6%
No formal diagnosis	0.2%	0.7%	0%

a. Multiple responses permitted

Chapter 5: What is the precise nature of the care being delivered via the Specialist Services pilot?

In total 11,192 sessions (41% rural and 59% urban) of care were provided through the Specialist Services pilot to 2,070 of the referrals made. This makes the average number of sessions per referral 5.4. While this represents a slight increase in the average number of sessions delivered as at January 2011, it is likely to be an underestimate as projects differ in their ability to identify re-referrals for the same consumer (i.e., the continuation of sessions following the GP review) which means they may inadvertently assign a given consumer both a new patient identification and referral number after the initial six sessions. The profile of these sessions is shown in Table 5 detailing national, rural, and urban data.

Almost all sessions comprising the Specialist Services pilot were delivered to individuals. Nationally sessions of 46-60 minutes accounted for 70% of Specialist Services delivered and approximately 17% of sessions were of over one hour in duration. More Specialist Services sessions conducted in rural areas were 30 minutes or less when compared with urban areas. Nationally, while the vast majority of sessions were delivered face-to-face, around 9% of all sessions were delivered via telephone and videoconferencing was also infrequently used in rural areas.

Overall CBT-cognitive interventions were most commonly delivered in the Specialist Services pilot. The next most commonly used interventions in rural areas were CBT-skills training and in urban areas diagnostic assessment.

Almost all of the sessions were delivered without a copayment. A copayment (of \$10 each) was charged for only 21 of the 6,157 Specialist Services sessions where this data was recorded.

In comparison to the sessions delivered via the national Tier 1 ATAPS projects,³¹ Specialist Services sessions were more likely to be: under or over 60 minutes in duration; delivered to individuals rather than groups; and more likely to be delivered using the telephone.³⁰ In addition, Specialist Services sessions were less likely to incur a copayment or to involve psycho-education, CBT-behavioural interventions, CBT-cognitive, CBT-relaxation strategies and interpersonal therapy.³¹ There was a roughly equivalent and low rate of non-attendance at sessions via both the Specialist Services and Tier 1 ATAPS.³⁰

Table 5: Summary characteristics of sessions provided to consumers through the Specialist Services pilot

	National	Rural	Urban
Duration			
0-30 mins	12.2%	14.8%	10.4%
31-45 mins	1.4%	2.3%	0.9%
46-60 mins	69.5%	65.5%	72.2%
Over 60 mins	16.9%	17.4%	16.5%
Type			
Group	0.5%	0.2%	0.6%
Individual	99.5%	99.8%	99.4%
Modality			
Face-to-face	90.5%	88.4%	91.6%
Telephone	9.3%	11.4%	8.1%
Videoconferencing	0.2%	0.1%	0.3%
Copayment			
Yes	0.3%	0%	0.5%
No	99.7%	100%	99.5%
Average copayment	\$10	-	\$10
Interventions^a			
Diagnostic assessment	21.8%	12.8%	27.2%
Psycho-education	14.2%	16.7%	12.8%
CBT Behavioural interventions	24.6%	21.8%	26.3%
CBT Cognitive interventions	42.7%	40.7%	43.9%
CBT Relaxation strategies	12.7%	14.1%	11.8%
CBT Skills training	17.4%	27.0%	11.7%
Interpersonal therapy	19.2%	17.2%	20.3%
Narrative therapy	0.3%	0.6%	0.3%
No show	6.2%	5.8%	6.4%

a. Multiple responses permitted

Chapter 6: What are the consumer outcomes being achieved by the Specialist Services pilot?

Number of consumers with outcome data

Investigation of all the available outcome data indicated that 328 (14%) of consumers had pre- and post-treatment scores on at least one outcome measure, which is consistent with the level of treatment scores provided in Tier 1 ATAPS.³² Table 6 describes the number of outcome measures used to assess each consumer. Of the 328 consumers, 245 had been assessed with the Modified Scale for Suicidal Ideation (MSSI), 128 with either the Depression, Anxiety and Stress Scales (DASS) 21 or 42 item version, and 102 with the Kessler 10 (K10). Therefore, the DASS and K10 are also described, analysed and reported. Seven consumers with pre- and post-treatment outcome data from five other outcome measures were excluded from the analyses due to insufficient data.

Table 6: Number of outcome measures available for consumers with pre- and post-treatment outcome data

Number of outcome measures	Number of consumers	Percent of consumers
1	195	59.5
2	5	1.5
3	30	9.1
4	50	15.2
5	48	14.6
Total	328	100.0

Description of most commonly used outcome measures

Modified Scale for Suicidal Ideation

In order to assess consumer outcomes for the Specialist Services, projects were advised to use the MSSI.³³ This measure represents a modified version of the psychometrically validated Scale for Suicidal Ideation (SSI) developed by Beck and colleagues (1979)³⁴, for administration and scoring by clinicians, to increase its utility by allied health professionals and researchers.

The MSSI is comprised of 18 items, 13 from the original SSI and five that are new, the first four of which serve as screening items. Consumers reporting a moderate or strong wish to die (Item 1) or no or weak desire to live (Item 2) or any desire to make an active (Item 3) or passive (Item 4) suicide attempt are considered to have sufficient ideation to merit administration of the entire scale, while consumers who do not meet this criterion are considered to have no suicidal ideation and are not administered the rest of the scale. Each of the 18 items is rated on a four point Likert scale ranging from 0 to 3, which are summed to yield a total score ranging from 0 to 54, with negative items reverse scored so that higher scores indicate higher suicidal ideation. Total scores from 0-8 indicate 'Low Suicidal Ideation', 9-20 indicate 'Mild-Moderate Suicidal Ideation' and 21+ indicate 'Severe Suicidal Ideation'.

The MSSI was selected as the outcome measure of choice on the grounds of: proven psychometric properties; the SSI informing its development; being freely available; its ability to be administered by all allied health professionals, not just psychologists or GPs; its reasonable length; its contents being likely to form part of clinical risk assessment; and its likely sensitivity to detect change given that it assesses suicidal ideation in the previous 48 hours.³³

Depression, Anxiety and Stress Scales

Both the DASS 21 item and 42 item scales, have three subscales - depression, anxiety, and stress - that are equivalent as the subscales of the 21-item version are simply doubled to be interpreted on the same scale as the 42-item scale.³⁵ Each of the DASS subscales is considered independently as it is not considered clinically meaningful to interpret a total score. The consumer is asked to rate the extent to which each of the statements applies to him- or her-self 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'). A total score for each subscale is derived by summing the individual items comprising the respective subscales, ranging from 0 to 42, with higher scores indicative of worse symptomatology. Specifically, scores on each of the subscales are classified from normal to extremely severe, with the scores for the various severities shown in Table 7.

Table 7: Score interpretation for each of DASS subscales

Classification	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely severe	28+	20+	34+

Kessler-10

The K10 is a 10-item consumer rated measure designed to assess non-specific psychological distress.³⁶ The consumer is asked 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'). The items are summed to produce a total score that ranges from 10 to 50, with higher scores indicative of higher distress.³⁷ Specifically, total scores from 10-19 indicate 'Likely to be well', 20-24 'Likely to have a mild disorder', 25-29 'Likely to have a moderate mental disorder', and 30-50 'Likely to have a severe mental disorder'.

Change in pre- and post-treatment outcome scores

Table 8 shows the mean pre-treatment, mean post-treatment and mean difference in pre- and post-treatment scores on the MSSSI, the three DASS subscales and the K10. A positive difference between pre- and post-treatment is indicative of improvements in symptoms on all of the scales. Across all measures, the mean difference was statistically significant and indicative of clinical improvement suggesting that the Specialist Services pilot has achieved positive consumer outcomes.

Table 8: Pre- and post-treatment outcome scores on available outcome measures for patients receiving care through the Specialist Services pilot

Outcome Measure	n	Pre-treatment		Post-treatment		Difference	
		Mean	s.d.	Mean	s.d.	Mean	s.d.
MSSI	245	11.1	11.3	2.5	5.3	8.6	10.2*
DASS-Anxiety	128	18.0	10.4	9.9	8.1	8.1	10.1*
DASS-Depression	128	26.4	11.0	12.0	9.4	14.4	12.3*
DASS-Stress	125	24.0	11.1	13.3	9.4	10.7	11.9*
K10	102	34.7	7.9	23.2	9.4	11.5	9.9*

N.B. Each of the DASS subscales is completed as one measure and therefore these represent the same consumers on all three subscales.

* p < 0.001.

Chapter 7: How have Divisions experienced the Specialist Services Pilot?

Divisions' experiences of the Specialist Services pilot were explored through an in-depth standardised phone interview with project officers or service managers of the 19 Divisions involved in the pilot. The interview focussed on: how the pilot had been operationalised within Divisions, key achievements, how any barriers or challenges had been managed, relationships with emergency departments and mental health services, the mandatory allied health professional (AHP) training, factors that facilitated and acted as a barrier to the services, suggestions for the ongoing evaluation of the services and the use of the outcome tool (the MSSI).

How were the Specialist Services operationalised?

The service delivery models used by Divisions varied in terms of how allied health professionals (AHPs) were engaged and how referrals were received and managed.

Engagement of allied health professionals

Divisions reported one or more methods of AHPs. Eight Divisions contracted AHPs. Eight Divisions employed AHPs. One Division commented that the employment model was preferable as it was perceived to provide a better opportunity for the Division to ensure that sessions delivered were cost effective, of a high quality, within the stipulated guidelines, and that consumer risk was appropriately managed.

Three Divisions had contracted agencies to manage their Specialist Services; for two of these Divisions the agency was Headspace, the other was a private psychology practice.

Referral sources

In terms of referral sources, four Divisions decided to only receive GP referrals, and did not promote the ability of other professionals to refer to the Specialist Services. In these cases, this decision had been made as the Divisions were either concerned about: inappropriate referrals and being '*inundated by referrals*', or were unwilling to further promote the service whilst the permanency (i.e., funding) of the Specialist Services was unknown.

Referral mechanisms

Four Divisions used a service model that involved direct referral from GPs, or other referrers, to AHPs. In this model, the referrer contacted the AHP directly and the AHPs took the responsibility for contacting the consumer within the prescribed 72 hours.

Eleven Divisions managed referrals through a centralised, Division-based, intake system which was usually staffed by an AHP and less commonly staffed by an administration person. In these instances the Division usually took the responsibility for contacting the consumer within the first 72 hours. Most of these Divisions had a group of employed AHPs who provided both their Tier 1 ATAPS and the Specialist Services. Three of these Divisions supplied an AHP appointment everyday that could be used for the initial appointment for the Specialist Services.

After hours referrals

Only two Divisions reported that they had received after hours referrals, with most Divisions advising GPs and other referrers to make referrals during business hours and to direct consumers to the relevant state mental health services or to the afterhours telephone support line provided by the Specialist Services. One Division provided an answering machine to receive referrals over the weekend, which was checked by an

AHP. Another Division, which had developed a quite different service model, employed a mental health nurse who was providing triage at the local hospital emergency department over the weekend only.

What were the key achievements of the Specialist Services as seen by Divisions?

Divisions reported a number of key achievements of their Specialist Services which largely focused on the benefits provided to consumers, the support provided to GPs, links with mental health services, and the development of policies and a service framework.

Benefits to consumers

Nine of the 19 Divisions commented on the perceived benefits to consumers provided by the Specialist Services. Divisions commented on their ability to '*fill a significant gap that has been much needed in the community*' and to '*do some preventative work*' with a group of higher risk consumers. They also commented on the high quality of the service provided as it was '*responsive*' and '*very very supportive*'.

Benefits to GPs

Seven of the Divisions commented on the benefits to GPs not only in giving them a new service option for a demanding group of consumers, but also in increasing their skill and confidence in working with these consumers. As one Division commented: '*prior they would refer to the mental health unit. The mental health unit would say no and doctors had no option. Now they have us. The doctors are happy they can refer and that patients are contacted straight away. It's a good system*'.

Links with mental health services

Five Divisions reported on the links they had worked to establish with the state mental health services. For many this had required great persistence and was seen as a '*major achievement*' and a '*real strength*' of the services.

Development of policies and a service framework

Two Divisions commented on their achievements in developing '*a really solid clinical base and framework in how to work with these people*'. This was seen as beneficial to the Division and '*actually minimised Division's risk*' in working with these consumers.

How did Divisions overcome any initial challenges and barriers to the Specialist Services?

Divisions were asked how they had overcome the initial challenges and barriers experienced, as reported in our first interview with them in the early stages of the Specialist Services in July 2009. In the first interview Divisions reported a range of barriers in implementing the Specialist Services. Divisions spoke at that time about the barriers posed by: the need to establish operating policies and procedures around this new consumer group, engaging GPs and AHPs in the services, the requirement of AHPs to undergo training, and building relationships with the new mental health referrers.²⁰ In the current interview, many of the Divisions reported that they had been able to successfully overcome the initial 'teething problems' associated with the implementation of the new Specialist Services.

Development of policy and procedures

In the current interviews all of the Divisions reported that the administrative barrier of establishing policy and procedures was no longer an issue and nearly all had settled on a service delivery model that they felt was working well for the Division, AHPs and consumers. A few Divisions reported that they were in the process of reviewing policies in light of their learnings from the Specialist Services over the past few years. Conversely, two Divisions now viewed the opportunity to develop '*a really strong clinical base and framework in how to work with these people*' not as a barrier but as a key achievement of the Specialist Services.

Engaging GPs

Eight of the Divisions reported that engaging GPs in the Specialist Services had been an initial barrier to the success of the Specialist Services. Some Divisions reported that this was still an ongoing issue due to the high turnover of GPs or the tendency of busy GPs to forget about the service in amongst the large amount of information they receive. Many Divisions reported that they had overcome this through regular and continued promotion of the Specialist Services to GPs. One Division said that overtime they had been able to demonstrate the quality of the services to GPs, which had resulted in increased referrals. Another Division had established an 'e-referral system' that was web based and enabled GPs to more easily make referrals. Another Division had offered and provided mental health skills training to GPs to increase their specialist skills.

Engaging AHPs

Six Divisions reported that engagement of AHPs was an initial barrier, with AHPs reluctant to do the training or work with this particular consumer group. Four Divisions reported that the quality of the training continued to be an issue for their AHPs, with one reporting that some of their AHPs had ceased their involvement in the Specialist Services due to this. Divisions had dealt with AHPs' hesitancy to work with the consumer group in a number of ways. One Division had dealt with this issue by developing 'a clinical governance framework' with guidelines, policy, supervision, and triage. This framework acted to support AHPs who were now all comfortable with providing the Specialist Services. Another Division provided AHPs the flexibility to 'opt out' of the Specialist Services for a while if needed 'because of the huge demand it places on their service' and then to 'opt in' when 'they feel that their workload is more manageable'. For a few other Divisions these issues had simply disappeared over time.

Relationships with the new mental health referrers

Three Divisions reported that linking with the mental health services had been challenging, and that not all mental health services had been receptive to their efforts. Divisions reported that they had found more success in developing individual relationships between staff members rather than through working on policies or service agreements between the services. Seven of the 19 Divisions now reported that they had a close effective working relationship with at least one of their local state mental health services.

Other barriers and challenges

One Division spoke of the challenge in delivering services in a rural area. They had overcome this barrier by implementing a service delivery model which enabled their AHP to travel to GP clinics to deliver services to consumers in different areas. However, they reported that the use of this model had led to increased session costs.

Do Divisions have arrangements in place to refer people at acute and immediate risk to themselves or others to crisis services?

Eleven of the 19 Divisions reported that there was a Division created policy about referring people at acute or immediate risk to themselves or others to the relevant crisis service. It was reported that generally the policy would state how a GP or AHP should act in this instance. Divisions reported varying degrees of involvement of crisis mental health services in these policies. One Division reported that they had 'an agreement with the Acute [Mental Health] Crisis Team'. Five Divisions reported that they had close relationships with the state mental health services which facilitated referrals for people at immediate risk to themselves. One Division reported that the mental health services 'didn't want to enter any new agreement with us'.

For other Divisions the arrangement to refer people at acute and immediate risk to themselves or others was entirely dependent on GP and/or AHP clinical judgement. Assumedly the referral process would then be based on individual relationships between GPs, AHPs and the relevant crisis services.

How have Divisions developed and maintained linkages and referral pathways with emergency departments and mental health services?

As previously mentioned, four Divisions had chosen only to receive referrals from GPs due to concerns about inappropriate referrals or becoming 'inundated' with referrals. As such, although they each reported some interactions with emergency departments and mental health services, they had not as yet worked on further developing these relationships.

Other Divisions reported varying successes in developing linkages and referral pathways with emergency departments and mental health services. A number of Divisions had found that emergency departments and mental health services were not receptive to their attempts to develop their relationships. One Division commented that *'a lot of it hangs on the person on the other end...we've tried to develop referral pathways, but a lot of it is personally based'*. Another Division similarly commented on the difficulties of building linkages when this is based on personal relationships: *'we had several meetings but our contact went on sick leave'*. Another Division commented on the difficulties establishing service boundaries with these other mental health care providers: *'It's an ongoing problem because the mental health service are worried that we are taking a piece of their work or client population'*.

Divisions who reported successful working relationships with emergency departments and mental health services were putting a substantial amount of time and energy into creating and maintaining these relationships. Successful working relationships seemed to be based on a combination of formal meetings, co-attendance at various mental health meetings and committees, regular formal and informal contact between managers, as well as individual relationships between clinicians. One Division reported: *'we improved links through building awareness and promoting the program'*.

What were the responses from GPs who had been asked by the Division to formally refer consumers who had been provisionally referred by an emergency department?

None of the Divisions reported any negative feedback from GPs who had been asked to formally refer consumers who had been provisionally referred by an emergency department. Five Divisions reported that this was not relevant as it had not been occurring. Two Divisions reported that they had received no feedback. The remaining 12 of the 19 Divisions reported that the response of GPs to the Specialist Services, and their role in referring, was positive. As one Division commented: *'GPs know the service and are happy to refer'*. Another Division commented that GPs are *'happier with the more efficient service and support'*. Two Divisions reported some issues with this referral pathway. One rural Division commented that the rural GPs *'didn't want to risk their duty of care, didn't engage in referring'*. Another commented that in their local area a lot of consumers didn't have a regular GP, which was *'definitely a barrier, sometimes people don't go to the GP'*.

What were Divisions' experiences with the APS training for allied health professionals?

All of the Divisions reported that their AHPs had completed the mandatory training for the Specialist Services. Five Divisions reported that the feedback from AHPs had been positive and that they had found it *'useful'* and *'appropriate'*. Nine Divisions reported that they had received negative feedback. They commented that AHPs had found the training to be *'poor'*, *'boring'*, *'not much transferable into practice'*, and that *'they were affronted by the base level of the training'*. The remaining Divisions had not received

any feedback from AHPs regarding the training. As mentioned previously, four of the 19 Divisions had cited this issue as a barrier to the engagement of AHPs in the Specialist Services.

What factors facilitated the effective operation of the Specialist Services?

Divisions spoke about a range of factors that had facilitated the effective operation of the Specialist Services.

Relationships between the Division, AHPs, and the referrers

Six Divisions mentioned the relationships between the Division, allied health professionals, GPs, and state mental health services. If these relationships were working well with good communication and information sharing, then it seems that the introduction of the new Specialist Services ran more smoothly. Divisions spoke of the facilitating effect of having: *'close liaison between GPs and providers'*, *'networking and the relationships we've been able to build'*, and *'communication and the relationship between the emergency department and the Division'*. Some of these relationships predated the Specialist Services, whilst other Divisions worked to establish these during the course of the pilot.

Flexibility of the services

Five Divisions indicated that the flexibility of the Specialist Services was of great benefit to the consumer and also allowed Divisions to more easily integrate them with their other mental health services. For example, as one Division said: *'it's a wonderful way to manage patients at high risk. For example, if we have a client who is suicidal in the alcohol program we can take them off the alcohol program and offer them a specialised suicide resource, and once they are better they can come back'*. Another Division also commented on the flexibility offered: *'the flexibility around the number of sessions and timing of sessions. Better able to meet persons' needs. Clinicians had a bit more flexibility to use session time to arrange things for them. It is more practical'*. Another commented on the benefit in consumers being able to *'access as much as they like for two months'*. An immense benefit was conferred by the fact that consumers could move from the Specialist Services to Tier 1 ATAPS services and vice versa.

Allied health professionals

Two Divisions spoke about the pivotal role of the AHP in the success of the Specialist Services. As one Division said, *'AHPs are the movers and shakers of the program. Having good providers works well'*. Another Division similarly commented: *'lots of clinicians can provide lots of support. It added on to an already strong ATAPS team'*.

General practitioners

Three Divisions commented on the role of the GP in the success of the Specialist Services. Having GPs who were willing to be involved and who took the service on board were seen as important facilitating factors. One Division commented on the importance of a trusting relationship between the Division and GPs: *'they trust us, and when we introduced suicide they trusted us'*. Another Division commented on the usefulness of having a Division run event in which a GP *'spoke about how great it is'*.

Division based administrative support

Two Divisions commented on the facilitating effect of having quality mental health administration support within the Division. As one Division commented, *'we have a very good admin person. She's the front line. Approachable, thorough'*.

Other factors that were seen to have facilitated the Specialist Services were the mandatory training provided to AHPs, and also the level of funding, which allowed one Division to employ a full time AHP to service a large rural area.

What factors posed a barrier to the effective operation of the Specialist Services?

When asked about what factors had posed a barrier to the effective operation of the Specialist Services some of the factors raised earlier were raised again, such as the relationship with mental health services, and engagement of GPs. Other barriers were cited such as: inappropriate referrals, the heavy caseload for AHPs, the funding of the services, and the accessibility of the services for all consumers in need. Other factors reported earlier in the interview as being initial barriers to the services, such as the development of policy and procedures and the engagement of AHPs, were not mentioned in response to this question.

Relationships with the mental health services

Seven Divisions spoke about ongoing difficulties in the relationship between the Division and the local state mental health services. Divisions commented on the continued need to work to establish trust with them and to educate them, which was made especially difficult by staff turnover within the mental health services. As one Division said, *'it's taken a while to establish trust. Mental health clinician turnover is a problem, we establish trust and they leave...when the service was introduced mental health services didn't know us'*. One Division spoke about the shortage of psychiatric services in their local area, resulting in few referral options for GPs. Another Division commented on the difficulties getting the mental health services to engage with the Division supposing that they may feel threatened by the Division's encroachment into their service area.

General practitioners

Five Divisions commented on ongoing issues related to GPs that had posed a barrier to the operation of the Specialist Services. Divisions spoke about the difficulties in engaging GPs in any new program: *'changing GP attitudes to refer to the program takes a long process'*. They also spoke of the continued need to educate GPs to ensure appropriate referrals.

Access for consumers

Five Divisions commented on the limited ability of the Specialist Services to reach all consumers in need. Two Divisions commented on their inability to service people with chronic suicidality, such as consumers with personality disorders. One of these Divisions saw this as a limitation of the services, whilst the other Division had struggled with pressure from GPs and mental health services to service these consumers when they felt that they did not fall within the services' guidelines. Three further Divisions were concerned about restricted accessibility of the service for indigenous people due to cultural barriers and the inability of non-government organisations to refer to the Specialist Services.

Inappropriate referrals

Four Divisions commented on the difficulties related to receiving inappropriate referrals from mental health services and GPs. One Division said that *'it's a struggle to determine appropriate referrals from GPs'* and another commented that GPs were referring high risk clients.

Funding

Four Divisions reported that issues related to service funding had posed a barrier to the success of the Specialist Services. They each commented that they felt the funding was not enough. One of these Divisions commented on the limited access to funding for interpreters. Another Division commented on the *'stop start nature of the funding'* that they felt had prevented them from implementing the Specialist Services to their full potential.

AHP caseload

Two Divisions commented that they were concerned about the heavy and demanding case load for AHPs in the Specialist Services. As one Division said, *'a suicidal client requires a lot of support but the practitioner also has the demands of running a private practice'*.

Suggestions for other data collection for the evaluation

Divisions were asked for their ideas about what other data might be useful to collect for the ongoing evaluation of the Specialist Services. Twelve of the 19 Divisions provided some suggestions. Eight of the Divisions were interested in gaining more information about the broader and longer term impact of the services on individual consumers, local suicide rates and presentations to emergency departments. As one Division suggested, *'linkage data of what happens to the patients from the emergency department to the GP to the Division to the psychologist and thereafter'*.

Two Divisions suggested conducting a survey with allied health professionals. One Division suggested that the incorporation of a field in the minimum data set related to travel time for each session would provide a more accurate representation of service activity for rural areas.

Use of the outcome tool: the Modified Scale for Suicide Ideation (MSSI)

Twelve of the 19 Divisions reported that their AHPs were using the MSSI with consumers. Eleven Divisions reported that they had received feedback from their AHPs about the tool; of these ten said that the feedback was negative. AHPs reported said that the tool: *'was not adding any clinical data', 'doesn't fit with the counselling approach at the time of the first meeting', 'is clinically counter-indicated', 'is clumsy', 'is cumbersome'*. Four Divisions reported that AHPs were using other outcome tools instead such as the Depression, Anxiety and Stress Scale (DASS), the Beck Depression Inventory (BDI), the Beck Anxiety Inventory (BAI), and the Collaborative Assessment and Management of Suicide (CAMS).

Other comments by Divisions

Divisions were asked whether they would like to make any other comments about the Specialist Services. The comments made by the nine Divisions who chose to answer this question were overwhelmingly positive. One of the Divisions who had received over 300 referrals to the Specialist Services made the following comment: *'It is a valuable addition to the suite of services already offered. We were already getting suicide referrals in wider general ATAPS, this allowed us to properly service these people and expand our services. Suicide money allows you to put in a much more comprehensive service. Now there is dedicated time'*. Another Division in a large rural area said, *'in rural areas there is nothing else like it. It's a real benefit'*.

Divisions who had less success with implementing the Specialist Services also had positive comments to make. As one of the Divisions who had received less than 20 referrals said *'the concept is really good, to be able to support people in a vulnerable time. Even if only one person used it, it can be life changing. It was a good service for those who came'*. Another Division commented: *'I think we've learnt a lot and we're now in a better position. We now know what we need to make it better in the future. I think it's a great service'*.

Chapter 8: Discussion and conclusions

Summary and interpretation of findings

The current report provides a summary of the achievements of the Specialist Services for Consumers at Risk of Suicide Pilot since its commencement in June 2008 until its completion in June 2011.

Uptake of the Specialist Services pilot by GPs, emergency departments, allied health professionals and consumers

Between 1 October 2008 and 30 June 2011, 2,312 referrals (857 rural and 1,455 urban) were made to the Specialist Services pilot. Referral source data were available for 2,054 (753 rural and 1301 urban) of these referrals. The majority of referrals came from GPs. Referrals were made by 826 GPs and sessions were conducted by 266 allied health professionals. A substantial number of emergency departments and a small number of community mental health services also referred consumers to the Specialist Services pilot.

From 1 October to 30 June 2011, 11,192 sessions (4,545 rural, 6,647 urban) were delivered, representing an increase of 4,282 sessions since January 2011. Overall, and consistent with Tier 1 ATAPS there were a greater proportion of referrals (63%) and sessions (59%) in urban compared to rural areas. Referrals and sessions reached a peak in early 2011. The greatest increase in referrals and sessions occurred in the last six months of the pilot.

The increase in referrals and sessions is in part attributable to the fact that this is the first evaluation report for the Specialist Services wherein all 19 participating Divisions have supplied data to the minimum dataset. In the time period October 2008 to July 2009 only fifteen projects had provided data to the minimum data set regarding the Specialist Services, by January 2010 an additional two projects had provided data, and by June 2010 one more project provided data. By the time of this current report, all 19 Divisions had provided data to the minimum data set. Some Divisions experienced some technical problems with data entry for the Specialist Services that were only recently resolved. It is also likely that as the pilot neared its completion, Divisions were more conscientious about entering data into the minimum dataset.

These considerations aside, the recent peak in referrals and sessions may also be reflective of the growing momentum of the Specialist Services as they become more firmly establishment as a mental health treatment option within Divisions. It may also be that as other ATAPS treatment options have been introduced through the Tier 2 funding (in July 2010), that this has raised Divisions', GPs' and allied health professionals' awareness and they are therefore more likely to consider alternative treatment options to Tier 1 or 'general' ATAPS.

In regards to the requirement for the treating allied health professional 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; the data indicated that in 60% of cases a session was received by a consumer within three days of the referral being made. The first session of care was delivered face to face in 72% of cases. However, the interview data suggested that many consumers are contacted by phone within 72, or even 24 hours, following referral and it is unknown whether all allied health professionals are entering this first phone contact as a 'session' into the minimum dataset.

Sociodemographic and clinical profiles of consumers of the Specialist Services pilot

Nationally, around three-fifths of consumers of the Specialist Services were female, their mean age was approximately 33 years and over half were on low incomes. About one third of the consumers had not previously accessed mental health care. Two percent of consumers were reported to be Aboriginal, and less than 1% Torres Strait Islander. Rural and urban consumers were similar in the main, with low income and Aboriginal status being reported slightly more frequently in rural compared to urban areas and previous psychiatric service use reported slightly more frequently in urban compared to rural areas.

For the 64% of referrals with diagnostic information supplied, nearly ninety per cent had been diagnosed with depression and about one third had been diagnosed with an anxiety disorder. There were very few reports of 'no formal diagnosis' despite this being a unique feature of the suicide pilot service. The reported diagnoses varied little between rural and urban areas.

The profile of the consumers of the Specialist Services for Consumers at Risk of Suicide pilot has been relatively stable over the course of the pilot. In comparison to national Tier 1 ATAPS consumers overall the consumers at risk of suicide were somewhat younger and less likely to be female. This data suggests that the Specialist Services pilot has been successful in reaching more male consumers and younger consumers. This is encouraging as Australian suicide data indicates that suicide rates are higher in males and comprise a much higher proportion of total deaths in younger age groups compared with older age groups.³⁸

The data suggests that the Specialist Services could improve their accessibility for indigenous people who may be at increased risk of suicide. National suicide data indicates that suicide accounted for 4% of all indigenous deaths as compared to 1.5% of all deaths in Australia in 2009,³⁸ however the consumers of the Specialist Services pilot were less likely to be Aboriginal when compared to Tier 1 ATAPS consumers. Consumers of the Specialist Services were also less likely to be on a low income.

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 their Tier 1 ATAPS counterparts.

Nature of the care delivered by the Specialist Services pilot

In total 11,192 sessions (41% rural and 59% urban) of care were provided through the Specialist Services pilot to 2,070 of the referrals made. This makes the average number of sessions per referral 5.4. This is slightly higher than the average of 5.2 sessions demonstrated in Tier 1 ATAPS.³⁰ However, as with Tier 1 ATAPS, it is likely to be an underestimate as projects differ in their ability to identify re-referrals for the same consumer (i.e., the continuation of sessions following the GP review). There was about an equivalent and low rate of non-attendance at sessions via both the Specialist Services and Tier 1 ATAPS.³²

Almost all sessions comprising the Specialist Services pilot were delivered to individuals. Nationally sessions of 46-60 minutes accounted for 70% of Specialist Services delivered and approximately 17% of sessions were of over one hour in duration. More Specialist Services sessions conducted in rural areas were 30 minutes or less when compared with urban areas. Nationally, while the vast majority of sessions were delivered face-to-face, the proportion of telephone sessions was much higher at 9% than is found for Tier 1 ATAPS (0.2%). This is perhaps not surprising given the flexibility afforded to AHPs in these services to provide a more intensive and responsive service to consumers and is also consistent with the interview data which indicated that Divisions were having more phone contact with these consumers.

Overall CBT-cognitive interventions were most commonly delivered in the Specialist Services pilot. The next most commonly used interventions in rural areas were CBT-skills training and in urban areas diagnostic assessment.

Co-payments were rarely charged with the vast majority of consumers receiving a free service. A copayment (of \$10 each) was charged for only 21 of the 6,157 Specialist Services sessions where this data was recorded. This level of reported copayment indicates that the Specialist Services are likely to be accessible to those on low incomes or in a time of crisis. Despite this however, consumers of the Specialist Services were somewhat less likely to be on a low income than Tier 1 consumers (56% vs. 64%).³²

Outcomes of the Specialist Services pilot for consumers

Investigation of all the available outcome data indicated that 328 (14%) of consumers had pre- and post-treatment scores on at least one outcome measure which is consistent with the level of treatment scores provided in Tier 1 ATAPS. Of the 328 consumers, 245 had been assessed with the Modified Scale for Suicidal Ideation (MSSI), 128 with either the Depression, Anxiety and Stress Scales (DASS) 21 or 42 item version, and 102 with the Kessler 10 (K10). Across all measures, the mean difference was statistically significant and indicative of clinical improvement suggesting that the Specialist Services pilot has achieved positive consumer outcomes.

The experiences of Divisions, GPs, emergency departments and allied health professionals with the Specialist Services pilot

During the implementation of the Specialist Services pilot phone interviews were conducted at three points in time to understand the experiences of the Divisions and professionals involved in delivering the Specialist Services.

1. Divisions - late 2008 to early 2009

In the first interview, conducted between late 2008 and early 2009, Divisions reported on issues associated with the implementation of the Specialist Services. Many Divisions emphasised the need to establish operating policies and procedures around this new client group; they said this was time consuming and had delayed service delivery. Management of consumer risk was a key issue. Issues related to the engagement of GPs, allied health professionals, and new external referrers (i.e. emergency departments and local mental health services) in the Specialist Services were also identified. Despite these challenges, most Divisions reported positive impacts related to the expansion of ATAPS services to fill a previously existing gap in services for those consumers of medium suicide risk.²⁰

It was reported by Divisions that the models of service delivery for the Specialist Services differed slightly from those of Tier 1 ATAPS. To deliver Specialist Services, project officers reported that allied health professionals were contracted in 68% of cases and directly employed 53% of the time (with a combination of contract and employed in some instances). Allied health professionals delivered services most often from GP rooms and their own rooms (42% and 32%, respectively). The favoured referral mechanism was direct referral from the GP to the allied health professional.²⁰

2. GPs, emergency departments and allied health professionals - late 2009

When professionals were interviewed in late 2009 about the benefits and disadvantages of the Specialist services pilot, they were generally positive about the projects from their own perspective and the perspective of their clients. Specifically, GPs and emergency department staff were happy with the referral process; they were confident in conducting the assessments and found the process simple to follow. The allied health professionals receiving the referrals reported that generally the referrals were for consumers of mild to moderate suicide risk, which they found to be appropriate. All interviewed professionals indicated that the Specialist Services were a positive new initiative filling a previously unmet need. They highlighted that consumers were receiving an appropriate service in a more timely fashion than was previously available and all without cost to the consumer. It was generally reported that consumers were happy to be offered the service and that they could receive the services very quickly and were happy to be receiving ongoing care.²¹

3. Divisions - reinterviewed mid 2011

Many of the initial 'teething' problems of the pilot reported in the first interview in late 2008 - early 2009 had been overcome. Most Divisions reported that any initial hesitancy experienced by GPs and allied health professionals was no longer an issue. Divisions largely attributed this to increased awareness of the service, and greater confidence of GPs and AHPs with the support provided by the service to both themselves and their patients. Divisions reported that this had been achieved through promotion by the Division, and also through the clinical and administrative support provided by Divisions in generating supportive practice models and tight policy and protocols regarding service provision to this at risk patient group.

However, some Divisions reported that GP engagement was an ongoing issue due to the high turnover of GPs or the tendency of busy GPs to forget about the service in amongst the large amount of information they receive. Many Divisions reported that they overcome this through regular and continued promotion of the Specialist Services to GPs.

Divisions reported a wide range of service delivery models. The model finally settled on by Divisions seemed to largely depend on three factors: the internal resources available within the Division (e.g., the quality and availability of administrative support and leadership), the structure and composition of their allied health workforce, and also the relationships with the local state mental health services (i.e., hospital and community based). For some Divisions these three factors pre-dated the pilot, whilst others worked hard to establish these within the course of the pilot. Needless to say, the Divisions who already had these factors in place found it easiest to integrate a new service into the mix. Other Divisions worked creatively to develop other service models that worked well despite some significant barriers experienced in one or all of these three factors. Finally, there were some Divisions who had less success due to difficulties in these three areas that they were unable to overcome during the time of the pilot.

There was little correlation between the success of Specialist Services (i.e. the number of referrals) and the service model employed (i.e. how AHPs were engaged and how referrals were managed). This suggests that Divisions had developed a model to suit their local context. However, the two Divisions with the highest number of referrals (over 300 each, as compared to between 100 and 200 for other Divisions) were using a centralised Division-based intake system. Both of these Divisions also reported a very strong and effective working relationship with their state mental health services, which seemed to be a key factor in the success of their Specialist Services.

Divisions who reported successful working relationships with emergency departments and mental health services were putting a substantial amount of time and energy into creating and maintaining these relationships. Successful working relationships seemed to be based on a combination of formal meetings, co-attendance at various mental health meetings and committees, regular formal and informal contact between managers, as well as individual relationships between clinicians.

Most of the Divisions reported that there was a Division created policy about referring people at acute or immediate risk to themselves or others to the relevant crisis service. However, this policy was rarely reported to be agreed upon by mental health services, instead often relying on organisational and individual relationships between the services.

Divisions commented negatively on the mandatory training for AHPs, which was largely found to be too basic and not applicable enough to practice. It may be timely then to reconsider the usefulness of the training for professionals. Divisions also commented negatively on the use of the MSSSI tool, which some AHPs found to be difficult or inappropriate to use. However, despite this negative feedback about the MSSSI, consumer outcome data was being supplied at the same rate at which it is supplied for Tier 1 consumers (i.e. for about 14% of consumers), and the MSSSI was being used for the majority of these consumers. The negative impacts of the mandatory training and use of the MSSSI were generally seen as relatively minor to Divisions.

Divisions were overwhelmingly positive about the Specialist Services, commenting on the benefits to consumers and GPs alike. Many of these benefits were attributed to the flexibility afforded by the Specialist Services to provide a quick, responsive, supportive service to consumers that otherwise would have missed out on services or been managed by GPs.

Limitations

Some caution should be exercised in interpreting the evaluation findings for a number of reasons. Firstly, there are often lags in data entry which are attributable to some Divisions not entering 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. Secondly, whilst interview participants were informed of their anonymity and every effort was made to protect their identity, participants were aware that the evaluation reports are publicly available and that they may be inadvertently identified within the sample number of participants. This may have affected their responses.

The reported achievements of the Specialist Services for Consumers at Risk of Suicide pilot are confined by the scope of the evaluation which has focussed on service uptake and the experience of professionals involved. Consumer outcomes were evaluated as a measure of treatment effectiveness, however the evaluation did not focus on consumer experience of the services. This was deliberate given the potential vulnerabilities of this particular consumer group. As suggested by some of the Divisions, an examination of the impact on local suicide rates and emergency department presentations, as well as consumer re-presentation to these and other mental health services, would give a more comprehensive picture of the reach and impact of the Specialist Services. Whilst this is presently outside the scope of the current ATAPS evaluation plan, it could be incorporated into future evaluations. In the meantime, the evaluators can assist Divisions, where practicable, with such evaluations in their local area.

Conclusions

These limitations aside, as with the previous four reports of the Specialist Services for Consumers at Risk of Suicide pilot, the current report confirms the status of the Specialist Services as a valuable and complementary sub-program of the general ATAPS projects. The Specialist Services are a prime example of the benefits of flexibility in both mental health policy and program implementation.

The Specialist Services have continued to attract referrals from GPs and emergency departments, with a peak in referrals and sessions in early 2011. Correspondingly, allied health professionals have delivered increasing numbers of sessions to a significant number of consumers. The profile of consumers continues to be fairly consistent over time and somewhat different from that of Tier 1 ATAPS. The consumer profile suggests that these Specialist Services are reaching a different group of consumers who are more likely to be younger and have a diagnosis of depression, and less likely to be female or have a diagnosis of anxiety. The nature of services being delivered remains at a point of relative consistency, which varies from that of Tier 1 ATAPS and between rural and urban areas. The vast majority of consumers are receiving a free of cost service. The Specialist Services have been well received and appreciated by GPs, allied health professionals and Divisions alike. There is good evidence that the pilot is achieving positive outcomes for consumers in terms of alleviating symptoms and improving levels of functioning.

Divisions experienced some significant challenges in implementing these new services to a vulnerable and 'risky' group of consumers. However, by the time of this last report Divisions' generally reported that they had overcome any initial teething problems with the Specialist Services and they had for the most part settled on a service delivery model that was successfully fitting within their local context. Divisions reported that they had learnt a great deal through the implementation of the Specialist Services. They commented on the ongoing importance of: building and maintaining relationships with state mental health services, promotion and education of GPs, and the need to support their allied health professionals with this clinically demanding consumer group. Many Divisions reported that they had put considerable effort into developing a sound clinical governance framework for working with this new consumer group, which had not only facilitated the implementation of these Specialist Services but also likely placed them in good stead to more seamlessly integrate new ATAPS programs in the future. However, these findings also suggest that the continuing implementation of these Specialist Services is quite demanding on Divisions' resources, through the continued need for promotion, education and clinical support and administration.

Whilst it would be expected that this demand on Divisions would lessen as they become more practiced and efficient at delivering these services it also highlights the potential challenges to be faced by Divisions implementing these and other new ATAPS programs for the first time.

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Appendix A: Divisions of General Practice involved in the Specialist Services

Division	State	Urban/Rural
NSW Central West DGP	NSW	Rural
GP Access	NSW	Urban
NSW Central Coast DGP	NSW	Urban
Central Sydney GP Network	NSW	Urban
Dandenong Casey GP Association	VIC	Urban
Peninsula GP Network	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 ^a	SA	Rural
Mid North Division of Rural Medicine	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 ^b	TAS	Rural

- a. Services for Flinders and Far North DGP were undertaken by the Mid North Division of Rural Medicine
b. DGP Northern Tasmania ceased participating in the pilot as at 30 June 2009.

Appendix B: Summary of previous reports for the Specialist Services for Consumers at Risk of Suicide

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Interim Report for the Specialist Services for Consumers at Risk of Suicide July 2009	19 GPNs selected by the Department of Health and Ageing	<ul style="list-style-type: none"> Phone survey conducted with project officers regarding program implementation and models of service delivery Minimum dataset 	<ul style="list-style-type: none"> What models of service delivery are being used by the ATAPS projects delivering Specialist Services to consumers at risk of suicide? What issues are associated with offering Specialist Services to consumers at risk of suicide via the ATAPS projects? What is the level of uptake of Specialist Services for consumers at risk of suicide by GPs, allied health professionals, and consumers at risk of suicide? What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing Specialist Services through the ATAPS projects. What is the precise nature of the services for consumers at risk of suicide being delivered through the ATAPS projects? 	<ul style="list-style-type: none"> To deliver Specialist Services project, officers reported that allied health professionals were contracted in 68% of cases and directly employed 53% of the time. Allied health professionals delivered services most often from GP rooms and their own rooms (42% and 32%, respectively). The favoured referral mechanism was direct referral from the GP to the allied health professional. Divisions commenced service delivery between October 2008 and July 2009. Many Divisions emphasised the need to establish operating policies and procedures around this new client group; they said this was time consuming and had delayed service delivery. Management of consumer risk was a key issue. Issues related to the engagement of GPs, allied health professionals, and new external referrers (i.e. emergency departments and local mental health services) to the Specialist Services were also identified. Despite these challenges, most Divisions reported positive impacts related to the expansion of ATAPS services to fill a previously existing gap in services for those consumers of medium suicide risk. As of July 2009, 11 of the 19 participating Divisions had entered data into the minimum data set for the Specialist Services, reporting that 150 GPs and 49 allied health professionals had been involved. New external referrers also became involved in the Specialist Services. Twenty-four per cent of the 242 referrals made to the Specialist Services were made by hospital emergency departments, and 1% were made by community mental health services, the rest were made by GPs. Two hundred and eighty-two referrals (181 urban, 101 rural) were made to the Specialist Services and 1,064 sessions (677 urban, 387 rural) were delivered. Around 60% of consumers to Specialist Services were female, and the mean age was approximately 33 years. About one half were on low incomes. One half of the urban consumers, and about two-thirds of the rural consumers reported to have a history of previous mental health care. About 1% of consumers were reported to be Aboriginal, and 1% Torres Strait Islander. Of those for whom a diagnosis was made by the referring GP (82% of consumers), almost all were diagnosed with depression (94%). Sessions of 46-60 minutes accounted for two thirds of sessions. Urban areas favoured 46-60 minute sessions in almost three-quarters of sessions. In rural areas two thirds of sessions were less than 30 minutes or more than 60 minutes. Session interventions differed between urban and rural areas. Over half of urban Specialist Services sessions involved diagnostic assessment and nearly half involved CBT-cognitive interventions. In rural areas, about half of the sessions involved CBT-skills training. Rural areas also reported less use of CBT-cognitive interventions than urban Specialist Services.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
<p>Second Interim Report for the Specialist Services for Consumers at Risk of Suicide</p> <p>February 2010</p>	<p>19 GPNs selected by the Department of Health and Ageing</p>	<ul style="list-style-type: none"> Phone survey conducted with GPs and allied health professionals involved in the program Minimum dataset 	<ul style="list-style-type: none"> 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? What is the level of uptake of Specialist Services for consumers at risk of suicide by GPs, allied health professionals, and consumers at risk of suicide? What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing Specialist Services through the ATAPS projects? What is the precise nature of the services for consumers at risk of suicide being delivered through the ATAPS projects? 	<ul style="list-style-type: none"> Generally, GPs were happy with the referral process to the Specialist Services and confident assessing and referring patients. Some GPs stated that there was poor communication from some Divisions, most were happy with the communication from the allied health professionals. All the GPs interviewed, reported that from the patients' perspective the Specialist Services were helpful in providing appropriate treatment in a timely fashion and patients were happy to accept the referral. Furthermore patients were satisfied as they were seen immediately. Most of the GPs said there were no negative impacts for themselves. Two psychologists and one mental health nurse, from three rural ATAPS projects, were interviewed and reported 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 favourably about the accessibility of the services to consumers who would not normally be able to access services. Two professionals raised concerns about difficulties in responding to consumers quickly following referral, especially for referrals received after hours. 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, the referral process had been clear and that emergency department staff had felt confident making referrals. All three professionals commented on the positive impact for the department of being able to refer consumers to the appropriate service quickly. The three professionals said that consumers had responded positively to the Specialist Services and cited positive impacts for consumers such as: immediate access to an allied health professional, consumers not having to go back to their GP for a referral as the emergency department does this for them, decreased stigma for consumers, and availability of ongoing care with no cost to the consumer. None of the professionals cited any negative impacts for their consumers. Uptake data was available for the 17 (of the 19) Divisions who had entered data into the minimum data set as at 4th 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. 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. More referrals were made by urban emergency departments than their rural counterparts. Between October 2008 and January 2010, 604 referrals were made to the Specialist Services, 196 rural and 407 urban, which resulted in 2,821 sessions (924 rural, 1897 urban) being delivered. These sessions were delivered to 569 consumers, making the average number of sessions provided to consumers 5. However, this is likely to be an underestimate as not all consumers would have completed treatment prior to the data being extracted. Around three-fifths of consumers to Specialist Services were female, and the mean age was approximately 33 years. About one half were on low incomes. Slightly less than half of the consumers had 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 for 83% of the referrals made; almost all were diagnosed with depression (90%). Sessions of 46-60 minutes accounted for two thirds of Specialist Services. Overall, session interventions were more likely to involve diagnostic assessment and CBT-skills training and less likely to involve psycho-education and CBT-behavioural interventions in the Specialist Services when compared to the national general ATAPS projects. No copayment was reported in any of the Specialist Services sessions.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
<p>Third Interim Report for the Specialist Services for Consumers at Risk of Suicide</p> <p>July 2010</p>	<p>19 GPNs selected by the Department of Health and Ageing</p>	<ul style="list-style-type: none"> Minimum dataset 	<ul style="list-style-type: none"> What is the level of uptake of Specialist Services for consumers at risk of suicide by GPs, allied health professionals, and consumers at risk of suicide? What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing Specialist Services through the ATAPS projects? What is the precise nature of the services for consumers at risk of suicide being delivered through the ATAPS projects? What are the consumer outcomes being achieved by the Specialist Services? 	<ul style="list-style-type: none"> Uptake data was available for the 18 (of the 19 funded) Divisions which had entered data into the minimum data set as at 28 June 2010. For the period 1 October 2008 to 28 June 2010, referrals were made by 445 GPs and sessions were conducted by 130 allied health professionals. Whilst the majority of referrals to the services were made by GPs (78%), 20% were made by emergency departments and 2% were made by community mental health services. The vast majority of the referrals made by emergency departments were in urban areas, with only three such referrals in rural areas. Between 1 October 2008 and 28 June 2010, 907 referrals (273 rural and 634 urban) were made to the Specialist Services. Overall, 4,263 sessions (1,328 rural, 2,935 urban) were delivered via the Specialist Services pilot. These sessions were delivered to 855 (or 94% of the referred) consumers, making the average number of sessions provided to consumers 5. Overall, there were a greater proportion of referrals (70%) and sessions (69%) 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 mid-2009. Around three-fifths of consumers of Specialist Services are female, and the mean age is approximately 32 years. Over half are on low incomes. About two fifths of the consumers have not previously accessed mental health care. About 2% of consumers were reported to be Aboriginal, and less than 1% Torres Strait Islander. A diagnosis was made by the referring GP for 78% referrals made; the vast majority had been diagnosed with depression (90%). In the main, the profiles of rural and urban consumers are similar. However, there was a trend for rural consumers to be somewhat: less likely to be on a low income, more likely to have accessed previous psychiatric care and to be Aboriginal, and less likely to have an alcohol and drug use disorder or a psychotic disorder than urban consumers. The profile of Specialist Services' consumers differed from that of the general ATAPS projects' consumers. Sessions of 46-60 minutes accounted for two thirds of Specialist Services. More sessions conducted via the Specialist Services were less than 30 minutes when compared with the national general ATAPS services. Overall and in urban areas, these sessions were more likely to involve diagnostic assessment, CBT-cognitive interventions, and CBT-behavioural interventions. However, sessions in rural areas were most likely to involve CBT-skills training and more likely to deliver this intervention than their urban counterparts. No copayment was reported in any of the Specialist Services sessions. The profile of Specialist Services' sessions differed from that of the general ATAPS projects' sessions. Investigation of all the available outcome data indicated that 170 (19%) consumers had pre- and post- treatment scores on at least one outcome measure. Of the 170 consumers, 140 had been assessed with the Modified Scale for Suicidal Ideation (MSSI), 68 with the Depression Anxiety and Stress Scale (DASS), and 58 with the Kessler 10 (K10). The Specialist Services pilot was achieving positive outcomes for consumers as evidenced by statistically and clinically significant levels of improvement across all outcome measures examined.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
<p>Fourth Interim Report for the Specialist Services for Consumers at Risk of Suicide: Improving access to and outcomes from mental health care</p> <p>February 2011</p>	<p>19 GPNs selected by the Department of Health and Ageing</p>	<ul style="list-style-type: none"> Minimum dataset 	<ul style="list-style-type: none"> What is the level of uptake of Specialist Services for consumers at risk of suicide by GPs, allied health professionals, and consumers at risk of suicide? What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing Specialist Services through the ATAPS projects? What is the precise nature of the services for consumers at risk of suicide being delivered through the ATAPS projects? What are the consumer outcomes being achieved by the Specialist Services? 	<ul style="list-style-type: none"> Uptake data was available for 18 (of the 19 funded) Divisions which had entered data into the minimum data set as at 24 January 2011. For the period 1 October 2008 to 24 January 2011, referrals were made by 636 GPs and sessions were conducted by 167 allied health professionals. Whilst the majority of referrals to the services were made by GPs (79%), 18% were made by emergency departments and 3% were made by community mental health services. The vast majority (n=188) of the referrals made by emergency departments were in urban areas, with only four such referrals in rural areas. Between 1 October 2008 and 24 January 2011, 1,401 referrals (399 rural and 1,002 urban) were made to the Specialist Services resulting in 6,910 sessions (2,184 rural, 4,726 urban) being delivered. These sessions were delivered to 1,255 (or 90% of the referred) consumers, making the average number of sessions provided to consumers 5.5. Overall, a greater proportion of referrals (72%) and sessions (68%) were in urban compared to rural areas. Around three-fifths of consumers of Specialist Services were female, and the mean age was approximately 32 years. Over half were on low incomes, as judged by their GP. About two fifths of the consumers had not previously accessed mental health care. Less than 2% of consumers were reported to be Aboriginal, and less than 1% Torres Strait Islander. A diagnosis was made by the referring GP (or in a minority of instances another professional) for 71% of the referrals made, the vast majority had been diagnosed with depression (89%). In the main, the profiles of rural and urban consumers were similar. However, there was a trend for rural consumers to be somewhat: more likely to be male, younger, and Aboriginal, and less likely to have an alcohol and drug use disorder or a psychotic or anxiety disorder than urban consumers. The profile of Specialist Services' consumers differed from that of the general ATAPS projects' consumers. Sessions of 46-60 minutes accounted for two thirds of Specialist Services. More sessions conducted via the Specialist Services were less than 30 minutes when compared with the national general ATAPS services. Overall and in urban areas, sessions were more likely to involve diagnostic assessment, CBT-cognitive interventions, and CBT-behavioural interventions. However, sessions in rural areas were most likely to involve CBT-skills training and to deliver this intervention than their urban counterparts. For the vast majority of Specialist Services sessions no copayment was reported. Investigation of all the available outcome data indicated that 234 (19%) consumers had pre- and post-treatment scores on at least one outcome measure. Of the 234 consumers, 188 had been assessed with the Modified Scale for Suicidal Ideation (MSSI), 88 with the Depression Anxiety and Stress Scales (DASS), and 77 with the Kessler 10 (K10). The Specialist Services pilot was achieving positive outcomes for consumers as evidenced by statistically and clinically significant levels of improvement across all outcome measures examined.

Appendix C: The Interview schedule

Questions for ATAPS project officers involved in the Specialist Services for Consumers at Risk of Suicide for the final August 2011 report

We are interested in the views of ATAPS project officers from Divisions of General Practice that are involved in the Specialist Services.

In late 2008 to early 2009 we conducted a survey with the project officers regarding the implementation of the Specialist Services. As this pilot is now finishing we are again surveying project officers regarding the Divisions' experiences with the pilot. We will report the findings of the survey in our next report in August with the intention to assist other Divisions who will be implementing Specialist Services for consumers at risk of suicide.

1. Name of Division(s) conducting Specialist Services for Consumers at Risk of Suicide?

2. No. Referrals and Sessions in MDS (obtained by us prior to the survey):

Please confirm with the Division that this number sounds right (no need to get specific) and remind them to have their data up to date, including as much matched outcome data as possible, by mid July.

3. Does your Division collect data for any other Division which is also conducting the Specialist Services for Consumers at Risk of Suicide?

- Yes**
 No

If yes, please specify,

4. Please describe how the Specialist Services have been operationalised within your Division: i.e.

are AHPs existing ATAPS professionals or were they employed/engaged only to see consumers at risk of suicide?

Where are the AHPs based?

How are consumers referred?

How do you ensure consumers are contacted within 72 hours?

What are the key achievements of your ATAPS project in the operationalisation of the Specialist Services?

5. In regards to the issues/barriers/challenges your Division raised in regards to the implementation of the services in the first survey in late 2008 (refer to their responses to that survey):

How have these changed? How have you overcome them?

6. * Does your Division have arrangements in place to refer people at acute and immediate risk to themselves or others to state/territory crisis services? If yes, please outline what these arrangements are and how these were developed and maintained

7. *How has your Division developed and maintained linkages and referral pathways with emergency departments and mental health services?

If you have experienced difficulties, how have these been overcome?

*What response has your Division received from GPs who have been asked to formally refer clients who have been provisionally referred by an emergency department?

8. *Has your Division offered the Suicide Prevention Pilot training to allied health professionals? Have AHPs undertaken the training? What has the feedback been from AHPs about the training?

9. What factors have facilitated the effective operation of the Specialist Services?

What went well?

10. What factors have posed a barrier to the effective operation of the Specialist Services?

What did not go well?

11. Other than the data that is already collected for the evaluation, that is the MDS data and surveys like this one, is there any other data that you think would be useful to collect?

Are your AHPs using the MSSSI?

Feedback regarding the use of the MSSSI?

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