



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

Eighteenth Interim Evaluation Report

An overview of the achievements of Tier 1 and Tier 2 ATAPS

**Bridget Bassilios, Kylie King, Justine Fletcher, Lennart Reifels,
Grant Blashki, Philip Burgess, Jane Pirkis**

July 2011

Table of Contents

Executive summary	2
Chapter 1: Background	5
Chapter 2: Method	8
Chapter 3: What is the level of uptake of ATAPS by consumers?	10
Chapter 4: What is the level of participation in ATAPS by professionals?	22
Chapter 5: What are the sociodemographic and clinical profiles of consumers of ATAPS?	26
Chapter 6: What is the nature of the treatment received by ATAPS consumers?	32
Chapter 7: Is ATAPS achieving positive outcomes for consumers?	37
Chapter 8: Discussion	40
References	45
Appendix A: Summary of focus of evaluation reports	52
Appendix B: Description of most commonly used outcome measures for consumers of ATAPS	70

Executive summary

Background

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

There are now two tiers of ATAPS; the original ATAPS services are referred to as Tier 1 while Tier 2 services target specific hard to reach groups and/or offers flexibilities in the delivery of psychological strategies. The current report examines a range of indicators of achievement for the two tiers of ATAPS including: participation rates by GPs, other referring professionals, allied health professionals and consumers; the sociodemographic and clinical profiles of consumers; the precise nature of the care they are receiving; and the outcomes of this care for consumers.

Method

Drawing on data from a purpose-designed minimum dataset, the report considers the current achievements of the Tier 1 and Tier 2 ATAPS over time, via the following evaluation questions:

Evaluation Question 1: What is the level of uptake of ATAPS by consumers?

Evaluation Question 2: What is the level of participation in ATAPS by professionals?

Evaluation Question 3: What are the sociodemographic and clinical profiles of consumers of ATAPS?

Evaluation Question 4: What is the treatment received by ATAPS consumers?

Evaluation Question 5: Is ATAPS achieving positive outcomes for consumers?

Key findings

Uptake of ATAPS by consumers

Between 1 July 2003 and 30 June 2011, 247,378 (96% Tier 1 and 4 % Tier 2) consumers were referred to the ATAPS projects. Of these referrals, 190,629 (77%) received services.

In total, 982,892 (96% Tier 1 and 4% Tier 2) sessions of care were provided through ATAPS, making 5.2 the average number of sessions provided per referral. This average 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.

All 110 GPNs are delivering Tier 1 and 106 GPNs are now delivering Tier 2 services. The uptake of the Tier 2 services has varied. For example, the uptake of the *Specialist suicide services* and *Perinatal depression* programs, has been more significant than others. This is probably due to the fact that these are the most widely available and longest running of the Tier 2 programs. The rate of referrals resulting in sessions also

varied somewhat between the programs; the lowest rate occurred in the *Rural and remote* and the highest occurred in the *Specialist suicide services* programs.

All new Tier 2 services showed a peak in referrals and sessions in February and/or March 2011, suggesting that it took GPNs seven to eight months from the introduction of the new funding to have the necessary systems in place to deliver services to the priority groups that had been identified.

Participation in ATAPS by professionals

Between 1 July 2003 and 30 June 2011, there were 20,950 professionals (41% rural; 59% urban) referring to all ATAPS programs. GPs make up 19,872 (99.9%) of the 19,882 referrers to Tier 1 ATAPS. GPs also represent the vast majority (83.3%) of referrers across all Tier 2 programs. However, the uptake of Tier 2 services by GP has been quite slow, with only 3,663 GPs in total referring to any of the Tier 2 services. The number of other referrers in the Tier 2 services is relatively small compared to the number of GPs involved in Tier 2.

Between 1 July 2003 and 30 June 2011, 5,044 (30% rural; 70% urban) allied health professionals delivered ATAPS services to consumers. The vast majority (98%) of allied health professionals are delivering Tier 1 while a minority deliver Tier 2 services.

Sociodemographic and clinical profiles of consumers of ATAPS

Sixty-seven percent of consumers of Tier 1 services are female, and their mean age is 38 years. About 3% of consumers are reported to be Aboriginal and 0.3% Torres Strait Islander. About half of the consumers are reported to be on low incomes and about a third have no history of mental health service use. English is the most commonly reported language used at home, with low levels of other languages reported.

Preliminary findings indicate that the profile of Tier 2 consumers varies significantly between the programs. For example, males are more strongly represented in the *Homelessness* and *Child* programs (59% and 48%, respectively). *T-CBT* pilot and *Bushfire* consumers are somewhat older than consumers of the *Aboriginal and Torres Strait Islander* and *Perinatal depression* programs. *Aboriginal and Torres Strait Islander* and *Homelessness* consumers are most likely to be reported to be on a low income. Consumers of the *Child* program are least likely to have used mental health services before, which is not surprising given their younger age.

The most common diagnoses in across all ATAPS and in the Tier 1 services were for depression (54.3%) and anxiety disorders (41.0%). There was some variability in diagnoses across the Tier 2 programs. *Homelessness* and *Aboriginal and Torres Strait Islander* consumers were reported to have a somewhat higher rate of alcohol and drug use disorders, whilst depression and anxiety disorders were both most commonly reported in *T-CBT* and *Aboriginal and Torres Strait Islander* consumers. Psychotic disorders and unexplained somatic disorders were less frequently reported across all ATAPS programs.

Nature of the treatment received by ATAPS consumers

Overall and across all programs, sessions of 46-60 minutes have been the most popular. Sessions of less than 30 minutes and greater than one hour in duration have been more common within several of the Tier 2 programs compared with the Tier 1 service, perhaps reflecting the intended flexibility afforded by the former. The vast majority of these sessions have been delivered to individuals rather than groups; however group sessions appear to have been particularly popular in the *Aboriginal and Torres Strait Islander* and *Perinatal depression* programs (41% and 10%, respectively).

The majority of all ATAPS sessions have been delivered face-to-face. Nonetheless, albeit at a lower rate, other modalities of session delivery such as the telephone are being utilised as needed across both Tier 1 and Tier 2 services. Other than the obvious *T-CBT* pilot, telephone sessions have been used most frequently in the *Specialist suicide services* and *Rural and remote* programs.

Nationally, the majority (66%) of sessions did not incur a copayment. For the 165,025 sessions where a copayment was incurred, the average *copayment* amount was \$15.79. The national average *cost per session* for the 810,173 sessions where this information was provided was \$3.22, with a lower average in rural (\$1.48, S.D. = \$6.13) compared with urban (\$4.35, S.D. = \$11.01) areas. The mean copayment and cost per session was lower for sessions delivered via most Tier 2 programs compared with Tier 1.

Overall, the most common interventions provided through sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 46% and 35% of sessions, respectively. In the main, this pattern can be observed across all programs, but there are some nuances. Overall, in approximately 7% of all ATAPS sessions, consumers did not attend. The rate of non-attendance at sessions was proportionally much higher for several of the Tier 2 programs.

Outcomes of ATAPS for consumers

Pre- and post-treatment outcome data were available for 24,581 (13.4%) of Tier 1, 88 (5.7%) of *Bushfire*, 332 (14.5%) of *Perinatal depression* and 356 (15.4%) of *Specialist suicide services* consumers. The remaining Tier 2 programs did not have sufficient data to be included in the analyses, which is expected based on their relative infancy (with the exception of the completed *T-CBT* pilot). Across all of the 13 most commonly used standardised outcome measures, the mean difference was statistically significant and indicative of clinical improvement.

Conclusions

The current report indicates that the ATAPS projects continue to be an integral part of the primary mental health care system in Australia. New GPs and allied health professionals continue to provide services to a substantial number of consumers. The number of Tier 1 referrals and sessions has remained fairly steady over the past couple of years. The profile of consumers and the care they are receiving is very consistent overtime. The majority are women with high prevalence disorders. Strategies usually involve CBT-based cognitive and behavioural interventions, which are typically delivered to individuals in sessions of one hour duration. Most importantly, the Tier 1 ATAPS projects are continuing to achieve considerable positive clinical outcomes for consumers.

Most of the Tier 2 services are still in their early start-up phase. One hundred and six GPNs are now delivering one or more Tier 2 services. The data indicate that new Tier 2 services that have been delivered have taken about seven to eight months to become established within GPNs, and once established increasingly attract referrers and consumers. The outcome data, where available, shows that these services are producing significant clinical improvement for consumers. The socio-demographic and diagnostic data indicate the Tier 2 services have been successful in reaching their intended target consumer groups in that their profiles differ somewhat from Tier 1 consumers. This suggests that Tier 2 ATAPS is carving an important niche by successfully addressing the unmet need of specific and/or hard to reach consumers and through means that are not available via Tier 1 ATAPS or the Better Access program.

Chapter 1: Background

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

Various policy changes have occurred during the life of the ATAPS projects which have had an impact on their nature and direction. In 2006, the Australian Government introduced the Better Access program, which facilitates equivalent access to mental health care from similar providers, but does so via a series of Medicare Benefits Schedule (MBS) item numbers rather than through GPN projects. In response to these policy changes, since 2008 several sub-programs have been or are being introduced that focus on particular at-risk populations and/or use specific modalities of service delivery. The additional funding for GPNs aims 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.²

Tier 1 services remain the 'core business' of the ATAPS program. Currently, 110 GPNs are running ATAPS projects which are delivering these services. The University of Melbourne's Centre for Health Policy, Programs and Economics (CHPPE) has been evaluating the Tier 1 ATAPS projects since their introduction. The evaluation has confirmed that the projects are being delivered in the way that was originally intended, under a range of models.^{3,4} It has also shown that their uptake has been high in both urban and rural areas, and that the projects have reached a broad range of patients.^{3,5-9} In addition, the evaluation has demonstrated that the projects have produced positive outcomes both for providers¹⁰ and for patients^{7,11} and that a range of socio-demographic, clinical and treatment-based variables are associated with the levels of outcomes achieved, but improvements are still substantial even for those in the relatively disadvantaged groups.¹²

The Tier 2 services have been introduced at different times, and at times in response to external events such as the 2009 Victorian bushfires and 2011 Queensland floods and cyclone Yasi. The Tier 2 sub-programs are focused on seven priority groups: women with perinatal depression, people at risk of suicide, people experiencing or at high risk of homelessness, people impacted by the Victorian Bushfires, people in remote locations including Indigenous communities, and children with mental disorders. In addition one, now completed sub-program, trialled the use of telephone cognitive behavioural therapy (T-CBT). Most of the Tier 2 services are available to all GPNs, with the exception of the Suicide Prevention Pilot, the Bushfire services, and the T-CBT trial. Some of the Tier 2 services have previously been evaluated and reported on, whilst others that have more recently been introduced are reported on for the first time in the current evaluation report. Brief descriptions of these services are now provided based on the Department of Health and Ageing's ATAPS operational guidelines.¹³

Telephone-based Cognitive Behaviour Therapy (T-CBT) pilot

The Telephone-based Cognitive Behaviour Therapy (T-CBT) trial was delivered between July 2008 and June 2010 by 22 rural and remote GPNs. This service was implemented to improve accessibility for selected consumers in rural and remote settings who for various reasons experience barriers to seeing a clinician face-to-face. CBT was provided to consumers by telephone or video-conferencing. The data related to these services has been previously reported in additional evaluation reports.¹⁴⁻¹⁶ While the T-CBT pilot has

ended the ability to deliver services using multiple communication modalities persists across the various ATAPS programs.

Women with perinatal depression

First introduced in April 2008 to all GPNs, this program targets women with perinatal depression. Specifically it provides focused psychological services, group sessions, liaison with child/maternal nurses regarding referral pathways, family therapy, telephone and web based services. This report provides an update to evaluation data previously reported in supplementary evaluation reports.¹⁷⁻¹⁹

Specialist services for consumers at risk of suicide

The Specialist services were first introduced as a pilot to 19 GPNs in July 2008 and ran until the end of June 2011. The pilot was delivered by trained ATAPS professionals and aimed to provide a more intensive, prioritised service for people who were at risk of suicide (e.g., those who had made a recent suicide attempt, had recently self-harmed, or are were having severe suicidal thoughts), who may or may not have had a mental disorder. Data related to the pilot has been previously reported in additional evaluation reports.²⁰⁻²³ The final report for this pilot will be submitted in August 2011.

These services initially delivered by the pilot have continued and expanded nationally in July 2010, now available to all GPNs. The services include focused psychological services, case management, proactive follow up, and liaison with local Accident and Emergency services. Data related to these services are reported together with data related to the Suicide Prevention Pilot for the first time in this evaluation report.

People impacted by the Victorian bushfires who have a diagnosis of a mental illness

Services for people impacted by the Victorian Bushfires are delivered by the nine GPNs participating in the Australian Government Mental Health Response to the 2009 Victorian Bushfires. These services were introduced in January 2009. The services are available for individuals who have been diagnosed as experiencing severe and persisting symptoms resulting from trauma or loss. This report provides an update to data previously reported in an additional evaluation report.²⁴

People who are experiencing, or are at high risk of homelessness

Services for people who are experiencing, or are at high risk of, homelessness were introduced in July 2010. These services are able to provide outreach services (including 'mobile clinics'), provisional referrals to ATAPS before a GP assessment, focused psychological services, and liaison with local NGOs supporting homeless individuals. Data related to these services are reported for the first time in this evaluation report.

People in remote locations including Indigenous communities

Services for people in remote locations, including Indigenous communities were introduced in July 2010. These services provide outreach services, focused psychological services, telephone and web based services. Data related to these services are reported for the first time in this evaluation report.

Children with mental disorders

Services for children with mental disorders were introduced in July 2010. These services are aimed at pre-adolescent children and provide ATAPS professionals with the flexibility to provide appropriate treatment and support that do not fit the parameters of focused psychological services funded under Tier 1 ATAPS. Specifically, services can include family therapies based on behaviour therapy involving parents or the whole family, parent training in behaviour management, and liaison with key providers in the children's other environments, such as schools. Data related to these services are reported for the first time in this evaluation report.

The current report

Previously the evaluation reports have focussed primarily on Tier 1 ATAPS, with data related to Tier 2 services provided in additional or supplementary reports. This report is the first to provide evaluation results for both Tier 1 and Tier 2 services together, and aims to provide a comprehensive overview of all ATAPS programs. This represents a new and continuing format for evaluation reports that will allow easy comparison and discussion of ATAPS programs in their entirety.

Drawing on data from a purpose-designed web-based minimum dataset, this report examines a range of indicators of achievement for the two tiers of ATAPS including: participation rates by GPs, other referring professionals, allied health professionals and consumers; the sociodemographic and clinical profiles of consumers; the precise nature of the care they are receiving; and the outcomes of this care for consumers.

The current report is the 18th in the series evaluating ATAPS.^{12 17 18 25-39} Appendix A presents a summary of the findings of the previous reports.

Chapter 2: Method

Evaluation questions

This report considers the achievements of Tier 1 and Tier 2 ATAPS over time, via the following evaluation questions:

Evaluation Question 1: What is the level of uptake of ATAPS by consumers?

Evaluation Question 2: What is the level of participation in ATAPS by professionals?

Evaluation Question 3: What are the sociodemographic and clinical profiles of consumers of ATAPS?

Evaluation Question 4: What is the nature of the treatment received by ATAPS consumers?

Evaluation Question 5: Is ATAPS achieving positive outcomes for consumers?

Data sources

All five evaluation questions were addressed using data from the previously mentioned minimum dataset (MDS), which captures de-identified, consumer-level and session-level information. Data from the minimum dataset was available for the period from 1 July 2003 (when the minimum dataset was first 'rolled out') to 30 June 2011 and were extracted on 4 July 2011.

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

It is important to note that the minimum dataset has evolved over the life of ATAPS in response to GPN stated needs and/or the introduction of new types of services. For example, the minimum dataset did not originally include outcome data fields; these were only added in mid-2005;^{11 40} this and other key changes and the dates they occurred are summarised in Table 1. The addition of new fields and/or new options to existing fields at different times and for selected GPNs affects the interpretation of the findings reported.

Data related to Tier 1 and Tier 2 ATAPS were extracted from the minimum dataset on the numbers of consumers and sessions (Evaluation Question 1), the numbers of GPs and allied health professionals providing services through the projects (Evaluation Question 2), the profile of consumers accessing these services (Evaluation Questions 3), the nature of these services (Evaluation Question 4), and consumer outcomes (Evaluation Question 5).

Table 1: Dates of key changes to the minimum dataset

Date	Changes to minimum data set	Available to which GPNs
Mid- 2005	<ul style="list-style-type: none"> • Addition to outcome measures 	<ul style="list-style-type: none"> • All
November 2009	<ul style="list-style-type: none"> • Addition of new referral (or program) types: <ul style="list-style-type: none"> ○ Prenatal depression ○ T-CBT ○ Suicide prevention ○ Routine ATAPS option became known as ‘general ATAPS’ to distinguish it from the new programs • Addition of session modality with the following options: face-to-face, telephone and video conferencing • Addition of outcome measures: <ul style="list-style-type: none"> ○ Strengths and Difficulties Questionnaire as an outcome measure for child and adolescent consumers ○ Edinburgh Post-natal Depression Scale ○ Modified Scale for Suicidal Ideation • Addition of new referral sources: <ul style="list-style-type: none"> ○ GP, community mental health, emergency department, psychiatrist • Addition of session information 	<ul style="list-style-type: none"> • All • GPNs involved in T-CBT pilot • GPNs involved in Suicide Prevention pilot • All • All • GPNs involved in Suicide Prevention pilot • GPNs involved in Suicide Prevention pilot • T-CBT pilot GPNs
April 2009	<ul style="list-style-type: none"> • Addition of new referral (or program) type: <ul style="list-style-type: none"> ○ 2009 Victorian Bushfires as a referral (or program) type • Addition of new referral sources: <ul style="list-style-type: none"> ○ Case manager 	<ul style="list-style-type: none"> • GPNs involved in delivery of bushfire services • GPNs involved in delivery of bushfire services
December 2010	<ul style="list-style-type: none"> • Addition of new referral (or program) types: <ul style="list-style-type: none"> ○ Homelessness ○ Aboriginal and Torres Strait Islander ○ Rural and Remote ○ Children ○ Availability of all existing referral (or program) types • Addition of session modality: web-based • Addition of session types: child, parent(s), child and parents, child in group, parent(s) in group, child and parent(s) in group • Availability of appropriate referral sources • Addition of referral sources: <ul style="list-style-type: none"> ○ GP, midwife, obstetrician, maternal health nurse ○ GP, non-government organisation • Addition of diagnostic category: no formal diagnosis • Addition of intervention strategies: <ul style="list-style-type: none"> ○ Family therapy ○ Parent training in behaviour management ○ Play therapy ○ Narrative therapy 	<ul style="list-style-type: none"> • All GPNs • All GPNs • GPN selecting <i>Children</i> referral (or program) type • GPNs selecting <i>Suicide prevention</i> referral (or program) type • GPNs selecting <i>Perinatal depression</i> referral(or program) type • GPNs selecting <i>Homelessness</i> referral (or program) type • GPNs selecting <i>Suicide prevention</i> referral (or program) type • GPNs selecting <i>Perinatal depression</i> or children referral (or program) types • GPNs selecting <i>Children</i> referral (or program) type • GPNs selecting <i>Children</i> referral (or program) type • All GPNs

Data analyses

Simple frequencies and percentages were calculated from the Tier 1 and Tier 2 ATAPS projects’ data in order to answer Evaluation Questions 1 to 4.

Evaluation Question 5 was analysed using paired t-tests to examine the difference between mean pre- and post-treatment scores on the range of outcome measures. Consumers who did not have a ‘matched pair’ of pre- and post-treatment scores were excluded, as were outcome measures for which there were fewer than 50 observations.

Chapter 3: What is the level of uptake of ATAPS by consumers?

Overall ATAPS uptake

Between 1 July 2003 and 30 June 2011, 247,378 referrals (43% rural and 57% urban) were made to all ATAPS programs. Of these referrals 190,629 (77%) resulted in sessions. In total, 982,892 sessions (41% rural and 59% urban) of care were provided through the projects, making the average number of sessions per referral 5.2. This average 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.

Overall ATAPS uptake by program

Table 1 shows the number of referrals and sessions for each of the Tier 1 and Tier 2 ATAPS programs and the number of GPNs delivering services under each program. The number of referrals and sessions varied between the Tier 2 programs, with the *Specialist suicide services* and the *Perinatal depression* programs reporting the highest numbers. This is not surprising given that these are the most widely available and longest running of the Tier 2 programs. The rate of referrals resulting in sessions also varied somewhat between the programs; the lowest rate occurred in the *Rural and remote* and the highest occurred in the *Specialist suicide services* programs.

Table 2: Referrals and sessions by program, July 2003 – June 2011

	No. GPNs	No. referrals	No. referrals resulting in sessions	No. sessions	Average no. sessions per referral ^a
Tier 1	115	237,765 (96.1%)	182,889(76.9%)	941,867 (95.8%)	5.1
Tier 2					
Aboriginal and Torres Strait Islander	20	209 (0.1%)	173 (83%)	831 (0.1%)	4.8
Bushfire	9	1,891 (0.8%)	1,535 (81%)	9,949 (1.0%)	6.5
Child	49	852 (0.3%)	618 (73%)	2,825 (0.3%)	4.6
Homelessness	26	554 (0.2%)	454 (82%)	1,713 (0.2%)	3.7
Perinatal depression	98	2,886 (1.2%)	2,291 (79%)	11,667 (1.2%)	5.1
Rural and Remote	13	495 (0.2%)	292 (59%)	1,147 (0.1%)	3.9
Specialist Suicide Services	41	2,654 (1.1%)	2,310 (87%)	12,569 (1.3%)	5.4
T-CBT	7	72 (0%)	58 (81%)	324 (0.0%)	5.6
Tier 2 total	106	9,613 (3.9%)	7,731 (80%)	41,025 (4.2%)	5.3
OVERALL TOTAL	115	247,378 (100%)	190,620(77%)	982,892 (100%)	5.2

^a Excluding referrals for which there were no sessions.

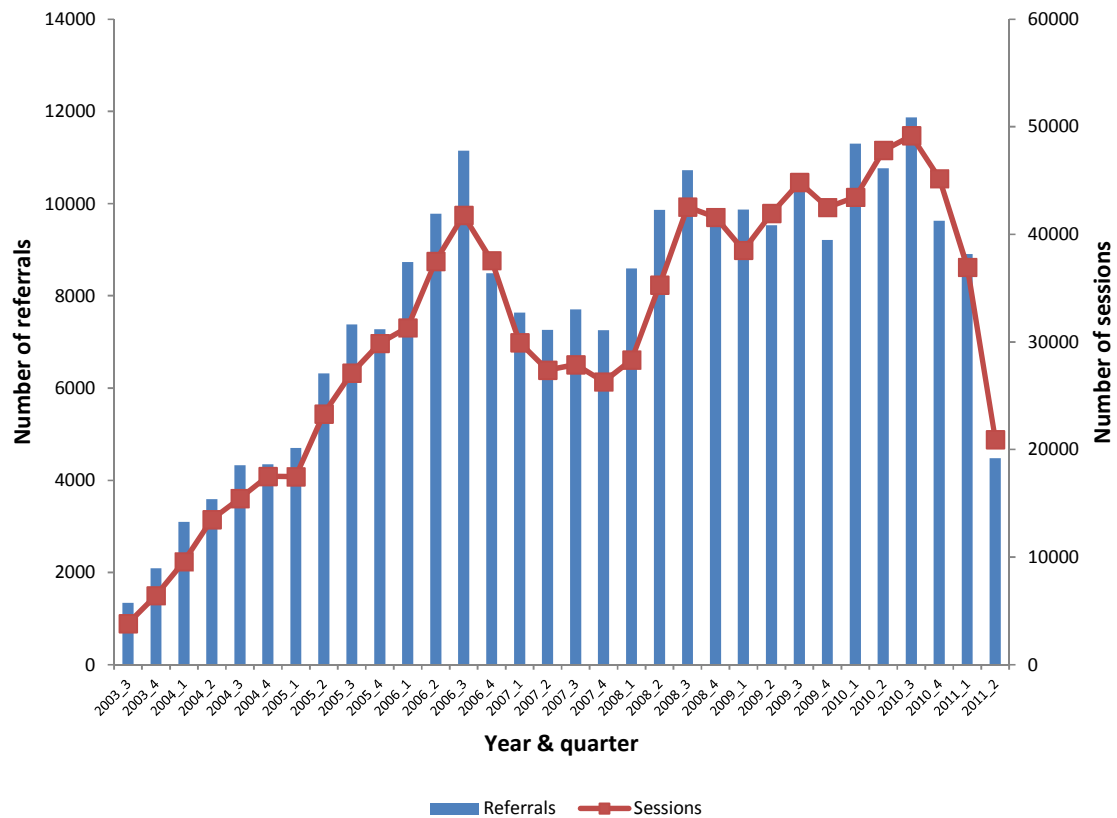
Uptake of ATAPS over time

The following ten figures show the number of sessions and referrals across time for each ATAPS program. It should be noted that the Figures represent different time frames and time scales consistent with the duration of each program.

Overall ATAPS

Figure 1 represents the number of referrals to and sessions delivered all ATAPS projects across Tier 1 and Tier 2 on a quarterly basis from July 2003 until the end of June 2011. The number of referrals and sessions increased steadily until the third quarter of 2006, after which there was a lull in the number of referrals and the number of sessions provided, corresponding with the introduction of the Better Access program. Since the start of 2008 the number of referrals and sessions delivered has been relatively consistent. The decline in the last three quarters may be attributable to lags in data entry.

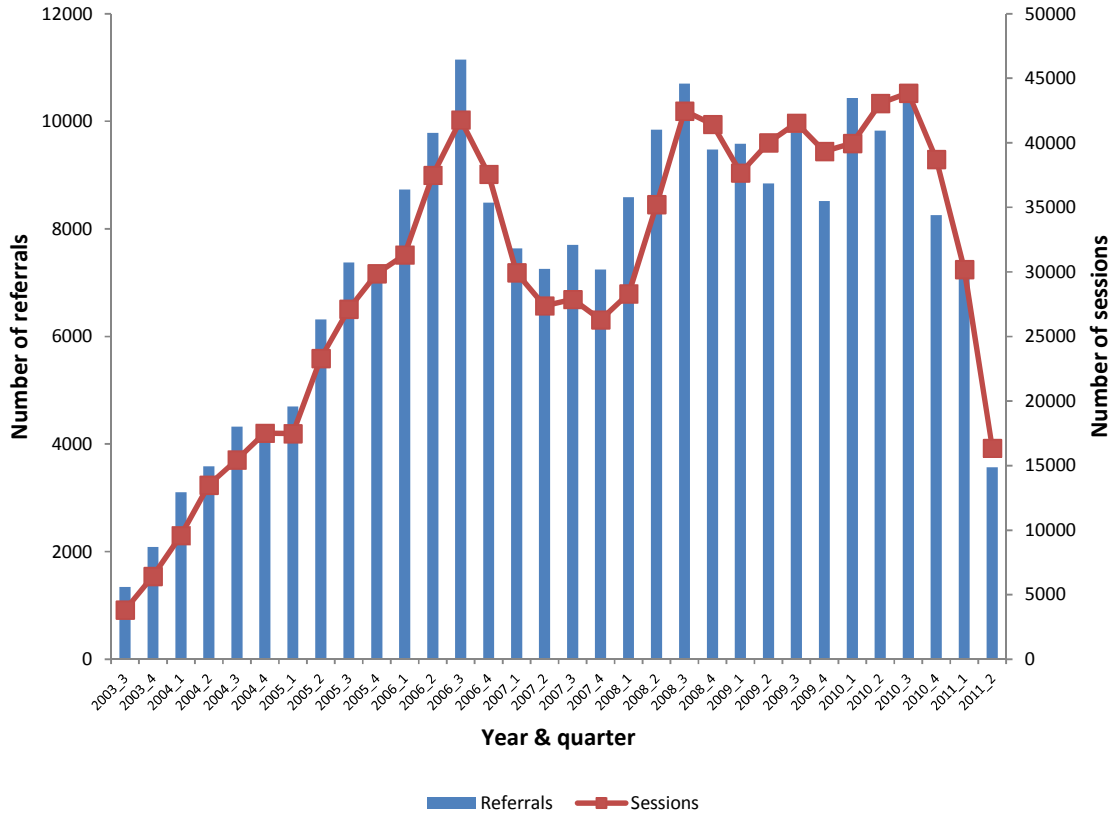
Figure 1: Referrals for sessions of care through all ATAPS by quarter, July 2003 – June 2011



Tier 1

The number of referrals and sessions delivered via Tier 1 ATAPS is shown in Figure 2 and follows the same pattern as described for Figure 1, as the Tier 1 referrals represent the vast majority of referrals and sessions that have taken place over the life of the ATAPS projects. The number of referrals peaked at 11,149 in the third quarter of 2006 and the number of sessions peaked in the third quarter of 2008 with 43,860 sessions delivered.

Figure 2: Referrals for sessions of care through Tier 1 ATAPS by quarter, July 2003 – June 2011



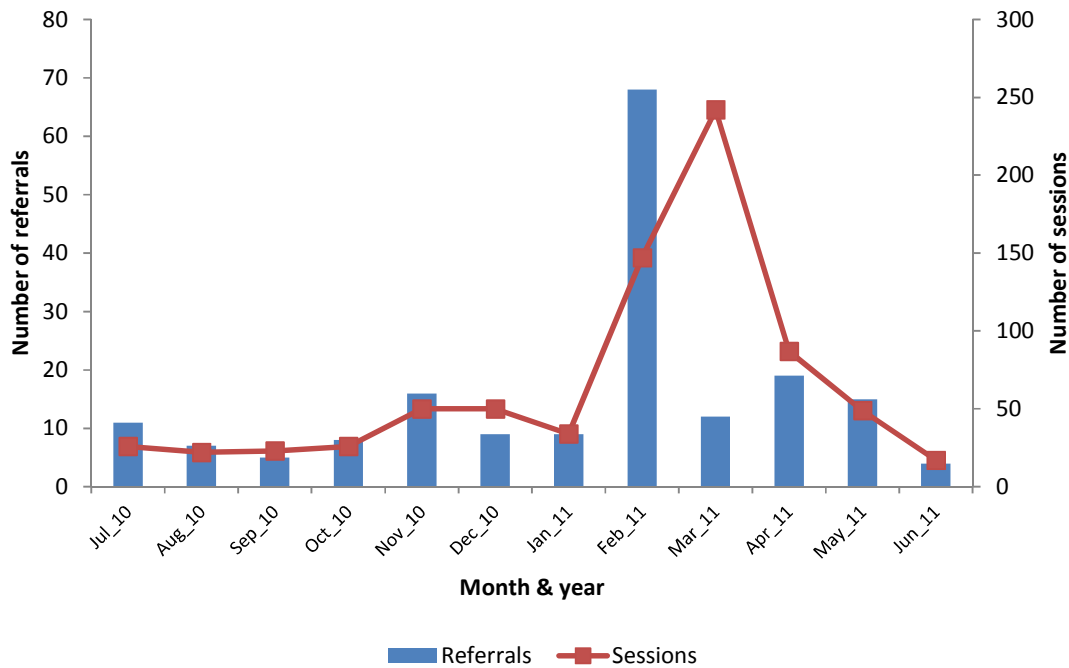
Tier 2

The number of referrals and sessions for all the Tier 2 ATAPS priority areas and other specific programs are depicted in Figures 3 to 10.

Aboriginal and Torres Strait Islander ATAPS

Figure 3 highlights the number of *Aboriginal and Torres Strait Islander ATAPS* referrals and sessions monthly between July 2010 and June 2011. The number of referrals each month ranges from four to 19, with the exception of February when there were 68 referrals. The number of sessions delivered ranged from 17 to 242 each month corresponding to the number of referrals in a given month. In the current reporting period there are 20 GPNs which have delivered services via the new *Aboriginal and Torres Strait Islander* program.

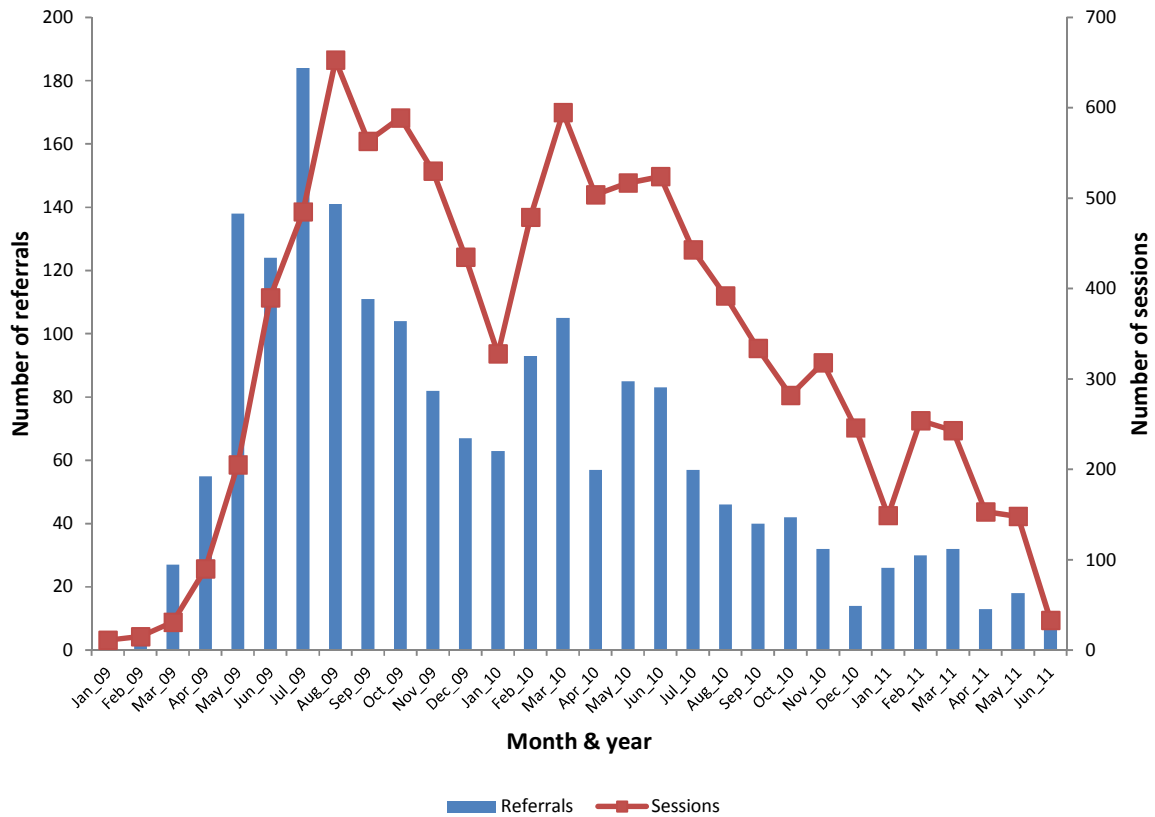
Figure 3: Referrals for sessions of care through *Aboriginal and Torres Strait Islander ATAPS* by month, July 2010 to June 2011



Bushfire ATAPS

Figure 4 shows the number of referrals to *Bushfire ATAPS* between January 2009 and June 2011 and the number of sessions delivered per month. The uptake of services increased until June 2009 at which time the number of referrals each month steadily declined, associated with a corresponding decline in the number of sessions. There was a second peak in referrals and sessions during February and March 2010 which corresponds with the first anniversary of the Victorian bushfires. Nine GPNs have delivered services via *Bushfire ATAPS*.

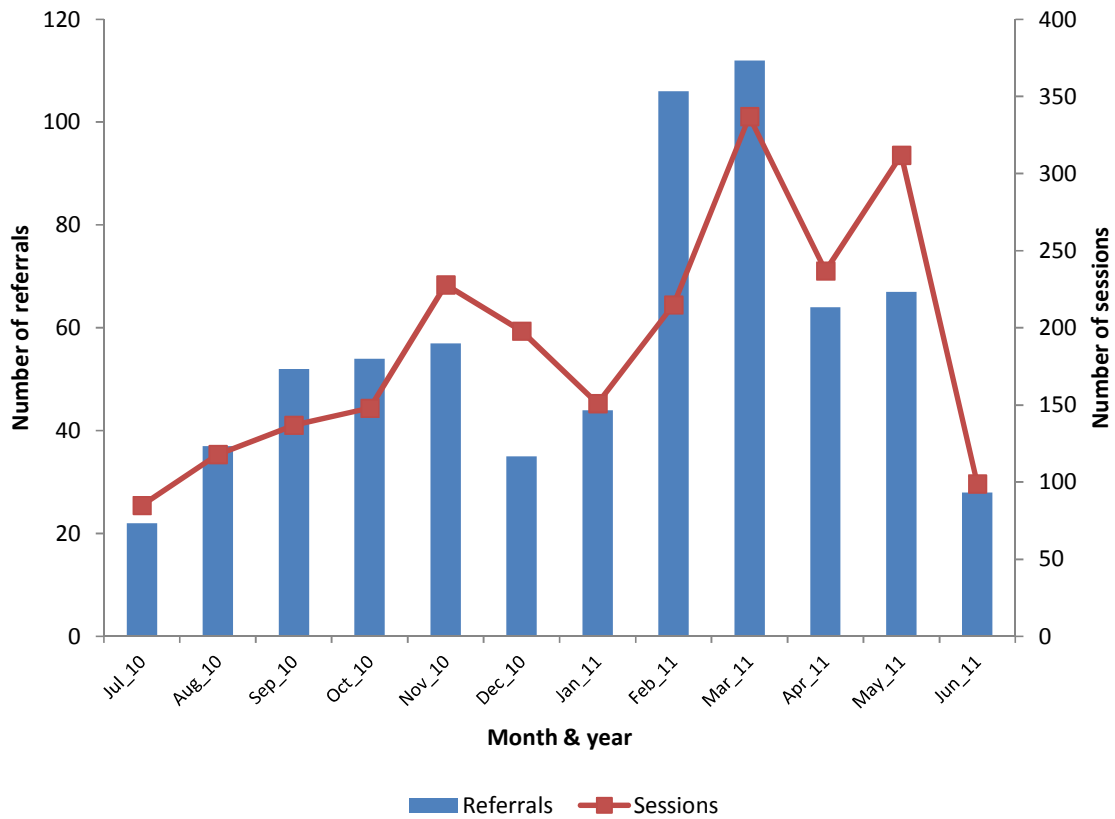
Figure 4: Referrals for sessions of care through *Bushfire ATAPS* by month, January 2009 – June 2011



Child ATAPS

Forty-nine GPNs have delivered services through Tier 2 *Child ATAPS* in the current reporting period. The number of children referred and the sessions they received are shown, by month, in Figure 5, between July 2010 and June 2011. Since being introduced as a priority area the number of children referred and the corresponding sessions continued to increase to a peak in February 2011, with 112 referrals made and 337 sessions delivered.

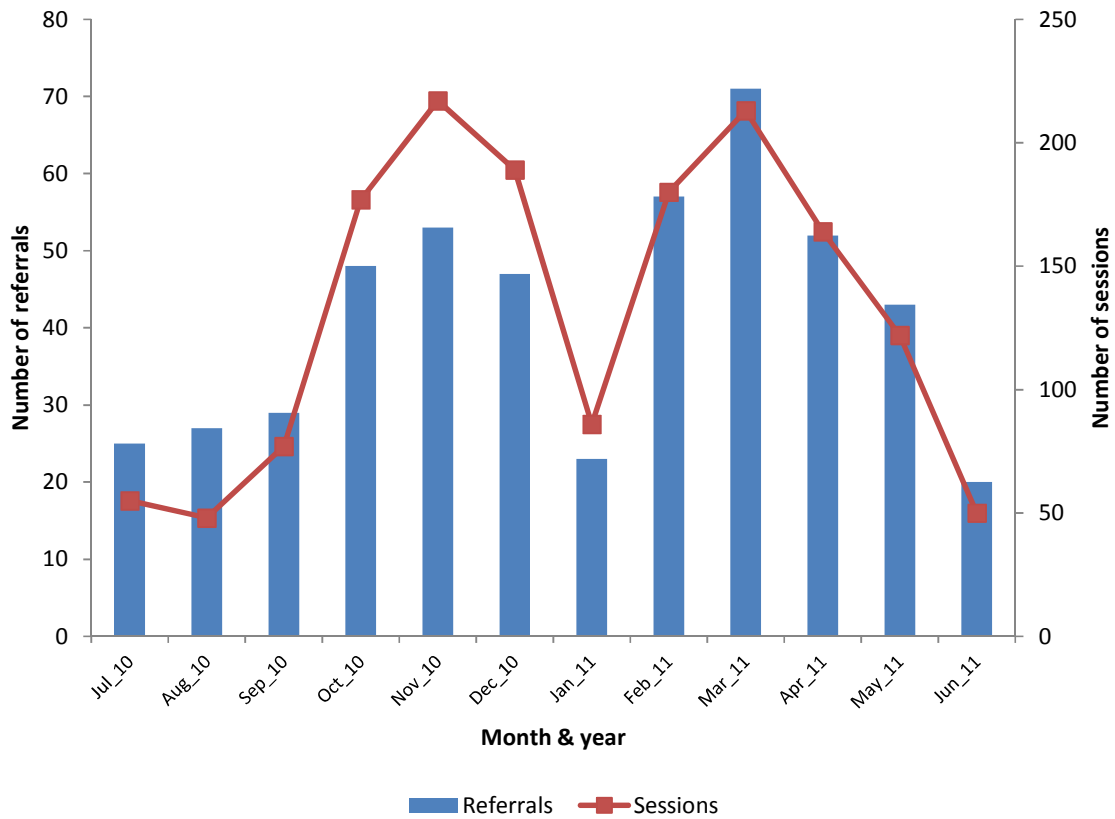
Figure 5: Referrals for sessions of care through *Child ATAPS* by month, July 2010 – June 2011



Homelessness ATAPS

Figure 6 indicates the number of referrals made and sessions delivered per month to people who are homeless or at risk of homelessness via *Homelessness ATAPS* between July 2010 and June 2011. The pattern is similar to that of *Child ATAPS* with a peak of referrals and sessions in March 2011. In the current reporting period there are 26 GPNs which have delivered services to people who are homeless or at risk of homelessness via this new Tier 2 priority area.

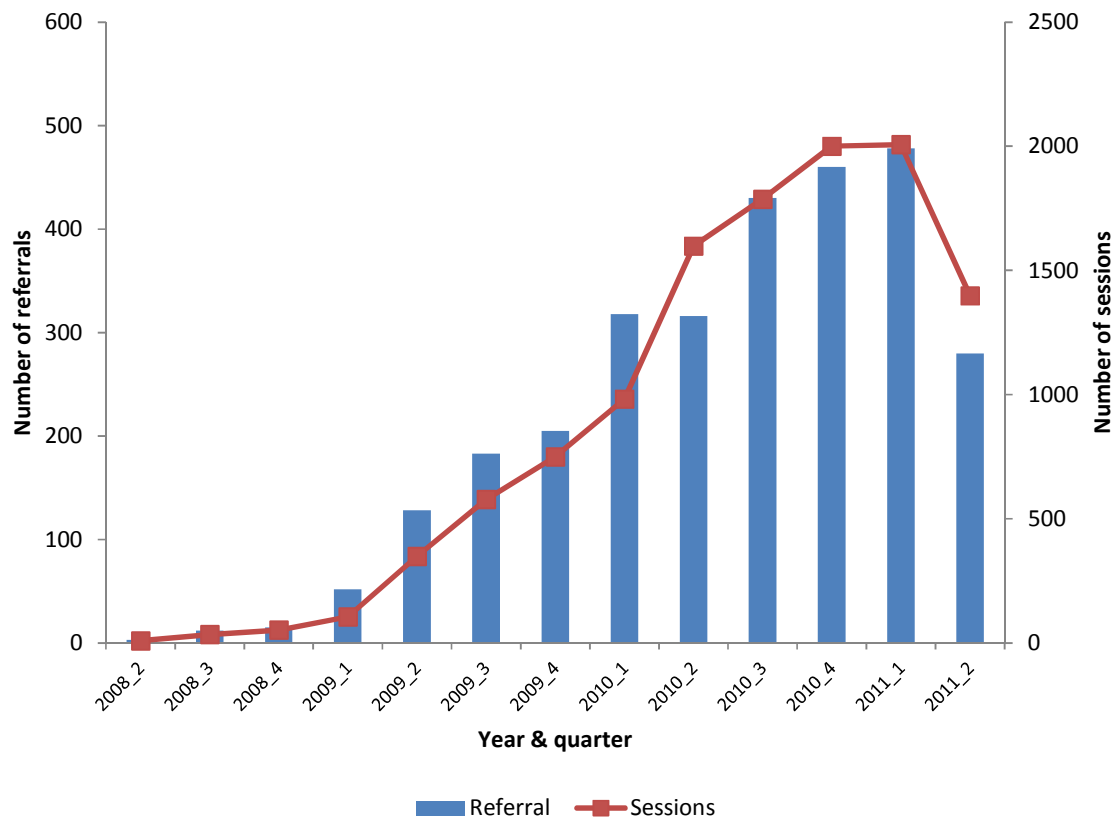
Figure 6: Referrals for sessions of care through *Homelessness ATAPS* by month, July 2010 to June 2011



Perinatal depression ATAPS

The number of referrals and sessions to *Perinatal depression ATAPS* are shown by quarter in Figure 7, from April 2008 to June 2011. The number of consumers referred and the sessions delivered to them has steadily increased over time. This corresponds with a steady increase in the number of GPNs delivering services over time, which may reflect changes in funding arrangements. Twenty-three GPNs were reported to be delivering services at the commencement of the *Perinatal depression services* in June 2009¹⁷, by July 2010 this number had grown to 69⁴¹, and currently 98 GPNs have delivered these services. In the January quarter of 2011 the highest numbers of referrals were received and sessions delivered (478 and 2,007 respectively).

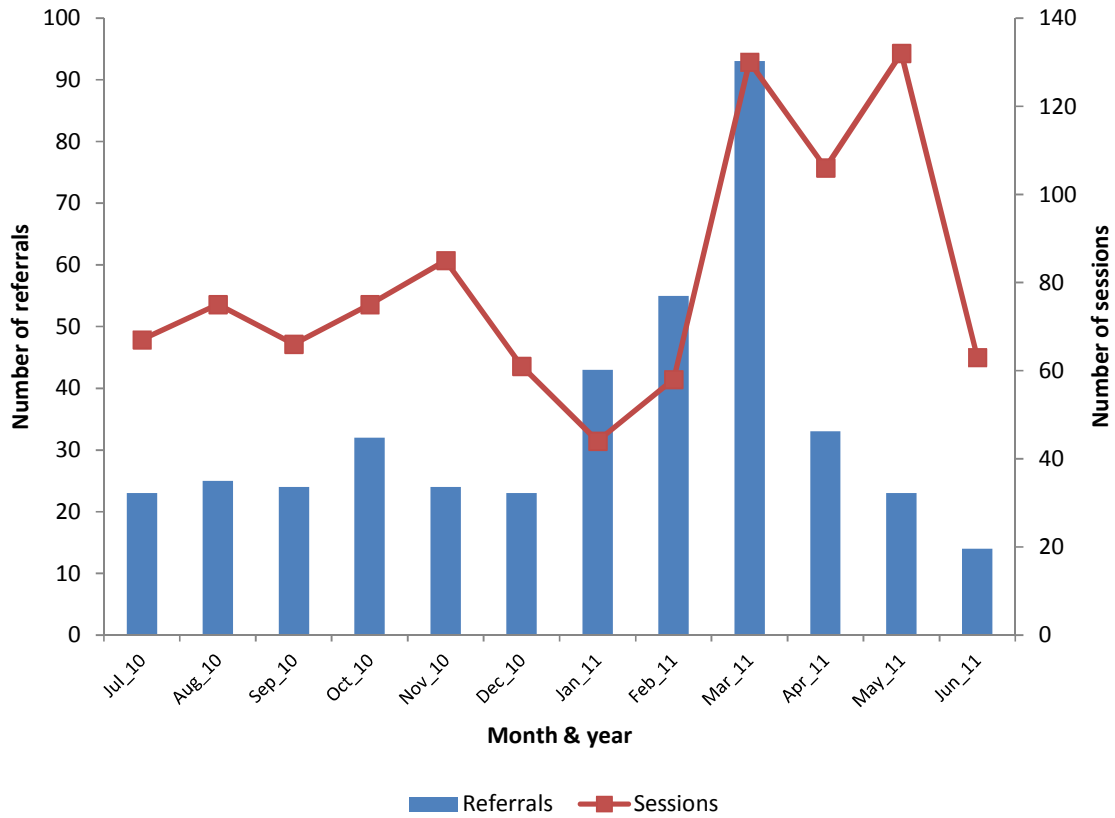
Figure 7: Referrals for sessions of care through *Perinatal depression ATAPS* by quarter, April 2008 to June 2011



Rural and remote ATAPS

Figure 8 highlights the number of referrals and sessions delivered via *Rural and remote ATAPS* between July 2010 and June 2011 on a monthly basis. Like other new Tier 2 programs, there was a peak in *Rural and remote* services in March 2011 with 93 consumers referred and 130 sessions delivered. In the current reporting period there are 13 GPNs which delivered services to people in rural and remote locations via this new Tier 2 priority area.

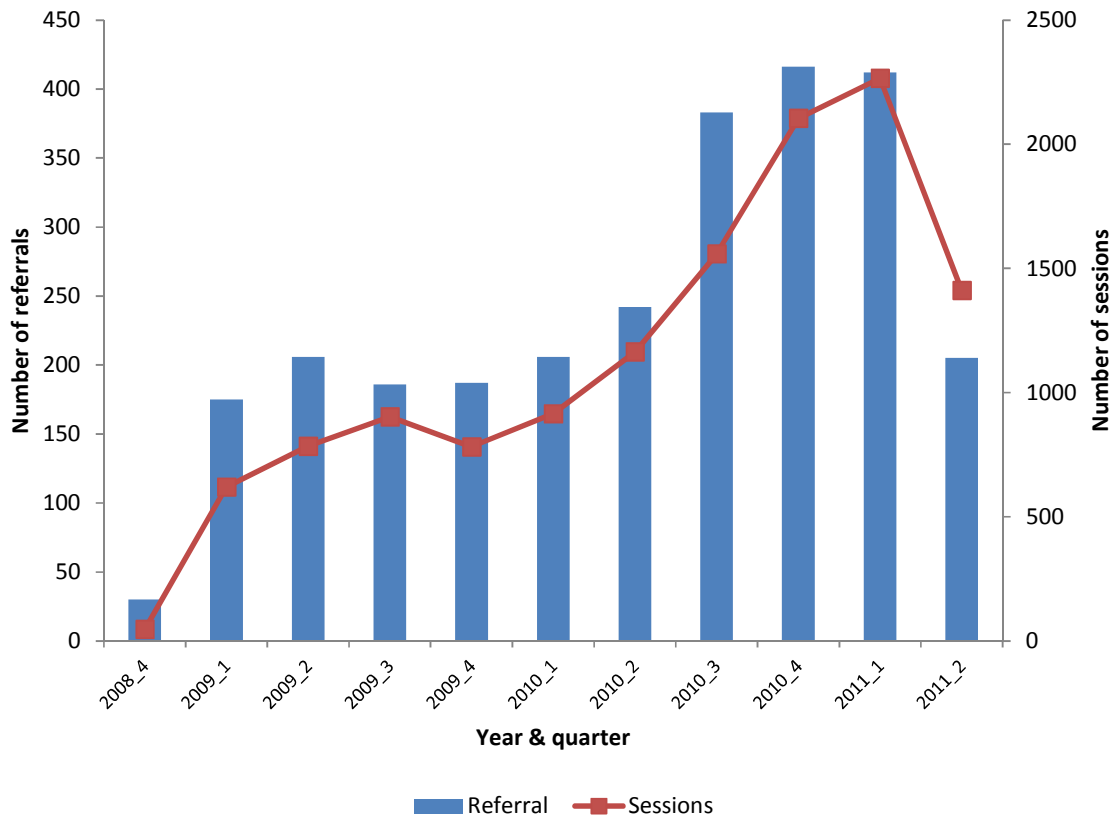
Figure 8: Referrals for sessions of care through *Rural and remote ATAPS* by month, July 2010 to June 2011



Specialist suicide ATAPS

Figure 9 shows the number of referrals and sessions via *Specialist suicide ATAPS*, quarterly from October 2008 to June 2011. The number of referrals increased each quarter to a peak of 416 in the October 2010 quarter. The number of sessions delivered was the highest in the January 2011 quarter at 2,266. In the July quarter of 2010 there was a substantial increase in the number of referrals and sessions delivered to consumers at risk of suicide. This increase in the uptake of the *Specialist Suicide services* is reflective of the expansion of these services under the Tier 2 funding in July 2010. As mentioned previously, the Suicide prevention pilot was initially available to only 19 GPNs, and is now being delivered by 41 GPNs since its expansion.

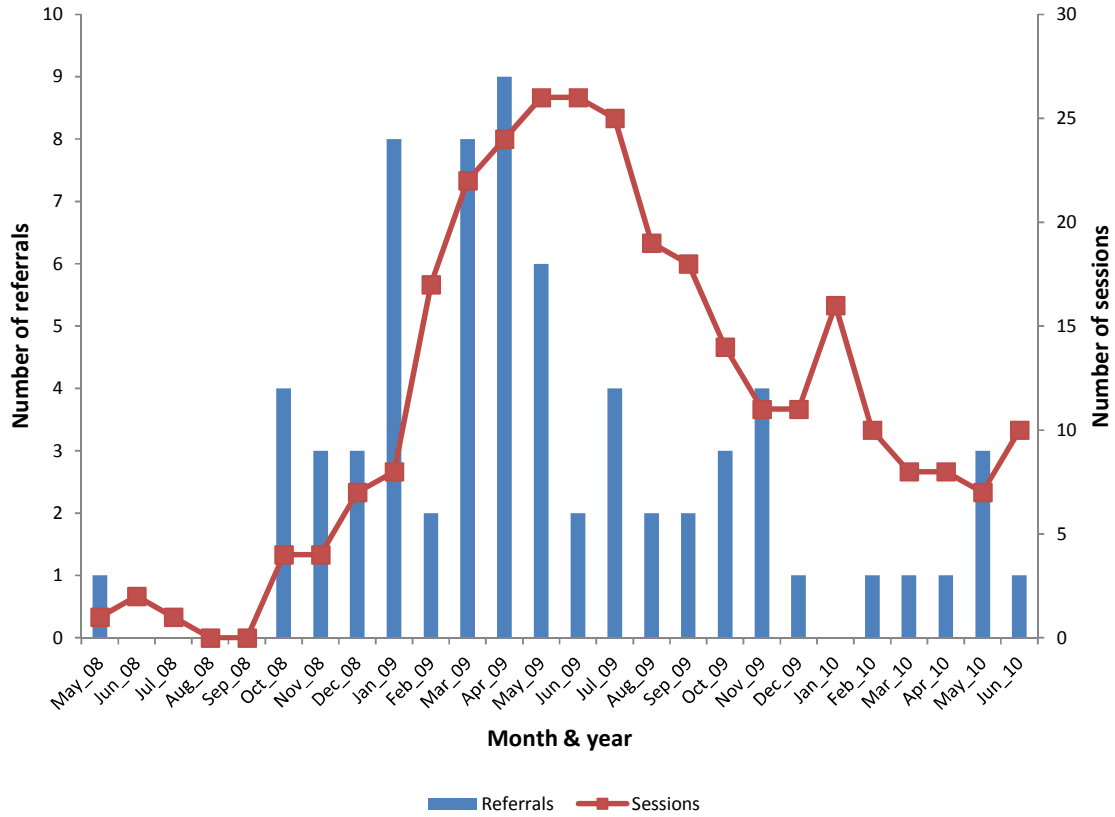
Figure 9: Referrals for sessions of care through *Specialist suicide ATAPS* by quarter, October 2008 – June 2011



T-CBT ATAPS

Figure 10 presents the number of referrals made and sessions delivered for the 15 GPNs participating in T-CBT ATAPS, by month from 1 July 2008 to the conclusion of the pilot in January 2010. The figure shows peaks in referrals and sessions in mid 2009 and a decline towards the conclusion of the pilot.

Figure 10: Referrals for sessions of care through T-CBT ATAPS by month, May 2008 to June 2010



Chapter 4: What is the level of participation in ATAPS by professionals?

Uptake of ATAPS by referrers

Between 1 July 2003 and 30 June 2011 the profile of ATAPS referrers has changed. Prior to June 2008 only GPs could refer consumers to ATAPS. In June 2008 the *Specialist suicide* program was introduced and with it the ability of emergency departments, community mental health services and psychiatrists to refer consumers to this ATAPS program. The introduction of other new programs has also introduced new referrers to ATAPS. The referrer type is unique to each program within ATAPS. For instance, emergency departments are only able to refer into the *Specialist suicide* program, whereas maternal and child health nurses are only able to refer into the *Perinatal depression services*. As previously noted, when the new referrers were introduced to ATAPS, the minimum dataset was also modified to capture data related to referrer type. The 'referrer' field was added to the MDS on the 13th November 2008. Prior to this referrer type was not recorded. Unfortunately as a consequence of the new 'referrer' field in the MDS there is a significant amount of data missing related to referrers prior to November 2008. For Tier 1 this missing data can be assumed to indicate a GP referral prior to 13 November 2008, however from this date the referrer type can no longer be assumed to be GP. Table 3 shows the usual range of permissible referrer types across all ATAPS programs and the dates these were added to the minimum dataset are in Table 1. Note that GPNs are able to negotiate alternative arrangements with the Department of Health and Ageing outside of these usual referral pathways.

Table 3: Permissible refer type by program

	Referrer type permitted (unless otherwise negotiated)
Tier 1	GP
Tier 2	
Aboriginal and Torres Strait Islander	GP, non-government organisations
Bushfire	GP, case manager
Child	GP
Homelessness	GP, non-government organisations
Perinatal depression	GP, midwife, obstetrician, maternal and child health nurse
Rural and remote	GP
Specialist suicide	GP, psychiatrist, community mental health, emergency department
T-CBT	GP

Overall

Table 4 shows the number of each referrer type who are referring to each ATAPS program. Overall there are 20,950 people (41% rural; 59% urban) referring to all ATAPS programs. The numbers of people referring to each program are reported as a percentage for each program. However, the overall numbers of each referrer type in Table 4 are greater than 100% as people can refer to more than one ATAPS program and are therefore represented in more than one program. As such, the totals for each referrer type are not reported as they are somewhat misleading.

Tier 1

Forty percent of the referrers to Tier 1 ATAPS are reported to be GPs. However, as the only permissible referrer for Tier 1 ATAPS is GPs, it can therefore be assumed that the missing data in Tier 1 refers to GP, such that in total GPs make up 19,872 (99.9%) of the 19,882 referrers to Tier 1 ATAPS. This represents a continued increase in the number of GPs from December 2010 when 18,545 GPs had referred to Tier 1 ATAPS⁴².

Tier 2

GPs also represent the vast majority of referrers across all Tier 2 programs. However, the uptake of Tier 2 services by GP has been quite slow, with only 3,663 GPs in total referring to any of the Tier 2 services which is largely attributable to the shorter lifespan of these services. The number of new referrers in the Tier 2 services is relatively small compared to the number of GPs involved. This is consistent with the range of permissible referrers across the Tier 2 programs.

The *Bushfire services* have attracted the highest number of new referrers in case managers (65 or 13%). The *Specialist suicide services* have also attracted a relatively high number of referrers in emergency departments (57 or 5%). The higher level of involvement of these referrers may be due to a greater likelihood of consumers attending alternative referrers rather than GPs as a first 'port of call' for these mental health issues. The newer Tier 2 programs such as the *Homelessness* and the *Child* programs have so far seen a very low involvement of new referrers.

Some other referrers have been recorded other than the permissible referrers for Tier 1 and Tier 2 services, this may be due to data entry error, a misunderstanding by some GPNs regarding permissible referrers, or a unique referral pathway that has been negotiated between a GPN and the Department of Health and Ageing.

Table 4: The number of referrers in each ATAPS program

	GP	Case manager	Community mental health	Emergency department	Psychiatrist	Maternal and child health nurse	Mid- wife	Non-government organisation	Obstetrician	Referrer type not provided	TOTAL per program
Tier 1	7,936(39.9%)	0(0%)	4(8.9%)	4(0%)	2(0%)	0(0%)	0(0%)	0(0%)	0(0%)	11,936(60%)	19882(100%)
Tier 2											
Aboriginal and Torres Strait Islander	85 (88.5%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	11 (11.5%)	96 (100%)
Bushfire	391 (78.7%)	65 (13.1%)	0 (0%)	0 (0%)	1 (0.2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	40 (8.1%)	497 (100%)
Child	519 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	519 (100%)
Homelessness	164 (95.3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	5 (2.9%)	0 (0%)	3 (1.7%)	172 (100%)
Perinatal depression	1,282 (76.4%)	0 (0%)	20 (1.2%)	3 (0.2%)	0 (0%)	12 (0.7%)	5 (0.3%)	0 (0%)	1 (0%)	357 (21.3%)	1,680 (100%)
Rural and remote	162 (100%)	0 (0%)	0(0%)	0 (0%)	0 (0%)	0 (0%)	0(0%)	0 (0%)	0 (0%)	0 (0%)	162 (100%)
Specialist suicide	1,051 (85.4%)	0 (0%)	21(1.7%)	57 (4.6%)	3 (0.2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	99 (8.0%)	1,231 (100%)
T-CBT	9 (20.9%)	0 (0%)	0(0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	34 (79.1%)	43 (100%)
Tier 2 total	3,663(83.3%)	65 (1.5%)	41(0.9%)	60 (1.4%)	4 (0.1%)	12 (0.3%)	5 (0.1%)	5 (0.1%)	1 (0%)	544 (12.4%)	4,400 (100%)

Uptake of ATAPS projects by allied health professionals

Between 1 July 2003 and 30 June 2011, 5,044 (30% rural; 70% urban) allied health professionals delivered ATAPS services to consumers. This represents a continued increase in the number of allied health professionals from December 2010 when there were 4,695 allied health professionals involved in ATAPS⁴². Table 5 shows the number and proportion of allied health professionals across Tier 1 and the various Tier 2 programs. The vast majority (98%) of allied health professionals are delivering Tier 1 services while a minority deliver Tier 2 services, which is likely to be largely attributable to the relative novelty of the latter.

Table 5: Allied health professionals delivering ATAPS services by program (N=5,044)

Program	Number of allied health professionals (%)
Tier 1	4,937 (97.9%)
Tier 2	
ATSI	53 (1.1%)
Bushfire	194 (3.8%)
Children	181 (3.6%)
Homeless	83 (1.6%)
Perinatal depression	600 (11.9%)
Rural & remote	42 (0.8%)
Specialist Suicide	359 (7.1%)
T-CBT	14 (0.3%)
Tier 2 total	1526 (30.2%)

NB. Total exceeds 100% because allied health professionals deliver services (sessions) across multiple programs

Chapter 5: What are the sociodemographic and clinical profiles of consumers of ATAPS?

Consumer characteristics

Tables 6 summarises some of the key sociodemographic characteristics of the consumers receiving care through each of the ATAPS programs. It should be noted that a number of the variables have a significant amount of missing data (i.e., data that was not supplied) and also high levels of 'unknown' responses which should be taken into account when interpreting the results, especially in relation to the Tier 2 programs with small number of consumers.

Overall

Sixty-seven percent of consumers of Tier 1 services are female, and their mean age is 38. About 2.7% of consumers are reported to be Aboriginal and 0.3% to be Torres Strait Islander. About half of the consumers are reported to be low income and about a third have no history of mental health care. The data related to language spoken and English level has a high level of missing data, and should be viewed as indicative only. For the data provided, English is the most commonly reported language used at home, with low levels of other languages reported.

Tier 1

Given the high proportion of Tier 1 consumers represented in overall ATAPS compared to Tier 2, the sociodemographic profile of Tier 1 consumers does not vary from that of overall consumers.

Tier 2

The profile of Tier 2 consumers varies significantly between the programs and again should be viewed as indicative only given the amount of missing data and the low number of consumers represented in each program. For the data provided: males are more strongly represented in the *Homelessness* and *Child* programs (59% and 48%, respectively). *T-CBT* pilot and *Bushfire* program consumers are somewhat older than those involved in the *Aboriginal and Torres Strait Island* and *Perinatal depression* programs (43 and 42 vs. 30). Consumers of the *Aboriginal and Torres Strait Island* and *Homelessness* programs are most likely to be reported to be on a low income (86% and 89%). Consumers of the *Child* program are least likely to have used mental health services before, which is not surprising given their young age (mean = 12 years) and consequent reduced opportunity to access services.

Table 6: Summary characteristics of consumers receiving care through ATAPS by program, July 2003 – June 2011

	Tier 1	Tier 2							OVERALL	
		Aboriginal and Torres Strait Islander	Bushfire	Child	Homelessness	Perinatal depression	Rural and remote	Specialist suicide		T-CBT
Gender										
Male	63,534 (28.4%)	42 (20.4%)	608 (32.5%)	402 (48.1%)	320 (59.1%)	58 (2.1%)	163 (33.9%)	932 (36.1%)	17 (23.3%)	65,945 (28.3%)
Female	150,029 (67.0%)	160 (77.7%)	1,151 (61.6%)	422 (50.5%)	214 (39.6%)	2,647 (94.9%)	316 (65.7%)	15,32 (59.4%)	56 (76.7%)	156,183 (67.1%)
Missing	10,403 (4.6%)	4 (1.9%)	111 (5.9%)	12 (1.4%)	7 (1.3%)	84 (3.0%)	2 (0.4%)	117 (4.5%)	0 (0%)	10,733 (4.6%)
Age										
Mean age	38.3	30.4	42.0	11.7	35.4	30.4	38.4	33.8	42.5	38.0
Missing	10,583 (4.5%)	5 (2.4%)	105 (5.6%)	13 (1.5%)	17 (3.1%)	121 (4.2%)	9 (1.8%)	117 (4.4%)	1 (1.4%)	10,971 (4.4%)
Low income										
Yes	134,525 (56.6%)	180 (86.1%)	1,202 (63.6%)	580 (68.1%)	492(88.8%)	1,804 (62.5%)	220 (44.4%)	1,431 (53.9%)	52 (72.2%)	140,486 (56.8%)
No	41,156 (17.3%)	8 (3.8%)	448 (23.7%)	81 (0.9%)	28 (5.1%)	462 (16.0%)	111 (22.4%)	376 (14.2%)	9 (12.5%)	42,679 (17.3%)
Unknown	34,119 (14.3%)	13 (6.2%)	205 (10.8%)	170 (20.0%)	28 (5.1%)	497 (17.2%)	163 (32.9%)	695 (26.2%)	10 (13.9%)	35,900 (14.5%)
Missing	27,966 (11.8%)	8 (3.8%)	36 (1.9%)	21 (2.5%)	6 (1.1%)	123 (4.3%)	1 (0.2%)	152 (5.7%)	1 (1.4%)	28,314 (11.4%)

(table continues)

Table 6: Summary characteristics of consumers receiving care through ATAPS by program, July 2003 – June 2011 (continued)

	Tier 1	Tier 2								OVERALL
		Aboriginal and Torres Strait Islander	Bushfire	Child	Homelessness	Perinatal depression	Rural and remote	Specialist suicide	T-CBT	
Previous psychiatric service use										
Yes	82,293 (34.6%)	65 (31.2%)	840 (44.4%)	194 (22.8)	211 (38.1%)	1,124 (38.9%)	170 (34.3%)	1,043 (39.0%)	31 (43.1%)	85,971 (34.0%)
No	89,544 (37.7%)	82 (39.2%)	780 (41.2%)	380 (44.6%)	116 (20.9%)	1,087 (37.7%)	184 (37.2%)	780 (29.4%)	21 (29.2%)	92,974 (37.5%)
Unknown	33,187 (14.0%)	42 (20.1%)	205 (10.8%)	241 (28.3%)	215 (38.8%)	473 (16.4%)	140 (28.3%)	618 (23.3%)	19 (26.4%)	35,140 (14.2%)
Missing	32,742 (13.8%)	20 (9.7%)	66 (3.5%)	37 (4.3%)	12 (2.2%)	202 (7.0%)	1 (0.2%)	213 (8.0%)	1 (1.4%)	33,294 (13.5%)
Aboriginal										
Yes	6,041 (2.7%)	165 (80.1%)	17 (0.9%)	27 (3.2%)	40 (7.4%)	101 (3.6%)	32 (6.7%)	59 (2.3%)	1 (1.4%)	6,262 (2.8%)
No	166,104 (74.2%)	28 (13.6%)	1,486 (78.5%)	581 (69.5%)	467 (86.3%)	2,237 (80.2%)	350 (72.8%)	1,821 (70.6%)	57 (78.1%)	172,750 (74.2%)
Unknown	21,736 (9.7%)	11 (5.3%)	246 (13.2%)	171 (20.5%)	26 (4.8%)	297 (10.6%)	80 (16.6%)	523 (20.3%)	15 (20.5%)	23,032 (9.9%)
Missing	30,085 (13.4%)	2 (1.0%)	139 (7.4%)	57 (6.8%)	8 (1.5%)	154 (5.5%)	19 (4.0%)	178 (6.9%)	0 (0%)	30,617 (13.1%)
Torres Strait Islander										
Yes	704 (0.3%)	15 (7.3%)	2 (0.1%)	4 (0.5%)	2 (0.4%)	21 (0.8%)	6 (1.2%)	10 (0.4%)	0 (0%)	762 (0.3%)
No	167,620 (74.8%)	123 (59.7%)	1,462 (78.2%)	575 (68.8%)	491 (90.8%)	2,290 (82.1%)	377 (78.4%)	1,846 (71.5%)	58 (79.5%)	174,474 (74.9%)
Unknown	22,576 (10.1%)	52 (25.2%)	247 (13.2%)	182 (21.8%)	31 (5.7%)	310 (11.1%)	79 (16.4%)	540 (20.9%)	13 (17.8%)	23,948 (10.3%)
Missing	33,066 (14.8%)	16 (7.8%)	159 (8.5%)	75 (9.0%)	17 (3.1%)	168 (6.0%)	19 (4.0%)	185 (7.2%)	2 (2.7%)	33,677 (14.5%)

(table continues)

Table 6: Summary characteristics of consumers receiving care through ATAPS by program, July 2003 – June 2011 (continued)

	Tier 1	Tier 2								OVERALL
		Aboriginal and Torres Strait Islander	Bushfire	Child	Homelessness	Perinatal depression	Rural and remote	Specialist suicide	T-CBT	
Language spoken at home										
Arabic	427 (0.2%)	0 (0%)	2 (0.1%)	4 (0.5%)	3 (0.6%)	8 (0.3%)	1 (0.2%)	4 (0.2%)	0 (0%)	448 (0.2%)
Cantonese	297 (0.1%)	0 (0%)	0 (0%)	2 (0.2%)	1 (0.2%)	2 (0.1%)	0 (0%)	2 (0.1%)	0 (0%)	304 (0.1%)
English	182,555 (81.5%)	141 (68.4%)	1,741 (93.1%)	675 (80.7%)	484 (89.5%)	2,455 (88.0%)	425 (88.4%)	2,165 (83.9%)	47 (64.4%)	190,262 (81.7%)
Greek	686 (0.3%)	0 (0%)	4 (0.2%)	2 (0.2%)	3 (0.6%)	4 (0.1%)	1 (0.2%)	5 (0.2%)	0 (0%)	704 (0.3%)
Italian	905 (0.4%)	0 (0%)	15 (0.8%)	5 (0.6%)	1 (0.2%)	10 (0.4%)	0 (0%)	7 (0.3%)	0 (0%)	943 (0.4%)
Mandarin	181 (0.1%)	0 (0%)	0 (0%)	1 (0.1%)	0 (0%)	6 (0.2%)	0 (0%)	2 (0.1%)	0 (0%)	189 (0.1%)
Unknown	8,098 (3.6%)	5 (2.4%)	0 (0%)	5 (0.6%)	10 (1.8%)	37 (1.3%)	20 (4.2%)	99 (3.8%)	0 (0%)	8,258 (3.5%)
Vietnamese	531 (0.2%)	0 (0%)	1 (0.1%)	1 (0.1%)	2 (0.4%)	5 (0.2%)	0 (0%)	6 (0.2%)	0 (0%)	544 (0.2%)
Missing	30,286 (13.5%)	60 (29.1%)	107 (5.7%)	141 (16.9%)	37 (6.8%)	262 (9.4%)	34 (7.1%)	291 (11.3%)	26 (35.6%)	31,209 (13.4%)
English comprehension level										
None	1,757 (0.8%)	2 (1.0%)	3 (0.2%)	13 (1.6%)	2 (0.4%)	20 (0.7%)	4 (0.8%)	14 (0.5%)	0 (0%)	1,808 (0.8%)
Unknown	6,090 (2.7%)	6 (2.9%)	4 (0.2%)	8 (1.0%)	9 (1.7%)	34 (1.2%)	18 (3.7%)	86 (3.3%)	0 (0%)	6,243 (2.7%)
Very Well	49,769 (22.2%)	110 (53.4%)	137 (7.3%)	271 (32.4%)	271 (50.1%)	839 (30.1%)	121 (25.2%)	558 (21.6%)	1 (1.4%)	51,863 (22.3%)
Well	7,951 (3.6%)	13 (6.3%)	15 (0.8%)	74 (8.9%)	42 (7.8%)	127 (4.6%)	32 (6.7%)	143 (5.5%)	0 (0%)	8,336 (3.6%)
Missing	158,399 (70.7%)	75 (36.4%)	1,711 (91.5%)	470 (56.2%)	217 (40.1%)	1,769 (63.4%)	306 (63.6%)	1,780 (69.0%)	72 (98.6%)	164,611 (70.7%)

Consumer diagnoses

Table 7 summarises the key diagnostic characteristics reported for ATAPS consumers within each program.

Overall

Diagnostic information was provided for 177,041 (72%) of the 247,378 referrals made to ATAPS. However, the totals in the table exceed 100% as consumers can receive more than one diagnosis. Of all the 247,378 referrals made to all ATAPS programs, 66,130 (27%) of referrals had no diagnostic information supplied. In addition to this, 4,208 referrals had only an 'other' diagnosis supplied that was uncategorised. Thus, in total 70,338 (28%) of referrals had either missing or uncategorised diagnosis information.

Overall the most common diagnoses were for Depression (54%) and Anxiety disorders (41%). Other disorders were reported relatively infrequently.

Tier 1

The most common diagnoses in the Tier 1 services were for Depression and Anxiety disorders, which were reported in 54% and 41% of all Tier 1 referrals respectively. Other diagnoses were reported relatively infrequently.

Tier 2

The diagnostic information related to the Tier 2 services should be viewed as indicative only as there are significant amounts of missing data (over 15% for all programs except *T-CBT*, and over 30% for four of the programs). Within the available data there was some variability across the Tier 2 services. *Homelessness service* and *Aboriginal and Torres Strait Islander service* consumers reported a somewhat higher prevalence of Alcohol and Drug use disorders (28% and 15%), whilst Depression and Anxiety Disorders were both most commonly reported in the *T-CBT* pilot and the *Aboriginal and Torres Strait Islander* consumers (85% and 67%). Psychotic disorders and unexplained somatic disorders were reported relatively infrequently across all ATAPS programs. Referrals to the *Child services* had a particularly high rate of missing or uncategorised diagnosis information (44%). However, it is noteworthy that many of the 'other' diagnoses provided for Children's services referrals were related to behavioural and development childhood disorders that do not otherwise fit into the diagnostic categories available in the MDS.

Table 7: Diagnostic characteristics of consumers by ATAPS program, July 2003 – June 2011

	Tier 1	Tier 2								OVERALL
		Aboriginal and Torres Strait Islanders	Bushfire	Children	Homelessness	Perinatal depression	Rural and remote	Specialist suicide	T-CBT	
Diagnosis										
Alcohol and drug use disorders	12,742 (5.4%)	32 (15.3%)	81 (4.3%)	5 (0.6%)	153 (27.6%)	40 (1.4%)	28 (5.7%)	134 (5.0%)	2 (2.8%)	13,217 (5.3%)
Psychotic disorders	3,718 (1.6%)	5 (2.4%)	18 (1.0%)	4 (0.5%)	43 (7.8%)	20 (0.7%)	14 (2.8%)	65 (2.4%)	0 (0%)	3,887 (1.6%)
Depression	129,038 (54.3%)	137 (65.6%)	910 (48.1%)	214 (25.1%)	338 (61.01%)	1,755 (60.8%)	283 (57.2%)	1,424 (53.7%)	61 (84.7%)	134,160 (54.2%)
Anxiety disorders	97,368 (41.0%)	106 (50.7%)	897 (47.4%)	325 (38.1%)	220 (39.7%)	805 (27.9%)	217 (43.8%)	650 (24.5%)	47 (65.3%)	100,635 (40.7%)
Unexplained somatic disorders	4,090 (1.7%)	3 (1.4%)	24 (1.3%)	25 (2.9%)	5 (0.9%)	21 (0.7%)	3 (0.6%)	23 (0.9%)	0 (0%)	4,194 (1.7%)
No formal diagnosis	37 (0%)	1 (0.5%)	0 (0%)	3 (5.4%)	4 (7.1%)	4 (0.1%)	5 (1.0%)	2 (0.1%)	0 (0%)	56 (0%)
Unknown	3,286 (1.4%)	3 (1.4%)	29 (1.5%)	21 (2.5%)	10 (1.8%)	23 (0.8%)	16 (3.2%)	43 (1.6%)	1 (1.4%)	3,432 (1.4%)
No. referrals with missing or uncategorised diagnosis	67,265/237,765 (28.3%)	32/209 (15.3%)	596/1,891 (31.5%)	374/852 (43.9%)	88/554 (15.9%)	870/2,886 (30.1%)	99/495 (20.0%)	1,011/2,654 (38.1%)	3/72 (4.2%)	70,338/274,378 (28.4%)

Chapter 6: What is the nature of the treatment received by ATAPS consumers?

Profile of sessions

Table 8 describes some of the key characteristics of the sessions delivered through each of the ATAPS programs. As noted previously, a number of the variables have a significant amount of missing data which should be taken into account when interpreting the results, especially in relation to the Tier 2 programs which have delivered a smaller number of sessions.

Overall

Overall sessions of 46-60 minutes have been the most popular, accounting for 78% of session (refer to Table 8). Sessions of over one hour in duration accounted for approximately 10% of all ATAPS services. The vast majority (92%) of sessions have been delivered to individuals (refer to Table 8). The majority (97%) of all sessions have been delivered face-to-face, occasionally being delivered by telephone and less frequently via videoconference or web-based.

Nationally, the majority (66%) of sessions did not incur a copayment; this information was missing for approximately 18% of sessions (refer to Table 8). For the 165,025 sessions where a copayment was incurred, the mean copayment amount was \$15.79 [rural: \$15.88 (S.D. \$18.35) and urban: \$15.77 (S.D. \$16.13)]. The national mean cost per session (including \$0 sessions) for the 810,173 sessions where this information was provided was \$3.22, with a lower mean in rural (\$1.48, S.D. = \$6.13) compared with urban (\$4.35, S.D. = \$11.01) areas.

Overall, the most common interventions provided through sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 46% and 35% of sessions, respectively (refer to Table 8). Across all Tier 1 and 2 ATAPS programs 3,701 (0.4%) sessions involved 'other CBT' strategies and 5,552 (0.6%) delivered 'other' (non-CBT) strategies. Overall, in approximately 7% of all ATAPS sessions, consumers did not attend.

Tier 1

Not surprisingly, the characteristics of the Tier 1 sessions, which comprise the majority of sessions delivered via all of ATAPS, very closely parallel the overall patterns described above (refer to Table 8).

Tier 2

Similarly, across all Tier2 programs sessions of 46-60 minutes have been the most popular (refer to Table 8). Sessions of less than 30 minutes duration have been more common within several of the Tier 2 programs compared with the Tier 1 (2%) service, particularly the *Rural and remote* (14%) and *Specialist suicide services* (14%) programs. Tier 2 sessions of over one hour in duration were particularly popular in the *Aboriginal and Torres Strait Islander* and *Rural and remote* programs (34% and 18%, respectively). To varying extents, the majority of Tier 2 programs have delivered sessions to individuals; however group sessions appear to have been particularly popular in the *Aboriginal and Torres Strait Islander* and *Perinatal depression* programs (41% and 10%, respectively).

The majority of all Tier 2 sessions have been delivered face-to-face, however sessions delivered via other modalities are being utilised as needed (refer to Table 8). Telephone sessions have been delivered most frequently not only via the now completed *T-CBT* pilot but also via the *Specialist suicide services* and the *Rural and remote* programs (34%, 7% and 2%, respectively).

The majority of Tier 2 sessions did not incur a copayment and were less likely to do so compared to Tier 1 sessions (refer to Table 8). This information was missing for large proportions of sessions within specific Tier 2 programs; however missing data possibly indicates that no copayment was made in many instances. The highest mean copayment is observed for the *Bushfire* program and the lowest for the *T-CBT* pilot (\$99.23 and \$6.54, respectively). The mean copayment for *Bushfire* sessions appears much higher than the copayment for any other program because, of the sessions delivered via this program, 64 (less than 1%) incurred a copayment of \$100 each and one of \$50. The mean cost per session (including \$0 sessions) across all Tier 2 programs is relatively low, with the highest overall cost for sessions associated with those delivered via the *Child* and lowest via the *Homelessness* program (\$4.46 and \$0.06, respectively).

In the main, CBT-based cognitive and behavioural interventions are the most common interventions delivered across all Tier 2 programs, but there are some nuances (refer to Table 8). For example, interpersonal therapy is more common (to differing extents) than behavioural interventions in the *Rural and remote* and *Aboriginal and Torres Strait Islander* programs (41% vs 29% and 20% vs 18%, respectively) and psycho-education has been most popular in the *Bushfire* program (42%) and somewhat more common than behavioural interventions in the *Rural and remote* program (34% vs 29%).

Around one in five sessions were not attended in the *Aboriginal and Torres Strait Islander*, *Homelessness* and *Rural and remote* programs. A smaller proportion of sessions were unattended across the remaining Tier 2 programs.

Table 8: Summary characteristics of sessions provided to consumers through the ATAPS projects by program, July 2003 – June 2011

	Tier 1	Tier 2							OVERALL	
		Aboriginal and Torres Strait Islander	Bushfire	Child	Homelessness	Perinatal depression	Rural and remote	Specialist suicide		T-CBT
Duration										
0-30 mins	19,898 (2.1%)	51 (6.1%)	53 (0.5%)	45 (0.2%)	122 (7.1%)	431 (3.7%)	163 (14.2%)	1,746 (13.9%)	12 (3.7%)	22,521 (2.3%)
31-45 mins	31,300 (3.3%)	11 (1.3%)	73 (0.7%)	39 (0.1%)	62 (3.6%)	152 (1.3%)	25 (2.2%)	198 (1.6%)	14 (4.3%)	31,874 (3.2%)
46-60 mins	736,419 (78.2%)	328 (39.5%)	8,430 (84.7%)	2,232 (79.0%)	1,214 (70.9%)	8,112 (69.5%)	690 (60.2%)	8,248 (65.6%)	256 (79.0%)	765,929 (77.9%)
Over 60 mins	96,423 (10.2%)	283 (34.1%)	693 (7.0%)	294 (10.4%)	108 (6.3%)	108 (6.3%)	201 (17.5%)	1,844 (1.8%)	30 (9.3%)	102,230 (10.4%)
Missing	57,827 (6.1%)	158 (19%)	700 (7.0%)	215 (7.6%)	207 (12.1%)	618 (5.3%)	68 (5.9%)	533 (4.2%)	12 (3.7%)	60,338 (6.1%)
Type										
Group	18,559 (2.0%)	339 (40.8%)	113 (1.1%)	36 (1.3%)	17 (1.0%)	1,185 (10.2%)	26 (2.3%)	51 (0.4%)	1 (0.3%)	20,327 (2.1%)
Individual	872,292 (92.6%)	463 (55.7%)	9,137 (91.8%)	1,130 (40.0%)	1,367 (79.8%)	10,118 (86.7%)	1,082 (94.3%)	11,952 (95.1%)	323 (99.7%)	907,864 (92.4%)
Child	79 (0.0%)	-	-	873 (30.9%)	3 (0.2%)	-	-	-	-	955 (0.1%)
Child & parent(s)	3 (0.0%)	-	-	395 (14.0%)	-	-	-	-	-	398 (0.0%)
Child in group	-	-	-	59 (2.1%)	-	-	-	-	-	59 (0.0%)
Parent(s)	1 (0.0%)	-	-	99 (3.5%)	-	-	-	-	-	100 (0.0%)
Parent(s) in group	-	-	-	2 (0.1%)	-	-	-	-	-	2 (0.0%)
Missing	50,933 (5.4%)	29 (3.5%)	699 (7.0%)	231 (8.2%)	326 (19.0%)	364 (3.1%)	39 (3.4%)	566 (4.5%)	-	53,187 (5.4%)

NB. 'Child' and 'Parent(s)' type sessions are individual but these categories were added to the minimum dataset to identify whether the child or parent(s) attended the sessions.

(table continues)

Table 9: Summary characteristics of sessions provided to consumers through the ATAPS projects by program, July 2003 – June 2011 (continued)

	Tier 1	Tier 2							OVERALL	
		Aboriginal and Torres Strait Islander	Bushfire	Child	Homelessness	Perinatal depression	Rural and remote	Specialist suicide		T-CBT
Modality										
Face-to-face	913,852 (97.0%)	334 (40.2%)	9,738 (97.9%)	2,615 (92.6%)	1,091 (63.7%)	10,882 (93.3%)	1,031 (89.9%)	10,712 (85.2%)	206 (63.6%)	950,461 (96.7%)
Telephone	2,299 (0.2%)	11 (1.3%)	41 (0.4%)	11 (0.3%)	9 (0.5%)	227 (1.9%)	28 (2.4%)	926 (7.4%)	118 (36.4%)	3,670 (0.4%)
Videoconference	163 (0.0%)	-	1 (0.0%)	2 (0.1%)	-	3 (0.0%)	-	21 (0.2%)	-	190 (0.0%)
Web-based	28 (0.0%)	-	-	-	1 (0.1%)	-	3 (0.3%)	4 (0.0%)	-	36 (0.0%)
Missing	25,525 (2.7%)	486 (58.5%)	160 (1.7%)	197 (7.0%)	612 (35.7%)	555 (4.8%)	85 (7.4%)	906 (7.2%)	-	28,535 (2.9%)
Copayment charged										
No	628,031 (66.7%)	191 (23.0%)	1,643 (16.5%)	1,296 (45.9%)	1,356 (79.2%)	5,135 (44.0%)	242 (21.1%)	7,042 (56.0%)	212 (65.4%)	645,148 (65.6%)
Yes	163,590 (17.3%)	15 (1.8%)	65 (0.7%)	402 (14.2%)	7 (0.4%)	1,303 (11.2%)	84 (7.3%)	134 (1.1%)	13 (4.0%)	165,613 (16.6%)
Mean copayment (S.D.)	\$15.75 (\$16.49)	\$17.00 (\$5.28)	\$99.23 (\$6.20)	\$18.38 (\$12.46)	\$10.71 (\$5.35)	\$15.40 (\$16.81)	\$11.67 (\$4.93)	\$14.20 (\$6.09)	\$6.54 (\$2.40)	\$15.79 (\$16.55)
Mean cost per session (S.D.)	\$3.24 (\$9.83)	\$1.24 (\$4.64)	\$3.77 (\$19.03)	\$4.46 (\$10.04)	\$0.06 (\$0.84)	\$3.12 (\$9.77)	\$3.01 (\$5.69)	\$0.27 (\$2.09)	\$0.38 (\$9.81)	\$3.22 (\$9.81)
Missing	150,246 (16.0%)	625 (75.2%)	8,241 (82.8%)	1,127 (39.9%)	350 (20.4%)	5,229 (44.8%)	821 (71.6%)	5,393 (42.9%)	99 (30.6%)	172,131 (17.5%)

(table continues)

Table 9: Summary characteristics of sessions provided to consumers through the ATAPS projects by program, July 2003 – June 2011 (continued)

	Tier 1	Tier 2							OVERALL	
		Aboriginal and Torres Strait Islander	Bushfire	Child	Homelessness	Perinatal depression	Rural and remote	Specialist suicide		T-CBT
Interventions^a										
Missing	146,184 (15.5%)	181 (21.7%)	692 (7.0%)	382 (13.5%)	357 (20.8%)	2,304 (19.7%)	193 (16.8%)	1,687 (13.4%)	119 (36.7%)	152,099 (15.5%)
Diagnostic assessment	148,728 (15.8%)	87 (10.5%)	1,605 (16.1%)	609 (21.6%)	437 (25.5%)	1,652 (14.2%)	166 (14.5%)	2,672 (21.3%)	40 (12.3%)	155,966 (15.9%)
Psycho-education	224,515 (23.8%)	158 (19.0%)	4,176 (42.0%)	600 (21.2%)	501 (29.2%)	3,234 (27.7%)	390 (34.0%)	1,695 (13.5%)	91 (28.1%)	235,360 (23.9%)
CBT-Behavioural	325,916 (34.6%)	147 (17.7%)	4,497 (45.2%)	942 (33.3%)	725 (42.3%)	3,786 (32.5%)	335 (29.2%)	3,046 (24.2%)	108 (33.3%)	339,502 (34.5%)
CBT-Cognitive	436,807 (46.4%)	485 (58.4%)	5,600 (56.3%)	800 (28.3%)	896 (52.3%)	5,018 (43.0%)	480 (41.8%)	4,821 (38.4%)	95 (29.3%)	455,002 (46.3%)
CBT-Relaxation	170,187 (18.1%)	101 (12.2%)	2,778 (27.9%)	433 (15.3%)	217 (12.7%)	2,082 (17.8%)	201 (17.5%)	1,430 (11.4%)	49 (15.15)	177,478 (18.1%)
CBT-Skills training	163,694 (17.4%)	88 (10.6%)	3,169 (31.9%)	458 (16.2%)	184 (10.7%)	2,227 (19.1%)	257 (22.4%)	1,895 (15.1%)	108 (33.3%)	172,080 (17.5%)
Interpersonal therapy	219,538 (23.3%)	166 (20.0%)	4,064 (40.8%)	588 (20.8%)	508 (29.7%)	2,766 (23.7%)	473 (41.2%)	2,049 (16.3%)	34 (10.5%)	230,986 (23.4%)
Narrative therapy	1,228 (0.1%)	15 (1.7%)	88 (0.9%)	24 (0.8%)	19 (1.1%)	87 (0.7%)	34 (3.0%)	69 (0.5%)	-	1,563 (0.2%)
Family therapy	10 (0.0%)	-	-	39 (1.4%)	-	82 (0.7%)	-	-	-	131 (0.0%)
Parent training in behaviour management	3 (0.0%)	-	-	47 (1.7%)	-	-	-	-	-	50 (0.0%)
Play therapy	49 (0.0%)	-	-	-	-	-	-	-	-	116 (0.0%)
No show	61,034 (6.5%)	171 (20.6%)	584 (5.9%)	226 (8.0%)	333 (19.4%)	1,035 (8.9%)	188 (16.4%)	807 (6.4%)	25 (7.7%)	64,403 (6.6%)

^a Multiple responses permitted

Chapter 7: Is ATAPS achieving positive outcomes for consumers?

Although previous chapters have reported aggregated overall ATAPS findings, it was not considered appropriate to aggregate the consumer outcomes of the various ATAPS sub-programs, because each program delivers different services to consumers with different needs, therefore results in relation to consumer outcomes are presented separately for each program.

To be included in the analyses of outcomes, a minimum of 50 consumers within each ATAPS sub-program were required to have pre- and post-treatment scores on a given outcome measure. Based on this prerequisite, pre- and post-treatment outcome data were available for 24,581 (13.4% of the 182,889 who received sessions) Tier 1 consumers, 88 (5.7% of the 1,535) *Bushfire*, 332 (14.5% of the 1,535) *Perinatal depression* and 356 (15.4% of the 2,310) *Specialist suicide services* - the remaining Tier 2 programs did not meet this prerequisite which is expected based on their relative infancy (with the exception of the completed *T-CBT* pilot).

Table 9 shows the number of measures used per consumer by each program. The majority of consumers included had outcome data from one measure only, but some had outcome data from multiple measures, with instances of three measures often being accounted for by use of the three Depression Anxiety and Stress Scales (DASS).⁴³

Table 9: Number of outcome measures used per consumer by program

Number of measures per consumer	Number (%) of consumers			
	Tier 1	Bushfire	Perinatal depression	Specialist suicide
1	15,109 (61.5%)	88 (84.9%)	183 (55.1%)	227 (63.8%)
2	2,725 (11.1%)	-	20 (6.0%)	5 (1.4%)
3	5,119 (20.8%)	-	64 (19.3%)	27 (7.6%)
4	1,409 (5.7%)	-	44 (13.3%)	50 (14.0%)
5	118 (0.5%)	-	20 (6.0%)	47 (13.2%)
6	99 (0.4%)	-	-	-
7	2 (0%)	-	-	-
8	-	-	1 (0.3%)	-
Total	24,581 (100%)	88 (100%)	332 (100%)	356 (100%)

Appendix B describes the 13 most commonly-used outcome measures: the Beck Anxiety Inventory (BAI),⁴⁴ the Behaviour and Symptom Identification Scale 32 (BASIS-32),⁴⁵ the Beck Depression Inventory (BDI),⁴⁶ the DASS,⁴³ the Edinburgh Post Natal Depression Scale (EPNDS),⁴⁷ the Global Assessment of Functioning (GAF),⁴⁸ the General Well-Being Index (GWBI),⁴⁹ the Hospital Anxiety and Depression Scale (HADS),⁵⁰ the Health of the Nation Outcome Scales (HoNOS),⁵¹ the Kessler 10 (K-

10),⁵² the Modified Scale for Suicidal Ideation (MSSI),⁵³ the Outcome Rating Scale (ORS),⁵⁴ and the Strengths and Difficulties Questionnaire(SDQ)⁵⁵.^a

Changes on outcome measures from pre- to post-treatment

Table 10 shows the mean difference in scores on the 14 most commonly-used outcome measures by program. With the exception of the DASS, the mean differences were based on total scores. In the case of the DASS, the mean differences were based on scores for each of the three sub-scales because a total score on this instrument is not regarded as meaningful.⁴³ Across all measures, the mean difference was statistically significant and indicative of clinical improvement.

^a Although pre- and post-treatment scores were available for the Session Rating Scale (SRS)⁵⁶. Duncan BL, Miller SD, Sparks JA, Claud DA, Reynolds LR, Brown J. The Session Rating Scale: Preliminary psychometric properties of a working alliance measure. *Journal of Brief Therapy* 2003;3(3). for over 50 Tier 1 consumers, results of its analysis are not reported because it assesses the therapeutic alliance rather than consumer outcomes.

Table 10: Pre- and post-treatment outcome scores on available outcome measures for patients receiving care through the ATAPS projects by program

Measure	Program															
	Tier 1				Bushfire				Perinatal depression				Specialist suicide services			
	n	Pre-treatment mean (S.D.)	Post-treatment mean (S.D.)	Mean difference (S.D.)*	n	Pre-treatment mean (S.D.)	Post-treatment mean (S.D.)	Mean difference (S.D.)*	n	Pre-treatment mean (S.D.)	Post-treatment mean (S.D.)	Mean difference (S.D.)*	n	Pre-treatment mean (S.D.)	Post-treatment mean (S.D.)	Mean difference (S.D.)*
BAI	514	22.9 (12.5)	14.2 (11.7)	8.7 (10.4)*	-	-	-	-	-	-	-	-	-	-	-	-
BASIS-32	2,681 ^a	1.2 (0.6)	0.2 (0.4)	1.0 (0.7)*	-	-	-	-	-	-	-	-	-	-	-	-
BDI	715	27.4 (12.0)	15.6 (11.9)	11.8 (11.1)*	-	-	-	-	-	-	-	-	-	-	-	-
DASS-A	6,712	15.8 (10.1)	9.7 (8.8)	6.1 (8.8)*	-	-	-	-	130	11.8 (9.4)	6.3 (7.4)	5.5 (8.5)*	124	17.8 (10.2)	10.0 (8.1)	7.8 (9.8)*
DASS-D	6,723	20.4 (11.3)	11.8 (10.1)	8.7 (10.6)*	-	-	-	-	131	17.1 (10.0)	8.7 (8.1)	8.4 (10.7)*	124	25.9 (10.8)	12.2 (9.1)	13.7 (12.4)*
DASS-S	6,610	22.2 (10.1)	14.4 (9.7)	7.9 (9.9)*	-	-	-	-	131	20.8 (9.2)	13.5 (9.0)	7.4 (9.0)*	121	23.4 (10.9)	13.5 (S.D)	9.9 (11.3) *
EPNDS	-	-	-	-	-	-	-	-	173	16.4 (5.3)	9.6 (6.3)	6.8 (7.4)*	-	-	-	-
GAF	1,135	58.2 (9.1)	69.8 (11.2)	-11.5 (8.4)*	-	-	-	-	-	-	-	-	-	-	-	-
GWBI	318	39.9 (15.0)	54.8 (16.2)	-15.0 (17.0)*	-	-	-	-	-	-	-	-	-	-	-	-
HADS	409	19.0 (6.8)	9.4 (6.8)	9.6 (6.8)*	-	-	-	-	-	-	-	-	-	-	-	-
HoNOS	2,893	11.8 (5.0)	6.4 (4.7)	5.4 (4.1)*	-	-	-	-	-	-	-	-	-	-	-	-
K-10	12,983	31.1 (7.9)	22.8 (8.4)	8.3 (8.5)*	88	31.0 (7.5)	25.2 (7.5)	5.8 (7.2)*	99	30.7 (7.5)	20.3 (8.0)	10.4 (9.1)*	138	34.5 (7.7)	24.3 (9.4)	10.2 (9.9)*
MSSI	-	-	-	-	-	-	-	-	-	-	-	-	241	11.0 (11.1)	2.5 (5.3)	8.5 (10.1)
ORS	145	20.1 (7.9)	28.8 (9.5)	-8.8 (10.0)*	-	-	-	-	-	-	-	-	-	-	-	-
SDQPCTD	102	14.4 (11.4)	6.6 (8.8)	7.7 (9.2)*	-	-	-	-	-	-	-	-	-	-	-	-

* p <0.001** p<0.05

^a This figure excludes cases where invalid both pre- and post-treatment scores of zero were detected.

Chapter 8: Discussion

Summary and interpretation of findings

The current report provides a comprehensive summary of the achievements across the various ATAPS programs.

Uptake of ATAPS by consumers

Between 1 July 2003 and 30 June 2011, 247,378 (96% Tier 1 and 4 % Tier 2) consumers were referred to the ATAPS projects. Of these referrals, 190,629 (77%) received services. This represents a strong uptake of services following referral, particularly since some referred consumers might not be expected to take up the service for a range of reasons (e.g., lack of readiness to receive psychological treatment; the length of time between referral and availability of the first session; the decision by consumers to seek alternative types of treatment such as psychotropic medication; or possible resolution of psychological issues).

In total, 982,892 (96% Tier 1 and 4% Tier 2) sessions of care were provided through ATAPS, making 5.2 the average number of sessions provided per referral. This average 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.

All 110 GPNs are delivering Tier 1 and 106 GPNs are now delivering Tier 2 services. The uptake of the Tier 2 services has varied. For example, the uptake of the *Specialist suicide services* and *Perinatal depression* programs, has been more significant than others. This is probably due to the fact that these are the most widely available and longest running of the Tier 2 programs. The rate of referrals resulting in sessions also varied somewhat between the programs; the lowest rate occurred in the *Rural and remote* and the highest occurred in the *Specialist suicide services* programs. The latter may be attributable to the program stipulation that consumers receive follow-up within 72 hours or the urgent nature of the presenting problem; either way this substantial rate of uptake of the *Specialist suicide services* suggests that this Tier 2 program is addressing a consumer need.

All new Tier 2 services showed a peak in referrals and sessions in February and/or March 2011, suggesting that it took GPNs seven to eight months from the introduction of the new funding to have the necessary systems in place to deliver services to the priority groups that had been identified. This may be attributable to a range of barriers experienced by GPNs in establishing new ATAPS services as reported in previous evaluations of the *Specialist suicide services*²⁰⁻²³ and the *T-CBT* pilot.^{15 16} Preparation and planning for new services were reported to be time consuming and resulted in delays in service commencement. In addition, developing relationships with new referrers, and training and recruiting allied health professionals (where needed) also delayed service commencement. These previous evaluations of Tier 2 services also demonstrated that GPNs varied widely in their capacity to integrate new services. This capacity was often dependent on the structure of their existing ATAPS workforce. Accordingly it is expected that over time as teething issues are resolved, Tier 2 services will become increasingly established.

Participation in ATAPS by professionals

Between 1 July 2003 and 30 June 2011, there were 20,950 professionals (41% rural; 59% urban) referring to all ATAPS programs. GPs make up 19,872 (99.9%) of the 19,882 referrers to Tier 1 ATAPS. GPs also represent the vast majority (83.3%) of referrers across all Tier 2 programs. However, the uptake of Tier 2 services by GP has been quite slow, with only 3,663 GPs in total referring to any of the Tier 2 services. The number of other referrers in the Tier 2 services is relatively small compared to the number of GPs involved in Tier 2.

Between 1 July 2003 and 30 June 2011, 5,044 (30% rural; 70% urban) allied health professionals delivered ATAPS services to consumers. The vast majority (98%) of allied health professionals are delivering Tier 1 while a minority deliver Tier 2 services.

The lower rate of participation of both referrers and allied health professionals in the Tier 2 programs is likely to be largely attributable to the fact that Tier 1 services have been available since 2001 whilst the first of the Tier 2 services commenced in 2008 and the remainder of the Tier 2 services became available in July 2010. Other possible explanations include: the fact that compared with Tier 1 the overall amount of funding is lower for Tier 2 programs; each GPN varies in the type and number of Tier 2 programs it operates; some Tier 2 programs may be perceived to require expertise in specialist areas (e.g., children's mental health, psychological impact of disasters) which not all professionals have; and additional training is required for one of the current Tier 2 programs (*Specialist suicide services*). Previous evaluations of the *Specialist suicide services*²⁰⁻²³ and *T-CBT services*^{14 16 57} have also suggested that some allied health professionals have been unwilling to be involved in these newer Tier 2 services, at times attributable to their reticence to undertake additional mandatory training. GPNs also reported that GPs had taken some time to become aware of and comfortable with new services, and were reluctant to refer to what have been viewed as 'pilot' programs. As such, we would expect to see a greater involvement of allied health professionals and GPs as the new Tier 2 services become more firmly and permanently embedded as mental health treatment options within ATAPS.

Sociodemographic and clinical profiles of consumers of ATAPS

Sixty-seven percent of consumers of Tier 1 services are female, and their mean age is 38 years. About 3% of consumers are reported to be Aboriginal and 0.3% Torres Strait Islander. About half of the consumers are reported to be on low incomes and about a third has no history of mental health service use. English is the most commonly reported language used at home, with low levels of other languages reported.

Preliminary findings indicate that the profile of Tier 2 consumers varies significantly between the programs. For example, males are more strongly represented in the *Homelessness* and *Child* programs (59% and 48%, respectively). *T-CBT* pilot and *Bushfire* consumers are somewhat older than consumers of the *Aboriginal and Torres Strait Islander* and *Perinatal depression* programs. *Aboriginal and Torres Strait Islander* and *Homelessness* consumers are most likely to be reported to be on a low income. Consumers of the *Child* program are least likely to have used mental health services before, which is not surprising given their younger age.

The differing profile of consumers across the programs provides some evidence that the Tier 2 services may be successfully reaching their intended target consumer groups, although this data should be interpreted cautiously due to the low numbers of consumers and different time frames represented.

The lack of diversity in language spoken across all ATAPS programs might suggest that ATAPS could improve its reach to people that speak a language other than English at home.

The most common diagnoses in the Tier 1 services were for depression (54%) and anxiety disorders (41%). This diagnostic profile is consistent with the stated aim of ATAPS to primarily treat high prevalence mental disorders.¹³ There was some variability in diagnoses across the Tier 2 programs. *Homelessness* and *Aboriginal and Torres Strait Islander* consumers were reported to have a somewhat higher rate of alcohol and drug use disorders, whilst depression and anxiety disorders were both most commonly reported in *T-CBT* and *Aboriginal and Torres Strait Islander* consumers. Psychotic disorders and unexplained somatic disorders were less frequently reported across all ATAPS programs.

Nature of the treatment received by ATAPS consumers

Overall and across all programs, sessions of 46-60 minutes have been the most popular. Sessions of less than 30 minutes and greater than one hour in duration have been more common within several of the Tier 2 programs compared with the Tier 1 service perhaps reflecting the intended flexibility afforded by the former. The vast majority of these sessions have been delivered to individuals rather than groups; however group sessions appear to have been particularly popular in the *Aboriginal and Torres Strait Islander* and *Perinatal depression* programs (41% and 10%, respectively).

The majority of all ATAPS sessions have been delivered face-to-face. This is likely to be attributable to the fact that the option to utilise other modalities, such as the telephone, video-conferencing or the web was only relatively recently introduced in 2008 and to some extent may reflect that despite the need for this type of service, most consumers and professionals prefer the face-to-face modality if this option exists.¹⁶ Nonetheless, albeit at a lower rate, other modalities of session delivery such as the telephone are being utilised as needed across both Tier 1 and Tier 2 services. Other than the obvious *T-CBT* pilot, telephone sessions have been used most frequently in the *Specialist suicide services* and *Rural and remote* programs, suggesting that this modality may particularly useful in crisis situations requiring an immediate response and for overcoming barriers such as commuting distance.

Nationally, the majority (66%) of sessions did not incur a copayment. For the 165,025 sessions where a copayment was incurred, the average *copayment* amount was \$15.79. The national average *cost per session* for the 810,173 sessions where this information was provided was \$3.22, with a lower average in rural (\$1.48, S.D. = \$6.13) compared with urban (\$4.35, S.D. = \$11.01) areas. The mean copayment and cost per session was lower for sessions delivered via most Tier 2 programs compared with Tier 1, which is consistent with the intention of Tier 2 programs to improve access to services for hard to reach or more disadvantaged consumers.

Overall, the most common interventions provided through sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 46% and 35% of sessions, respectively. In the main, this pattern can be observed across all programs, but there are some nuances. Overall, in approximately 7% of all ATAPS sessions, consumers did not attend. The rate of non-attendance at sessions was proportionally much higher for several of the Tier 2 programs perhaps reflecting the more complex presentations of these harder to reach groups.

Outcomes of ATAPS for consumers

Pre- and post-treatment outcome data were available for 24,581 (13.4%) of Tier 1, 88 (5.7%) of *Bushfire*, 332 (14.5%) of *Perinatal depression* and 356 (15.4%) of *Specialist suicide services* consumers. The remaining Tier 2 programs did not have sufficient data to be included in the analyses, which is expected

based on their relative infancy (with the exception of the completed *T-CBT* pilot). Across all of the 13 most commonly used standardised outcome measures, the mean difference was statistically significant and indicative of clinical improvement. Despite the low rate of available pre- and post-treatment outcome measures, these findings indicate that the Tier 1 program is continuing to achieve, and the Tier 2 programs for which data were available are achieving, the intended objective of the program in which they are embedded, namely better outcomes in mental health.

Limitations

Some caution should be exercised in interpreting the above findings. There are lags in data entry into the minimum dataset, with some GPNs not entering session data until all sessions for a given consumer are complete. This specifically affects the more recent uptake figures across all Tier 1 and 2 ATAPS programs.

Comparisons between ATAPS sub-programs also need to be interpreted with caution given that they vary in lifespan and accordingly their uptake by consumers. Furthermore, given the different groups targeted by the Tier 2 programs, variability in uptake and consumer and session characteristics are expected.

There is also a significant amount of missing data in relation to some variables and some data fields which have been more recently added to the minimum dataset to accommodate the introduction of the Tier 2 services and their unique flexibilities which need to be taken into consideration when interpreting the data. Furthermore, given the 'real-world' nature of the evaluation, in response to policy changes Tier 2 service delivery commencement has often preceded commensurate decisions about, and implementation of, changes to the minimum dataset; GPNs are likely to differ in the way that they manage this challenge not to mention our lack of knowledge about whether GPNs which upload their data have kept up with the pace of changes to the minimum dataset in terms of updating their internal data capture systems. Despite the achievements of the Tier 2 programs, their impact has been reported in isolation of local needs analyses and community profiling, prohibiting comment on the true magnitude of their achievements or their reach within the intended target consumer group.

It was not possible to evaluate the consumer outcomes achieved across all of the ATAPS sub-programs because of the insufficient numbers of consumers with pre- and post-treatment outcome data. The proportion of patients for whom pre- and post-treatment outcome data were available was less than optimal ranging from about 13% in Tier 1 to 6% in the *Bushfire* program. It is possible that this may have introduced a systematic bias, such that those for whom no outcome data were available may have had poorer outcomes (if, for example, outcome data were unavailable because they dropped out of treatment). The findings still stand, but they may present a somewhat over-optimistic picture. At the very least, it is possible to say with certainty that the outcomes of care from the three ATAPS sub-programs included in the analyses are excellent for the thousands of patients observed here. From an evaluation perspective, more comprehensive collection and collation of outcome data would be desirable, as would rationalising the number of outcome measures used by GPNs. Strengthening the ATAPS outcome data collection in this way would enable more definitive statements about the achievements of ATAPS to be made.

Furthermore, the reported achievements of ATAPS overall are confined by the scope of the evaluation, which although comprehensive, emphasises uptake and mental health outcomes. Further investigation

of the Tier 2 programs in particular might be useful in elucidating key success factors in the establishment phase and the impact of flexible service models, such as outreach and community liaison which are not captured by the minimum dataset.

Conclusions

The current report indicates that the ATAPS projects continue to be an integral part of the primary mental health care system in Australia. New GPs and allied health professionals continue to provide services to a substantial number of consumers. The number of Tier 1 referrals and sessions has remained fairly steady over the past couple of years. The profile of consumers and the care they are receiving is very consistent overtime. The majority are women with high prevalence disorders. Strategies usually involve CBT-based cognitive and behavioural interventions, which are typically delivered to individuals in sessions of one hour duration. Most importantly, the Tier 1 ATAPS projects are continuing to achieve considerable positive clinical outcomes for consumers.

Most of the Tier 2 services are still in their early start-up phase. One hundred and six GPNs are now delivering one or more Tier 2 services. The data indicate that new Tier 2 services that have been delivered have taken about seven to eight months to become established within GPNs, and once established increasingly attract referrers and consumers. The outcome data, where available, shows that these services are producing significant clinical improvement for consumers. The socio-demographic and diagnostic data indicate the Tier 2 services have been successful in reaching their intended target consumer groups in that their profiles differ somewhat from Tier 1 consumers. This suggests that Tier 2 ATAPS is carving an important niche by successfully addressing the unmet need of specific and/or hard to reach consumers and through means that are not available via Tier 1 ATAPS or the Better Access program.

References

1. Hickie I, Groom G. Primary care-led mental health service reform: An outline of the Better Outcomes in Mental Health Care initiative. *Australasian Psychiatry* 2002;10:376-82.
2. Australian Government Department of Health and Ageing. Outcomes and Proposed Next Steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program. Canberra: Commonwealth of Australia, 2010.
3. Pirkis J, Morley B, Kohn F, Blashki G, Burgess P, Headey A. Improving access to evidence-based mental health care: General practitioners and allied health professionals collaborate. *Primary Care Psychiatry* 2004;9(4):125-30.
4. Pirkis J, Burgess P, Kohn F, Morley B, Blashki G, Naccarella L. Models of psychological service provision under Australia's Better Outcomes in Mental Health Care program. *Australian Health Review* 2006;30(3):277-85.
5. Hickie I, Pirkis J, Blashki G, Groom G, Davenport T. General practitioners' response to depression and anxiety in the Australian community: A preliminary analysis. *Medical Journal of Australia* 2004;181(7):S15-S20.
6. Fletcher J, Bassilios B, Kohn F, Naccarella L, Blashki G, Burgess P, et al. Meeting demand for psychological services by people with depression and anxiety: Recent developments in primary mental health care. *Medical Journal of Australia* 2008;188(S107-S109).
7. Fletcher J, Pirkis J, Bassilios B, Kohn F, Blashki G, Burgess P. Australian primary mental health care: Improving access and outcomes. *Australian Journal of Primary Health* 2009;15:244-53.
8. Morley B, Pirkis J, Naccarella L, Kohn F, Blashki G, Burgess P. Improving access to and outcomes from mental health care in rural Australia. *Australian Journal of Rural Health*. 2007;15:304-12.
9. Bassilios B, Pirkis J, Fletcher J, Burgess P, Gurrin L, King K, et al. The complementarity of two Australian primary mental health care initiatives: The Better Outcomes in Mental Health Care Program and the Better Access Program. *Australian and New Zealand Journal of Psychiatry* In press.
10. Pirkis J, Stokes D, Morley B, Kohn F, Mathews R, Naccarella L, et al. Impacts of Australia's Better Outcomes in Mental Health Care program for psychologists. *Australian Psychologist* 2006;41(3):152-59.

11. Morley B, Pirkis J, Sanderson K, Burgess P, Kohn F, Naccarella L, et al. Better outcomes in mental health care: The impact of different models of psychological service provision on consumer outcomes. *Australian and New Zealand Journal of Psychiatry* 2007;41:142-49.
12. Pirkis J, Bassilios B, Fletcher J, Sanderson K, Spittal MJ, King K, et al. Evaluating the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care program (BOiMHC): Sixteenth Interim Evaluation Report - Clinical improvement after treatment provided through the ATAPS projects: Do some patients fare better than others? Melbourne: Centre for Health Policy, Programs and Economics, The University of Melbourne, 2010.
13. The Department of Health and Ageing. 2010-2011 Operational Guidelines for the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Australian Government, 2010.
14. Bassilios B. Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program - First progress report for the evaluation of a trial of telephone-based cognitive behavioural therapy. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2008.
15. Bassilios B, Fletcher J, King K, Kohn F, Blashki G, Burgess P, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Second interim evaluation of a trial of telephone-based cognitive behaviour therapy. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2010.
16. Bassilios B, Fletcher J, King K, Kohn F, Blashki G, Burgess P, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program - Evaluation of a trial of telephone-based cognitive behavioural therapy: Uptake and outcomes. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2010.
17. Fletcher J, Bassilios B, King K, Kohn F, Blashki G, Burgess P, et al. Evaluation the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program: Fourteenth Interim Evaluation Report Supplement - Preliminary findings of the National Perinatal Depression Initiative. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2009.
18. Fletcher J, Bassilios B, King K, Kohn F, Blashki G, Burgess P, et al. Evaluating the Access to Psychological Services component of the Better Outcomes in Mental Health Care Initiative: Sixteenth Interim Evaluation Report Supplement - Second report of the Perinatal Depression Initiative: Consumers, their treatment and outcomes. Melbourne: Centre for Health Policy, Programs and Economics, The University of Melbourne, 2010.

19. Ftanou M, Bassilios, B., Fletcher, J., King, K., Kohn, F., Blashki, G., Burgess, P., Pirkis, J. Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health care program: Seventeenth Interim Evaluation Report Supplement: Third report of the Perinatal Depression Initiative: Consumers, their treatment and outcomes: The Centre for Health Policy, Programs and Economics, The University of Melbourne, 2011.
20. King K, Kohn F, Bassilios B, Fletcher J, Blashki G, Burgess P, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program : Interim Report for the Evaluation of the Specialist Services for Consumers at Risk of Suicide. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2009.
21. King K, Kohn F, Bassilios B, Fletcher J, Blashki G, Burgess P, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program : Second interim report for the evaluation of the Specialist Services for Consumers at Risk of Suicide. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2010.
22. Bassilios B, King K, Fletcher J, Blashki G, Kohn F, Burgess P, et al. Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care Program: Third interim report of a trial of the Specialist Services for Consumers at Risk of Suicide - Improving access to and outcomes from mental health care. Melbourne: Centre for Health Policy, Programs and Economics, The University of Melbourne, 2010.
23. Reifels L, Bassilios, B., King, K., Fletcher, J., Kohn, F., Blashki, G., Burgess, P., Pirkis, P. Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program: Fourth interim report for the evaluation of the Specialist Consumers at Risk of Suicide: Improving access to and outcomes from mental health care: The Centre for Health Policy, Programs and Economics, The University of Melbourne, 2011.
24. Reifels L, Bassilios, B., Pirkis, P. Evaluation of the Australian Federal Government Mental Health Response to the Victorian Bushfires: The Centre for Health Policy, Programs and Economics, The University of Melbourne, 2010.
25. Pirkis J, Blashki G, Headey A, Morley B, Kohn F. Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: First Interim Evaluation Report. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2003.

26. Morley B, Kohn F, Pirkis J, Blashki G, Burgess P. Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: Second Interim Evaluation Report. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2004.
27. Morley B, Kohn F, Pirkis J, Blashki G, Burgess P. Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: Third Interim Evaluation Report: Benefits and Barriers Associated with Different Models of Service Delivery. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2005.
28. Kohn F, Morley B, Pirkis J, Blashki G, Burgess P. Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: Fourth Interim Evaluation Report. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2005.
29. Pirkis J, Morley B, Kohn F, Blashki G, Burgess P. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Fifth Interim Evaluation Report - Models of Service Delivery: Profile and Association with Access. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2005.
30. Kohn F, Morley B, Pirkis J, Shandley K, Naccarella L, Blashki G, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Sixth Interim Evaluation Report: Progressive Achievements over Time. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2005.
31. Morley B, Kohn F, Naccarella L, Pirkis J, Blashki G, Burgess P. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Seventh Interim Evaluation Report - Rural and Urban Projects: Similarities and Differences. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2006.
32. Morley B, Pirkis J, Sanderson K, Burgess P, Kohn F, Naccarella L, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Eighth Interim Evaluation Report - Consumer Outcomes: The Impact of Different Models of Psychological Service Provision. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2006.
33. Naccarella L, Morley B, Pirkis J, Kohn F, Blashki G, Burgess P. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Ninth Interim Evaluation Report - Demand Management Strategies. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2006.

34. Fletcher J, Pirkis J, Kohn F, Bassilios B, Blashki G, Burgess P. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Tenth Interim Evaluation Report - Progressive Achievements Over Time. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2007.
35. Kohn F, Pirkis J, Bassilios B, Fletcher J, Morley B, Naccarella L, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Eleventh Interim Evaluation Report - Utilisation of Evaluation Findings. Melbourne: Centre for Health Policy, Programs and Economics, School of Population Health, The University of Melbourne, 2007.
36. Fletcher J, Bassilios B, Pirkis J, Kohn F, Blashki G, Burgess P. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Twelfth Interim Evaluation Report - Making an Impact on the Australian Mental Health Care Landscape. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne, 2008.
37. Bassilios B, Fletcher J, Pirkis J, King K, Kohn F, Blashki G, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Thirteenth Interim Evaluation Report - Relationship between ATAPS projects and the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (Better Access) initiative. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2009.
38. Fletcher J, Bassilios B, King K, Kohn F, Blashki G, Burgess P, et al. Evaluation the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program: Fourteenth Interim Evaluation Report - Ongoing gains in improving access to mental health care in Australia. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2009.
39. Fletcher J, King K, Bassilios B, Kohn F, Blashki G, Burgess P, et al. Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program. Fifteenth Interim Evaluation Report - Current profile of, and innovations in, service delivery of Access to Psychological Services projects. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2010.
40. Pirkis J, Kohn F, Morley B, Burgess P, Blashki G. Better Outcomes in Mental Healthcare? *Primary Care Mental Health* 2004;2:141-49.

41. Fletcher J, Bassilios B, King K, Kohn F, Blashki G, Burgess P, et al. Evaluation the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program: Sixteenth Interim Evaluation Report Supplement - Second report of the Perinatal Depression Initiative: Consumers, their treatment and outcomes. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2010.

42. Bassilios B, Machlin, A., Reifels, L., Fletcher, J., King, K., Kohn, F., Blashki, G., Burgess, P., Pirkis, J. Evaluating the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care (BOiMHC) program. Seventeenth Interim Evaluation Report: Update on the achievements of the ATAPS projects.: The Centre for Health Policy, Program and Economics, The University of Melbourne. , 2011.

43. Lovibond SH, Lovibond PF. *Manual for the Depression Anxiety Stress Scales, 2nd Edition*. Sydney: Psychology Foundation, 1995.

44. Beck AT, Epstein N, Brown G, Steer RA. An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology* 1988;56:893-97.

45. Eisen SV, Grob, M. C., and Klein, A. A. BASIS: the development of a self-report measure for psychiatric inpatient evaluation. *Psychiatric hospital* 1986;17(4):165-71.

46. Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J. An inventory for measuring depression. *Archives of General Psychiatry* 1961;4:561-71.

47. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 1987(150):782-86.

48. Endicott J, Spitzer R, Fleiss J, Cohen J. The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry* 1976;33:766-71.

49. Gaston J, Vogl L. Psychometric properties of the General Well-Being Index. *Quality of Life Research* 2005;14:71-75.

50. Zigmond AS, Snaith RP. The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica* 1983;67:361-70.

51. Wing JK, Beevor AS, Curtis RH, Park SB, Hadden S, Burns A. Health of the Nation Outcome Scales (HoNOS). Research and development. *British Journal of Psychiatry* 1998;172:11-8.

52. Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, Normand SLT, et al. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine* 2002;32(6):959-76.
53. Miller IW, Norman WH, Dow MG, Bishop SB. the Modified Scale for Suicidal Ideation: Reliability and validity. *Journal of Consulting and Clinical Psychology* 1986;54(5):724-25.
54. Miller SD, Duncan BL, Brown J, Sparks JA, Claud DA. The Outcome Rating Scale: A Preliminary Study of the Reliability, Validity, and Feasibility of a Brief Visual Analog Measure. *Journal of Brief Therapy* 2003;2:91-100.
55. Mathal J, Anderson P, Bourne A. Use of the Strengths and Difficulties Questionnaire as an outcome measure in a child and adolescent mental health service. *Australasian Psychiatry* 2003;11:334-37.
56. Duncan BL, Miller SD, Sparks JA, Claud DA, Reynolds LR, Brown J. The Session Rating Scale: Preliminary psychometric properties of a working alliance measure. *Journal of Brief Therapy* 2003;3(3).
57. Bassilios B, Zoteyeva V, King K, Fletcher J, Kohn F, Blashki G, et al. Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Interim evaluation report of a trial of telephone-based therapy. Melbourne: Centre for Health Policy, Programs and Economics, Melbourne School of Population Health, The University of Melbourne, 2009.
58. Beck A, Kovacs M, Weissman A. Assessment of suicidal intention. *Journal of Consulting and Clinical Psychology* 1979;47:343-52.

Appendix A: Summary of focus of evaluation reports

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

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

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

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

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

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
<p>Fourteenth Evaluation Report</p> <p>June 2009</p> <p>Including Preliminary findings of the Perinatal Depression Initiative</p>	<p>Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects – Australia</p>	<ul style="list-style-type: none"> • Minimum dataset • Minimum dataset 	<ul style="list-style-type: none"> • Has participation in the general ATAPS projects by GPs and allied health professionals changed over time? • Has the profile of consumers of general ATAPS projects varied over time, and has the care they are receiving changed? • Are the projects achieving positive outcomes for general ATAPS consumers? • What is the uptake of the Perinatal Depression Initiative by GPs and allied health professionals? • What is the profile of consumers and the care they are receiving? 	<ul style="list-style-type: none"> • Since the January-March 2008 quarter the number of GPs has increased steadily to an all time peak in April-June 2008 to 2,616 (1,116 rural; 1,500 urban). • Similarly, since October-December 2007 the number of participating allied health professionals also steadily increased to 1218 (390 rural; 891 urban) in the October-December 2008 quarter. • The number of GPs and allied health professionals in urban and rural areas has followed a similar pattern to that of the national figures although the impact of Better Access appears to have been much less pronounced in rural areas. • The profile of referred consumers has remained relatively consistent over time, and is similar across urban and rural projects. • The profile of these sessions has not changed greatly since the ATAPS projects began. • The only notable change over time with respect to the sessions of care provided has been in the charging of a copayment. Relatively small proportions of sessions were associated with copayments • The projects were shown to be achieving positive outcomes of large or medium magnitude in 86% of cases. • 23 GPNs have entered data in the minimum-dataset. The majority of referrals and sessions have been in rural areas consistent with the intent of the initiative to target rural and remote locations. • Almost all consumers referred have been female with an average age of 31 years. Eighty-two percent have been diagnosed with depressive disorders and 37% with anxiety disorders. Almost all sessions were individual and an hour in length.
<p>Interim Report for the Specialist Services for Consumers at Risk of Suicide</p> <p>July 2009</p>	<p>19 GPNs selected by the Department of Health and Ageing</p>	<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 	<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) 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. • 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 1064 sessions (677 urban, 387 rural) were delivered.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
			<p>risk of suicide being delivered through the ATAPS projects?</p>	<ul style="list-style-type: none"> • Around 60% of consumers to specialist services were female, and their mean age was approximately 33 years. About one half are on low incomes. One half of the urban consumers, and about two-thirds of the rural consumers reported 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 (82.2% of consumers), almost all have been diagnosed with depression (94%). • Sessions of 46-60 minutes account for two thirds of sessions overall and in three quarters of sessions in urban areas. 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 sessions were diagnostic sessions and nearly half were CBT-cognitive interventions. In rural areas, about half of sessions were CBT-skills training. Rural areas also reported less use of CBTcognitive interventions than urban specialist services.
<p>Interim Evaluation Report of a trial of Telephone-based Cognitive Behaviour Therapy August 2009</p>	<p>22 rural and remote projects</p>	<ul style="list-style-type: none"> • Minimum dataset • Phone survey conducted with project officers regarding program implementation and models of service delivery 	<ul style="list-style-type: none"> • What is the uptake of the T-CBT pilot and what are the profiles of consumers and sessions? • What models of service delivery are being utilised by Divisions implementing the T-CBT pilot? • What issues have arisen in implementing the T-CBT pilot? 	<ul style="list-style-type: none"> • Between October 2008 and July 2009, 43 consumers have been referred by 21 GPs to 11 allied health professionals, of whom 30 consumers have received 123 sessions of care. However, it is noteworthy that the Divisions involved in the T-CBT pilot have also reported a further 123 sessions of care delivered by telephone but have indicated the associated referrals are for the 'general' ATAPS projects. Unfortunately, this means that the consumer and session profiles described are not truly representative of all consumers receiving telephone sessions because only data strictly entered on the minimum dataset as being part of the T-CBT pilot was used for these analyses, respectively. Therefore, consumer and session characteristics should be interpreted with caution. • The majority (79%) of consumers are females, aged around 40 years, and are on low incomes. Over a third of consumers have not received any previous psychiatric care. About 2% of T-CBT consumers are Aboriginal and none are Torres Strait Islanders. • The vast majority of consumers have been diagnosed with a depressive disorder and/or an anxiety disorder. In the main, T-CBT consumer characteristics are not too dissimilar from consumers of the rural ATAPS projects, with the following exceptions: T-CBT consumers are more likely to be females, with a diagnosis of a depressive disorder and on low incomes, and less likely to be indigenous. • Thirty consumers had session data entered into the minimum dataset, with 4 sessions being the average per consumer. As with the rural ATAPS projects, the vast majority of sessions are 46-60 minutes in length, delivered to individuals, and rarely incur a copayment. Interestingly, 43% of sessions were delivered face-to-face even though consumers were referred for T-CBT. Compared with the rural ATAPS projects, T-CBT sessions were more likely to involve diagnostic assessment (42% <i>cf.</i> 19%) and psycho-education (48% <i>cf.</i> 31%), and never involved CBT-skills training (0% <i>cf.</i> 22%). Over one third of T-CBT sessions involved CBT-cognitive interventions and almost two-fifths of sessions involved CBT-behavioural interventions. • The majority (64%) of allied health professionals involved in the T-CBT pilot are retained via contractual arrangements. The most common locations for allied health professionals delivering T-CBT services included GP rooms, own (allied health professional) rooms and Division sites (in 36%, 32%, and 32% of cases, respectively). Thirty-eight percent of project officers reported that allied health professionals deliver T-CBT sessions from multiple locations. With the exception of one Division, which reported using the voucher

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
				<p>system to track T-CBT referrals, the majority of Divisions were using the same referral mechanism for T-CBT as for their general ATAPS projects. The most commonly utilised referral mechanisms for the T-CBT pilot are direct referral (55%) and brokerage (36%).</p> <ul style="list-style-type: none"> • A number of implementation issues were highlighted, including; a delay in commencement of service delivery was due to a delay in the availability of webinar training for allied health providers and slow uptake by GPs. • T-CBT services were promoted using multiple communication modalities – from hardcopy, electronic, telephone, to face-to-face. It was common for multiple strategies to be used by any one Division, with provider newsletters and practice visits being the most commonly reported promotion strategies. • GP and allied health professional responses have been varied, with allied health professionals viewing the service as more positive than negative and more positively than GPs. Importantly, GPs were more likely to engage and refer to the pilot when they received positive feedback about the service from consumers. Despite favourable views of GPs, both GP and consumers had a preference for face-to-face services, if available. Allied health professional responses were reported to be favourable when T-CBT was combined with face-to-face sessions in some instances. Despite an overall positive response by allied health professionals, it was noted that they experienced: difficulty associated with the loss of behavioural cues of patients and disappointment with the low uptake, the webinar training, and the amount of paperwork. • A substantial number of project officers commented that positive provider responses acted as facilitators of the T-CBT pilot. In addition, the flexibility of the guidelines around the referral mechanism and multimodal (i.e., the ability to combine telephone and face-to-face) service delivery was considered to be a facilitator of the T-CBT pilot. Flexibility, education of stakeholders, and less paperwork emerged as key factors that would improve the T-CBT pilot. • The most commonly mentioned barrier was the low rate of GP referrals, which was attributed to difficulty convincing GPs to use the service, which in turn, is probably attributable to their (and consumers') preference for face-to-face treatment. Telephone equipment /coverage issues and the additional paperwork were the next most, and equally, frequently cited barriers. • A substantial number of project officers indicated that the T-CBT pilot has had positive impacts for the Division. The flexibility and option of the mode of service delivery, and in turn, its effect of increasing accessibility for consumers that may otherwise experience difficulties accessing psychological services, was the most frequently mentioned positive impact of the T-CBT pilot for Divisions. A minority of project officers expressed that the T-CBT pilot has had negative impacts for the Division in terms of additional workload demand.
<p>Fifteenth Evaluation Report February 2010</p>	<p>Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects – Australia</p>	<ul style="list-style-type: none"> • Minimum dataset • Survey of models of service delivery 	<ul style="list-style-type: none"> • What is the level of uptake of the general ATAPS projects by GPs, allied health professionals and consumers? • What is the sociodemographic and clinical profile of consumers of general ATAPS projects and what is the nature 	<ul style="list-style-type: none"> • Between 1 July 2003 and 31 December 2009, 15,251 (9,032, 59% urban; 6,219, 41% rural) GPs referred consumers to 4,042 (2,933, 73% urban; 1,109, 27% rural) allied health professionals. • During this period, 135,033 (or 77%) of the 174,675 consumers referred to projects took up the referral receiving a total of 709,684 sessions of care. • The profile of referred consumers has remained relatively consistent over time, and is similar across urban and rural projects. Around three quarters of consumers are female with a mean age of 39 years. Two thirds are on low incomes and about half have no

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
			<ul style="list-style-type: none"> of the care they are receiving? Have the models of service delivery being utilised by the general ATAPS projects changed over time? 	<p>previous history of mental health care. 75% of diagnoses relate to depression and 57% to anxiety disorders.</p> <ul style="list-style-type: none"> The profile of sessions has not changed greatly since the ATAPS projects began. Four fifths of all sessions were 46-60 minutes in duration. Almost all sessions were delivered to individuals, 79% did not incur a co-payment and most common intervention types involved CBT-based cognitive (44%) and behavioural interventions (58%). Some significant changes to service delivery models used by projects since 2005 included increases in the use of: direct employment arrangements; other locations (most notably GPNs' rooms); the brokerage system, as well as a decrease in the use of the voucher system. There continues to be considerable variability across projects in terms of the models of service delivery utilised. This indicated that there is not a 'one model fits all' approach to the services being delivered and that projects continue to flexibly adapt models to local needs.
<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, someone cared about them, 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 about the accessibility of the services to consumers who would not normally be able to access services. Two professionals also 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, that the referral process had been '<i>very straightforward and smooth</i>' and that emergency department staff had felt confident making the referral. All three professionals commented on the positive impact for the department of being able to refer consumers to the appropriate service quickly. One professional reported that this had resulted in lessened workload for the department. The three professionals said that consumers had responded positively to the Specialist Services. All three professionals cited positive impacts for consumers including: the consumers are happy because they are able to access an allied health professional quickly, consumers don't have to go back to their GP for a referral as the emergency department does this for them, decreased stigma for consumers, availability of ongoing care, and availability of care with no cost to the consumer. None of the professionals cited any negative impacts for their consumers. Uptake data is 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

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
				<p>professionals.</p> <ul style="list-style-type: none"> • 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 will have completed treatment prior to the data being extracted. • Around three-fifths of consumers to Specialist Services are female, and their mean age is approximately 33 years. About one half are on low incomes. Slightly less than half of the consumers have a history of previous mental health care. One and one half per cent of consumers were reported to be Aboriginal, and less than 1% Torres Strait Islander. A diagnosis was made by the referring GP in 82.8% of the referrals made, almost all have been diagnosed with depression (89.8%). In the main, the profiles of rural and urban consumers were similar; however there is a trend for rural consumers to be less likely to be on a low income and to be slightly younger than urban consumers. • Sessions of 46-60 minutes account for two thirds of Specialist Services and are less popular than in the national ATAPS projects. More sessions conducted in the Specialist Services are less than 30 minutes when compared with the national ATAPS services. Session interventions differed between urban and rural areas and from the national ATAPS projects. Overall, session interventions were more likely to be diagnostic assessment and CBT-skills training and less likely to be psycho-education and CBT-behavioural interventions in the Specialist Services when compared to the national ATAPS projects. Urban Specialist Services were more often reported to be diagnostic assessment and CBT-cognitive interventions and less likely to be CBT-skills training than rural Specialist Services. No copayment was reported in any of the Specialist Services sessions.
<p>Second Interim Evaluation Report of a trial of Telephone-based Cognitive Behaviour Therapy</p> <p>February 2010</p>	<p>22 rural and remote projects</p>	<ul style="list-style-type: none"> • Minimum dataset • Phone survey conducted allied health professionals involved in the program 	<ul style="list-style-type: none"> • What is the level of uptake of the T-CBT pilot and of telephone sessions delivered external to the T-CBT pilot? • What are the sociodemographic and clinical profiles of consumers of the T-CBT pilot and of telephone sessions delivered external to the T-CBT pilot? • What is the nature of care being delivered by the T-CBT pilot and of telephone sessions delivered external to the T-CBT pilot? • What are the benefits and challenges of the T-CBT pilot from the perspective of allied 	<ul style="list-style-type: none"> • The uptake of the T-CBT pilot has been slow, with only seven of the 22 Divisions reporting uptake data on the minimum dataset. To date, 61 consumers have been referred by 37 GPs to 12 allied health professionals, of whom 50 consumers have received 259 sessions of care (63 delivered by telephone and 196 delivered face-to-face). However, it is noteworthy that 11 of the Divisions involved in the T-CBT pilot have also reported a further 359 sessions of care delivered by telephone but have indicated the associated referrals are for the 'general' ATAPS projects; it is unclear whether this represents errors in data entry or whether consumers were referred for face-to-face sessions but provided with telephone sessions as deemed appropriate. In any case, a total 422 sessions were delivered by telephone via T-CBT participating Divisions, accounting for 1.5% all ATAPS projects' sessions delivered via the 22 Divisions since the introduction of the pilot. • In addition, further sessions have been delivered by telephone via Divisions not involved in the T-CBT pilot: 234 via the 'general' ATAPS projects, 239 via the Specialist Services for Consumers at Risk of Suicide projects (75 of these were delivered by Divisions also participating in the T-CBT pilot), 5 via the Perinatal Depression Initiative, and 4 via the Bushfire Service. • In total, 904 sessions have been delivered by telephone via both Divisions participating in the T-CBT pilot and Divisions external to the T-CBT pilot, representing 0.6% of all

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
			health professionals?	<p>sessions delivered via all the ATAPS projects.</p> <ul style="list-style-type: none"> • The majority of consumers receiving sessions by telephone (within and external to the T-CBT pilot) are females (70%). Proportionally, more males receive telephone sessions external to the T-CBT pilot than within it (31% <i>cf.</i> 23%). The average age of consumers referred to the T-CBT pilot is slightly older than those receiving telephone sessions external to the pilot (43 <i>cf.</i> 39 years). There are proportionally more T-CBT consumers (72%) on low incomes than consumers receiving telephone sessions external to the T-CBT pilot (55%). The majority of all consumers who have received telephone sessions have not received any previous psychiatric care. Aboriginal consumers receiving telephone sessions are more represented external to the T-CBT pilot (9% <i>cf.</i> 2%). There were no Torres Strait Islanders who had received telephone sessions. The vast majority of consumers of telephone services have been diagnosed with a depressive disorder and/or an anxiety disorder, particularly those involved in the T-CBT pilot. • Comparisons between consumers of telephone sessions and general ATAPS consumers indicate that in the main, consumers of telephone sessions (via the T-CBT pilot and external to it) are not too dissimilar from consumers of the rural ATAPS projects, with the exception that they are more likely to be Aboriginal. • For the 50 consumers participating in the T-CBT pilot and who had (both telephone and face-to-face) session data entered on the minimum dataset, the average number of sessions received was five. As with the rural ATAPS projects, the vast majority of sessions are 46-60 minutes in length, delivered to individuals, and rarely incur a copayment. Telephone sessions delivered external to the T-CBT pilot however, were almost equally likely to be delivered in 30 minutes or less as they were to be delivered in about an hour (42% <i>cf.</i> 49%). • Sixty eight percent of (the 259) sessions delivered via the T-CBT pilot were face-to-face even though consumers were referred for T-CBT. Consumers who received sessions by telephone external to the T-CBT trial also received sessions delivered via other modalities: 60.5% face-to-face, 38.8% by telephone and 0.7% by videoconference. • Compared with the rural ATAPS projects, T-CBT sessions (delivered either by telephone or face-to-face) were particularly more likely to involve CBT-skills training (42% <i>cf.</i> 22%). All sessions delivered by telephone were less likely than the rural ATAPS projects to involve CBT-behavioural and CBT-cognitive strategies (34% <i>cf.</i> 42% and 30% <i>cf.</i> 56%, respectively). These differences may be attributable to the nuances associated with the telephone modality of service delivery. The vast majority of sessions across all categories did not incur a copayment. • Additional session data, collected specifically for the T-CBT pilot, confirms the fidelity of the interventions delivered as CBT. For sessions that had data recorded about homework completion, homework was completed in the majority of instances. Homework sheets were sent to clients for 11% of sessions delivered via the T-CBT pilot. Written materials were not applicable to 21% of sessions, and when they were provided, postal mail was the most common means of provision. • Of the 10 allied health professionals, representing 10 Divisions, who took part in the purpose-designed interview, six were psychologists, two were social workers and one each was a psychiatric nurse and a psychotherapist. Four allied health professionals reported that they had not delivered T-CBT services to any consumers via the pilot, although one reported providing telephone services to many consumers external to the T-CBT pilot.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
				<ul style="list-style-type: none"> • A couple of professionals reported that the referral process was satisfactory. Most however, reported experiencing difficulties with the referral process that were associated with GPs' lack of response to the T-CBT pilot. Overall, allied health professionals reported that the referrals received for T-CBT services have been suitable for this type of service. • Difficulties of delivering sessions via the telephone highlighted by allied health professionals included difficulties building rapport, which was attributable to the loss of non-verbal / visual cues; an inability to control the environments of their consumers, which led to frustration; and it was hard to manage risk. • Face to face service delivery was said to be the preferred modality when possible and some allied health professionals delivered the first session face to face when possible. It was noted that allied health professionals had to listen differently when using the telephone to deliver services, but that telephone services were better than none. • The most commonly reported positive impact of the T-CBT pilot was the ability to service rural or remote areas and provide a greater continuity of service to these consumers. The ability to offer high need consumers telephone contact was also perceived positively. • Positive impacts were noted for consumers by the allied health professionals, specifically the TCBT project provided access to those who otherwise would not have access or may have been reluctant to attend face to face sessions. Also a convenience for the consumer who can access the services from home, a quick response for consumers, and more frequent contact for consumers. • The most commonly reported negative impact, cited by three professionals, was that the professional does not know what happens to consumers who do not answer their telephones, and that this means it is easier for consumers to drop out the service and 'get lost'. • The most common suggestion for improvement of the pilot, made by five professionals, was the need for increased education and liaison with GPs regarding the services. Professionals commented that GPs were not aware of the program and that it "<i>can be difficult to get GPs used to a new idea</i>". Professionals also suggested that "<i>less paperwork</i>" for consumers, and charging consumers a copayment might improve the services. • In regards to the mandatory training for allied health professionals, eight of the ten interviewed professionals said that it had been helpful. Four professionals made suggestions for further support and training, including: putting forms for allied health professionals and consumers online, offering a review training session to professionals after they have conducted some sessions, and providing an opportunity to "<i>link up with other [professionals] across Australia to discuss patients</i>". • It is noteworthy that consumers in urban areas may also experience barriers to accessing face-to-face services. This, combined with the prevalence of telephone sessions external to the T-CBT pilot, supports the consideration of integrating multi-modal service delivery more generally (nationally) under the ATAPS projects.
Sixteenth Evaluation Report July 2010	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects – Australia	<ul style="list-style-type: none"> • Minimum dataset 	<ul style="list-style-type: none"> • What are the clinical improvements after treatment provided through the ATAPS projects? • Do some patients fare better than others? 	<ul style="list-style-type: none"> • Patients are benefiting from the ATAPS projects, and the gains they are making are considerable. A range of socio-demographic, clinical and treatment-based variables are associated with the levels of outcomes achieved, but improvements are still substantial even for those in the relatively disadvantaged groups. • More specifically, pre- and post-treatment outcome data were available for 16,700 patients from nine different outcome measures. Across all measures, the mean difference was statistically significant and indicative of clinical improvement. The most commonly-used

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Including Second report of the Perinatal Depression Initiative		<ul style="list-style-type: none"> Minimum dataset 	<ul style="list-style-type: none"> What is the uptake of the Perinatal Depression Initiative by GPs, allied health professionals, and consumers? What is the profile of consumers and the care they are receiving? What are the outcomes for consumers of the Perinatal Depression Initiative? 	<p>measure was the Kessler-10 (K-10), and pre- and post-treatment K-10 data were available for 7,747 patients. After adjusting for clustering by GPN, outcome on the K-10 was associated with age, levels of income and education, previous receipt of mental health care, number of sessions, treatment received and pre-treatment K-10 score. The benchmark was sufficiently high, however, that even the groups that fared relatively less well still showed strong improvement in absolute terms.</p> <ul style="list-style-type: none"> Since March 2008, 764 (345 urban; 419 rural) consumers have been referred by 505 (264 urban; 241 rural) GPs to 208 (98 urban 110 rural) allied health professionals for 2,708 (1289 urban; 1419 rural) sessions of care. Almost all consumers were female with an average age of 31 years. Eighty-seven percent were diagnosed with depressive disorders and 40% with anxiety disorders. Half of all consumers were identified as having a low income. Consumers in urban areas were more likely, than rural consumers, to be charged a copayment. Almost all sessions were individual and an hour in length in rural areas. Whereas in urban areas 17% of sessions were delivered to groups and almost a quarter of sessions were over 60 minutes in length. Consumer outcomes as measured by the EDPS, DASS subscales and the K10 all indicate a significant improvement in consumers from the start to the end of treatment.
Third Interim Report for the Specialist Services for Consumers at Risk of Suicide July 2010	19 GPNs selected by the Department of Health and Ageing	<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 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 is 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 their 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 have been diagnosed with depression (90%). In the main, the profiles of rural and urban consumers are similar. However, there is 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 differs from that of the general ATAPS projects' consumers. Sessions of 46-60 minutes account for two thirds of Specialist Services. More sessions conducted via the Specialist Services are less than 30 minutes when compared with the

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
				<p>national general ATAPS services. Session interventions differed between urban and rural areas and from the national general ATAPS projects. Overall and in urban areas, these sessions are more likely to involve diagnostic assessment, CBT-cognitive interventions, and CBT-behavioural interventions. However, sessions in rural areas are 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 differs from that of the general ATAPS projects' sessions.</p> <ul style="list-style-type: none"> Investigation of all the available outcome data indicated that 170 (19%) consumers had pre and post 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 is achieving positive outcomes for consumers as evidenced by statistically and clinically significant levels of improvement across all outcome measures examined.
<p>Final Interim Evaluation Report of a trial of Telephone-based Cognitive Behaviour Therapy</p> <p>August 2010</p>	<p>22 rural and remote projects</p>	<ul style="list-style-type: none"> Minimum dataset Phone survey conducted allied health professionals involved in the program 	<ul style="list-style-type: none"> What is the level of uptake of the T-CBT pilot and of telephone sessions delivered external to the T-CBT pilot? What are the sociodemographic and clinical profiles of consumers of the T-CBT pilot and of telephone sessions delivered external to the T-CBT pilot? What is the nature of care being delivered by the T-CBT pilot and of telephone sessions delivered external to the T-CBT pilot? What are the outcomes achieved for and experiences of consumers referred to the T-CBT pilot and/or in receipt of telephone sessions? 	<ul style="list-style-type: none"> Uptake data were available for 15 (of the 22 funded) Divisions, seven of which had data flagged on the minimum dataset as being part of the T-CBT pilot by selecting T-CBT as the 'referral type' and eight of which had sessions delivered by telephone (for referrals not specifically flagged as being part of the T-CBT pilot). For the period between 1 July 2008 and 30 June 2010, referrals were made by 172 GPs and sessions were conducted by 53 allied health professionals. During this period, 72 referrals were flagged as participating specifically in the T-CBT pilot and a further 229 referrals received any number of telephone sessions, totalling 301 consumers. The number of sessions delivered to these consumers was 1,683 (45% by telephone and 55% face-to-face), making the average number of sessions provided to consumers 5.6. Of these sessions, 308 (18.1%) were delivered to consumers flagged as being part of the T-CBT pilot. The number of sessions delivered by telephone across all of the ATAPS projects was 1,519 sessions. About half of these sessions were delivered via T-CBT participating Divisions across all sub-programs of ATAPS; the rest were delivered via Divisions not involved in the T-CBT pilot. This indicates that approximately 0.5% of all ATAPS projects' sessions have been delivered by telephone since the addition of the modality field on the minimum dataset. The majority of consumers referred to the T-CBT pilot and/or in receipt of telephone sessions are females with a mean age of 40 years. Just over half of the consumers are on low incomes as identified by their GPs. One third of consumers have not received any previous psychiatric care. The vast majority of consumers have been diagnosed with a depressive disorder and/or an anxiety disorder. In the main, the profile of consumers referred to the T-CBT pilot and/or in receipt of telephone sessions is similar to that of the aggregated national rural ATAPS projects. The exceptions are that these consumers are somewhat more likely to have previously accessed psychiatric care and to be indigenous, and less likely to be on a low income and to be diagnosed with anxiety, than their national counterparts. The majority of sessions are 46-60 minutes in length, delivered to individuals and do not incur a copayment. The most common psychological interventions delivered involve behavioural and cognitive therapeutic approaches. Frequently, telephone sessions were combined with face-to-face sessions. Compared

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
			<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • with face-to-face sessions, telephone sessions are: all delivered to individuals (as would be expected); more likely to be of shorter duration, to incur a copayment and to deliver both behavioural and skills training interventions; and less likely to involve diagnostic assessment. • Compared with the aggregated national rural ATAPS projects, sessions (telephone and face-to-face) delivered to consumers referred to the T-CBT pilot and/or in receipt of telephone sessions were: more likely to be shorter in duration, less likely to involve behavioural interventions and to incur a copayment. • Additional session data collected specifically for the T-CBT pilot confirmed the fidelity of the interventions delivered as CBT as did the individual session goals. • Investigation of all the available outcome data for consumers referred to the T-CBT pilot and/or in receipt of telephone sessions indicated that 85 (28%) consumers had pre- and post-treatment scores on at least one outcome measure. Of these 85 consumers, 32 had been assessed with either the Depression Anxiety Stress Scale (DASS)-21 or -42 item version, 28 with the Health of the Nation Outcome Scales (HoNOS), and 21 with the Behaviour and Symptom Identification Scale 32 (BASIS-32). The T-CBT pilot and/or telephone sessions delivered by T-CBT participating Divisions have achieved positive outcomes for consumers as evidenced by statistically and clinically significant levels of improvement across all outcome measures examined. Exploration of the sociodemographic and clinical profiles of the consumers included in the outcomes analysis, as well as the characteristics of the care they received via ATAPS, indicated that they were generally representative of all consumers of the T-CBT pilot and/or in receipt of telephone sessions. • Only five of the 72 consumers flagged as participating in the T-CBT pilot returned consumer experience surveys. Four of the five consumers reported that they had not received psychological treatment in the past. Barriers preventing psychological treatment in the past included transport, distance and cost. Nearly all of the consumers rated their overall experience of T-CBT as 'positive' or 'very positive'. The most useful aspects of T-CBT reported were both typical of psychological (CBT) treatment in general and specifically with the modality of service delivery. The latter included the reduced burden associated with not having to commute and comfort afforded by having sessions from home. The least useful aspects of T-CBT reported were the insufficient length of treatment and duration of sessions. • Importantly, there is evidence that the telephone modality has achieved positive outcomes for consumers in terms of alleviating symptoms and improving levels of functioning. This, combined with the prevalence of telephone sessions in Divisions not participating in the T-CBT pilot, supports the value of multi-modal service delivery more generally (nationally) via the ATAPS projects.
Evaluation of the Australian Federal Government Mental Health Response to the Victorian Bushfires		<ul style="list-style-type: none"> • Minimum data set • Survey of providers • Existing evaluation reports/other documentation 	<ul style="list-style-type: none"> • The evaluation was based on 22 evaluation questions. Please see the report for a summary of all these questions. The first four evaluation questions are summarised here: • What is the level of uptake of services for bushfire affected consumers by GPs, bushfire 	<ul style="list-style-type: none"> • From 1 January 2009 to 31 October 2010, referrals were made by 430 GPs and sessions were conducted by 166 allied health professionals in nine Divisions. Approximately one fifth and one quarter of GPs and allied health professionals, respectively, were from rural areas. While the majority of referrals came from GPs, especially in urban area, Department of Human Services bushfire case managers (bushfire case managers) were responsible for almost one third of referrals in rural areas. • Between 1 January 2009 and 31 October 2010, nine Divisions received 1,550 referrals (291 rural and 1,259 urban) for ATAPS bushfire services. The nine Divisions reported delivering 6,930 sessions (1,312 rural, 5,618 urban) to 1,163 (or 75% of the referred)

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
November 2010		<ul style="list-style-type: none"> on Interviews with key stakeholders 	<ul style="list-style-type: none"> case managers and allied health professionals? What is the level of uptake of services for bushfire affected consumers What is the profile (socio-demographic and clinical) of consumers accessing bushfire services through the ATAPS projects? What is the precise nature of the bushfire services for consumers being delivered through the ATAPS projects? 	<ul style="list-style-type: none"> consumers, making the average number of sessions provided to consumers six. Around two thirds of consumers of the ATAPS bushfire services were female, and their mean age was approximately 42 years. Almost two thirds were on low incomes, as judged by their GP. Almost one half of the consumers have not previously accessed mental health care. The majority were diagnosed with depression (68%) and /or anxiety disorders (69%). In the remaining 35% of cases 'other diagnosis' was selected, with many but not all of the specifiers being indicative of variants of stress, trauma, post-traumatic stress disorder and bereavement. Almost all sessions were delivered to individuals. Overall, sessions of 46-60 minutes accounted for the vast majority of ATAPS bushfire services delivered, particularly in urban areas. More ATAPS bushfire services sessions conducted in rural areas (24%) were of over 60 minutes duration when compared with urban areas (4%). The most popular intervention delivered via ATAPS bushfire sessions in both urban and rural areas was CBT-cognitive. Sessions delivered in urban areas were much more likely to involve psychoeducation and CBT-skills training and more likely to deliver interpersonal therapy than their rural counterparts. For all 1,275 (18%) of ATAPS bushfire sessions where this data was recorded, no copayment was charged.
Seventeenth Evaluation Report February 2011	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects – Australia	<ul style="list-style-type: none"> Minimum dataset 	<ul style="list-style-type: none"> What is the level of uptake of the ATAPS projects by GPs, allied health professionals and consumers? What are the sociodemographic and clinical profiles of consumers of the ATAPS projects, and what is the nature of the care they are receiving? Are the ATAPS projects achieving positive outcomes for consumers? 	<ul style="list-style-type: none"> Between 1 July 2003 and 31 December 2010, 18,545 (10,979, 59.2% urban; 7,566, 40.8% rural) GPs referred consumers to 4,695 (3,324, 70.8% urban; 1,371, 29.2% rural) allied health professionals through the ATAPS projects. Between 1 July 2003 and 31 December 2010, 223,851 consumers were referred to the ATAPS projects, 171,894 (76.9%) of whom took up the referrals provided. In total, 879,331 sessions of care were provided through the projects, making the average number of sessions provided to consumers 5.1. This average is likely to be an underestimate as projects differ in their ability to identify re-referrals because some have systems which preclude a consumer carrying the same identifier across referrals. The profile of referred consumers has remained relatively consistent over time. Approximately 70% of all consumers are female, and their mean age is 39 years. About 3.5% of consumers are of Aboriginal or Torres Strait Islander descent. The majority (around two thirds) are on low incomes, as judged by their GP. About half have no previous history of mental health care. Of those for whom a diagnosis was made by the referring GP (n=160,201 or 72%), most have been diagnosed with depression (76%) or anxiety disorders (57%). The profile of sessions has also remained fairly consistent since the ATAPS projects began. 83% of sessions are of 46-60 minutes reflecting the complexity of care provided in these sessions. Almost all of these sessions have been delivered to individuals, rather than groups. CBT-based cognitive and behavioural interventions are the most common, delivered in approximately 55% and 41% of sessions, respectively. These interventions are evidence-based, and widely regarded as appropriate for treating the types of high prevalence disorders with which consumers are presenting. In the main, the profiles of sessions in rural and urban projects mirror the profile for all projects, but there are some nuances. Nationally, for the 759,508 (86%) sessions where this information was available, 79% of sessions did not incur a copayment. For the 21% of sessions where a copayment was incurred, the average amount was \$15.70. The national average cost per session was \$3.22 (S.D. = \$9.72), with a lower average in rural (\$1.19, S.D. = \$6.13) and a higher average in urban (\$4.48, S.D. = \$11.21) areas.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Including Third report of the Perinatal Depression Initiative		<ul style="list-style-type: none"> Minimum dataset 	<ul style="list-style-type: none"> What is the uptake of the Perinatal Depression Initiative by GPs, allied health professionals, and consumers? What is the profile of consumers and the care they are receiving? What are the outcomes for consumers of the Perinatal Depression Initiative? 	<ul style="list-style-type: none"> Pre- and post-treatment outcome data were available for 23,536 patients (10.5% of the 223,851). Across all of the nine most commonly used standardised outcome measures, the mean difference was statistically significant and indicative of clinical improvement. Between April 2008 to December 2010, a total of 1450 professionals (1043 GPs; 407 allied health professionals) participated in the initiative. In July 2010 the number of participating professionals was 713 (505 GPs and 208 allied health professionals), representing an increase of 103%. There are 18% more urban than rural GPs involved in the initiative, whereas the proportion of allied health professionals in urban and rural Divisions are relatively even (approximately 50% each). Between April 2008 and December 2010, 1724 referrals (881 urban; 843 rural) were made to allied health professionals. A total of 6591 (3130 urban; 3461 rural) sessions of care were delivered to 1347 (or 78% of the referred) consumers making the average number of sessions provided to consumers 5. Nationally 98% of consumers are female, The mean age of consumers is approximately 30 years (31 and 29 years for urban and rural consumers, respectively). Nearly two thirds of the consumers are on low incomes as identified by their GPs; just over 40% of consumers have never accessed previous mental health care; in rural areas almost 5% of consumers are Aboriginal whereas in urban areas about 3% of consumers are Aboriginal. 88% of consumers have been diagnosed with a depressive disorder whilst around 38% have been diagnosed with an anxiety disorder. In the main, the profiles of rural and urban consumers were similar with the exception that anxiety disorders were slightly higher in urban consumers and rural consumers were somewhat less likely to have previously accessed mental health care. The vast majority of sessions were 46-60 minutes in duration delivered to individuals. Urban Divisions delivered more group sessions (16%) compared with rural Divisions (2%). Approximately 79% of sessions did not attract a co-payment. CBT-based cognitive interventions were the most commonly used treatment modalities in sessions, occurring 42% of the time. Followed by CBT-based behavioural (31%) and psycho-education interventions (23%). The EPDS, DASS (42 or 21 item version) subscales, and K10 were used to measure consumer outcomes, 199 (15% of the 1347 consumers who attended sessions) had pre- and post-treatment scores on at least one outcome measure. Across all measures, the mean difference was statistically significant and indicative of clinical improvement suggesting that the National Perinatal Depression Initiative is achieving positive consumer outcomes.
Fourth Interim Report for the Specialist Services for Consumers at Risk of Suicide: Improving access to and outcomes	19 GPNs selected by the Department of Health and Ageing	<ul style="list-style-type: none"> Phone survey conducted with GPs and allied health professionals involved in the program Minimum 	<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 	<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,

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
<p>from mental health care</p> <p>February 2011</p>		dataset	<p>through the ATAPS projects?</p> <ul style="list-style-type: none"> • 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? 	<p>4,726 urban) being delivered These 6,910 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.</p> <ul style="list-style-type: none"> • Around three-fifths of consumers of Specialist Services were female, and their 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. Session interventions differed between urban and rural areas and from the national general ATAPS projects. 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 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 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 B: Description of most commonly used outcome measures for consumers of ATAPS

Measure	Description
BAI	Patient-rated measure designed to measure anxiety. Consists of 21 items, each of which describes a common symptom of anxiety. Patients are asked to rate how much they have been bothered by each symptom over the past week on a 4-point scale ranging from 0 (Not at all) to 3 (Severely – it bothered me a lot). The total score can range from 0 to 63. A positive difference between pre- and post-treatment scores indicates improvement.
BASIS-32	Patient-rated measure comprising 32 items which collectively measure symptoms and behavioural distress in people with a mental illness over the previous week. Each item is rated from 0 (No difficulty) to 4 (Extreme difficulty). The total score is an average of the item scores, and therefore also ranges from 0 to 4. A positive difference between pre- and post-treatment scores indicates improvement.
BDI	Patient-rated measure comprising 21 items which assess depressive symptoms over the previous two weeks. Each item has a set of four possible answers, ranging from 0 to 3 where 0 is low intensity (e.g., I do not feel sad) and 3 is high intensity (e.g., I am so sad or unhappy that I can't stand it). The lowest total score is 0 and the highest is 63. A positive difference between pre- and post-treatment scores indicates improvement.
DASS_Anxiety	Patient-rated sub-scale of the DASS designed to measure anxiety. Consists of 14 items on the DASS-42 or 7 items on the DASS-21, each of which consists of a statement relating to a symptom of anxiety. The patient is asked to consider how much each statement applied to him or her in the past week. Each item is scored from 0 ('Did not apply to me at all') to 3 (Applied to me very much, or most of the time'). The sub-scale score on the DASS-42 ranges from 0 to 42; the raw sub-scale score on the DASS-21 ranges from 0 to 21 but is then doubled so that it also ranges from 0 to 42. A positive difference between pre- and post-treatment scores indicates improvement.
DASS_Depression	Patient-rated sub-scale of the DASS designed to measure depression. Consists of 14 items on the DASS-42 or 7 items on the DASS-21, each of which consists of a statement relating to a symptom of depression. The patient is asked to consider how much each statement applied to him or her in the past week. Each item is scored from 0 ('Did not apply to me at all') to 3 (Applied to me very much, or most of the time'). The sub-scale score on the DASS-42 ranges from 0 to 42; the raw sub-scale score on the DASS-21 ranges from 0 to 21 but is then doubled so that it also ranges from 0 to 42. A positive difference between pre- and post-treatment scores indicates improvement.
DASS_Stress	Patient-rated sub-scale of the DASS designed to measure stress. Consists of 14 items on the DASS-42 or 7 items on the DASS-21, each of which consists of a statement relating to a symptom of stress. The patient is asked to consider how much each statement applied to him or her in the past week. Each item is scored from 0 ('Did not apply to me at all') to 3 (Applied to me very much, or most of the time'). The sub-scale score on the DASS-42 ranges from 0 to 42; the raw sub-scale score on the DASS-21 ranges from 0 to 21 but is then doubled so that it also ranges from 0 to 42. A positive difference between pre- and post-treatment scores indicates improvement.
EPNDS	Patient-rated measure developed to assess post natal depression. Comprises 10 items which ask consumers about symptoms of post natal depression in the past seven days. Each item is scored from 0 to 3 according to the severity of the symptom. Resulting in scores of 0 to 30. A score above 10 indicates the likely presence of depressive illness of varying severity. A positive difference between pre- and post-treatment scores indicates improvement.
GAF	Clinician-rated measure of functioning which seeks a single rating from 1 (Persistent danger of severely hurting self or others OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death) to 100 (Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his/her many positive qualities. No symptoms). A negative difference between pre- and post-treatment scores indicates improvement.
GWBI	Patient-rated measure comprising 22 items designed to establish how he or she has been feeling during the past 2 weeks. Each item is scored from 0 to 5, with 0 indicating low general well being and 5 indicating high general well being. The total score ranges from 0 to 88. A negative difference between pre- and post-treatment scores indicates improvement.
HADS	Patient-rated measure developed to detect anxiety and depression in a non-psychiatric hospital setting. Comprises 14 items, seven of which are concerned with anxiety and seven of which are concerned with depression. Each item is scored from 0 to 3, where 0 indicates low levels of symptomatology in the previous week and 3 indicates high levels. The total score ranges from 0 to 42. A positive difference between pre- and post-treatment scores indicates improvement.

Measure	Description
HoNOS	Clinician-rated measure of severity of symptoms in people with a mental illness which covers the previous two weeks. Comprises 12 items that collectively cover the sorts of problems that may be experienced by people with a mental illness. Each item is rated from 0 (No problem) to 4 (Very severe problem), resulting in a total score that can range from 0 to 48. A positive difference between pre- and post-treatment scores indicates improvement.
K-10	Patient-rated measure developed to assess non-specific psychological distress. Comprises 10 items which ask the patient about symptoms of depression and anxiety in the past four weeks. Each item is rated from 1 (None of the time) to 5 (All of the time), resulting in a total score that ranges from 10 to 50. A positive difference between pre- and post-treatment scores indicates improvement.
MSSI	Clinician-rated measure of suicidal ideation representing a modified version of the Scale for Suicidal Ideation (SSI) developed by Beck and colleagues (1979). ⁵⁸ Comprised of 18 items, 13 from the original SSI and five that are new, the first four of which serve as screening items. 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. A positive difference between pre- and post-treatment scores indicates improvement.
ORS	Patient-rated measure of general wellbeing, personal wellbeing, family relationships and social relationships since the last contact. Comprises 4 statements on a visual analogue scale ranging from 'Low' at one end to 'High' at the other. This yields four separate scores between 0 and 100 using a millimetre for scale measurement. A negative difference between pre- and post-treatment scores indicates improvement.
SDQ	There are various versions of this measure; the parent-rated version for children aged 0 to 14 years is the one applicable here. Comprises 5 scales (emotional symptoms, conduct problems, hyperactivity, peer problems, of 5 items each, which are rated on a three-point scale from 0 (not true) to 2 (certainly true). A total difficulties score, ranging from 0 to 40, is generated by summing the scores from all the scales except the prosocial scale. A positive difference between pre- and post-treatment scores indicates improvement.
SRS	Patient-rated measure of relationships, goals and topics, approach and method, and overall session rating. Comprises 4 visual analogue scales yielding four separate scores between 0 and 100 using a millimetre for scale measurement. A negative difference between pre- and post-treatment scores indicates improvement in these areas.