



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

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Executive summary

Background

The Better Outcomes in Mental Health Care program, introduced in July 2001, and the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (Better Access) program, introduced in November 2006, aim to improve consumers' access to high quality primary mental health care. Both programs enable GPs to refer consumers to allied health professionals for up to 12 (or 18 in exceptional circumstances) individual and/or group sessions of evidence-based care per calendar year. This occurs via 106 Access to Allied Psychological Services projects being conducted by Divisions of General Practice in the case of the former and via a set of new item numbers as part Medicare Benefits Schedule (MBS) in the case of the latter. This report explores the changes in the level of uptake of services provided by the projects following the introduction of the Better Access program.

Method

The current report is the thirteenth in a series of interim evaluation reports, produced as part of the ongoing evaluation of the Access to Allied Psychological Services projects. The report draws on data from the projects' minimum dataset and MBS data supplied by the Medicare Benefits Branch of the Department of Health and Ageing.

Results

Divisional-level analysis of the number of sessions provided through both programs in the twenty-one months since the introduction of the Better Access program (1 November 2006) revealed a dramatic uptake of Better Access sessions in urban areas, which coincided with a temporary reduction in sessions provided in urban areas under the Access to Allied Psychological Services projects. Similarly, sessions through rural Access to Allied Psychological Services projects temporarily decreased but to a lesser extent. Currently, the uptake of sessions through both programs is steadily increasing. The correlations between the number of sessions provided by both programs overall and in urban and rural areas were positive and significant but small. This suggests that the two programs are complementary in terms of addressing significant community need.

Conclusions

The current report indicates that the introduction of the Better Access program has not reduced the demand for psychological services provided through the Access to Allied Psychological Services projects and that the demand for both programs continues to rise steadily. The consistent prevalence rates of mental disorders and increased (GP and public) awareness, contribute to the persistent demand for affordable and accessible primary mental health care services.

Background

The 1997 and 2007 National Surveys of Mental Health and Wellbeing (NSMHWB) showed that 6% (1,299,600 and 995,900, respectively) of Australian adults experience an affective disorder in a given 12-month period, while 10% (778,600) and 14% (2,300,000), respectively, experienced an anxiety disorder in the 12 months preceding the interview.^{1 2} Moreover, the 2007 NSMHWB reported that of the 16 million Australians aged 16-85, almost half (45% or 7,300,000) had a mental disorder at some point in their life². Due to increased awareness of the prevalence of mental health disorders and problems historically associated with accessing effective treatment,³⁻⁶ mental health care delivery in Australia has been reformed over the past two decades.

In an effort to improve access to effective primary mental health care, the Better Outcomes in Mental Health Care program was introduced in July 2001, followed by the initiation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (Better Access) program in November 2006. Both programs enable GPs to refer consumers to psychologists (and other relevant providers) for low-cost, evidence-based sessions of mental health care. Key characteristics of both programs are elaborated below.

For the past six years, the Centre for Health Policy, Programs and Economics (formerly the Program Evaluation Unit) in the University of Melbourne's School of Population Health has been conducting an evaluation of the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program. Our primary data sources have been a purpose-designed minimum dataset (which is a repository for consumer-based and session-based data, and includes data on consumer outcomes as assessed by scores on a range of standardised outcome measures) and several targeted surveys of Access to Allied Psychological Services project officers.

The Better Outcomes in Mental Health Care program

The Better Outcomes in Mental Health Care program, introduced in 2001, aims to improve consumers' access to high quality primary mental health care by offering GPs training, systemic and professional support, and financial incentives via a number of interlocking components (described in more detail in Appendix 1).⁷

Central among these components is the Access to Allied Psychological Services component, which 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 collaborate to provide optimal mental health care. Specifically, this component enables GPs to refer consumers to allied health professionals for up to 12 (or 18 in exceptional circumstances) individual and/or group sessions of evidence-based care per calendar year.

This collaborative approach to mental health care is occurring through 106 Access to Allied Psychological Services projects being conducted by 111 Divisions of General Practice. The Divisions 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), one Division of which is no longer operating and two of which have been absorbed in amalgamations; 33 from July 2004 (Round 3 projects); six from July 2005 (Round 4 projects), one Division of which is no longer operating and one Division has since amalgamated with a Division in a previous funding round; and a further two funded in 2007. Appendix 2 provides a full list of the Divisions involved in these projects.

The Better Access program

The Better Access program was introduced in November 2006 as a cornerstone of the Council of Australian Governments (COAG) reform package of \$1.9 billion over five years, with \$507 million committed specifically to the Better Access component of the package.⁸ The Better Access

program is designed to improve access for people with clinically diagnosed mental health disorders to psychologists, psychiatrists, GPs and other allied health providers via a series of new Medicare Benefits Schedule (MBS) item numbers.⁹

Amongst the modifications to the MBS was the addition of a set of item numbers that make the services of registered psychologists (and selected social workers and occupational therapists) eligible for a rebate. Similar to the Access to Allied Psychological Services projects, under the new item numbers, a GP can refer a consumer to an allied health professional for up to 12 (or 18 in exceptional circumstances) individual and/or group sessions of evidence-based care per calendar year. Allied health professionals can directly bill Medicare Australia (the body that administers the MBS) or can bill the consumer who can then obtain a partial or full rebate from Medicare Australia.⁹

The current report

The current report is the thirteenth in a series about the ongoing evaluation of the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program. The reports have utilised multiple data sources, including projects' local evaluations and project implementation reports, a purpose-designed minimum dataset, a Divisional forum, and one-off surveys.¹⁰⁻²¹ The focus of each of these reports is summarised in Appendix 3.

The current report explores changes in the level of uptake of services provided by the Access to Allied Psychological Services projects in the twenty-one month period from the introduction of the Better Access program on 1 November 2006 to 31 July 2008. The changes are examined overall (nationally) and broken down by urban and rural Divisions. The findings represent an update to data provided in the 10th interim report,¹⁹ which examined the relationship between the two programs in the first five months succeeding the introduction of Better Access, and was disseminated in November 2007. Based on the findings of this report, it was concluded that the two programs were operating relatively independently of each other but were complementary in addressing a previously unmet need for affordable primary mental health care.

Method

Evaluation questions

This report considers the following evaluation question: have there been changes in the uptake of the Access to Allied Psychological Services provided by the projects following the introduction of the Better Access program?

Data sources

The evaluation question was addressed using data from the minimum dataset, which captures de-identified, consumer-level and session-level information. Data were extracted from the minimum dataset on the numbers of sessions provided by the projects in urban and rural areas.

In addition, MBS data on services rendered by allied health professionals under the Better Access program was made available by the Medicare Benefits Branch of the Department of Health and Ageing. Specifically, the Medicare Benefits Branch extracted monthly postcode-level session data, aggregated these data so that all of the postcode areas within a given Division were combined for a given month, and provided the evaluation team with Division-level data.

The numbers of sessions provided by Access to Allied Psychological services allied health professionals and Better Access allied health professionals were calculated at a Divisional level for each month from 1 November 2006 to 31 July 2008, and correlations between the two were examined.

Data analysis

Simple frequencies and percentages were calculated in order to compare urban and rural session provision through the two programs.

Correlation (Pearson's r) analyses were conducted to assess the linear relationship between the monthly number of sessions provided through the Access to Allied Psychological Services projects and Better Access program, since the introduction of the latter.

Results

Comparing the number of sessions provided through the Access to Allied Psychological Services projects and the Better Access program

Divisional-level data on the number of sessions provided through the Access to Allied Psychological Services projects (from the minimum dataset) and the Better Access program (from the Medicare Benefits Branch of the Department of Health and Ageing) were available from 1 November 2006 to 31 July 2008. It should also be noted that the analysis dataset only included data from 105 Divisions where both Access to Allied Psychological Services and Better Access data were available.^a

Table 1 provides a descriptive comparison of session characteristics of both programs. Fifty-five per cent of the Access to Allied Psychological Services project sessions were provided in urban areas, compared with 82% of the Better Access program sessions. Only a minority of sessions delivered under the Access to Allied Psychological Services projects incurred a copayment (15%); comparable data is not available for sessions delivered through Better Access. The average copayment amount was smaller for sessions delivered under the Access to Allied Psychological Services projects than for those delivered through Better Access, both in urban (\$2.79 compared to \$19.03) and rural (\$0.76 compared to \$15.31) areas. The majority of Better Access sessions have been delivered by general psychologists in urban areas (51%), followed by clinical psychologists in urban areas (29%) and general psychologists in rural areas (13%). Equivalent data for session delivery under the Access to Allied Psychological Services projects will be available in a future evaluation report.

^a Some Divisions (projects) did not have session data in the minimum dataset for specific months within the data analysis period. When this was attributable to the absence of a corresponding Access to Allied psychological Service project or data entry issues (as opposed to actually not having sessions for that month), the corresponding monthly Better Access data for that Division was excluded from the analysis. Where it was definite that there were no sessions for that month, the Access to Allied Psychological Services project was retained in the analysis and the number of sessions was entered as zero. There were four Divisions that had Better Access sessions but have never run an Access to Allied Psychological services project, therefore these Divisions were excluded.

Table 1: Comparison of session delivery under Access to Allied Psychological Services (ATAPS) projects and Better Access

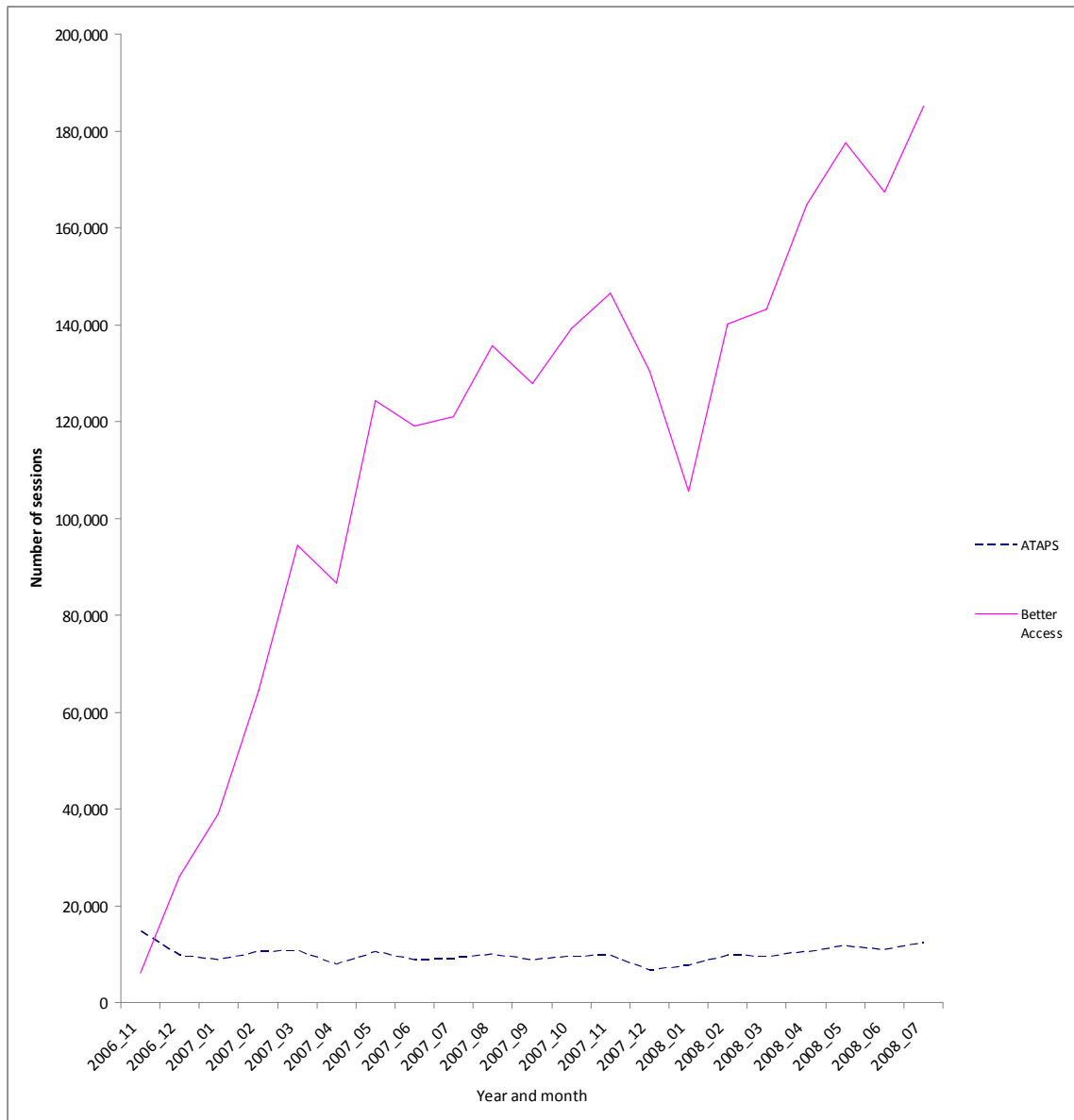
	ATAPS	Better Access
Average monthly sessions (standard deviation)	98 (86)	1,159 (1,264)
Proportion urban sessions	55%	82%
Proportion rural sessions	45%	18%
Proportion sessions with no copayment	85%	Not available
Average urban session copayment (standard deviation)	\$2.79 (\$6.07) ^a	\$19.03 (\$20.45)
Range urban session copayment	\$0-\$30	\$0-\$596.44
Average rural session copayment (standard deviation)	\$0.76 (\$3.62)	\$15.31 (\$17.76)
Range rural session copayment	\$0-\$30	\$0-\$332.50
Proportion of all sessions delivered by various allied health professional groups (urban and rural)	Data to be collected	<i>Urban</i> <i>Rural</i>
	Clinical psychologist	28.68% 4.04%
	General psychologist	50.59% 12.54%
	Social Worker	0.51% 0.14%
	Occupational therapist (N=2,782,762)	2.63% 0.88%

^a Extreme outliers were excluded.

Figure 1 presents the overall number of sessions delivered under each program in the twenty-one month observation. It shows a steady delivery of a total of 206,645 sessions in the analysis period through the Access to Allied Psychological Services projects. In contrast, a much more pronounced increase in the number of sessions provided through the Better Access program in the analysis period is observed, accounting for a total 2,443,835 sessions^b.

^b This figure is an underestimate of sessions delivered by allied health providers through Better Access due to the data analysis approach described above. The actual number of sessions delivered by allied health professionals through Better Access in the data analysis period was 2,790,596 (data report available from Medicare website).²²

Figure 1: Overall number of sessions provided through Access to Allied Psychological Services projects and Better Access program from 1 November 2006 to 31 July 2008



Figures 2 and 3 show the monthly breakdown of sessions provided under each program in urban and rural areas, respectively. As shown in Figure 2, there was a dramatic uptake of Better Access sessions in urban areas, which coincided with an initial reduction in sessions provided in urban areas under the Access to Allied Psychological Services projects. This reduction in urban Access to Allied Psychological Services projects reached a plateau within approximately six months and is currently increasing again. A similar pattern is noted in Figure 3, with the exception that the initial reduction of sessions delivered by rural Access to Allied Psychological Services projects was less pronounced while the current increase is more pronounced than that of their urban counterparts.

Figure 2: Urban sessions delivered through Access to Allied Psychological Services projects and the Better Access program from 1 November 2006 to 31 July 2008

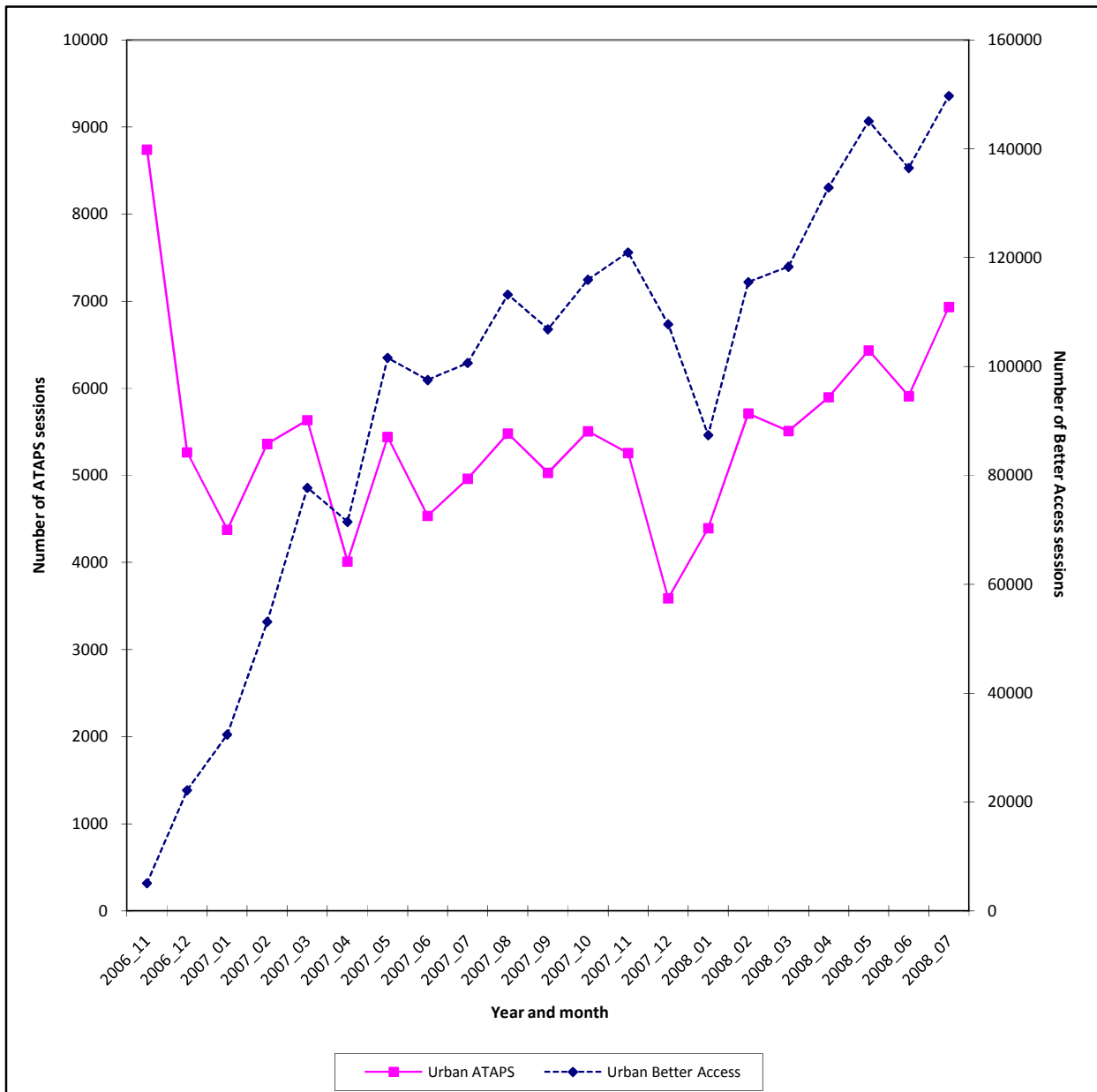
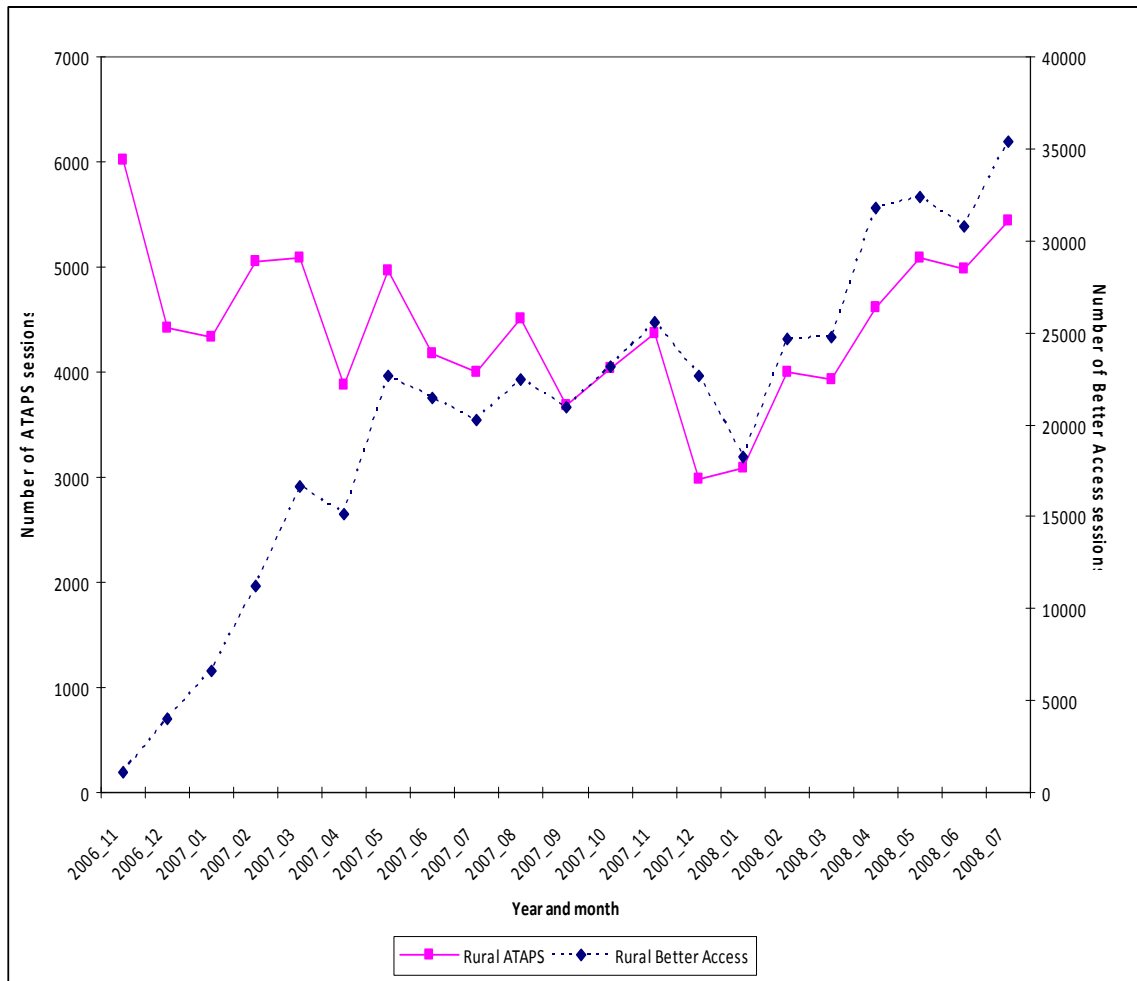


Figure 3: Rural sessions delivered through Access to Allied Psychological Services projects and the Better Access program from 1 November 2006 to 31 July 2008



Correlation analyses were conducted to assess the relationship between the number of sessions provided through the Access to Allied Psychological Services projects and Better Access program, per Division, per month. Three separate analyses were conducted – one for all areas combined, one for rural areas, and one for urban areas. The analyses found a small, significant positive correlation overall ($r = .181, p = .000$). There were also small, significant positive correlations found for both urban areas ($r = .137, p = .000$) and rural areas ($r = .075, p = .014$).

Discussion and conclusions

Summary of the relationship between the Access to Allied Psychological Services projects and Better Access

The current report focussed on the relationship between the Access to Allied Psychological Services projects and Better Access from the time of the introduction of the latter on 1 November 2006 to 31 July 2008.

Divisional-level analysis of the number of sessions provided through both programs in the twenty-one months since the introduction of the Better Access program (1 November 2006) demonstrates that the uptake of the Better Access program has been dramatic, particularly in urban areas. However, there has not been a commensurate decrease in the number of sessions provided through the Access to Allied Psychological Services projects, except for a small early drop in the number of sessions, which has since been increasing. Anecdotally, the initial decrease in session numbers may have been attributable to misconception among GPs about the redundancy of the Access to Allied Psychological Services projects and their substitution by the Better Access program.

The correlations between the number of sessions provided by both programs overall, and in urban and rural areas were small and significant. However, it is noteworthy that while the majority of sessions delivered through Better Access have been in urban areas, the provision of sessions through the Access to Allied Psychological Services projects has been relatively more equally distributed. This may be attributable to flexibility of service delivery models granted to the Access to Allied Psychological Services projects, particularly in terms of the ability to retain allied health professionals by means of employment and/or contractual arrangements.

Overall, the findings demonstrate that the uptake of both programs is increasing and that the Better Access program is far from replacing the Access to Allied Psychological Services projects. Rather, the two programs are operating in a complementary fashion to meet the significant community need for primary mental health care. However, it is noteworthy that the Access to Allied Psychological Services projects have a relatively greater reach in rural areas. Many Divisions continue to provide support to GPs wishing to refer to the Better Access program, and some allied health professionals are providing services under both programs.

Caveats

Caution should be exercised in interpreting the above findings because the true magnitude of the relationship between the number of sessions provided through both programs is confounded by the fact that funding for the Access to Allied Psychological Services projects is capped while Better Access services are not. Additionally, the large sample size (and session numbers) may produce false positive results.

Conclusions

The current report indicates that the introduction of the Better Access program has not reduced the demand for psychological services provided through the Access to Allied Psychological Services projects and that the demand for both programs continues to rise steadily. This continued increase in the uptake of the two programs may in part be attributable to the fact that the prevalence rates of affective disorders have remained consistent and anxiety rates have increased over the past decade.^{1 2} In addition, the 2007 NSMHWB reveals that there are significant proportions of people with these high prevalence disorders who do not use services, therefore it is important to continue to offer a range of options to improve consumer access.²

The continuing, steady uptake of the Access to Allied Psychological Services projects, despite the introduction of the Better Access program may also be attributable to an excess demand for psychological services that could not be met by the projects due to the capped nature of their funding, which is now being addressed, at least to some extent, by psychologists and allied health professionals providing care through the Better Access program. This interpretation is consistent with other findings of the current evaluation, such as the fact that many Divisions have had to institute demand management strategies to deal with excess requests for services.¹⁸ Moreover, one of the reasons for the ongoing high demand for services provided through the Access to Allied Psychological Services may be the evidence that they are achieving positive consumer outcomes.

Together, the Access to Allied Psychological Services projects and the Better Access program appear to be successfully increasing GP (and public) awareness of mental health issues, providing GPs with accessible and effective referral pathways, recognising the value of psychological services, reducing the stigma associated with seeking mental health care, rendering mental health services accessible to consumers by reducing out of pocket expenses, and improving the mental health and overall wellbeing of Australians.

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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^c 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

^c 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 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 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: List of Divisions involved in Access to Allied Psychological Services projects

Round	Division(s)	State	Urban/Rural
1 (pilot)	NSW Central West	NSW	Rural
1 (pilot)	NSW Outback DGP	NSW	Rural
1 (pilot)	Top End DGP (amalgamated with Central Australia DGP, Now known as General Practice Network Northern Territory)	NT	Rural
1 (pilot)	Logan Area	QLD	Urban
1 (pilot)	SE Alliance of GP Bris (formerly Assoc. of Bayside)	QLD	Urban
1 (pilot)	Sunshine Coast (clinical service based at FOCUS)	QLD	Rural
1 (pilot)	Toowoomba & District (Now GP Connections)	QLD	Rural
1 (pilot)	Adelaide Northern DGP	SA	Urban
1 (pilot)	Bendigo & District	Vic	Rural
1 (pilot)	Dandenong Casey DGP (formerly known as Dandenong DGP & is a fund holder for Greater Monash DGP)	Vic	Urban
1 (pilot)	East Gippsland DGP (fund holder for Sth Gipp & Central West Gippsland Div)	Vic	Urban
1 (pilot)	General Practice Alliance - South Gippsland Limited (funds held by East Gippsland DGP)	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 NW Melbourne)	Vic	Urban
1 (pilot)	Central West Gippsland DGP	Vic	Rural
1 (pilot)	Fremantle Regional DGP	WA	Urban
1 (pilot)	Perth & Hills (now amalgamated with Perth Central Coast and known as Perth Primary Care Network)	WA	Urban
1 (supplementary)	ACT DGP	ACT	Urban
1 (supplementary)	Hastings Macleay GPN	NSW	Rural
1 (supplementary)	Mid North Coast (NSW) DGP	NSW	Rural
1 (supplementary)	NSW Central Coast DGP	NSW	Urban
1 (supplementary)	Riverina	NSW	Rural
1 (supplementary)	Nth & West QLD Primary Health Care	QLD	Rural
1 (supplementary)	General Practice Network South (formerly known as, Southern Division of GP SA or Adelaide Southern)	SA	Urban
1 (supplementary)	Ballarat & District DGP	Vic	Rural
1 (supplementary)	Central Highlands DGP	Vic	Urban
1 (supplementary)	General Prac Ass of Geelong	Vic	Urban
1 (supplementary)	Mornington Peninsula	Vic	Urban
1 (supplementary)	NE 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 DGP	NSW	Urban
2	Canterbury (no longer providing ATAPS)	NSW	Urban
2	Dubbo / Plains DGP	NSW	Rural

Round	Division(s)	State	Urban/Rural
2	Illawara DGP	NSW	Urban
2	Murrumbidgee	NSW	Rural
2	Nepean DGP	NSW	Urban
2	New England DGP	NSW	Rural
2	NW 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 DGP	QLD	Rural
2	Far Nth QLD Rural	QLD	Rural
2	General Practice Gold Coast/Tweed Valley DGP	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 DGP)	SA	Urban
2	Adelaide Hills DGP	SA	Rural
2	Adelaide NE DGP	SA	Urban
2	Adelaide Western General Practice Network (formerly Adelaide Western DGP)	SA	Urban
2	Limestone Coast DGP	SA	Rural
2	Murray Mallee DGP	SA	Rural
2	DGP Northern TAS (formerly Nth Tas)	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	Inner Eastern Melbourne DGP (now amalgamated with Whitehorse and known as Melbourne Eastern GPN)	Vic	Urban
2	Melbourne DGP	Vic	Urban
2	Murray Plains	Vic	Rural
2	NE Valley	Vic	Urban
2	Southcity GP Services (formerly Inner SE Melb)	Vic	Urban
2	Pivot west (formerly Western Melbourne)	Vic	Urban
2	Westgate	Vic	Urban
2	Whitehorse DGP (formerly know as Inner East Melb, now amalgamated with Inner East Melbourne and known as Melbourne Eastern GPN)	Vic	Urban
2	Canning	WA	Urban
2	GP Coastal (Perth Central Coast has amalgamated with Perth Hills, Known as Perth Primary care Network)	WA	Urban
2	Great Southern	WA	Rural
2	Osborne	WA	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 DGP (Includes SE Sydney Div)	NSW	Urban
3	GP Network Northside (Hornsby Ku-ring-gai Ryde) (fundholder 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	Nth 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 GP Support	NSW	Urban
3	GP Partners (Bris Nth)	QLD	Urban
3	Sthrn 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 DGP	SA	Rural
3	Riverland DGP	SA	Rural
3	Yorke Peninsula DGP	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 General Practice Division	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: 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.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
				<ul style="list-style-type: none"> • 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'.
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. Divisional rooms, community health centres, hospitals and other general health and mental health facilities, other community agencies, and universities); and in 27%, voucher systems are used; in 24% brokerage systems are used; in 25% register systems are used; and in 51% direct referral systems are used. • 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—	<ul style="list-style-type: none"> • Minimum dataset • Survey of models of service delivery • Project case 	<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 	<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

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
	Australia	studies	<p>projects?</p> <ul style="list-style-type: none"> • 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? 	<p>professionals via the rural projects. The equivalent figures for the urban projects are 1639, 16 649 and 770, respectively.</p> <ul style="list-style-type: none"> • 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.
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	Round 1 pilot and supplementary projects, Round	<ul style="list-style-type: none"> • Minimum dataset • Medicare 	<ul style="list-style-type: none"> • Has participation in the projects by GPs and allied health professionals changed 	<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

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Nov 2007	2 projects, Round 3 and Round 4 projects—Australia	Benefits Schedule data	<p>over time?</p> <ul style="list-style-type: none"> • 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? 	<p>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</p> <ul style="list-style-type: none"> • 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 Divisions.
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 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? 	<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.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
			<ul style="list-style-type: none"> • Are the projects achieving positive outcomes for consumers? 	<ul style="list-style-type: none"> • The projects are achieving positive outcomes of large or medium magnitude in 65% of cases.