



**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**

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July 2009

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Executive summary

Background

In July 2001, the Better Outcomes in Mental Health Care program was introduced in an effort to improve consumers' access to high quality primary mental health care, through a number of components, key among which is the Access to Allied Psychological Services (ATAPS) component which supports GPs and allied health professionals to work together to provide optimal mental health care. Specifically, this component enables GPs to refer consumers with high prevalence disorders to allied health professionals for twelve sessions of evidence-based mental health care (or 18 in exceptional circumstances). This collaborative approach to mental health care is occurring through 105 ATAPS projects being conducted by 111 Divisions of General Practice and progressively funded through four funding rounds.

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

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

The current report considers the implementation and achievements of the specialist services for consumers at risk of suicide so far. It looks at the models of service delivery being used by the ATAPS projects delivering specialist services, issues associated with offering specialist services, the level of uptake by GPs, allied health professionals, and consumers at risk of suicide, the profile (socio-demographic and clinical) of consumers at risk of suicide, and the precise nature of services being delivered.

Method

The report draws on data from a survey of project officers representing the 19 divisions providing specialist suicide services and from a purpose-designed minimum dataset which collects consumer- and session-based data on the projects. It considers the implementation and the achievements of the projects via the following evaluation questions:

Evaluation Question 1: What models of service delivery are being used by the ATAPS projects delivering specialist services to consumers at risk of suicide?

Evaluation Question 2: What issues are associated with offering specialist services to consumers at risk of suicide via the ATAPS projects?

Evaluation Question 3: What is the level of uptake of specialist services for consumers at risk of suicide by GPs, allied health professionals, and consumers?

Evaluation Question 4: What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing specialist services through the ATAPS projects?

Evaluation Question 5: What is the precise nature of the services for consumers at risk of suicide being delivered through the ATAPS projects?

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

Key findings

What models of service delivery are being used by the ATAPS projects delivering specialist services to consumers at risk of suicide?

Divisions reported that they had re-evaluated their existing models of service delivery and operating policies and procedures to meet the requirements of the specialist services. Compared to the general ATAPS projects there was a trend away from reliance on contractual allied health professionals (82.4% vs. 68%) and an increased use of directly employed professionals (39.8% vs. 53%). In regards to the location of allied health professionals, a trend away from GPs rooms (56.5% vs. 42%) and from allied health professionals own rooms (57.4% vs. 32%) was reported. The favoured referral mechanism was direct referral from the GP to the allied health professional.

What issues are associated with offering specialist services to consumers at risk of suicide via the ATAPS projects?

Divisions began delivering services at different times. Some Divisions commenced service delivery in October 2008, whilst others had not yet started as at July 2009. Divisions reported that the delay in the commencement of service delivery was due to a range of factors. 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.

Divisions said that to have more stability around the funding would provide reassurance for allied health professionals and GPs, and would enable the Division to more confidently market and implement the services.

What is the level of uptake of specialist services for consumers at risk of suicide by GPs, allied health professionals and consumers?

As of July 2009, 11 of the 19 participating Divisions had entered data into the minimum data set for the specialist services. None of the Divisions reported any service delivery prior to October 2008. Four Divisions had delivered services but were unable to enter data into the minimum data set due to data entry difficulties. Four Divisions had not commenced service delivery.

Between October 2008 and July 2009 the 11 Divisions who had entered data into the minimum data set reported that 150 GPs had made referrals to the specialist services and sessions had been conducted by 49 allied health professionals. New external referrers also became involved in the specialist services. Twenty-four per cent of the 242 referrals made to the specialist services within these 11 Divisions were made by hospital Emergency Departments, and 1% were made by community mental health services, the rest were made by GPs.

Between October 2008 and July 2009 15 Divisions reported that 282 referrals (181 urban, 101 rural) were made to the specialist services. The 11 Divisions who had entered data into the minimum data set reported delivering 1064 sessions (677 urban, 387 rural). Overall there were a greater number of referrals and sessions in urban areas. The number of sessions and referrals in urban and rural areas both gradually increased from late 2008 and peaked in March 2009.

What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing specialist services through the ATAPS projects?

Around 60% of consumers to specialist services were female, and their mean age was approximately 33 years. About one half are on low incomes, as judged by their GP. Approximately 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%). In the main, the profiles of rural and urban consumers are similar, however there is a trend for rural consumers to be less likely to be on a low income and more likely to have used mental health care services before. Comparisons are made with the general ATAPS projects.

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

Sessions of 46-60 minutes account for two thirds of sessions. Urban areas favoured 46-60 minute sessions in almost three-quarters of sessions. However, in rural areas session duration was variable, with two thirds of sessions being 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. This trend was not noted in rural areas. In rural areas, about half of sessions were CBT-skills training. Rural areas also reported less use of CBT-cognitive interventions than urban specialist services. Comparisons are made with the general ATAPS projects.

Conclusions

The current report indicates that Specialist Services for Consumers at Risk of Suicide were received positively by most Divisions. Many Divisions reported some challenges in developing policy and procedures for the services, and then in engaging GPs, allied health professionals and new external referrers, which resulted in a delay in the commencement of service delivery. The services have begun to steadily attract referrals from GPs and Emergency Departments. Sessions delivered by allied health professionals to consumers are also steadily rising. The profile of consumers is somewhat different from the general ATAPS projects suggesting that these specialist services are reaching a different group of consumers and are complementing the general ATAPS projects. The nature of services being delivered varies from that of general ATAPS and between rural and urban areas. Consumers are receiving a free of cost service, with no co-payments reported in any sessions. These findings are preliminary pending the final report which is to be submitted in early 2010.

Chapter 1: Background

Since the late 1990s, Australia has seen significant changes in the way in which mental health care is delivered in Australia. There has been increased recognition that disorders such as depression and anxiety are prevalent; the 1997 National Survey of Mental Health and Wellbeing showed that 6% of Australian adults (around 1,299,600) experience an affective disorder in a given 12-month period, and 10% (around 778,600) experience an anxiety disorder.¹ There has also been increased acknowledgement that many people with these high prevalence disorders receive no treatment or ineffective treatment,² and that those who do receive treatment tend to utilise GPs rather than providers like psychologists (29% utilise the former; 7% the latter³). GPs are well-placed to assess people with these disorders, who often present with a mix of physical and psychological symptoms, but they have traditionally been ill-equipped to provide effective psychological treatment (particularly non-pharmacological therapies⁴), citing barriers such as lack of training and time constraints⁵. By contrast, psychologists' training and mode of service delivery equips them well to provide treatment for common disorders such as depression and anxiety, but their services have tended to be out of the reach of many individuals, due to barriers of cost.

Suicide continues to be a major public health issue. There were 1881 deaths from suicide in 2007 in Australia. Males accounted for over three-quarters of these deaths⁶. Many of these people may not have a mental illness or access to specialised mental health care and many may have visited a GP during that time⁷.

In July 2001, the Department of Health and Ageing (DoHA) introduced the Better Outcomes in Mental Health Care (BOiMHC) program. This program aims to improve consumers' access to high quality primary mental health care, through a number of components (see Appendix 1). Key among these is the Access to allied Psychological Services (ATAPS) component which supports GPs and allied health professionals to work together to provide optimal mental health care. Specifically, this component enables GPs to refer consumers with high prevalence disorders (e.g., depression and anxiety) to allied health professionals for twelve sessions of evidence-based mental health care (predominantly Cognitive Behavioural Therapy, or CBT), delivered in six time-limited sessions (or 18 in exceptional circumstances). One hundred and eleven (58 rural; 53 urban) Divisions of General Practice are facilitating this collaborative approach to mental health care through 111 projects (see Appendix 2).

DoHA has now provided funding to 19 Divisions (see Appendix 3) to offer a more intensive, prioritised service for people who are at risk of suicide (e.g., those who have made a recent suicide attempt, have recently self-harmed, or are having severe suicidal thoughts), who may or may not have a mental disorder. These Divisions were selected by DoHA on the basis of their capacity to deliver such a service, and in a manner that ensures representation from all states and territories. These Divisions have been provided with an additional \$100,000-\$150,000 to secure the services of specialised allied health professionals who will provide intensive care and follow-up to referred consumers. This project commenced in June 2008 and will conclude on 30 December 2009

The project differs from the general ATAPS services in a number of ways. The specialist services for consumers at risk of suicide focus on the treatment and care of three groups of individuals;

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

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

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

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

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

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

In mid-2003, the University of Melbourne's Centre for Health Policy, Programs and Economics (CHPPE) was contracted to evaluate the ATAPS projects. To date, 14 interim evaluation reports have been produced drawing on a number of data sources, including information from projects' local evaluation and project implementation reports, a purpose-designed minimum dataset, a Division forum, and one-off surveys⁸⁻²⁴. Our ongoing evaluation has drawn on a number of data sources, including information from projects' local evaluation and project implementation reports, a purpose-designed Minimum Dataset, a Divisional forum, and one-off surveys. In June 2008, our contract was varied to incorporate an evaluation of the new specialist ATAPS services for people at risk of suicide.

The current report is the second to document the progress of the evaluation of the specialist services. It represents an update of the first progress report of the specialist services, which was submitted to the Department of Health and Ageing in November 2008²⁵. The current report considers the implementation and achievements of the specialist services for consumers at risk of suicide component of the ATAPS projects since its introduction in June 2008. It looks at the models of service delivery being used by the ATAPS projects delivering specialist services, issues associated with offering specialist services, the level of uptake by GPs, allied health professionals and consumers at risk of suicide, the profile (socio-demographic and clinical) of consumers at risk of suicide, and the precise nature of services for consumers.

Chapter 2: Method

Evaluation questions

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

Evaluation Question 1: What models of service delivery are being used by the ATAPS projects delivering specialist services to consumers at risk of suicide?

Evaluation Question 2: What issues are associated with offering specialist services to consumers at risk of suicide via the ATAPS projects?

Evaluation Question 3: 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?

Evaluation Question 4: What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing specialist services through the ATAPS projects.

Evaluation Question 5: What is the precise nature of the services for consumers at risk of suicide being delivered through the ATAPS projects?

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

Data sources

Evaluation questions 1 and 2 were addressed through phone surveys with the ATAPS project workers at each participating Division (see Appendix 4). All 19 Divisions participated in this survey. The survey focussed on issues relating to the implementation of the specialist services for consumers at risk of suicide. Survey data was also compared to a purpose-designed survey of general ATAPS project officers conducted between October 2008 and February 2009 regarding models of service delivery.

Evaluation questions 3, 4, and 5 were addressed using data from the previously-mentioned minimum dataset, which captures de-identified, consumer-level and session-level information. Data from the minimum dataset was analysed for the period from October 2008 to 31 July 2009. Data was compared also to aggregated data from the national general ATAPS projects.

Of the 19 Divisions involved in the specialist services for consumers at risk of suicide, 11 submitted data to the minimum dataset during this period (6 urban, 5 rural). Four Divisions reported difficulties with data entry and management for the specialist services, specifically they reported their data management systems had not been updated in time to allow upload of specific suicide services data onto the MDS. A further 4 projects reported no referrals for the project, and therefore had no data.

Data was downloaded in July 2009 from the MDS in relation to evaluation question 3, 4, and 5 for the 11 Divisions and was combined with relevant survey data from the 4 Divisions that had been unable to enter their data into the MDS.

Data analysis

Qualitative analyses of surveys of project officers were used to answer evaluation questions 1 and 2. Simple frequencies and percentages were calculated in order to answer evaluation questions 3, 4, and 5.

Chapter 3: What models of service delivery are being used by the ATAPS projects delivering specialist services to consumers at risk of suicide?

As discussed in the background to this report, the specialist services are different to the general ATAPS projects in regards to method of referral into the services, the limited time frame within which allied health professionals are required to contact and see consumers (24-72 hours), consumer eligibility for services, and the intensity and duration of treatment.

The models of service delivery being used for the specialist services were explored by a survey of the ATAPS project officers of the 19 participating Divisions.

Divisions reported that they had re-evaluated their existing models of service delivery and operating policies and procedures to ensure that they were able to meet the requirements of the specialist services. Some Divisions reported that they have made changes to their model of service delivery; other Divisions reported that there have been no changes. Many Divisions emphasised the need to establish operating policies and procedures around the specialist services prior to the commencement of service delivery. Management and assessment of consumer risk was a key issue, as were procedures related to referral pathways.

Data obtained from this survey was compared to data obtained from another survey previously completed by project officers of 106 (out of 108) general ATAPS projects regarding their general ATAPS service delivery models between October 2008 and February 2009. This survey was also completed at that time by project officers of the 19 Divisions participating in the specialist services, in regards to their general ATAPS services. The surveys explored the methods of retaining allied health professionals, location of allied health professionals and referral mechanisms. These are described in Box 1.

Box 1: A framework to describe the models of service delivery being used by the projects

Means of retaining allied health professionals	Contractual arrangements	Allied health professionals are retained under some sort of contract or memorandum of understanding, where payment is on a fee for service basis. In most cases, contracts are with individual providers, but some Divisions have elected to enter into contracts with agencies.
	Direct employment	Allied health professionals are directly employed by the Division.
Location of allied health professionals	GPs' rooms	Allied health professionals provide services to the projects in rooms at the GPs' practices.
	Own rooms	Allied health professionals provide services at their own premises.
	Other location	Allied health professionals provide services at a third location.
Referral mechanisms	Voucher system	This involves a system whereby the Division distributes vouchers to participating GPs who, in turn, give them to consumers. Consumers then use the vouchers to visit nominated allied health professionals, and the allied health professional redeems the vouchers for payment from the Division.
	Brokerage system	This involves an agency (either the Division or a contracted third party) acting as a broker. GPs refer to this agency, which then allocates the referral to a specific allied health professional, sometimes using prioritisation or matching criteria.
	Register system	This involves a system whereby a register that profiles eligible allied health professionals is provided to participating GPs, who can then make their own decisions about referral.
	Direct referral	This involves a system whereby the GP refers the consumer directly to the allied health professional. Often this takes place in the context of the allied health professional being co-located with the GP. However, there are exceptions, where the allied health professional is located elsewhere.

Source: Morley et al¹²

Retention of allied health professionals

The implementation of the specialist services required additional staffing capacity for service delivery. Divisions managed the additional staffing needs of the specialist services in different ways. Some Divisions recruited new allied health professionals, whilst other Divisions were able to use their existing ATAPS allied health professionals. Divisions reported differences also in the way they managed the client load of the specialist services. Divisions reported either having dedicated allied health professionals working exclusively on the specialist services, or having a team of allied health professionals that shared the client load of general ATAPS and the specialised services.

Table 1 shows a comparison between the methods of retaining allied health professionals in the specialist suicide services and the general ATAPS program. Two-thirds of Divisions delivering the specialist services reported using contracted allied health professionals, and just over half of the Divisions reported directly employing allied health professionals. The comparison with the general ATAPS projects shows a trend away from a reliance on contractual allied health professionals to an increased use of directly employed allied health professionals. Note that the total percent shown in the table is more than 100% as some Divisions reported using more than one method of retaining allied health professionals.

Table 1: Comparison of retention of allied health professionals between general ATAPS and the specialist suicide services.

	Contractual arrangements	Direct employment	Other
ATAPS (N=106)	82.4%	39.8%	2.8%
Specialist Suicide Services (N=19)	68%	53%	0%

Location of allied health professionals

Of the 19 Divisions, eight reported that allied health professionals were located in the GPs rooms, six reported that the allied health professionals were located in their own rooms, six in Divisions' rooms, four in community rooms, and two were located at other settings namely Headspace, a Private Hospital and consumers homes (outreach). A few Divisions expressed a preference for the allied health professional to be located in a community or hospital setting, rather than an isolated setting, such as the allied health professionals' own rooms, for this consumer group. Table 2 shows a comparison of the location of allied health professionals for the specialist services with general ATAPS. This comparison shows a trend away from location in GPs rooms and allied health professionals' own rooms in the specialist services.

Table 2: Comparison of the location of allied health professionals between general ATAPS and the specialist suicide services.

	GPs rooms	Own rooms	Community rooms	Educational	Division's rooms	Other
ATAPS (N=106)	56.5%	57.4%	23.1%	0.9%	29.6%	19.4%
Specialist Suicide Services (N=19)	42%	32%	21%	0%	32%	11%

Referral mechanisms

Of the 19 participating Divisions, two reported using a voucher system for referral, five reported using a brokerage system, one reported using a register system, and ten reported the use of direct referral from the GP to the allied health professional. Table 3 shows a comparison between the referral mechanisms for the specialist services and general ATAPS program. This comparison shows that the favoured referral mechanism for the general ATAPS program and the specialist services is direct referral. A decrease in the use of the register system in the specialist services is also evident.

Table 3: Comparison of referral mechanisms between general ATAPS and the specialist suicide services.

	Voucher system	Brokerage system	Register system	Direct referral	Other
ATAPS (N=106)	13.9%	39.8%	25%	64.8%	1%
Specialist Suicide Services (N=19)	11%	26%	5%	53%	11%

After hours referrals

Seventeen of the 19 Divisions reported that they had not received any after hours referrals. This was for a range of reasons. Five Divisions reported that they have made a policy decision not to accept after hours referrals and that consumers were directed by Emergency Departments to attend their GP during business hours. Other Divisions reported that there either had not been any demand for after hours contact, or that the Emergency Departments and mental health services in their region attended to suicidal consumers after hours. Only one Division reported a system whereby staff are on call to attend to after hours contact from consumers.

Some Divisions were unclear regarding the purpose of the after hours phone service provided for the specialist services. Many of the Divisions reported that they had promoted the after hours phone number to consumers of these services. Many Divisions have produced posters and cards as reminders for GPs and consumers. Divisions reported use of the phone service in rural and remote areas, and that it is appreciated by allied health professionals.

Referrals from Emergency Departments

Unlike general ATAPS, Emergency Departments at hospitals are able to make provisional referrals to the specialist services, to allow immediate contact between the consumer and the allied health professionals, which would be followed up within one week by a GP referral. Relationship building between Divisions and local Emergency Departments was therefore a key component of the specialist services affecting referral rate.

Ten Divisions reported positive responses from Emergency Departments and mental health services when contacted regarding the specialist services. As one respondent stated that *'the Emergency Department and psychiatric service always knew we existed and are very keen'*.

Another Division established a relationship with a particular Emergency Department that provided triage for the specialist suicide services alongside triage for the mental health services. However, some Divisions commented that referrals were *'slow to come'* even though a good working relationship existed between the Emergency Department and the Division.

Three Divisions reported negative responses from their local Emergency Departments. As one division commented; *'they did not want to play ball'*, and another commented that *'it's hard to bring in something different'*.

Two Divisions had not started relationship building with Emergency Departments. A further two Divisions reported that they only wanted referrals from the GP as they felt that this ensured the consumers referred to the specialist services were suitable.

Chapter 4: What issues are associated with offering specialist services to consumers at risk of suicide via the ATAPS projects?

The issues associated with offering specialist services to consumers at risk of suicide via the ATAPS projects were also explored via the survey of the ATAPS project officers of Divisions participating in the specialist services. Project officers reported that implementation of the specialist services posed unique challenges and opportunities to Divisions, GPs, allied health professionals, and consumers.

Funding was received by Divisions for the specialist services in late 2008, however many Divisions did not immediately start delivering services. One Division reported that they began delivering services in November 2008, one in December 2008, five in January 2009, three in February 2009, two in March-April 2009, and three in May 2009. Four Divisions had not yet started delivering services as of July 2009.

Delays in the implementation of the specialist services

Divisions reported a range of factors that had delayed service delivery. Six Divisions reported that the requirement for allied health professionals to undergo training had acted as a barrier to service delivery. Divisions reported that the training was delayed. Two Divisions also reported that the delay in the provision of teaching resources to GPs was a significant factor.

Many Divisions emphasised the need to establish operating policies and procedures around this new client group. Management of consumer risk was a key issue, with some Divisions reporting concern regarding their legal liability for consumers at risk of suicide. Service delivery was delayed for six Divisions whilst activities related to the development of policy and procedures around client eligibility, referral pathways and risk assessment were undertaken. In addition, three Divisions reported that building relationships and establishing working agreements with external agencies delayed service provision. One of these Divisions had been unable to deliver any services due to difficulties engaging an external mental health care agency.

Issues related to the involvement of GPs in the specialist services were identified as key factors delaying the implementation of the services by seven Divisions. Five of these Divisions reported that time was needed to educate and promote the service to GPs before referrals were made by GPs to allied health professionals. Two of the seven Divisions reported that gaining GP confidence was a significant barrier to the implementation of the project. As one Division commented '*there is a problem with GPs getting their head around it*'. Another Division commented on the need for constant marketing as GPs '*forgot as soon as we left the room*'.

A lack of allied health professionals was identified as delaying the implementation of service delivery for five Divisions. These Divisions reported that existing ATAPS allied health professionals were too busy or did not want to take part. Two Divisions reported that they had recruited specifically for the specialist services.

A delay with the funding agreement with the Commonwealth was identified by three Divisions as a factor that delayed service delivery.

Two Divisions reported that they had been closed over the end of year period and this had resulted in a delay in service provision. One Division's service delivery was delayed by difficulties in finding a suitable location for the allied health professionals, as they had decided it was best for these consumers to be seen in a supported setting such as a community health service or hospital, rather than in an isolated setting, such as allied health professionals' own rooms.

Response of allied health professionals

Divisions reported mixed reactions from their existing ATAPS allied health professionals. Eight Divisions reported that their allied health professionals responded positively, saying *'we do this in practice anyway'*. Three Divisions reported negative reactions from allied health professionals who were not interested in working with this population group, who were too busy and felt unable to commit to the requirement to respond to the consumer within 72 hours, or who pulled out due to the amount of training required. Three Divisions felt unable to comment on the reactions of their allied health professionals.

Response of GPs

Mixed responses were also reported by Divisions from GPs. Seven Divisions reported that GPs had been *'slow'*, *'cautious'* and *'hesitant'*. GPs had been *'wary of sending patients to a service that is a pilot'* preferring instead to continue with existing trusted referral pathways. Six Divisions reported that the response from GPs had been very positive, commenting that *'anything that gets patients seen quickly is good'* and that it *'gives the GPs a back up'*. As discussed previously, two Divisions stated that it had been *'difficult for GPs to get their head around it'*. Two Divisions also commented that GPs were having *'issues assessing levels of patient risk'* and that they had had contact from GPs who weren't sure which consumers were suitable for the program. Three Divisions said GPs expressed mixed response, and one Division said it was too early to comment on the response of GPs.

Sixteen of the 19 Divisions reported that they had promoted the specialist services to GPs. These Divisions reported a variety of promotion strategies. Eight Divisions reported that they sent emails, letters or faxes to GPs to promote the services. Five Divisions undertook practice visits wherein they spoke to practice managers and/or GPs. Three Divisions reported promoting the services through Division publication materials such as newsletters or magazines. Two Divisions conducted an information night for GPs. One Division reported that there was no need to promote the specialist services as they already had a long wait list for general ATAPS services from which they selected suitable consumers and liaised with these consumers' GPs as needed. Two Divisions reported that they had not yet promoted the service to GPs, but were planning to begin promotion soon.

Factors which have acted as facilitators to effective operation

Ten Divisions identified factors that had contributed to the effective implementation and operation of the specialist services.

Five of these Divisions commented that having good pre-existing relationships with external referrers, such as local hospital Emergency Departments and mental health services, facilitated the project. An additional two of these ten Divisions said that working on developing relationships with external agencies was a facilitating factor for the project.

Three Divisions commented that their Division already had an effectively operating team of allied health professionals within the Division delivering mental health services and that the existence of the team, and the Divisions pre-existing commitment to delivering mental health services facilitated the implementation of this new specialist service. As one Division commented; the specialist services for consumers at risk of suicide *'integrates with what we are already doing, it was already in the realm... so it was a seamless transition'* and that it *'gives us another arm to provide a more integrated service'*.

Two Divisions reported that good project co-ordination by the Division had facilitated implementation. Two Divisions reported that the existing ATAPS allied health professionals had facilitated the implementation of the project through their work on policies and development of a service model, and through their good existing relationships with GPs.

One Division said that it had paid for the training required for allied health professionals and this had facilitated the project.

Factors which act as barriers to effective operation

The most commonly cited barriers to the effective operation of the specialist service were issues related to engaging allied health professionals in the project. Three Divisions commented on issues relating to locating and recruiting allied health professionals. Three further Divisions commented on the difficulties associated with training allied health professionals. Divisions said that the training was delayed and that allied health professionals were reluctant to do the training.

Engaging GPs in the project was also cited as a significant barrier by five Divisions. As discussed previously, Divisions reported that a significant barrier was getting the GPs familiar and used to the program in order for them to make referrals. As one Division commented, *'when they have the patient in front they do not always remember the referral pathway'*. Another Division commented that *'it takes about 12 months for GPs to get used to a new program'*. A few Divisions reported that GPs were wary of referring to a pilot program. One Division reported that *'some GPs felt uncomfortable with this client group and referred them to other GPs in the practice'*.

Whilst two Divisions reported that good project co-ordination by the Division had facilitated implementation, four Divisions commented that the administration required to implement the services had acted as a significant barrier to the effective operation of the services.

Three Divisions reported that the pilot nature of project was a significant barrier to its effective operation. Some Divisions were reluctant to strongly market the project as there was *'no guarantee of ongoing funding'*.

Negative impacts for Divisions

Fourteen of the 19 Divisions did not identify any negative impacts from the specialist services for the Divisions. Four Divisions commented on the significant amount of time required to facilitate appropriate and necessary systems, procedures and policies. One Division commented that they had been required to take the funding for the project even though they did not think it was the best way to deliver services in their local area. This same Division noted the frustration they experienced at having to close their general ATAPS program due to the high demand for the services, whilst they had funding for this specialist service that they were unable use.

Positive impacts for Divisions

Eleven Divisions cited positive impacts for the Division mostly related to the expansion of ATAPS services to fill a previously existing gap in services for those consumers of medium suicide risk. As one Division commented; the specialist service *'has increased access for clients who need it, there was a gap, and this is helping meet that need'*. Another Division similarly commented that it provides *'a referral pathway for clients at risk who can bypass the waitlist... it is very good'*. Other Divisions described the service as *'hugely valuable'*, *'great opportunity'*, *'making health better for people'*. One Division commented that *'this is a program that has been needed for a long time and makes sense'*, *'it is really needed as mainstream is so tight. It will add to the program.'*

Four Divisions stated that there had been no positive impacts for the Divisions. A further four Divisions were unsure or felt it was too early to comment on positive impacts for the Division.

What would make the specialist services work better?

When asked what would make the specialist services for consumers at risk of suicide work better, five Divisions said that to have more stability around the funding and know that it is not a pilot would provide reassurance for allied health professionals and GPs, and would enable the Division to more confidently market the services.

Three Divisions suggested that better distribution of information and training materials from the various stakeholders (i.e. Government departments, the APS, and Melbourne University) at the beginning and throughout the project would have been helpful. Divisions commented that information had been delayed and fragmented. Two divisions suggested that an online forum may contribute to improved information distribution, suggesting a website that provided information from stakeholders and provided

Divisions the opportunity to share resources and information regarding protocols and templates '*so that Divisions didn't have to work from scratch*'. A circular for Divisions regarding support available for Divisions was also suggested. It is noteworthy that a list serve (electronic mailing list) was developed by the Australian General Practice Network for this purpose and similarly the University of Melbourne has online support available at the BOiMHC website, however Divisions did not report using these resources.

Three Divisions suggested that better education of, and promotion of the specialist services, to GPs would help the project work better, and commented that a longer time to focus on implementing the project would have been more beneficial.

Chapter 5: What is the level of uptake of specialist services for consumers at risk of suicide by GPs, allied health professionals and consumers?

Uptake data is available for the 11 Divisions who had entered data into the minimum data set as at July 2009. As discussed previously, four further Divisions had undertaken specialist services but had not entered their data into the minimum data set. A further four Divisions had not delivered any specialist services as at July 2009. Unless otherwise mentioned, the following data is in relation to the 11 Divisions who had entered data into the minimum data set.

Uptake by GPs and allied health professionals

For the period October 2008 to July 2009, referrals were made by 150 GPs and sessions were conducted by 49 allied health professionals in the 11 Divisions.

New referrers

New referrers were eligible to provisionally refer to the specialist services. Table 4 shows a summary of referral sources. Emergency Departments were responsible for a significant proportion of referrals in urban areas. The majority of referrals came from GPs, especially in rural areas.

Table 4: Summary of referral sources for Consumers at Risk of Suicide.

	National	Rural	Urban
Community Mental Health Services	1%	0%	1%
Emergency Department	24%	1%	39%
GPs	75%	99%	60%

Uptake by consumers

Between October 2008 and July 2009, 11 Divisions reported that 242 referrals were made to the specialist services for consumers at risk of suicide, 152 urban and 90 rural. In addition, a further four Divisions reported, via the qualitative survey, 40 referrals (29 urban, 11 rural) that had not been entered into the minimum data set. Four Divisions reported no referrals. In sum, the total referrals into the services were 282 (181 urban, 101 rural) through 15 Divisions.

Eleven Divisions reported delivering 1064 (677 urban, 387 rural) sessions to 240 consumers to date, making the average number of sessions provided to consumers 4.4, however this is likely to be an underestimate as not all consumers will have completed treatment prior to the data being extracted. Data regarding sessions were unavailable for the four Divisions who had not entered their data into the minimum data set. Four Divisions reported that they had not delivered any sessions.

Further analysis of referrals and sessions was only possible for the 242 referrals and 1064 sessions that had been entered into the minimum data set from 11 Divisions. Figure 1 shows referrals and sessions by month for all participating Divisions from October 2008 to July 2009. Figures 2 and 3 show these referrals and sessions by month broken down into rural and urban Divisions. None of the Divisions reported referrals to the specialist services prior to this time period. Overall, there were a greater number of referrals and sessions in urban compared to rural areas. The number of sessions and referrals in urban and rural areas both gradually increased from late 2008 and peaked in March 2009. The tables show a decline in sessions and referrals after March 2009, but this may be due to a data entry lag.

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

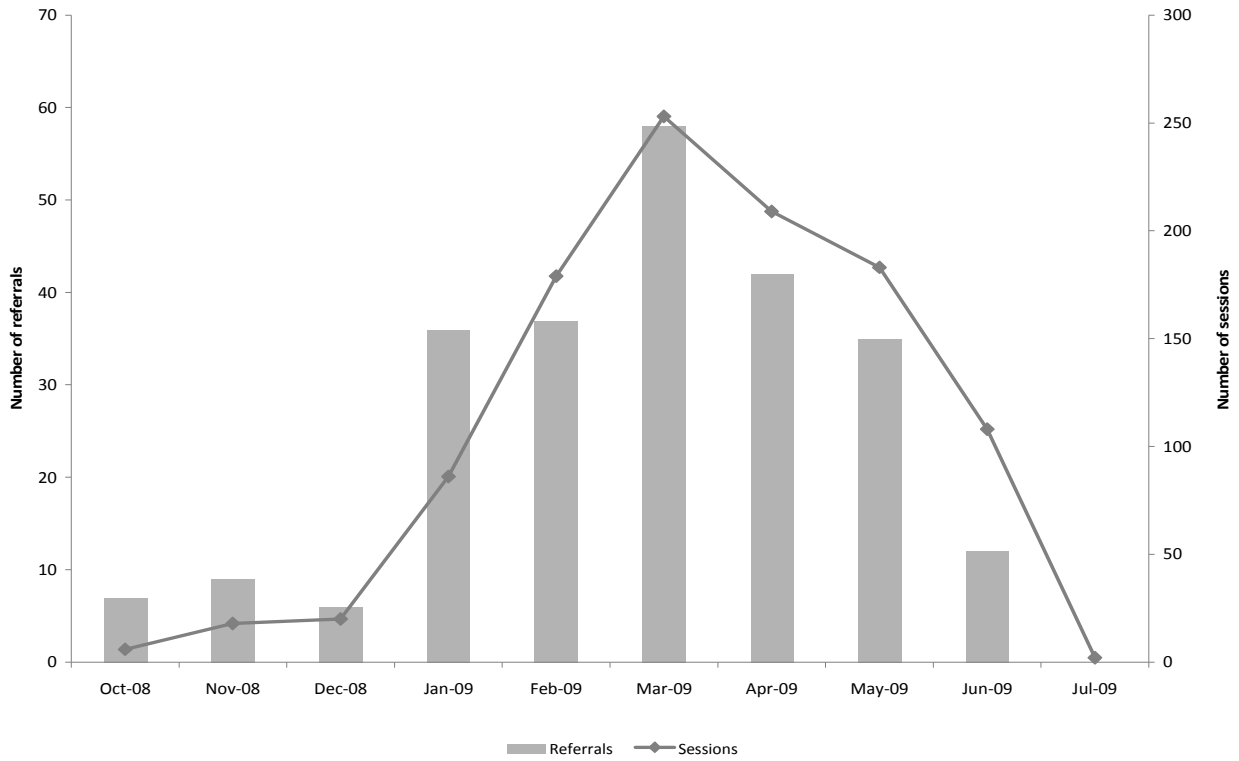


Figure 2: Referrals for sessions of care through the Specialist Services for Consumers at Risk of Suicide ATAPS projects, by month (urban Divisions).

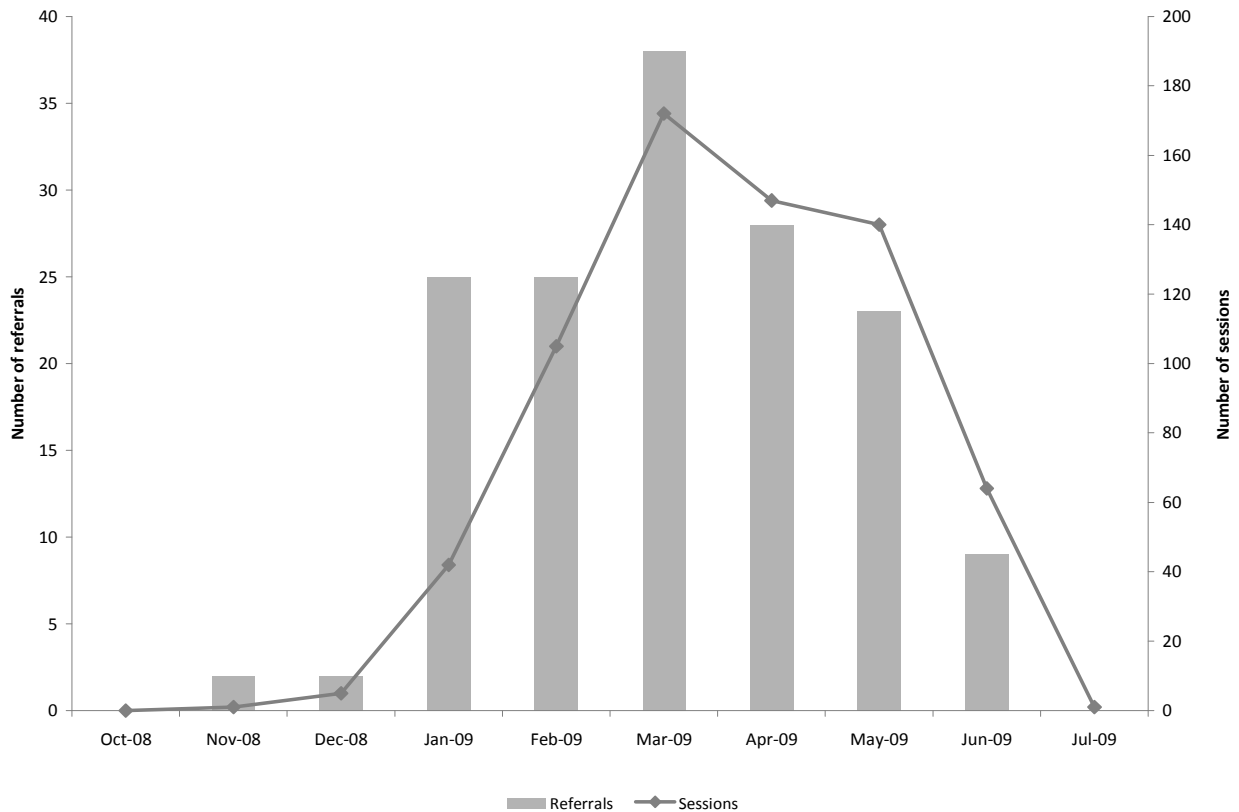
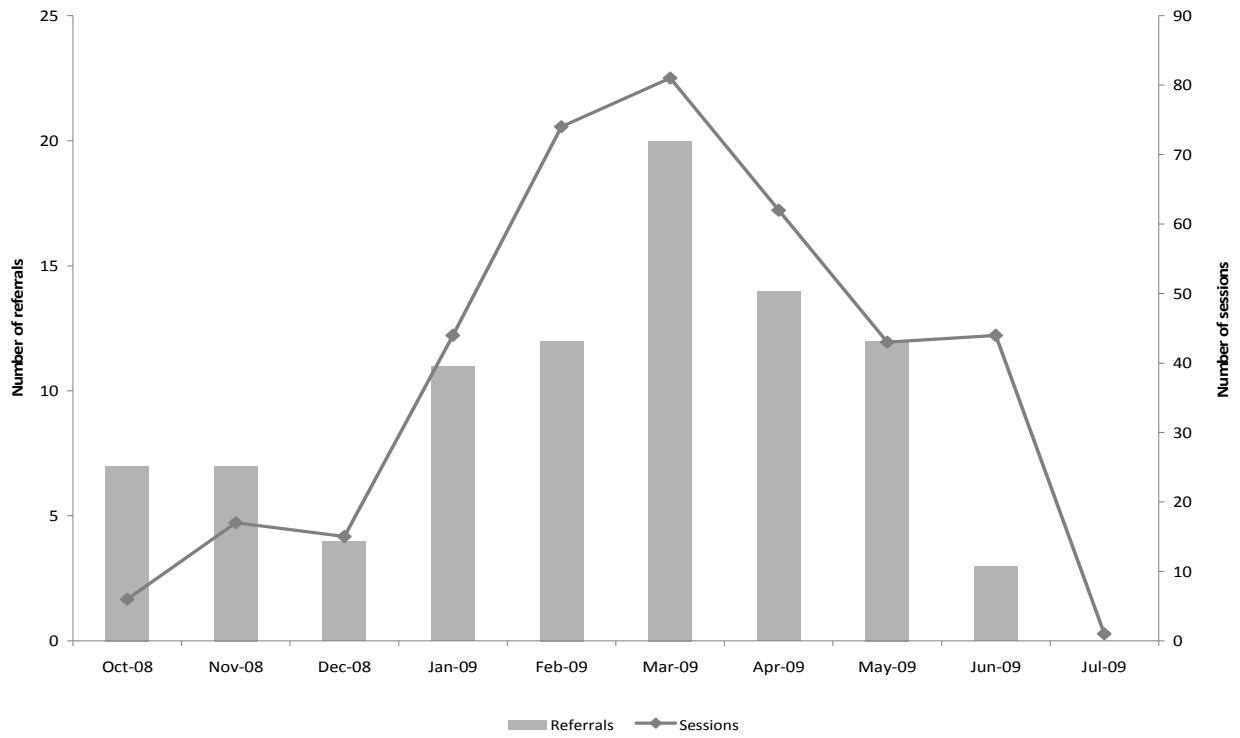


Figure 3: Referrals for sessions of care through the Specialist Services for Consumers at Risk of Suicide ATAPS projects, by month (rural Divisions).



Chapter 6: What is the profile of consumers at risk of suicide accessing services through the ATAPS projects?

Profile of consumers

Table 5 summarises some of the key characteristics of the consumers receiving care through the specialist services compared to national aggregated general ATAPS consumers⁸⁻²⁴³, displaying data at the national, rural, and urban level. Note that whilst consumers of the specialist services are described in urban and rural areas, the comparison is made with national (both urban and rural) general ATAPS consumers.

Around three-fifths of consumers to specialist services are female, and their mean age is approximately 33 years. About one half are on low incomes, as judged by their GP. About a half of the urban consumers, and about two-thirds of the rural consumers have a history of previous mental health care. A diagnosis was made by the referring GP for 82.2% (199) of the 242 consumers. For these 199 consumers, almost all have been diagnosed with depression (94%). In the main, the profiles of rural and urban consumers are similar, however there is a trend for rural consumers to be less likely to be on a low income and more likely to have used mental health care services before.

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

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

	National General ATAPS	National Specialist Services	Rural Specialist Services	Urban Specialist Services
Gender				
• Female	71.5%	59.5%	60.7%	58.7%
• Male	28.5%	40.5%	39.3%	41.3%
Mean age	39	32.9	33	32.8
Low income				
• Yes	63.9%	54.1%	42.2%	61.5%
• No	21.4%	26.2%	30%	23.8%
• Unknown	14.7%	19.7%	27.8%	14.7%
Aboriginal				
• Yes	2.4%	1.3%	2.3%	0.8%
• No	74.7%	80.2%	70.9%	86.2%
• Unknown	22.9%	18.5%	26.8%	13%
Torres Strait Island				
• Yes	0.3%	1%	1.2%	0.8%
• No	75.5%	80%	71.7%	85.4%
• Unknown	24.7%	19%	27.1%	13.8%
Previous psychiatric service use				
• Yes	39.7%	51.5%	57.1%	47.9%
• No	44.6%	29.9%	12.1%	41.4%
• Unknown	15.7%	18.6%	30.8%	10.7%
Diagnosis^a				
• Alcohol and drug use disorders	7.2%	10.6%	11.7%	9.8%
• Psychotic disorders	2.0%	5.0%	0%	8.2%
• Depression	75.5%	94.0%	96.1%	92.6%
• Anxiety disorders	56.9%	31.7%	32.5%	31.1%
• Unexplained somatic disorders	2.6%	0.5%	0%	0.8%
• Unknown	2.0%	1.5%	0%	2.5%

a. Multiple responses permitted

Chapter 7: What is the precise nature of the services being delivered?

Profile of sessions

In total 1064 sessions of care were provided through the specialist services to 240 consumers, making the average number of sessions provided to consumers 4.4. The profile of these sessions is shown in Table 6 detailing national, rural, and urban data compared to aggregated data for the general national ATAPS projects⁸⁻²⁴. Note that whilst consumers of the specialist services are described in urban and rural areas, the comparison is made with national (both urban and rural) general ATAPS consumers.

Sessions of 46-60 minutes account for two thirds of specialist services and are less popular than in the national ATAPS projects. Urban areas favoured 46-60 minute sessions. However in rural areas session duration was variable, with two thirds of session being less than 30 minutes or more than 60 minutes. Session interventions differed between urban and rural areas and from the national ATAPS projects. Over half of urban specialist sessions were diagnostic sessions and nearly half were CBT-cognitive interventions. However, this trend was not noted in rural areas. In rural areas, about half of sessions were CBT-skills training, which is a much higher proportion than reported for both the general ATAPS projects and the urban specialist services. Rural areas also reported less use of CBT-cognitive interventions than the general ATAPS projects and urban specialist services.

No copayment was reported in any of the specialist services sessions. This varies considerably from the general ATAPS projects where since July-September 2007 copayments have been charged in between 19% - 24% of sessions for urban projects and in 3 - 4% of sessions for rural projects²⁴.

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

		General National ATAPS	National Specialist Services	Rural Specialist Services	Urban Specialist Services
Duration	• 0-30 mins	1.9%	18.8%	27.4%	13.7%
	• 31-45 mins	4.5%	0.6%	1.3%	0.2%
	• 46-60 mins	82.0%	60.2%	37.7%	73.6%
	• Over 60 mins	11.6 %	20.4%	33.5%	12.6%
Type	• Group	2.2%	0.4%	0%	0.6%
	• Individual	97.8%	99.6%	100%	99.4%
Interventions^a	• Diagnostic assessment	16.1%	35.8%	18.1%	52.1%
	• Psycho-education	23.6%	18.0%	24.1%	13.8%
	• CBT-Behavioural interventions	35.5%	31.0%	36.7%	27.1%
	• CBT-Cognitive interventions	46.9%	35.1%	22.3%	43.8%
	• CBT-Relaxations strategies	18.6%	12.5%	16%	10.2%
	• CBT-Skills training	18%	26.5%	51.2%	9.8%
	• Interpersonal Therapy	22.7%	22.5%	24.1%	21.4%

a. Multiple responses permitted

Chapter 8: Discussion and conclusions

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

The current report focussed on how the specialist services for consumers at risk of suicide has been implemented, the uptake of the services, the profile of consumers, and the types of services for consumers. Specifically, it set out to investigate five evaluation questions, the answers to which are summarised below.

What models of service delivery are being used by the ATAPS projects delivering specialist services to consumers at risk of suicide?

Divisions reported that they had re-evaluated their existing models of service delivery and operating policies and procedures to meet the requirements of the specialist services. Compared to the general ATAPS projects there was a trend away from reliance on contractual allied health professionals (82.4% vs. 68%) and an increased use of directly employed professionals (39.8% vs. 53%). In regards to the location of allied health professionals, a trend away from GPs rooms (56.5% vs. 42%) and from allied health professionals own rooms (57.4% vs. 32%) was reported. The favoured referral mechanism was direct referral from GP to the allied health professional.

What issues are associated with offering specialist services to consumers at risk of suicide via the ATAPS projects?

Divisions began delivering services at different times since October 2008. Some Divisions had not yet started delivering sessions as at July 2009. Many Divisions reported that the delay in the commencement of service delivery was due to a range of factors. 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. Divisions said that to have more stability around the funding would provide reassurance for allied health professionals and GPs, and would enable the Division to more confidently market and implement the services.

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?

As at July 2009, 11 of the 19 Divisions had entered data into the minimum data set for the specialist services. None of the Division reported any service delivery prior to October 2008. Four Divisions had delivered services but were unable to enter data into the minimum data set due to data entry difficulties. Four Divisions had not commenced service delivery.

Between October 2008 and July 2009, the 11 Divisions who had entered data into the minimum data set reported that 150 GPs had made referrals to the specialist services and sessions had been conducted by 49 allied health professionals. New external referrers also became involved in the specialist services. Twenty-four per cent of the 242 referrals made to the specialist services within these 11 Divisions were made by hospital Emergency Departments, and 1% were made by community mental health services.

Between October 2008 and July 2009, 15 Divisions reported that 282 referrals (181 urban, 101 rural) were made to the specialist services. The 11 Divisions who had entered data into the minimum data set

reported delivering 1064 sessions (677 urban, 387 rural). Overall there were a greater number of referrals and sessions in urban areas. The numbers of sessions and referrals in urban and rural areas both gradually increased from late 2008 and peaked in March 2009.

What is the profile (socio-demographic and clinical) of consumers at risk of suicide accessing specialist services through the ATAPS projects?

Around 60% of consumers to specialist services were female, and their mean age was approximately 33 years. About one half were on low incomes, as judged by their GP. About a 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 are Aboriginal and about 1% are 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%). In the main, the profiles of rural and urban consumers are similar, however there is a trend for rural consumers to be less likely to be on a low income and more likely to have used mental health care services before.

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

Sessions of 46-60 minutes account for two thirds of sessions. Urban areas favoured 46-60 minute sessions in almost three-quarters of session. However, in rural areas session duration was variable, with two thirds of session being 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. This trend was not noted in rural areas. In rural areas, about half of sessions were CBT-skills training. Rural areas also reported less use of CBT-cognitive interventions than urban specialist services.

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

Some caveats

Some caution should be exercised in interpreting the above findings, because the minimum dataset has two limitations. Firstly, there are lags in data entry because some Divisions do not enter session data into the minimum dataset until treatment has been completed for a given consumer. This is likely to have the greatest impact on recent data. Data lag may therefore have had a great impact on the quality of the data in the minimum data set for the specialist services as these have only been implemented very recently. Secondly, some Divisions experienced various difficulties in relation to entering data into the minimum dataset. Of the 19 participating Divisions, only 11 had entered data into the minimum data set. Four Divisions were prevented from entering their data due to problems with their existing data systems. Given these two limitations it is recommended that the data presented here be considered as preliminary data pending the full report to be submitted early next year.

Conclusions

These caveats aside, the current report indicates that the Specialist Services for Consumers at Risk of Suicide were received positively by most Divisions. Many Divisions reported some challenges in developing policy and procedures for the services, and then in engaging GPs, allied health professionals and new external referrers, which resulted in a delay in the commencement of service delivery. The services have begun to steadily attract referrals from GPs and Emergency Departments. Sessions delivered by allied health professionals to consumers are also steadily rising. The profile of consumers is somewhat different from the general ATAPS projects. This suggests that the specialist services are reaching a different group of consumers and are therefore likely to be complementing the general ATAPS projects. The nature of services being delivered varies from that of general ATAPS and between rural and urban areas. Consumers are receiving a free of cost service, with no co-payments reported in any sessions. These findings are preliminary pending the final report which is to be submitted in early 2010. The evaluation team will be supporting Divisions to provide further consumer outcome data so that this can be evaluated in the final report

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Appendix 1: Components of the Better Outcomes in Mental Health Care program

Education and training for GPs (Component 1)

The education and training component of the Better Outcomes in Mental Health Care program is designed to assist GPs to extend their skills in mental health care. Three levels of training are available:

- Familiarisation Training: This familiarises GPs with the program.
- Level 1 Training: This equips GPs to perform develop mental health plans and consult and review progress against these plans (see below).
- Level 2 Training: This promotes skills and knowledge that enable GPs to deliver Focussed Psychological Strategies (see below).

To complete Familiarisation Training, GPs attend a two-hour session provided by local Divisions of General Practice, supplemented by a Familiarisation Training E-learning CD-ROM. To qualify for completion of both Level 1 and Level 2 Training, GPs must either apply for recognition of prior learning (RPL) or complete a recognised educational activity, delivered by an eligible provider. The General Practice Mental Health Standards Collaboration^a sets and administers the education and training standards that govern which previous and current activities satisfy the requirements of Level 1 and Level 2 Training.

Originally, training was mandatory for GPs wishing to participate in the program. All GPs had to attend Familiarisation Training and Level 1 Training to qualify to register with Medicare Australia (formerly the Health Insurance Commission) to access Service Incentive Payments for providing a GP Mental Health Care Plan (formerly a 3 Step Mental Health Process) (see below) and to refer patients to the Access to Allied Psychological Services projects (see below). Level 2 Training qualified GPs to access the Medical Benefits Schedule item numbers that provide rebates for the delivery of Focussed Psychological Strategies (see below).

There is still a strong emphasis on education and training under the Better Outcomes in Mental Health Care program, and such training is strongly recommended. It is no longer obligatory for GPs to complete Familiarisation Training and Level 1 Training in order to take part in the program. However, it is mandatory for GPs to have undertaken Level 2 Training in order to register with Medicare Australia to provide Focussed Psychological Strategies.

The GP Mental Health Care Plan (formerly the 3 Step Mental Health Process) (Component 2)

The GP Mental Health Care Plan was included in the Better Outcomes in Mental Health Care program to provide a framework for the management of mental health problems and mental illness in a primary care setting, by encouraging effective and longitudinal care of consumers. Originally known as the 3 Step Mental Health Process, it included: (a) an assessment (Step 1); (b) preparation of a mental health plan (Step 2); and (c) a review of the mental health plan (Step 3). GPs were reimbursed for providing the 3 Step Mental Health Plan via a blended mechanism of payment. When they registered with Medicare Australia, they were paid a sign-on Service Incentive Payment of \$150. The GP then billed Medicare Australia under normal attendance items (Level C or D) for the assessment and the mental health plan. He or she used a specific item number to bill Medicare Australia for the review (Items 2574, 2575, 2577, 2578, 2704, 2707, 2705 or 2708), and this triggered the payment of a Service

^a The General Practice Mental Health Standards Collaboration is a collaboration of the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine, the Royal Australian and New Zealand College of Psychiatrists, the Australian Psychological Society, and the Mental Health Council of Australia.

Incentive Payment (\$150 per 3 Step Mental Health Process per consumer per year) in addition to attracting a Medicare rebate for the consumer.

The 3 Step Mental Health Process ceased operating in its original form on 30 April 2007, and its structure and incentives were incorporated into the GP Mental Health Care Plan. This comprises three new GP mental health care items that were introduced on to the Medicare Benefits Schedule under the Better Access program. Item 2710 provides for the preparation by a GP of a mental health care plan, Item 2712 provides for attendance by a GP to review a mental health care plan, and Item 2713 provides for a mental health consultation.

Focussed Psychological Strategies (Component 3)

The Better Outcomes in Mental Health Care program places emphasis on the delivery of Focussed Psychological Strategies, or specific mental health care treatment strategies, derived from evidence based psychological therapies. The strategies approved under the initiative are generally limited to psycho-education, cognitive behavioural therapy (including behavioural interventions, cognitive interventions, relaxation strategies and skills training), motivational interviewing and interpersonal therapy. These strategies are time limited, normally being deliverable in up to six planned sessions, each lasting a minimum of 30 minutes. In some instances, following review, an additional six planned sessions may be warranted.

Under the Better Outcomes in Mental Health Care program, Medicare Benefits Schedule rebates were introduced in November 2002 to provide an incentive for GPs to deliver Focussed Psychological Strategies, via Items 2721 and 2725. Only those GPs who are registered with the who satisfy the Level 2 Training requirements set by the General Practice Mental Health Standards Collaboration (see above) are eligible to register with Medicare Australia to bill for the delivery of these services.

The Better Outcomes in Mental Health Care initiative also provides opportunities for GPs who do not feel confident in the delivery of Focussed Psychological Strategies or who have not undertaken Level 2 Training to refer consumers on. Consumers may be referred to another GP who has undertaken Level 2 Training or to an allied health professional under the Access to Allied Psychological Services component (Component 4) of the of the program (see below).

Access to Allied Psychological Services (Component 4)

The Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program supports GPs and allied health professionals (predominantly psychologists, but also social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers) to work together to provide optimal mental health care. Specifically, this component enables eligible GPs to refer consumers to allied health professionals for six sessions of Focussed Psychological Strategies, delivered in six time-limited sessions with an option of a further six sessions following a mental health review by the referring GP.

Access to Psychiatrist Support (Component 5)

The Access to Psychiatrist Support component of the Better Outcomes in Mental Health Care program has two sub-components, both of which broaden the role of psychiatrists in providing mental health care. The first involves a series of Medicare Benefits Schedule rebates which enable psychiatrists to organise or take part in case conferences on a consumer's behalf (Items 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838, 855, 857, 858, 861, 864 and 866). The second involves the provision of consultancy assistance to GPs by psychiatrists via GP Psych Support, a service that was originally provided by McKesson and Educational Health Solutions and is now being provided by the Royal Australian College of General Practitioners. GP Psych Support provides GPs with telephone, fax and email access to quality management advice from a psychiatrist within 24 hours, seven days a week.

Appendix 2: Divisions of General Practice involved in general ATAPS projects

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

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

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

Appendix 3: Divisions of General Practice involved in the Specialist Services for Consumers at Risk of Suicide

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

Appendix 4: Survey of ATAPS Project Officers for the Specialist Suicide Services.

Questions for ATAPS project officers involved in the Suicide Prevention Pilot

We are interested in the views of ATAPS project officers from Divisions of General Practice that are involved in the Suicide Prevention Pilot.

We are interested in your views and experience regarding the implementation of this pilot.

1. Name of Division(s) conducting Suicide Prevention Pilot:

2. Is your Division a fund holder for another Division which is also conducting the Suicide Prevention Pilot?

- Yes
- No

If yes, please specify,

3. How many suicide prevention pilot referrals have been received by the Division?

3a. If there have been none, are you aware why?

3b. If there have been some, have any of these consumers been referred to general ATAPS?

4. When was the Division able to start delivering Suicide Prevention Pilot services?

4a. If there was a delay starting, what was the reason for the delay?

5. Which of the following means of retaining allied health professionals is being used for your Suicide Prevention Pilot? Please tick appropriate response(s)

- Contractual arrangements:** Allied health professionals are retained under some sort of contract or memorandum of understanding. In most cases, contracts are with individual providers, but some Divisions have elected to enter into contracts with agencies. In some cases, a formal contract may not exist but the allied health professional is paid a 'fee for service'.
- Direct employment:** Allied health professionals are directly employed by the Division.
- Other** _____ [Please specify]

6. From which of the following locations are allied health professionals providing services in your Suicide Prevention Pilot project? Please tick appropriate response(s)

- GPs' rooms:** Allied health professionals provide services to the projects in rooms at the GPs' practices.
- Own rooms:** Allied health professionals provide services at their own premises.
- Division's rooms:** Allied health professionals provide services to the projects in rooms at Division office.
- Community organisation:** Allied health professionals provide services at Community Centre / organisation.
- Educational setting:** Allied health professionals provide services to the projects at a school / TAFE/ university.
- Other location** [Please specify] _____

7. Which of the following referral mechanisms is being used in your Suicide Prevention Pilot project? Please tick appropriate response(s)

- Voucher system:** This involves a system whereby the Division distributes vouchers to participating GPs who, in turn, give them to consumers. Consumers then use the vouchers to visit nominated allied health professionals, and the allied health professional redeems the vouchers for payment from the Division.
- Brokerage system:** This involves an agency (either the Division or a contracted third party) acting as a broker. GPs refer to this agency, which then allocates the referral to a specific allied health professional, sometimes using prioritisation or matching criteria.
- Register system:** This involves a system whereby a register that profiles eligible allied health professionals is provided to participating GPs, who can then make their own decisions about referral.
- Direct referral:** This involves a system whereby the GP refers the consumer directly to the allied health professional. Often this takes place in the context to the allied health professional being co-located with the GP. However, there are exceptions, where the allied health professional is located elsewhere.
- Other** [Please specify] _____

8. Are any aspects of the model of service delivery (i.e., means of retaining allied health professional, location of allied health professional, referral mechanism) different from those for general ATAPS?

- Yes
- No

8a. If yes, how do they differ?

9. How are referrals from Emergency departments and other referrers for the Suicide Prevention Pilot handled by the Division?

10. What experiences has the Division had in working with new referrers, e.g. Emergency Departments?

10a. How have working relationships been developed with existing referrers outside the Division?

11. How did the Division promote the Suicide Prevention Pilot to GPs and ATAPS allied health professionals?

12. How did GPs respond to the introduction of the Suicide Prevention Pilot?

13. How did ATAPS allied health professionals respond to the introduction of the Suicide Prevention Pilot?

14. What factors have facilitated the effective operation of the Suicide Prevention Pilot?

15. What factors have posed a barrier to the effective operation of the Suicide Prevention Pilot?

15a. Where there any difficulties with which the evaluation team could provide support?

16. Have you found that being able to refer patients via the Suicide Prevention Pilot has had positive impacts for the Division? if so, what have these impacts been?

17. Have you found that being able to refer patients via the Suicide Prevention Pilot has had negative impacts for the Division? if so, what have these impacts been?

18. What would make the Suicide Prevention Pilot work better?

19 Are there any other comments you would like to make about the Suicide Prevention Pilot?
