THE UNIVERSITY OF MELBOURNE

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

Ten year consolidated ATAPS evaluation report

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BACKGROUND

The Access to Allied Psychological Services (ATAPS) program was introduced by the Australian Government in July 2001 in response to low treatment rates for common mental disorders. The program, now implemented by Medicare Locals, enables predominantly general practitioners (GPs) to refer patients with high prevalence disorders (e.g., depression and anxiety) to mental health professionals for low-cost evidence-based mental health care (most commonly cognitive behavioural therapy, or CBT). This care is typically delivered in up to 12 (or 18 in exceptional circumstances) individual and/or 12 group sessions.[1] Review by the referring GP is essential after each block of six sessions and/or the final session.

There are now two tiers of ATAPS: the original ATAPS program is referred to as the Tier 1 initiative while Tier 2 initiatives target specific hard-to-reach groups and/or offer flexibilities in the delivery of psychological strategies. Specific Tier 2 initiatives provide and/or target: Telephone-based Cognitive Behaviour Therapy *('T-CBT')*; women with perinatal depression (*'Perinatal depression'*); individuals who have attempted suicide or self-harm or who are identified as being at high risk of suicide (*Suicide prevention'*); people impacted by the Victorian bushfires who have a diagnosis of a mental illness (*'Bushfire'*); people who are experiencing, or at high risk of, homelessness *('Homelessness')*; people in remote locations (*'Rural and remote'*); Aboriginal and Torres Strait Islander people *('Aboriginal and Torres Strait Islander')*; children who have, or are at risk of developing a mental, childhood behavioural or emotional disorder (*'Child'*); and people impacted by the 2010-2011 floods and cyclone Yasi (*'Floods and cylone Yasi'*).

The current report examines a range of indicators of achievement for the two tiers of ATAPS, including participation rates by GPs, other referring professionals, mental health professionals and consumers; the sociodemographic and clinical profiles of consumers; the precise nature of the care they are receiving; and the outcomes of this care for consumers. These findings are complemented by a synthesis of our qualitative data collection activities over the life of the evaluation, highlighting the models of service delivery used to implement the ATAPS program, and the achievements and challenges of delivering ATAPS over time.

METHOD

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

> *Evaluation Question 1:* What is the level of uptake of ATAPS by consumers?
>
> *Evaluation Question 2:* What is the level of participation in ATAPS by professionals?
>
> *Evaluation Question 3:* What are the sociodemographic and clinical profiles of consumers of ATAPS?
>
> *Evaluation Question 4:* What is the nature of the treatment received by ATAPS consumers?

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

Evaluation Question 6: What lessons have been learned about the processes, impacts and outcomes of delivering the ATAPS program?

KEY FINDINGS

Uptake of ATAPS by consumers

Overall, between 1 July 2003 and 31 December 2012, 351,576 (90% Tier 1 and 10% Tier 2) referrals were made to the ATAPS program. Of these referrals 277,307 (79%) resulted in sessions of care. In total, 1,432,130 (90% Tier 1 and 10% Tier 2) sessions of care were delivered via ATAPS, making the average number of sessions per referral 5.2.

The uptake of the ATAPS program overall has incrementally increased for each financial year since its inception, with the exception of a temporary drop in 2007-2008 following the introduction of the Better Access program. Similarly, the uptake of the individual Tier 2 initiatives has increased over time since their respective introductions, with the exception of the time-limited T-CBT pilot and the extreme climatic events initiatives.

Participation in ATAPS by professionals

Between 1 July 2003 and 31 December 2012, 32,076 professionals referred consumers to ATAPS, with the number of referrers increasing during each financial year from 1,716 in 2003-2004 to 13,157 in 2011-2012. GPs continue to comprise the vast majority of ATAPS referrers (88%) and are likely to account for much of the unrecorded referrer type data (11%).

Between 1 July 2003 and 31 December 2012, 7,300 mental health professionals delivered ATAPS services to consumers. Like referrers, the number of mental health professionals delivering services has shown an overall pattern of increase, but at a slower rate. There were 609 mental health professionals delivering services in 2003-2004 and around 3,000 in the most recent two financial years, including the current half-complete year.

Sociodemographic and clinical profiles of ATAPS consumers

Overall, sixty-seven percent of consumers of ATAPS were female, and the mean age was 37 years. Approximately 3% of consumers were reported to be Aboriginal and 0.5% to be Torres Strait Islander. Children aged zero to 11 years accounted for just under 4% of all consumers. Over half of the consumers (60%) were reported to be on a low income and about a third (36%) had no history of mental health care. English was the most commonly reported language spoken at home (83%), with low levels of other languages reported. Overall, the most common diagnoses were depression (54%) and anxiety disorders (41%).

The profile of Tier 2 consumers varied significantly between the initiatives. Males were more strongly represented in the *Homelessness* and *Child* initiatives (56% and 51%, respectively). Among currently operating Tier 2 initiatives, the *Bushfire* initiative consumers were the oldest and *Perinatal depression* initiative consumers were the youngest (42 vs. 30 years), with the obvious exception of *Child* initiative consumers (11 years). Consumers of the *Homelessness, Aboriginal and Torres Strait Islander* and *T-CBT* initiatives were most likely to be reported to be on a low income (89%, 74% and 72%, respectively). *Child* initiative consumers were least likely (26%) to have previously accessed mental health services. With the exception of the *Child* initiative, consumers of the *Floods and cyclone Yasi* initiative were least likely,

and those of the *Bushfire* initiative most likely, to have previously accessed psychiatric services (30% and 46%, respectively). Not surprisingly, the *Child* initiative reported the highest percentage of referrals for children aged 0 to 11 years (59%), while the *Floods and cyclone Yasi* initiative also reported a relatively high number of referrals for children (8%).

While depression and anxiety disorders were most common across all Tier 2 initiatives, there was some variability in the most common diagnoses across initiatives. For example, the highest prevalence of depression was reported in consumers of *T-CBT* (85%) followed by the *Perinatal depression* (62%) and *Suicide prevention* (60%) initiatives. Anxiety disorders were reported by more than half of the consumers of the *T-CBT* and *Bushfire* initiatives (65% and 51%, respectively) and by 42% or more of consumers of each of the *Aboriginal and Torres Strait Islander, Child*, and *Rural and remote* initiatives. Consumers of the *Homelessness* and *Aboriginal and Torres Strait Islander* initiatives reported a somewhat higher prevalence of alcohol and drug use disorders (21% and 13%, respectively than Tier 1 and other Tier 2 consumers). Psychotic disorders were most prevalent among consumers in the *Floods and cyclone Yasi* and *Homelessness* initiatives (7% and 6%, respectively). Unexplained somatic disorders were reported relatively infrequently across all ATAPS initiatives and were highest among consumers of the *Child* initiative (2%).

The proportion of male consumers has increased over time from 25% of all ATAPS consumers in 2003-2004 to 33% in 2012-2013. While less than 1% of consumers in 2003-2004 were aged 0-11 years, in 2012-2013 the prevalence of consumers aged 0-11 years has increased to 5%. The proportion of Aboriginal consumers has increased over time, ranging from under 2% of all ATAPS consumers in 2005-2006 to around 6% in 2012-2013, with a similar trend apparent in the prevalence of Torres Strait Islander consumers. The prevalence of previous psychiatric care fluctuated, with consumers in 2003-2004 and 2007-2008 the least likely to have previously used psychiatric services (32%) and consumers in 2011-2012 and 2012-2013 most likely to have used services (41% and 40%, respectively). The prevalence of consumers on a low income also increased over time from 54% in 2003-2004 to 71% of consumers in 2012-2013.

Depression and anxiety disorders were common across all financial years, with depression reported by more than half of all consumers in each financial year. The highest rate of depression was reported in 2004-2005 (59%) and the lowest prevalence in 2008-2009 (52%). Anxiety disorders were reported by 40% or more consumers across most financial years. Psychotic and unexplained somatic disorders were reported relatively infrequently, with the former somewhat increasing and the latter decreasing, across all years.

Nature of the treatment received by ATAPS consumers

Overall and within Tier 1, sessions of 46-60 minutes have been the most common, accounting for 80% of sessions. Similarly, across all Tier 2 initiatives sessions of 46-60 minutes have also been the most popular. Sessions of less than 30 minutes have been more common within several of the Tier 2 initiatives compared with the Tier 1 (2%) initiative, particularly the *Suicide prevention* (10%) and *Homelessness* (9%) initiatives. The majority of Tier 2 initiatives have delivered sessions to individuals; however, group sessions appear to have been particularly common in the *Aboriginal and Torres Strait Islander* and *Perinatal depression* initiatives (10% and 8%, respectively).

For the 203,412 sessions where a copayment was incurred (i.e., $1 or more), the mean copayment amount was $18.15 (S.D. $22.30). The national mean cost to consumers per session (including sessions which did not incur a copayment) for the 1,032,531 sessions where this co-payment information was provided was $3.58 (S.D. $12.26). The majority of Tier 2 sessions did not incur a copayment and were less likely to do so than Tier 1 sessions.

Across Tier 1 and Tier 2, CBT-based cognitive and behavioural interventions continue to be the most common interventions delivered. However, there are some nuances among the Tier 2 initiatives. For example, psycho-education was more common than behavioural interventions in the *Rural and remote* initiative (46% vs. 30%). Psycho-education and interpersonal therapy have

been frequently delivered across all initiatives, with both being particularly utilised in the *Bushfire* initiative and the former in the *Rural and remote* initiative.

While the treatment characteristics have remained relatively consistent over time, there are some nuances. For example, sessions of 45 minutes duration or less accounted for 13% of sessions in 2003-2004 but less than 6% since 2005-2006. The ability to deliver sessions via modalities other than face-to-face was introduced to the program guidelines and the minimum dataset in 2008-2009, with telephone sessions increasing from 0.2% at this time to 1.3% in 2012-2013. In comparison with earlier years, a smaller percentage, 10% or less, of consumers were charged a copayment in recent years.

Narrative therapy, family therapy, parent training in behaviour management and play therapy account for 2% or less of interventions used in the financial years since their introduction in 2009-2010.

Outcomes of ATAPS for consumers

Pre- and post-treatment outcome data were available for 32,792 Tier 1 consumers (13% of the 250,001 who received sessions), 303 *Bushfire* consumers (15% of 1,965), 139 *Child* consumers (3% of 4,648), 77 *Homelessness* consumers (4% of 1,926), 930 *Perinatal depression* consumers (15% of 6,428) and 831 *Suicide prevention* consumers (10% of 8,313). The remaining Tier 2 initiatives did not have sufficient data to be included in the analyses, which may be attributed to their relative infancy. Across all of the 13 most commonly used standardised outcome measures, the mean difference between pre- and post-outcomes scores was statistically significant and indicative of clinical improvement.

Lessons learned about processes, impacts and outcomes

Twenty interim ATAPS evaluation reports have gathered qualitative data, an overview of the findings of which follows.

Tier 1 ATAPS initiative

Models of service delivery

A multitude of combinations of models across three dimensions - retention of mental health professionals, locations of service delivery and referral mechanisms - have been used to implement ATAPS and these have been suited to the local context. Across these three dimensions the most popular models have included direct referral from GP to mental health professionals, contractual arrangements for retention of mental health professionals and use of mental health professionals' and GP rooms for the delivery of services. The models of service delivery have not affected consumers' access to services, nor the positive outcomes achieved. A range of advantages and disadvantages of the various models of service delivery have been identified from the perspectives of Divisions, GPs, mental health professionals and consumers.

Early experiences of ATAPS

Selected advantages and facilitating factors reported for Divisions, GPs, mental health professionals and consumers early in the life of ATAPS included benefits associated with collaboration between GPs and mental health professionals; expanded treatment pathways; a wider referral base for mental health professionals; and improved access to, and outcomes from, psychological treatment for consumers. Early barriers and disadvantages of the pilot, such as unfamiliarity with the program and remuneration and administrative issues, may be viewed as early 'teething' challenges that were later resolved using various strategies, such as educating stakeholders about ATAPS and forging partnerships with relevant organisations.

Demand management strategies

In late 2006, the majority of Divisions reported using at least one demand management strategy to manage the demand for ATAPS services within the allocated budget for services and within other resource constraints. The most common demand management strategies were informing GPs of alternative referral pathways and encouraging GPs to attend Level 2 training, systems and/or administrative procedures such as a centralised point for management of referrals, and monitoring and limiting referrals. The latter was ranked as the most useful demand management strategy. There was consensus that demand management strategies needed to be underpinned by strong partnerships and solid infrastructure. Concerns that the need for demand management was indicative of under-resourcing, and that strategies such as limiting referrals could have a negative effect on stakeholder perceptions, were noted.

Use of ATAPS evaluation reports

In late 2007, stakeholders indicated that the evaluation reports produced up to that point in time were useful and of acceptable quality. Common uses of the evaluation reports were to describe what was happening 'in the field' in ATAPS in relation to uptake, models of service delivery and referral pathways; to promote the program; and to update Division staff, GPs and mental health professionals about patterns of service delivery and to describe their contribution to improved consumer outcomes.

Tier 2 ATAPS initiatives

Suicide prevention pilot

Overall, the *Suicide prevention* pilot was well received. Specific requirements of the *Suicide prevention* pilot required many Divisions to re-evaluate their models of service delivery, operating policies and procedures. Management of consumer risk was central to these changes and patient referral pathways were a primary focus. Engagement of GPs, emergency departments and mental health services, such as state services, required significant and ongoing effort on the part of Divisions. Examples of implementation barriers reported were difficulties engaging mental health professionals; delays in, and/or the quality of, the mandatory training; and engaging GPs for referrals received from emergency departments. Factors that facilitated implementation included the pivotal role of mental health professionals delivering services, Division links with GPs and other health services, and the flexibility of the pilot.

Telephone-CBT pilot

While the uptake of the *T-CBT* pilot was low, the ability to offer sessions by telephone was seen to improve access for consumers, and the impact on Divisions was reported as mostly positive. Some of the factors that facilitated implementation of the pilot were positive provider response, flexibility in the guideline around combining face-to-face and *T-CBT* sessions, and enabling mental health professionals and project officers to make decisions about referral to the pilot, a need for remote service delivery, and embedding the pilot in the broader ATAPS program. Barriers to implementation of the *T-CBT* pilot included the low rate of GP referrals, consumer preference for face-to-face services, limited telephone equipment and coverage, and funding issues related to cost of telephone calls and travel for mixed face-to-face/T-CBT sessions.

Bushfire initiative

Overall, the *Bushfire* initiative was well received. Benefits and facilitating factors to implementation of the initiative included the ability of case managers to refer to the service, the immediacy of response of the service, the ability to offer consumers a free service, the flexibility of service guidelines, and the collaborations fostered between Divisions and other relevant organisations. Disadvantages and barriers were less commonly reported but included factors such as the reliance on GP referrals, a need for enhanced communication, and a perception that funding was required for services other than psychological treatment.

Floods and Cyclone Yasi initiative

Overall, the *Floods and cyclone Yasi* initiative appeared to have had a positive impact on the majority of Divisions in that it increased capacity to provide services in affected areas and raised awareness of mental health and support options in the wider community. While the GP response to the initiative appeared to be variable, the response of mental health professionals was reported to be overwhelmingly positive. Among the factors facilitating effective operation of the initiative were local community engagement and education, and the initiative's existing flexibilities. Among the barriers to effective operation of the initiative were delays in the availability of funding; difficulties in meeting a need for more informal community-level support services; destroyed infrastructure; inaccessibility of flood- affected areas; and the stigma surrounding mental health, particularly in rural areas.

Experiences of Divisions with Tier 2 ATAPS initiatives

In 2012, the vast majority of Divisions (72%) reported delivering between two and four Tier 2 initiatives. The initiatives that have been available for the longest times, namely the *Suicide prevention* and *Perinatal depression* initiatives, showed the highest rate of implementation, while the *Bushfire* and *Floods and cyclone Yasi* initiatives had the lowest, due to their availability to only a limited number of Divisions whose populations were affected by these events. Division-level population data related to Indigenous status, age, fertility rate and avoidable mortality (suicide and self-harm) from the 'Divisions of General Practice Atlas, 2012'[2] indicated that more Divisions should be targeting Aboriginal and Torres Strait Islander peoples, children, and people at risk of suicide and self-harm as indicated by having the highest prevalence of these target groups, but that women with perinatal depression were appropriately being offered ATAPS. The impact of the implementation of Tier 2 initiatives on consumers was almost unanimously rated as positive or very positive from the perspective of project officers or service managers.

Overall ATAPS program

Client satisfaction

In 2009, surveys were most commonly handed out by mental health professionals during or soon after their last session with a consumer, and less commonly posted to clients by the Divisions in order to gauge client satisfaction with ATAPS. With the exception of a question regarding overall satisfaction with the service and/or the service provider, there were few other commonalities between the surveys. Consumer feedback about ATAPS was overwhelmingly positive, particularly with respect to the positive impact of treatment on their lives and symptoms, the quality of their service provider and the availability of the service.

ATAPS workforce

In June 2011, 472 ATAPS mental health professionals, representing 21% of ATAPS mental health professionals, completed a survey requesting information regarding their demographic and professional characteristics. The majority of mental health professionals were female (79%) and aged between 35 and 64 years (80%), with a mean age of 49 years. The majority of survey respondents (82%) were psychologists (general, 56% and clinical, 26%), with a Master's degree being the most common highest qualification (44%). Time elapsed since achieving the highest qualification was on average 13 years. The majority (93%) of respondents indicated that they belonged to the relevant professional body.

CONCLUSIONS

The current report indicates that the ATAPS program, delivering services to a substantial number of consumers, continues to be an integral part of the primary mental health care system in Australia. The profile of Tier 1 consumers and the care they are receiving has been relatively consistent over time. The majority are women with high prevalence disorders. Strategies usually

involve CBT-based cognitive and behavioural interventions, which are typically delivered to individuals in sessions of one hour in duration. Most importantly, the Tier 1 initiative is continuing to achieve considerable positive clinical outcomes for consumers.

The outcome data, where available, show that the Tier 2 initiatives are also producing significant clinical improvement for consumers. The socio-demographic and diagnostic data indicate that the Tier 2 initiatives have been successful in reaching their intended target consumer groups in that their profiles differ somewhat from Tier 1 consumers. This suggests that Tier 2 ATAPS continues to carve an important niche by successfully addressing the unmet need of specific and/or hard-to-reach consumers and through means that are not available via the Tier 1 initiative or the Better Access program.

Background

chapter one

Chapter 1: Background

The Access to Allied Psychological Services (ATAPS) program, a key component of the Better Outcomes in Mental Health Care (BOiMHC) initiative, was introduced by the Australian Government in July 2001 in response to low treatment rates for common mental disorders. The program, which is now implemented nationwide by 61 Medicare Locals (formerly Divisions of General Practice, or Divisions), enables predominantly general practitioners (GPs) to refer patients with high prevalence disorders (e.g., depression and anxiety) to mental health professionals for low-cost evidence-based mental health care (most commonly cognitive behavioural therapy, or CBT). This care is typically delivered in up to 12 (or 18 in exceptional circumstances) individual and/or up to 12 group sessions.[1] Review by the referring GP is essential after each block of six sessions and/or the final session.

Various policy changes have occurred during the life of the ATAPS program which have had an impact on its nature and direction. In 2006, the Australian Government introduced the Better Access to Psychiatrists, Psychologists and GPs (Better Access) initiative, which facilitates equivalent access to mental health care from similar providers but does so via a series of Medicare Benefits Schedule (MBS) item numbers rather than through Medicare Locals.[3] In 2009, a review, which included significant consultation with key stakeholders and input from an ATAPS Review Expert Advisory Committee, led to refocusing the program to better complement Better Access and to target service gaps for people who cannot easily access Medicare-based programs.[4] Four key areas that an enhanced ATAPS program could focus upon to better meet the needs of consumers experiencing mental illness were identified, including better addressing service gaps, increasing efficiency, encouraging innovation and improving quality.[4] In response to these policy changes, several ATAPS sub-programs have been introduced since 2008 that focus on particular at-risk populations and/or use specific modalities of service delivery. The additional funding for Medicare Locals aims to enhance capacity to address the needs of these at-risk groups and provide increased service flexibility or innovation. The original ATAPS arrangements are now termed the Tier 1 initiative and remain the 'core business' of the ATAPS program, and the sub-programs are termed Tier 2 initiatives.5

Also in response to the above mentioned policy changes, the Department of Health and Ageing engaged a consultant, Healthcare Management Advisors, who has recently completed a project exploring feasible options for enhancing the efficiency of the ATAPS program, specifically the Tier 1 initiative. At the time of this report, the findings from this project are not in the public domain.

TIER 2 INITIATIVES

Tier 2 initiatives have been introduced at different times, and at times in response to external events such as the 2009 Victorian bushfires and 2010-2011 floods and cyclone Yasi. The Tier 2 initiatives are focused on seven priority groups: women with perinatal depression; people at risk of suicide or self-harm; people experiencing or at high risk of homelessness; people impacted by extreme climatic events; people in remote locations; Aboriginal and Torres Strait Islander people; and children with, or at risk of, developing mental, childhood behavioural or emotional disorders. In addition one now completed initiative trialled the use of telephone cognitive behavioural therapy (T-CBT).[6] Most of the Tier 2 initiatives are available to all Medicare Locals, with the exception of the T-CBT trial. Brief descriptions of the Tier 2 initiatives are provided below based on the Department of Health and Ageing's ATAPS operational guidelines.[7]

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

The Telephone-based Cognitive Behaviour Therapy (T-CBT) trial (referred to as the *T-CBT* initiative throughout this report) was delivered between July 2008 and June 2010 by 22 rural and remote Divisions. This service was implemented to improve accessibility for selected consumers in rural and remote settings who for various reasons experienced barriers to seeing a clinician face-to-face. CBT was provided to consumers by telephone or video-conferencing. While the *T-CBT* pilot has ended, the ability to deliver services using multiple communication modalities has been retained across the various ATAPS initiatives.

Women with perinatal depression

First introduced in April 2008 and originally mandatory for all Divisions and now Medicare Locals since July 2012, this initiative targets women with perinatal depression (referred to as the *Perinatal depression* initiative throughout this report). Specifically it provides focused psychological services, group sessions, liaison with child/maternal nurses regarding referral pathways, family therapy, telephone and web-based services.

Individuals who have attempted suicide or self-harm or who are identified as being at high risk of suicide

Services for people who have attempted suicide or self-harm or who are identified as being at high risk of suicide (referred to as the *Suicide prevention* initiative throughout this report) were first introduced as a pilot initiative which was implemented by 19 Divisions in July 2008 and which ran until the end of June 2011. The pilot was delivered by specifically trained ATAPS mental health professionals and aimed to provide a more intensive, prioritised service for people who were at risk of suicide (e.g., those who had made a recent suicide attempt, had recently self-harmed, or were having severe suicidal thoughts), who may or may not have had a mental disorder.

The services initially delivered by the pilot have continued and expanded nationally in July 2010, and have been mandatory for all Medicare Locals since July 2011. The services include focused psychological services, case management, proactive follow up, and liaison with local Accident and Emergency services. Data related to these expanded Suicide prevention services are reported together with data related to the pilot in this evaluation report.

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

Services for people impacted by the Victorian Bushfires (referred to as the *Bushfire* initiative throughout this report) have been delivered by the nine Divisions participating in the Australian Government Mental Health Response to the 2009 Victorian Bushfires.[8] These services were introduced in January 2009. The services were initially available for individuals who were experiencing severe and persisting symptoms resulting from trauma or loss and now to those with a mental disorder.

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

Services for people who are experiencing, or are at high risk of, homelessness (referred to as the *Homelessness* initiative throughout this report) were introduced in July 2010. This initiative allows provision of outreach services (including 'mobile clinics'), provisional referrals to ATAPS before a GP assessment, focused psychological services, and liaison with local non-government organisations (NGOs) supporting homeless individuals.

People in remote locations

Services for people in remote locations (referred to as the *Rural and remote* initiative throughout this report) were introduced in July 2010 when there was a generic Tier 2 pool of funding. These services provide outreach services, focused psychological services, telephone- and web-based services. Note that rural and remote services do not receive explicit funding as a Tier 2 initiative.

Aboriginal and Torres Strait Islander people

Although Aboriginal and Torres Strait Islander peoples have always been able to access ATAPS, services specifically devoted to Aboriginal and Torres Strait Islander peoples (referred to as the *Aboriginal and Torres Strait Islander* initiative throughout this report) were introduced via Tier 2 in July 2010. This initiative provides innovative and culturally appropriate services. Delivery of these services has been mandatory for all Medicare Locals since July 2012.

Children who have, or are at risk of developing, a mental, childhood behavioural or emotional disorder

Services for children who have, or are at risk of developing, a mental, childhood behavioural or emotional disorder (referred to as the *Child* initiative throughout this report) were introduced in July 2010 and have been mandatory for all Medicare Locals since July 2012. These services are aimed at children aged 11 years or under (or up to and including 15 years of age in exceptional circumstances) and provide ATAPS professionals with the flexibility to deliver appropriate treatment and support beyond the parameters of focused psychological services funded under Tier 1 ATAPS. Specifically, services can include family therapies based on behaviour therapy involving parents or the whole family, parent training in behaviour management, and liaison with key providers in the children's other environments, such as schools.

People impacted by the 2010-2011 floods and Cyclone Yasi

Services for people impacted by the 2010-2011 floods and cyclone Yasi in Queensland, New South Wales and Victoria (referred to as the *Floods and cyclone Yasi* initiative throughout this report), were introduced in January 2011 through additional funding provided originally to 11 Divisions and now their corresponding Medicare Locals. These services initially introduced further flexibilities in relation to service access and eligibility, which included: a) provisional referral pathways (i.e., client self-referral, referral through Centrelink Social Workers or State Mental Health Services); b) relaxed formal diagnosis requirements (for people experiencing significant distress and anxiety as a result of the floods and at risk of developing a mental disorder); and c) a relaxed 12-session limit for people diagnosed through a Mental Health Treatment Plan. People currently accessing these services are required to have a formal diagnosis of mental illness.

EVALUATING THE ATAPS PROGRAM

From the outset, there has been a commitment to the evaluation of the ATAPS program, as reflected in the establishment of an Evaluation Working Group early in the life of the program, whose remit was to provide advice to the Department of Health and Ageing on a range of issues associated with the evaluation.[9] The Centre for Mental Health (formerly the Centre for Health Policy, Programs and Economics, CHPPE) from the University of Melbourne was commissioned to conduct the evaluation of the ATAPS program from its inception.

The purpose of the ongoing evaluation of the ATAPS program has been to assess the overall appropriateness (whether consumers' needs have been met), effectiveness (whether program objectives have been met) and impact (or effects) of the program,[10] and specifically whether ATAPS has improved

access to primary mental health services and in turn mental health outcomes for people with high prevalence disorders. The evaluation approach has been both formative, assessing implementation processes or how the program operates, and summative, assessing the program's impact and outcomes to inform Government decisions regarding continuation of the program.[10] Consequently, the design has been multifaceted, evolving in response to changes in the program itself and incorporating a range of different data sources and approaches to analysis.

Specifically, the evaluation has drawn on routinely collected data from a purpose-designed minimum dataset, program documentation, Division-level evaluation reports, a forum with project staff, and topic-specific surveys and interviews of various stakeholders. The latter have included project staff, GPs, other referring professionals and mental health professionals. Quantitative program utilisation data from the minimum dataset has provided breadth of information and this has been complemented with qualitative data from the stakeholder consultations to provide depth of information. Triangulation [10] [11] of the various data sources has strengthened the evaluation by producing findings that point in a similar direction. Thirty-four evaluation reports have been produced to date, most of which are in the public domain - 20 interim reports,[12-31] three supplementary reports[32-34] and 14 special reports.[35-47] Seventeen journal articles have also been published.[6 8 48-62]

THE CURRENT REPORT

This report outlines evaluation outcomes for both Tier 1 and Tier 2 services over the last 10 years, and aims to provide a comprehensive overview of all ATAPS initiatives.

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

This summary of the quantitative data is complemented by a synthesis of the findings of our qualitative evaluation activities. These activities have aimed to assess the processes, impacts and outcomes of implementing the ATAPS program since its inception. Drawing on our previous evaluation reports, this report also highlights the achievements and challenges of service delivery.

Method

chapter two

Chapter 2: Method

EVALUATION QUESTIONS

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

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

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

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

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

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

Evaluation Question 6: What lessons have been learned about processes, impacts and outcomes of delivering the ATAPS program?

DATA SOURCES

The first five evaluation questions were addressed using data from our purpose-designed minimum dataset, which captures de-identified, consumer-level and session-level information. Data from the minimum dataset was available for the period from 1 July 2003 (when the minimum dataset was first 'rolled out') to 31 December 2012 and were extracted on 1 April 2013. This download date was purposefully selected to minimise the impact on the current data of data entry lag.

Up to July 2012, 120 Divisions had been involved with the ATAPS program and data is included for all of them relevant to the period of time they were involved. The majority of Divisions were funded in four funding rounds: 18 from June 2002 (Round 1 pilot projects[a]); 15 from January 2003 (Round 1 supplementary projects); 42 from July 2003 (Round 2 projects); 33 from July 2004 (Round 3 projects); and six from July 2005 (Round 4 projects). Over the life of the ATAPS program some Divisions ceased operation, amalgamated with other Divisions, or were funded outside of the four rounds described. The delivery of ATAPS has now transitioned to Medicare Locals.

Currently, 61 Medicare Locals are implementing the ATAPS program. Medicare Locals were funded in three tranches: 19 in July 2011, 18 in January 2012 and 24 in July 2012. During the period of transition of ATAPS delivery from Divisions to Medicare Locals, in some instances services were delivered by Divisions, whilst others were delivered by newly formed Medicare Locals. This created some complexities for Divisions/Medicare Locals in managing their ATAPS data, including lack of clarity around data entry requirements and responsibilities during the transition period, which may have impacted on the data during the transition period; specifically, data from July 2011 to June 2012 may underestimate the true number of services delivered.

[a] The term 'project' as it is used here may denote one Division implementing ATAPS as a single project within its own Division or acting as a fundholder for multiple Divisions implementing a single ATAPS project.

However, the Department of Health and Ageing, the University of Melbourne evaluation team and Medicare Locals have collaborated and invested great effort to optimise the overall accuracy of ATAPS data in the minimum dataset. The University of Melbourne and its subcontractor, Strategic Data Pty Ltd. continue to work with Medicare Locals to support them to enter/upload data using the minimum dataset to accurately reflect ATAPS uptake.

It is important to note that the minimum dataset has evolved over the life of ATAPS in response to the implementation of organisations' stated needs, the introduction of new types of services and the transition to Medicare Locals. For example, the minimum dataset did not originally include outcome data fields; these were only added in mid-2005. This and other key changes, and the dates they occurred are summarised in Table 1. The addition of new fields and/or new options to existing fields at different times and for selected organisations affects the interpretation of the findings reported. In May 2013, the minimum dataset fields were updated (see https://boimhc.org/bin/view/Main/Referral Types)[63] to align with the latest ATAPS Operational Guidelines.[7]

The following data related to Tiers 1 and 2 ATAPS were extracted from the minimum dataset: the numbers of consumers and sessions (Evaluation Question 1); the numbers of GPs, other referring professionals, and mental health professionals providing ATAPS (Evaluation Question 2); the profile of consumers accessing these services (Evaluation Question 3); the nature of these services (Evaluation Question 4); and consumer outcomes (Evaluation Question 5).

The sixth evaluation question was addressed by reviewing all 34 of our evaluation reports to date and extracting the qualitative data collection methods and findings. Table 2 provides a summary of the focus of each qualitative evaluation activity and the qualitative data sources used. Note that 20 of the 34 evaluation reports have utilised qualitative methods.

DATA ANALYSES

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

Evaluation Question 5 was analysed using paired t-tests to examine the difference between mean pre- and post-treatment scores on the range of outcome measures. Consumers who did not have a 'matched pair' of pre- and post-treatment scores were excluded, as were outcome measures for which there were fewer than 50 observations and those for which pre- and post-treatment scores were 'zero'. It is extrapolated that where the pre- and post- treatment score was 'zero' that the outcome measure was not actually administered and that matched pre- and post-treatment scores in the absence of recorded sessions were invalid.

Evaluation Question 6 was analysed by summarising processes, impacts and outcomes from all 20 evaluation reports containing qualitative data, particularly noting the models of service delivery used to implement ATAPS, and the achievements and challenges of delivering ATAPS over time.

Table 1: Dates of key changes to the minimum dataset

Date	Changes to minimum data set	Available to which Divisions/Medicare Locals
July 2003	• MDS rolled out	• All
Mid- 2005	• Addition of outcome measures	• All
November 2008	• Addition of new referral (or initiative) types: > Perinatal depression > T-CBT > Suicide prevention > 'Routine ATAPS' option became known as 'general ATAPS' to distinguish it from the new initiatives	> All > Divisions involved in T-CBT pilot > Divisions involved in Suicide prevention pilot > All
	• Addition of session modality with the following options: face-to-face, telephone and video conferencing	• All
	• Addition of outcome measures: > Strengths and Difficulties Questionnaire as an outcome measure for child and adolescent consumers > Edinburgh Post-natal Depression Scale > Modified Scale for Suicidal Ideation	> All > All > Divisions involved in Suicide prevention pilot
	• Addition of new referral sources: > GP, community mental health, emergency department and psychiatrist	> Divisions involved in Suicide prevention pilot
April 2009	• Addition of new referral (or initiative) type: > 2009 Victorian Bushfires as a referral (or initiative) type	• Divisions involved in delivery of Bushfire services
September 2009	• Addition of extra session information	• Divisions involved in T-CBT pilot
November 2009	• Addition of new referral sources: > Case manager	• (Victorian) Divisions involved in delivery of Bushfire services

(table continues)

Table 1: Dates of key changes to the minimum dataset (continued)

Date	Changes to minimum data set	Available to which Divisions/Medicare Locals
December 2010	• Addition of new referral (or initiative) types: > Homelessness > Aboriginal and Torres Strait Islander > Rural and remote > Child > Availability of all existing referral (or initiative types)	• All Divisions
	• Addition of session modality: web-based	
	• Addition of session types: child, parent(s), child and parents, child in group, parent(s) in group, child and parent(s) in group	• All Divisions
	• Availability of appropriate referral sources	• All Divisions
	• Addition of referral sources: > GP, midwife, obstetrician and maternal health nurse > GP and non-government organisation	• All Divisions > All Divisions > Divisions delivering Homelessness services
	• Addition of diagnostic category: no formal diagnosis	• Divisions delivering Suicide prevention services
	• Addition of intervention strategies: > Family therapy > Parent training in behaviour management > Play therapy > Narrative therapy	> Divisions delivering Perinatal depression or Child services > Divisions delivering Child services > Divisions delivering Child services > All Divisions
July 2011	• Addition of new referral (or initiative) type: > 2010-11 Floods and cyclone Yasi as a referral (or initiative) type	• (Queensland, NSW and Victorian) Divisions involved in delivery of Flood and cyclone Yasi services
	• Addition of new referral sources: • Self • Centrelink social worker • State mental health services	• (Queensland, NSW and Victorian) Divisions involved in delivery of Flood and cyclone Yasi services
October 2012	• Addition of patient Statistical Linkage Key (SLK)	• All
August 2012 – 5 March 2013	• Migration of contemporary data to Medicare Locals	• Migration of data from 'Divisions of General Practice' to 'Medicare Locals' • All data fields available to all Medical Locals (with the exception of extreme climatic events, which will become available in May 2013)

Table 2: Qualitative data sources and evaluation focus by ATAPS initiative and date reported

Initiative	Data sources	Number and type of participants	Date reported	Evaluation focus
Tier 1				
ATAPS Tier 1 pilot	Analysis of local implementation and evaluation reports	15 ATAPS Round one pilots	December 2003	> Models of service delivery > Advantages and disadvantages of the pilot
ATAPS Tier 1 pilot	Analysis of local implementation and evaluation reports	15 pilot projects and 14 supplementary projects	July 2004	> Models of service delivery > Advantages and disadvantages of the pilot
ATAPS Tier 1	Evaluation forum	Representatives from 17 of the 25 Victorian ATAPS projects running at the time and 1 from Tasmania	February 2005	> Benefits and barriers of different models of service delivery
ATAPS Tier 1	Analysis of local evaluation reports	15 pilot projects and 14 supplementary projects and 40 Round 2 projects	April 2005	> Models of service delivery > Benefits of ,and barriers to, the projects > Lessons learned from early experiences of projects
ATAPS Tier 1	Survey	Division project managers, project officers and Divisional Chief Executive Officer (CEO) from 14 pilot projects, 29 Round 2 projects and 30 Round 3 projects	June 2005	> Models of service delivery > Are different models associated with different levels of consumer access?
ATAPS Tier 1	Analysis of local evaluation reports	84 local evaluation reports from pilot, Round 2 and Round 3 projects.	November 2005	> Have GP, mental health professional and consumer experiences of the projects changed over time?
ATAPS Tier 1	Survey	Earlier survey data (early 2005) from 97 projects	March 2006	> Do models of service delivery differ between rural and urban projects? > Do issues faced by urban and rural projects differ and do the solutions vary?
ATAPS Tier 1	Survey	Project officers from 89 projects	October 2006	> Use and success of demand management strategies
ATAPS Tier 1	Survey completed between October and February 2009 compared with earlier survey results from April 2005	2005 survey data from 97 projects 2008-2009 survey data from 104 projects	February 2010	Have service delivery models changed over time?
Use of CHPPE evaluation reports for ATAPS Tier 1	30-minute semi-structured interviews	Three Division project officers whose Divisions had been funded in different funding rounds, one Division Liaison Officer, one representative each from the Australian Medical Association, the Royal Australian College of General Practitioners, the Australian Psychological Society, Australian Divisions of General Practice, the Department of Health and Ageing and the Primary Mental Health Care Australian Resource Centre	October 2007	> How information from CHPPE evaluation reports is used by stakeholders > Suggestions for further evaluations

(table continues)

Table 2: Qualitative data sources and evaluation focus by ATAPS initiative and date reported (continued)

Initiative	Data sources	Number and type of participants	Date reported	Evaluation focus
Tier 2				
Suicide prevention pilot	Telephone survey (also compared with Tier 1 ATAPS survey administered between October 2008 and February 2009)	19 Division project officers where Divisions were providing Suicide prevention services	July 2009	- Models of service delivery - Issues associated with offering Suicide prevention services to consumers
Suicide prevention pilot	15-minute telephone interview	Six GPs, three mental health professionals and three emergency departments representing ten different ATAPS projects	February 2010	- Benefits and disadvantages of Suicide prevention program for consumers, GPs, mental health professionals and emergency departments
Suicide prevention pilot	Structured telephone interviews	Division project officers or service managers from all 19 Divisions	August 2011	- Division experiences of the Suicide prevention pilot
T-CBT pilot	Structured telephone interviews	22 project officers (one from each Division participating in the pilot)	August 2009	- Models of service delivery - Issues arising from implementation of T-CBT
T-CBT pilot	Structured telephone interviews	10 mental health professionals from different Divisions participating in the pilot	February 2010	- Benefits and challenges of providing T-CBT for mental health professionals
Bushfire	Survey	One GP, two case-management coordinators, three mental health professionals	November 2010	- Models of service delivery - Benefits, issues and challenges associated with service delivery
	Interviews	Ten Division project officers and one CEO representing a total of 10 of 11 Divisions, Three representatives from Victorian Department of Health, one from General Practice Victoria and one from Australian Healthcare Associates		
Floods and cyclone Yasi	Interviews and survey	Interviews with eight ATAPS project officers and managers of Divisions Survey completed by one provider	August 2012	- Experiences of Divisions and mental health professionals of the Floods and cyclone Yasi initiative
Divisions' experiences of Tier 2 ATAPS	Survey	83 project officers and service managers across 93 Divisions	August 2012	- Delivery of Tier 2 initiatives - Influences on decisions to deliver or not deliver initiatives - Models of service delivery

(table continues)

Table 2: Qualitative data sources and evaluation focus by ATAPS initiative and date reported (continued)

Initiative	Data sources	Number and type of participants	Date reported	Evaluation focus
Tier 1 and Tier 2				
Client satisfaction	Divisions provided client satisfaction measures and methods of collection	9 Divisions	March 2012 (Data collected 2009)	> Measurement of client satisfaction with ATAPS services
ATAPS Workforce	Survey	472 mental health professionals providing ATAPS services	February 2013 (Data collected June 2011)	> Demographic and professional characteristics of ATAPS providers

What is the level of uptake of ATAPS by consumers?

chapter three

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

OVERALL ATAPS UPTAKE

Between 1 July 2003 and 31 December 2012, 351,576 referrals were made to the ATAPS program. Of these referrals 277,307 (78.9%) resulted in sessions. In total, 1,432,130 sessions of care were delivered via ATAPS, making the average number of sessions per referral 5.2.

ATAPS uptake by initiative and financial year

Tables 3 to 6 show the following data for Tier 1 and Tier 2 overall, by initiative, and by financial year from July 2003 to December 2012: number of referrals, number of referrals resulting in sessions, number of sessions, and average number of sessions per referral.

Tier 1

Tier 1 represents approximately 90% of all referrals and sessions that have taken place over the life of the ATAPS program, which is to be expected given its longevity relative to the Tier 2 initiatives, which commenced in 2008. The number of Tier 1 referrals and sessions increased significantly from the commencement of the ATAPS program up until the 2006-2007 financial year and temporarily dropped in the 2007-2008 financial year, corresponding with the implementation of the Better Access program. Since 2008-2009 there has been a gradual increase in referrals and sessions, peaking in 2011-2012 with 45,928 referrals and 187,359 sessions. The 2012-2013 financial year represents a half-complete financial year and despite potential data entry lags, shows promise of continued increase in uptake of Tier 1 services. The average number of sessions has remained fairly consistent over the 10 years with an overall average of 5.2 sessions.

Tier 2

Tier 2 initiatives commenced progressively from 2008 and collectively the number of referrals and sessions increased steadily each year, peaking in 2011-2012 (12,659 and 54,498, respectively). The number of referrals and sessions for each Tier 2 initiative has varied, with the *Suicide prevention* and *Perinatal depression* initiatives reporting the highest numbers (9,699 and 7,858 referrals and 49,650 and 33,070 sessions, respectively). This is not surprising given that these two initiatives are mandatory for Medicare Locals and are also the longest running of the Tier 2 initiatives. The now completed *T-CBT* pilot reported the lowest number of referrals. The number of referrals resulting in sessions also varied somewhat between the initiatives; the lowest rate occurred in the *Rural and remote* initiative (73.6% of referrals resulted in sessions) and the highest occurred in the *Homelessness* initiative (86.4% of referrals resulted in sessions). The average number of sessions per referral was the highest for the *Bushfire* and *Suicide prevention* initiatives (7.0 and 6.2, respectively) and lowest for the *Rural and remote* and *Aboriginal and Torres Strait Islander* initiatives (4.4 each).

Table 3: Number of referrals by initiative and financial year, July 2003–December 2012

	2003-2004		2004-2005		2005-2006		2006-2007		2007-2008		2008-2009		2009-2010		2010-2011		2011-2012		2012-2013		Overall	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Tier 1	10,124	100.0	19,694	100.0	33,165	100.0	34,549	100.0	33,437	99.9	38,824	100.0	39,290	92.0	40,103	83.8	45,928	78.4	23,573	74.7	318,687	90.6
Tier 2																						
Aboriginal & Torres Strait Islander	-		-		-		-		-		-		39	0.1	334	0.7	1,003	1.7	842	2.7	2,218	0.6
Bushfire	-		-		-		-		-		356	0.9	1,209	2.8	471	1.0	233	0.4	51	0.2	2,320	0.7
Child	-		1*	0.0*	-		1*	0.0*	16*	0.0*	48*	0.9*	122*	0.3*	1,064	2.2	2,500	4.3	1,873	5.9	5,625	1.6
Floods and cyclone Yasi	-		-		-		-		-		-		-		406	0.8	448	0.8	83	0.3	937	0.3
Homelessness	-		-		-		-		-		-		76*	0.2*	624	1.3	1,108	1.9	419	1.3	2,227	0.6
Perinatal depression	1*	0.0*	-		1*	0.0*	1*	0.0*	7*	0.0*	207	0.5	1,028	2.4	2,084	4.4	2,999	5.1	1,530	4.9	7,858	2.2
Rural and remote	-		-		-		-	-		0.5*	2*	0.0*	88*	0.2*	677	1.4	716	1.2	450	1.4	1,933	0.5
Suicide prevention	-		-		-		-		6*	0.0*	412	1.0	831	1.9	2,075	4.3	3,652	6.2	2,723	8.6	9,699	2.8
T-CBT	-		-		-		-		2*	0.0*	45	0.1	23	0.1	2	0.0	0	0.0	0	0.0	72	0.0
Tier 2 total	1*	0.0*	1*	0.0*	1*	0.0*	2*	0.0*	31*	0.1*	1,070	2.7	3,416	8.0	7,737	16.2	12,659	21.6	7,971	25.3	32,889	9.4
Overall Total	10,125	100.0	19,695	100.0	33,166	100.0	34,551	100.0	33,468	100.0	39,894	100.0	42,706	100.0	47,840	100.0	58,587	100.0	31,544	100.0	351,576	100.0

*Data preceding commencement of Tier 2 initiatives and following completion of the T-CBT initiative reflects (referral date) data entry errors by minimum dataset users.

Table 4: Number of referrals resulting in sessions by initiative and financial year, July 2003–December 2012

	2003-2004		2004-2005		2005-2006		2006-2007		2007-2008		2008-2009		2009-2010		2010-2011		2011-2012		2012-2013		Overall	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Tier 1	7,881	100.0	15,447	100.0	25,948	100.0	25,717	100.0	24,933	99.9	30,812	97.2	32,130	91.7	32,472	83.1	36,821	78.0	17,840	73.4	250,001	90.2
Tier 2																						
Aboriginal & Torres Strait Islander	-		-		-		-		-		-		39*	0.1*	276	0.7	798	1.7	664	2.7	1,777	0.6
Bushfire	-		-		-		-		-		274	0.9	1,024	2.9	420	1.1	202	0.4	45	0.2	1,965	0.7
Child	-		1*	0.0*	-		1*	0.0*	16*	0.1*	38*	0.1*	108*	0.3*	909	2.3	2,087	4.4	1,488	6.1	4,648	1.7
Floods and cyclone Yasi	-		-		-		-		-		-		-		325	0.8	371	0.8	72	0.3	768	0.3
Homelessness	-		-		-		-		-		-		74*	0.2*	575	1.5	930	2.0	347	1.4	1,926	0.7
Perinatal depression	1*	0.0*	-		1*	0.0*	1*	0.0*	5	0.0	179	0.6	852	2.4	1,756	4.5	2,442	5.2	1,191	4.9	6,428	2.3
Rural and remote	-		-		-		-		-		2*	0.0*	72*	0.2*	480	1.2	532	1.1	337	1.4	1,423	0.5
Suicide prevention	-		-		-		-		6*	0.0*	368	1.2	738	2.1	1,859	4.8	3,017	6.4	2,325	9.6	8,313	3.0
T-CBT	-		-		-		-		2*	0.0*	37	0.1	17	0.0	2	0.0	0	0.0	0	0.0	58	0.0
Tier 2 total	1*	0.0*	1*	0.0*	1*	0.0*	2*	0.0*	29*	0.1*	898	2.8	2,924	8.3	6,602	16.9	10,379	22.0	6,469	26.6	27,306	9.8
Overall Total	7,882	100.0	15,448	100.0	25,949	100.0	25,719	100.0	24,962	100.0	31,710	100.0	35,054	100.0	39,074	100.0	47,200	100.0	24,309	100.0	277,307	100.0

*Data preceding commencement of Tier 2 initiatives and following completion of the T-CBT initiative reflects (referral date) data entry errors by minimum dataset users.

Table 5: Number of sessions by initiative and financial year, July 2003–December 2012

	2003-2004		2004-2005		2005-2006		2006-2007		2007-2008		2008-2009		2009-2010		2010-2011		2011-2012		2012-2013		Overall	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Tier 1	33,313	100.0	73,744	100.0	125,802	100.0	136,688	100.0	117,763	99.9	161,905	98.1	165,795	91.7	174,064	84.0	187,359	77.5	109,317	73.0	1,285,750	89.8
Tier 2																						
Aboriginal & Torres Strait Islander	-		-		-		-		-		-		84	0.0	1,069	0.5	3,457	1.4	2,841	1.9	7,451	0.5
Bushfire	1*	0.0*	-		-		-		1*	0.0*	751	0.5	6,384	3.5	4,026	1.9	2,146	0.9	490	0.3	13,799	1.0
Child	-		7*	0.0*	-		-		63*	0.1*	206*	0.1*	345	0.2	3,622	1.7	10,130	4.2	9,394	6.3	23,767	1.7
Floods and cyclone Yasi	-		-		-		-		-		-		0	0.0	920	0.4	2,104	0.9	797	0.5	3,821	0.3
Homelessness	-		-		-		-		-		-		202	0.1	2,305	1.1	4,011	1.7	1,898	1.3	8,416	0.6
Perinatal depression	12*	0.0*	-		3*	0.0*	5*	0.0*	20*	0.0*	541	0.3	3,918	2.2	9,292	4.5	12,359	5.1	6,920	4.6	33,070	2.3
Rural and remote	-		-		-		-		-		-		187	0.1	1,682	0.8	2,584	1.1	1,629	1.1	6,082	0.4
Suicide prevention	-		1*	0.0*	2*	0.0*	2*	0.0*	8*	0.0*	1,451	0.9	3,782	2.1	10,311	5.0	17,707	7.3	16,386	10.9	49,650	3.5
T-CBT	-		-		-		-		12*	0.0*	139	0.1	157	0.1	16*	0.0*	0	0.0	0	0.0	324	0.0
Tier 2 total	13*	0.0*	8*	0.*	5*	0.0*	7*	0.0*	104*	0.1*	3,088	1.9	15,059	8.3	33,243	16.0	54,498	22.5	40,355	27.0	146,380	10.2
Overall Total	33,326	100.0	73,752	100.0	125,807	100.0	136,695	100.0	117,867	100.0	164,993	100.0	180,854	100.0	207,307	100.0	241,857	100.0	149,672	100.0	1,432,130	100.0

*Data preceding commencement of Tier 2 initiatives and following completion of the T-CBT initiative reflects (referral date) data entry errors by minimum dataset users.

Table 6: Average number of sessions per referrals by initiative and financial year, July 2003–December 2012

	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	Overall
Tier 1	5.4	5.4	5.4	5.1	5.3	5.3	5.4	5.3	5.1	4.0	5.2
Tier 2											
Aboriginal and Torres Strait Islander							6.6*	5.7	4.7	3.5	4.4
Bushfire						8.8	6.9	6.7	6.3	6.4	7.0
Child		7.0*		12.0*	8.0*	5.8*	6.8*	5.8	5.6	4.4	5.3
Floods and cyclone Yasi								4.9	5.3	4.2	5.0
Homelessness							7.3*	5.4	3.9	3.7	4.5
Perinatal depression	12.0*		12.0*	6.0*	7.0*	5.9	6.0	5.7	5.2	4.1	5.3
Rural and remote						8.0*	6.8	4.5	4.6	3.2	4.4
Suicide prevention					5.5*	5.6	6.0	6.4	6.4	5.8	6.2
T-CBT					7.5*	5.6	5.6	3.0*	-	-	5.6

*Data preceding commencement of Tier 2 initiatives and following completion of the T-CBT initiative reflects (referral date) data entry errors by minimum dataset users. [a]Excluding referrals for which there were no sessions. The average includes only referrals, and their associated sessions, occurring within the specified financial year.

What is the level of participation in ATAPS by professionals?

chapter four

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

UPTAKE OF ATAPS BY REFERRERS

The profile of ATAPS referrers has changed over the life of ATAPS. Prior to June 2008 only GPs could refer consumers to ATAPS. In June 2008, the *Suicide prevention* initiative was introduced and with it the ability of emergency departments, community mental health services and psychiatrists to refer consumers to this ATAPS initiative. The introduction of other new initiatives has also introduced new referrers to ATAPS. The referrer type is unique to each initiative within ATAPS. For instance, emergency departments are only able to refer into the *Suicide prevention* initiative, whereas maternal and child health nurses are only able to refer into the *Perinatal depression* initiative. Most recently, the introduction of the *Floods and cyclone Yasi* initiative enabled, for the first time, self-referral.

As previously noted, when the new referrers were introduced to ATAPS, the minimum dataset was also modified to capture data related to referrer type. The 'referrer' field was added to the minimum dataset on 13 November 2008, prior to which referrer type was not recorded and assumed to be GPs in line with the ATAPS guidelines at that time. Table 7 shows the range of referrer types enabled in the minimum dataset across the ATAPS initiatives. Note that some Medicare Locals are able to negotiate alternative arrangements with the Department of Health and Ageing outside of these usual referral pathways and the minimum dataset is updated to reflect this when it is made known to the evaluators. As noted in the Method chapter, some changes to referrer options on the minimum dataset are in progress to align with the current Operational Guidelines.[7]

Table 7: Minimum dataset-enabled referrer types by initiative

Initiative	Minimum dataset-enabled referrer type
Tier 1	GP
Tier 2	
Aboriginal and Torres Strait Islander	GP, non-government organisations
Bushfire	GP, case manager
Child	GP
Floods and Cyclone Yasi	GP, self, Centrelink social workers, state mental health services
Homelessness	GP, non-government organisations
Perinatal depression	GP, midwife, obstetrician, maternal and child health nurse
Rural and remote	GP
Suicide prevention	GP, psychiatrist, community mental health, emergency department
T-CBT	GP

Note. T-CBT is no longer available as a Tier 2 initiative.

Table 8 shows the number of people referring to ATAPS and mental health professionals delivering ATAPS in total, and for each financial year from 1 July 2003 to 31 December 2012.

Table 8 shows the types and frequencies of referrers to the ATAPS program (Tier 1 and Tier 2 combined). Overall 32,076 professionals have referred consumers to ATAPS, with the number of referrers increasing during each financial year from 1,716 in 2003-2004 to 13,157 in 2011-2012. The decline to 9,637 in the current financial year is attributable to the year being half-complete. GPs continue to comprise the vast majority of ATAPS referrers (87.9%) and are likely to account for much of the unrecorded referrer type data (10.5%).

UPTAKE OF ATAPS BY MENTAL HEALTH PROFESSIONALS

Table 8 demonstrates that between 1 July 2003 and 31 December 2012, 7,300 mental health professionals delivered ATAPS services to consumers. Like referrers, the number of mental health professionals delivering services has shown an overall pattern of increase, but at a slower rate. There were 609 mental health professionals delivering services in 2003-2004 and around 3,000 in the most recent two financial years, including the current half-complete year.

Table 8: Referrers to, and mental health professionals delivering, ATAPS by financial year

	2003-2004		2004-2005		2005-2006		2006-2007		2007-2008		2008-2009		2009-2010		2010-2011		2011-2012		2012-2013		Overall	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Referrers																						
GP	1,716	100.0	2,851	100.0	4,082	100.0	5,231	100.0	6,231	100.0	5,508	67.8	4,954	55.1	9,259	88.7	12,875	97.9	9,416	97.7	28,206	87.9
Case manager	-	-	-	-	-	-	-	-	-	-	25	0.3	44	0.5	7	0.1	5	0.0	1	0.0	67	0.2
Community mental health service	-	-	-	-	-	-	-	-	-	-	2	0.0	3	0.0	23	0.2	65	0.5	39	0.4	106	0.3
Emergency department	-	-	-		-		-	-	-	-	4	0.0	20	0.2	22	0.2	97	0.7	96	1.0	171	0.5
Maternal health nurse	-	-	-	-	-	-	-	-	-	-	-	-	-	-	12	0.1	60	0.5	55	0.6	89	0.3
Midwife	-	-	-	-	-	-	-	-	-	-	-	-	-	-	7	0.1	26	0.2	14	0.1	36	0.1
Non-government organisation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4	0.0	12	0.1	8	0.1	14	0.0
Obstetrician	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0.0	3	0.0	2	0.0	4	0.0
Psychiatrist	-	-	-	-	-	-	-	-	-	-	-	-	2	0.0	2	0.0	10	0.1	6	0.1	10	0.0
Self	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	0.0	1	0.0	0.0	0.0	1	0.0
State mental health service	-	-	-	-	-	-	-	-	-	-	-	-	-		2	0.0	0	0.0	0	0.0	2	0.0
Referrer type not provided	-	-	-	-	-	-	-	-	-	-	2,587	31.8	3,962	44.1	1,103	10.6	3	0.0	0	0.0	3,370	10.5
Total referrers	1,716	100.0	2,851	100.0	4,082	100.0	5,231	100.0	6,231	100.0	8,126	100.0	8,985	100.0	10,444	100.0	13,157	100.0	9,637	100.0	32,076	100.0
Mental health professionals	609	100.0	1,163	100.0	1,161	100.0	1,891	100.0	1,717	100.0	2,143	100.0	2,303	100.0	2,530	100.0	3,037	100.0	2,870	100.0	7,300	100.0

Note. The overall total shown in the table is not simply the sum of Tier 1 and Tier 2 professionals as one professional may refer to, or deliver services, across multiple financial years.

What are the sociodemographic and clinical profiles of consumers of ATAPS?

chapter five

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

OVERALL CONSUMER CHARACTERISTICS

Tables 9 and 10 summarise some of the key sociodemographic characteristics of ATAPS consumers overall and by initiative and by financial year, respectively. Tables 11 and 12 describe the key diagnostic characteristics reported for ATAPS consumers overall and by initiative and by financial year, respectively. It should be noted that a number of the variables have a significant amount of missing data (i.e., data that was not supplied) and also high levels of 'unknown' responses which should be taken into account when interpreting the results, especially in relation to the Tier 2 initiatives with smaller numbers of consumers.

Tables 9 and 10 demonstrate that 66.7% of consumers of all ATAPS initiatives were female, and the overall mean age of consumers was 37.4 years. Overall, 3.3% of consumers were reported to be Aboriginal and 0.5% to be Torres Strait Islander. Children aged zero to 11 years accounted for 3.5% of all referrals. Over half of the consumers (60.0%) were reported to be on a low income and about a third (36.4%) had no history of mental health care. The data related to language spoken and English level has a high level of missing data, and should be viewed as indicative only. For the data provided, English was the most commonly reported language spoken at home (82.8%), with low levels of other languages reported.

Tables 11 and 12 show that diagnostic information was not provided for 70,291 (20.0%) of all referrals made to ATAPS. The totals in the table exceed 100% as consumers can receive more than one diagnosis. Overall the most common diagnoses were depression (54.3%) and anxiety disorders (41.0%). Other disorders were reported relatively infrequently. 'Other' (or uncategorised) diagnoses were provided for 61,120 (17.4%) of referrals.

Consumer characteristics by initiative

Tier 1

Given the high proportion of Tier 1 relative to Tier 2 consumers represented in overall ATAPS, the sociodemographic (Table 9) and diagnostic (Table 11) profiles of Tier 1 consumers were very similar to that of overall ATAPS consumers, as described above.

Tier 2

The profile of Tier 2 consumers varied significantly between the initiatives and again should be viewed as indicative only given the amount of missing data and the low number of consumers represented in some initiatives (Table 9). For the data provided, males were more strongly represented in the *Homelessness* and *Child* initiatives (55.8% and 50.7%, respectively). Among currently operating Tier 2 initiatives, the *Bushfire* initiative consumers were the oldest and *Perinatal depression* initiative consumers were the youngest (41.9 vs. 30.4 years), with the obvious exception of *Child* initiative consumers (10.7 years). Consumers of the *Homelessness, Aboriginal and Torres Strait Islander*, and *T-CBT* initiatives were most likely to be reported to be on a low income (89.1%, 74.4% and 72.2%, respectively).

Child initiative consumers were least likely (25.5%) to have previously accessed mental health services, which is not surprising given their young age (mean = 10.7 years). With the exception of consumers of the *Child* initiative, consumers of the *Floods and cyclone Yasi* initiative were least likely, while those of the *Bushfire* initiative were most likely, to have previously accessed psychiatric services (29.8% and 45.8%, respectively). Not surprisingly, the *Child* initiative reported the highest percentage of referrals for children aged 0 to 11 years (59.2%), while the *Floods and cyclone Yasi* initiative also reported a relatively high number of referrals for children (8.0%).

Table 11 summarises the key diagnostic characteristics reported for ATAPS consumers within each initiative. As is the case for Tier 1, depression and anxiety disorders were common across all Tier 2 initiatives (Table 11). Across all Tier 2 initiatives the highest prevalence of depression was reported in consumers of the *T-CBT* (84.7%), followed by *Perinatal depression* (61.9%) and *Suicide prevention* (60.1%) initiatives. Anxiety disorders were reported by 42.0% or more consumers of each of the *Aboriginal and Torres Strait Islander, Child*, and *Rural and remote* initiatives, and by more than half of the consumers of the *Bushfire* and *T-CBT* initiatives (50.7% and 65.3%, respectively). Consumers of the *Homelessness* and *Aboriginal and Torres Strait Islander* initiatives reported a somewhat higher prevalence of alcohol and drug use disorders (20.9% and 12.8%, respectively). Psychotic disorders were most prevalent among consumers in the *Homelessness* and *Floods and cyclone Yasi* initiatives (6.6% and 6.1%, respectively). Unexplained somatic disorders were reported relatively infrequently across the ATAPS program and were highest among consumers of the *Child* initiative (2.3%).

The highest rates of combined 'missing' or 'other' diagnosis information were for referrals to the *Floods and cyclone Yasi* (62.2%) and *Bushfire* initiatives (53.2%), which is not surprising given that these consumers were initially not required to have a diagnosis in order to receive services. Referrals to the *Child* initiative also had a high rate of combined 'missing' or 'other' diagnosis information (52.1% together). However, it is noteworthy that many of the 'other' diagnoses provided for *Child* initiative referrals were related to behavioural and developmental childhood disorders that do not otherwise fit into the diagnostic categories currently available in the minimum dataset.

Consumer characteristics by financial year

Table 10 summarises key consumer characteristics by financial year for all ATAPS consumers. The proportion of male consumers has increased over time from 25.0% in 2003-2004 to 32.7% in 2012-2013. Whilst less than 1.0% of consumers in 2003-2004 were aged 0-11 years, in 2012-2013 the prevalence of consumers aged 0-11 years has increased to 5.4% - the mean age also reflects this shift as it slightly decreased over time. The proportion of Aboriginal consumers has increased over time, increasing from 1.6% in 2005-2006 to 5.7% in 2012-2013, with a similar trend apparent in the prevalence of Torres Strait Islander consumers (0.1% in 2003-2004 to 1.5% in 2012-2013). The prevalence of previous psychiatric service use fluctuated with consumers in 2003-2004 and 2007-2008 the least likely to have previously used psychiatric services (32.0%) and consumers in 2011-2012 and 2012-2013 most likely to have used services (41.4% and 40.2%, respectively).

The prevalence of consumers on a low income also increased over time from 53.9% of all ATAPS consumers in 2003-2004 to 71.3% in 2012-2013. For the data provided, English was the most commonly reported language spoken at home, with low levels of other languages reported across all financial years. While it appears that the proportion of consumers speaking a language other than English has increased over time, it should be noted that the proportion of missing information has reduced in the most recent half-complete financial year.

Table 12 summarises the key diagnostic characteristics reported for all ATAPS consumers within each financial year. More than one-fifth of diagnostic information was missing between the 2007-2008 and 2010-2011 financial years, which should be taken into account when interpreting the results. Within the available data there was some variability across years. Depression and anxiety disorders were common across all financial years, with depression reported by more than half of all consumers in each financial year. The highest rate of depression was reported in 2004-2005 (59.1%) and the lowest prevalence in 2008-2009 (51.7%). Anxiety disorders were reported by 40.0% or more of consumers across most financial years. Psychotic and unexplained somatic disorders were reported relatively infrequently, with the former somewhat increasing and the latter decreasing, across all years. An unknown diagnosis was also reported relatively infrequently, with the highest rates reported for 3.5% and 4.6% of consumers in the 2011-2012 and 2012-2013 financial years, respectively.

Table 9: Summary characteristics of consumers receiving care through ATAPS by initiative, July 2003–December 2012

	Tier 1		Tier 2																		OVERALL	
			Aboriginal and Torres Strait Islander		Bushfire		Child		Floods and cyclone Yasi		Homelessness		Perinatal depression		Rural and remote		Suicide prevention		T-CBT			
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Gender*																						
Female	195,481	66.7	1,389	65.9	1,430	62.3	2,547	47.6	536	59.0	892	43.2	7,106	96.0	1,229	65.0	5,504	59.9	55	77.5	216,169	66.7
Male	85,443	29.2	693	32.9	743	32.4	2,712	50.7	343	37.7	1,151	55.8	135	1.8	652	34.5	3,372	36.7	16	22.5	95,260	29.4
Missing	12,123	4.1	27	1.3	123	5.4	94	1.8	30	3.3	20	1.0	158	2.1	11	0.6	310	3.4	0	0.0	12,896	4.0
TOTAL	293,047	100	2,109	100	2,296	100	5,353	100	909	100	2,063	100	7,399	100	1,892	100	9,186	100	71	100	324,325	100
Low income																						
Yes	188,970	59.3	1,651	74.4	1,497	64.5	3,850	68.4	491	52.4	1,984	89.1	4,908	62.5	1,147	59.3	6,307	65.0	52	72.2	210,857	60.0
No	49,333	15.5	125	5.6	514	22.2	554	9.8	72	7.7	71	3.2	1,222	15.6	296	15.3	1,068	11.0	9	12.5	53,264	15.2
Unknown	50,267	15.8	380	17.1	271	11.7	1,116	19.8	359	38.3	144	6.5	1,565	19.9	469	24.3	2,048	21.1	10	13.9	56,629	16.1
Missing	30,117	9.5	62	2.8	38	1.6	105	1.9	15	1.6	28	1.3	163	2.1	21	1.1	276	2.8	1	1.4	30,826	8.8
TOTAL	318,687	100	2,218	100	2,320	100	5,625	100	937	100	2,227	100	7,858	100	1,933	100	9,699	100	72	100	351,576	100
No. referrals by age																						
No. referrals 0-11 years	8,423	2.6	80	3.6	133	5.7	3,328	59.2	75	8.0	16	0.7	21	0.3	19	1.0	136	1.4	0	0.0	12,231	3.5
No. referrals 12+ years	295,058	92.6	2,017	90.9	2,062	88.9	1,988	35.3	753	80.4	2,030	91.2	7,469	95.0	1,833	94.8	9,072	93.5	71	98.6	322,353	91.7
Missing	15,206	4.8	121	5.5	125	5.4	309	5.5	109	11.6	181	8.1	368	4.7	81	4.2	491	5.1	1	1.4	16,992	4.8
TOTAL	318,687	100	2,218	100	2,320	100	5,625	100	937	100	2,227	100	7,858	100	1,933	100	9,699	100	72	100	351,576	100
Age	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Mean age	38.2	16.2	33.8	15.1	41.9	17.0	10.7	4.8	40.0	19.3	34.2	14.2	30.4	7.1	39.4	16.1	33.8	14.7	42.5	14.7	37.4	16.3

*As this is a stable demographic characteristic, the Frequencies (Freq.) and Percentages (%) are reported on the basis of the total number of unique persons in receipt of services within each initiative rather than the number of referrals, since a single person can receive multiple referrals to the same initiative. Since a unique person can have more than one referral across the initiatives, the overall column total (unique demographics across time) does not represent the sum of the row totals. For all other demographics the referral total has been used as these demographics can change over time.

(table continues)

Table 9: Summary characteristics of consumers receiving care through ATAPS by initiative, July 2003–December 2012 (continued)

Characteristic	Tier 1		Tier 2																		OVERALL	
			Aboriginal and Torres Strait Islander		Bushfire		Child		Floods and cyclone Yasi		Homelessness		Perinatal depression		Rural and remote		Suicide prevention		T-CBT			
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Previous psychiatric care																						
Yes	115,612	36.3	773	34.9	1,063	45.8	1,436	25.5	279	29.8	826	37.1	3,169	40.3	643	33.3	4,249	43.8	31	43.1	128,081	36.3
No	116,316	36.5	655	29.5	908	39.1	2,763	49.1	309	33.0	561	25.2	2,993	37.7	747	38.6	2,839	29.3	21	29.2	128,112	36.4
Unknown	49,467	15.5	634	28.6	281	12.1	1,257	22.3	314	33.5	575	25.8	1,353	17.5	521	27.0	2,077	21.4	19	26.4	56,498	16.1
Missing	37,292	11.7	156	7	68	2.9	169	3.0	35	3.7	265	11.9	343	4.4	22	1.1	534	5.5	1	1.4	38,885	11.2
TOTAL	318,687	100	2,218	100	2,320	100	5,625	100	937	100	2,227	100	7,858	100	1,933	100	9,699	100	72	100	351,576	100
Aboriginal*																						
Yes	8,024	2.7	1749	82.9	20	0.9	164	3.1	10	1.1	149	7.2	260	3.5	126	6.7	327	3.6	1	1.4	10,830	3.3
No	219,812	75.0	245	11.6	1,783	77.7	3,994	74.6	603	66.3	1,766	85.6	5,908	79.8	1,452	76.7	6,925	75.4	56	78.9	242,544	74.8
Unknown	34,087	11.6	98	4.6	357	15.5	954	17.8	275	30.3	123	6.0	1,015	13.7	287	15.2	1,477	16.1	14	19.7	38,687	11.9
Missing	31,124	10.6	17	0.8	136	5.9	241	4.5	21	2.3	25	1.2	216	2.9	27	1.4	457	5.0	0	0.0	32,264	9.9
TOTAL	293,047	100	2,109	100	2,296	100	5,353	100	909	100	2,063	100	7,399	100	1,892	100	9,186	100	71	100	324,325	100
Torres Strait Islander*																						
Yes	1,115	0.4	236	11.2	3	0.1	23	0.4	3	0.3	52	2.5	42	0.6	10	0.5	55	0.6	0	0.0	1,539	0.5
No	211,483	72.2	1,164	55.2	1,754	76.4	3,098	57.9	527	58.0	1,823	88.4	5,499	74.3	1,446	76.4	6,073	66.1	57	80.3	232,924	71.8
Unknown	34,742	11.9	294	13.9	344	15.0	888	16.6	273	30.0	139	6.7	979	13.2	289	15.3	1,396	15.2	12	16.9	39,356	12.1
Missing	45,707	15.6	415	19.7	195	8.5	1,344	25.1	106	11.7	49	2.4	879	11.9	147	7.8	1,662	18.1	2	2.8	50,506	15.6
TOTAL	293,047	100	2,109	100	2,296	100	5,353	100	909	100	2,063	100	7,399	100	1,892	100	9,186	100	71	100	324,325	100

*As these are stable demographic characteristics, the Frequencies (Freq.) and Percentages (%) are reported on the basis of the total number of unique persons in receipt of services within each initiative rather than the number of referrals, since a single person can receive multiple referrals to the same initiative. Since a unique person can have more than one referral across the initiatives, the overall column total (unique demographics across time) does not represent the sum of the row totals. For all other demographics the referral total has been used as these demographics can change over time.

(table continues)

Table 9: Summary characteristics of consumers receiving care through ATAPS by initiative, July 2003–December 2012 (continued)

Characteristics	Tier 1		Tier 2																		OVERALL	
			Aboriginal and Torres Strait Islander		Bushfire		Child		Floods and cyclone Yasi		Homelessness		Perinatal depression		Rural and remote		Suicide prevention		T-CBT			
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Language spoken at home*																						
Arabic	600	0.2	1	0.0	3	0.1	13	0.2	0	0.0	5	0.2	21	0.3	1	0.1	20	0.2	0	0.0	664	0.2
Cantonese	464	0.2	0	0.0	0	0.0	7	0.1	0	0.0	4	0.2	13	0.2	1	0.1	28	0.3	0	0.0	517	0.2
English	241,536	82.4	1,749	82.9	2,147	93.5	4,789	89.5	647	71.2	1,946	94.3	6,385	86.3	1,691	89.4	7,752	84.4	45	63.4	268,687	82.8
Greek	849	0.3	0	0.0	5	0.2	10	0.2	1	0.1	6	0.3	8	0.1	3	0.2	14	0.2	0	0.0	896	0.3
Italian	1,047	0.4	1	0.0	17	0.7	9	0.2	1	0.1	1	0.0	18	0.2	0	0.0	12	0.1	0	0.0	1,106	0.3
Mandarin	402	0.1	0	0.0	0	0.0	8	0.1	0	0.0	1	0.0	21	0.3	0	0.0	30	0.3	0	0.0	462	0.1
Vietnamese	809	0.3	2	0.1	1	0.0	3	0.1	1	0.1	4	0.2	8	0.1	1	0.1	14	0.2	0	0.0	843	0.3
Unknown	12,588	4.3	124	5.9	3	0.1	195	3.6	6	0.7	28	1.4	219	3.0	83	4.4	597	6.5	0	0.0	13,843	4.3
Missing	34,752	11.9	232	11.0	120	5.2	319	6.0	253	27.8	68	3.3	706	9.5	112	5.9	719	7.8	26	36.6	37,307	11.5
TOTAL	293,047	100	2,109	100	2,296	100	5,353	100	909	100	2,063	100	7,399	100	1,892	100	9,186	100	71	100	324,325	100
English comprehension level*																						
Not at all	460	0.2	2	0.1	0	0.0	8	0.1	0	0.0	1	0.0	14	0.2	0	0.0	11	0.1	0	0.0	496	0.2
Not well	2,425	0.8	21	1.0	3	0.1	119	2.2	12	1.3	21	1.0	47	0.6	23	1.2	82	0.9	0	0.0	2,753	0.8
Well	14,801	5.1	346	16.4	25	1.1	1,108	20.7	91	10.0	180	8.7	415	5.6	347	18.3	806	8.8	0	0.0	18,119	5.6
Very well	88,337	30.1	1,142	54.1	298	13.0	2,213	41.3	466	51.3	1,402	68.0	3,667	49.6	786	41.5	4,571	49.8	2	2.8	102,884	31.7
Unknown	10,555	3.6	139	6.6	20	0.9	178	3.3	7	0.8	20	1.0	257	3.5	79	4.2	618	6.7	0	0.0	11,873	3.7
Missing	176,469	60.2	459	21.8	1,950	84.9	1,727	32.3	333	36.6	439	21.3	2,999	40.5	657	34.7	3,098	33.7	69	97.2	188,200	58.0
TOTAL	293,047	100	2,109	100	2,296	100	5,353	100	909	100	2,063	100	7,399	100	1,892	100	9,186	100	71	100	324,325	100

*As these are stable demographic characteristics, the Frequencies (Freq.) and Percentages (%) are reported on the basis of the total number of unique persons in receipt of services within each initiative rather than the number of referrals, since a single person can receive multiple referrals to the same initiative. Since a unique person can have more than one referral across the initiatives, the overall column total (unique demographics across time) does not represent the sum of the row totals. For all other demographics the referral total has been used as these demographics can change over time.

Table 10: Summary characteristics of consumers receiving care through ATAPS by financial year, July 2003–December 2012

	2003-4		2004-5		2005-6		2006-7		2007-8		2008-9		2009-10		2010-11		2011-12		2012-13		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Gender*																						
Female	7,016	69.4	13,606	69.6	22,446	69.0	21,830	68.2	20,500	67.0	24,056	65.9	25,691	65.3	28,356	65.2	34,648	65.8	18,020	65.5	216,169	66.7
Male	2,530	25.0	4,975	25.4	8,473	26.1	8,697	27.2	8,917	29.1	10,949	30.0	11,880	30.2	13,396	30.8	16,460	31.2	8,983	32.7	95,260	29.4
Missing	558	5.5	980	5.0	1,605	4.9	1,460	4.6	1,175	3.8	1,513	4.1	1,761	4.5	1,761	4.0	1,574	3.0	509	1.9	12,896	4.0
TOTAL	10,104	100	19,561	100	32,524	100	31,987	100	30,592	100	36,518	100	39,332	100	43,513	100	52,682	100	27,512	100	324,325	100
Low income																						
Yes	5,461	53.9	10,976	55.7	18,138	54.7	18,129	52.5	17,988	53.7	23,181	58.1	25,097	58.8	29,264	61.2	40,117	68.5	22,506	71.3	210,857	60.0
No	2,060	20.3	4,203	21.3	7,350	22.2	6,773	19.6	5,589	16.7	6,581	16.5	5,949	13.9	5,716	11.9	6,031	10.3	3,012	9.5	53,264	15.2
Unknown	1,510	14.9	2,483	12.6	3,361	10.1	4,339	12.6	4,870	14.6	5,438	13.6	7,862	18.4	10,502	22.0	10,746	18.3	5,518	17.5	56,629	16.1
Missing	1,094	10.8	2,033	10.3	4,317	13.0	5,310	15.4	5,021	15.0	4,694	11.8	3,798	8.9	2,358	4.9	1,693	2.9	508	1.6	30,826	8.8
TOTAL	10,125	100	19,695	100	33,166	100	34,551	100	33,468	100	39,894	100	42,706	100	47,840	100	58,587	100	31,544	100	351,576	100
No. referrals by age																						
0-11 yrs	84	0.8	290	1.5	735	2.2	796	2.3	1,074	3.2	1,438	3.6	1,647	3.9	1,848	3.9	2,628	4.5	1,691	5.4	12,231	3.5
12+ yrs	9,308	91.9	18,190	92.4	30,735	92.7	32,118	93.0	31,325	93.6	36,998	92.7	39,312	92.1	43,725	91.4	52,451	89.5	28,191	89.4	322,353	91.7
Missing	733	7.2	1,215	6.2	1,696	5.1	1,637	4.7	1,069	3.2	1,458	3.7	1,747	4.1	2,267	4.7	3,508	6.0	1,662	5.3	16,992	4.8
TOTAL	10,125	100	19,695	100	33,166	100	34,551	100	33,468	100	39,894	100	42,706	100	47,840	100	58,587	100	31,544	100	35,1576	100
Age	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Mean age	38.78	14.6	38.50	14.9	38.37	15.4	38.31	15.5	38.43	16.2	38.16	16.5	37.55	16.6	36.86	16.7	36.26	16.9	35.01	17.0	37.41	16.3

*As this is a stable demographic, the Frequencies (Freq.) and Percentages (%) are reported on the basis of the total number of unique persons in receipt of services across each financial year, rather than the number of referrals, since one person can have more than one referral within a financial year. Note that because a unique person can have more than one referral across financial years, the overall column total (unique persons across time) does not represent the sum of the row totals. For all other demographics the referral total has been used.

(table continues)

Table 10: Summary characteristics of consumers receiving care through ATAPS by financial year, July 2003–December 2012 (continued)

	2003-4		2004-5		2005-6		2006-7		2007-8		2008-9		2009-10		2010-11		2011-12		2012-13		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Previous psychiatric care																						
Yes	3,245	32.0	6,954	35.3	11,773	35.5	11,585	33.5	10,723	32.0	13,484	33.8	15,393	36.0	18,000	37.6	24,229	41.4	12,695	40.2	128,081	36.4
No	4,222	41.7	8,179	41.5	13,613	41.0	12,657	36.6	12,361	36.9	14,571	36.5	15,053	35.2	16,608	34.7	19,699	33.6	11,149	35.3	128,112	36.4
Unknown	1,798	17.8	2,631	13.4	3,475	10.5	4,273	12.4	4,220	12.6	5,718	14.3	7,378	17.3	9,928	20.8	11,121	19.0	5,956	18.9	56,498	16.1
Missing	860	8.5	1,931	9.8	4,305	13.0	6,036	17.5	6,164	18.4	6,121	15.3	4,882	11.4	3,304	6.9	3,538	6.0	1,744	5.5	38,885	11.1
TOTAL	10,125	100	19,695	100	33,166	100	34,551	100	33,468	100	39,894	100	42,706	100	47,840	100	58,587	100	31,544	100	351,576	100
Aboriginal*																						
Yes	211	2.1	360	1.8	525	1.6	672	2.1	927	3.0	1,265	3.5	1,389	3.5	1,664	3.8	2,262	4.3	1,555	5.7	10,830	3.3
No	7,926	78.4	15,736	80.4	26,242	80.7	23,398	73.1	20,985	68.6	26,134	71.6	28,582	72.7	32,623	75.0	40,362	76.6	20,556	74.7	242,544	74.8
Unknown	1,278	12.6	1,782	9.1	1,614	5.0	2,024	6.3	2,513	8.2	4,442	12.2	4,801	12.2	7,158	16.5	8,715	16.5	4,360	15.8	38,687	11.9
Missing	689	6.8	1,683	8.6	4,143	12.7	5,893	18.4	6,167	20.2	4,677	12.8	4,560	11.6	2,068	4.8	1,343	2.5	1,041	3.8	32,264	9.9
TOTAL	10,104	100	19,561	100	32,524	100	31,987	100	30,592	100	36,518	100	39,332	100	43,513	100	52,682	100	27,512	100	324,325	100
Torres Strait Islander*																						
Yes	13	0.1	34	0.2	74	0.2	79	0.2	67	0.2	120	0.3	167	0.4	227	0.5	332	0.6	426	1.5	1,539	0.5
No	7,948	78.7	15,403	78.7	25,730	79.1	22,590	70.6	20,470	66.9	25,264	69.2	27,695	70.4	31,807	73.1	38,334	72.8	17,683	64.3	232,924	71.8
Unknown	1,235	12.2	1,864	9.5	1,624	5.0	2,096	6.6	2,460	8.0	4,471	12.2	5,065	12.9	7,469	17.2	8,873	16.8	4,199	15.3	39,356	12.1
Missing	908	9.0	2,260	11.6	5,096	15.7	7,222	22.6	7,595	24.8	6,663	18.2	6,405	16.3	4,010	9.2	5,143	9.8	5,204	18.9	50,506	15.6
TOTAL	10,104	100	19,561	100	32,524	100	31,987	100	30,592	100	36,518	100	39,332	100	43,513	100	52,682	100	27,512	100	324,325	100

*As these are stable demographic characteristics, the Frequencies (Freq.) and Percentages (%) are reported on the basis of the total number of unique persons in receipt of services across each financial year, rather than the number of referrals, since one person can have more than one referral within a financial year. Note that because a unique person can have more than one referral across financial years, the overall column total (unique persons across time) does not represent the sum of the row totals. For all other demographics the referral total has been used

(table continues)

Table 10: Summary characteristics of consumers receiving care through ATAPS by financial year, July 2003–December 2012 (continued)

	2003-4		2004-5		2005-6		2006-7		2007-8		2008-9		2009-10		2010-11		2011-12		2012-13		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Language spoken at home*																						
Arabic	9	0.1	25	0.1	64	0.2	81	0.3	62	0.2	72	0.2	81	0.2	96	0.2	111	0.2	63	0.2	664	0.2
Cantonese	18	0.2	32	0.2	44	0.1	32	0.1	43	0.1	45	0.1	48	0.1	60	0.1	126	0.2	69	0.3	517	0.2
English	8,070	79.9	16,747	85.6	27,196	83.6	26,173	81.8	24463	80.0	29,983	82.1	31,452	80.0	36,040	82.8	45,061	85.5	23,502	85.4	268,687	82.8
Greek	47	0.5	105	0.5	141	0.4	112	0.4	64	0.2	106	0.3	71	0.2	99	0.2	99	0.2	52	0.2	896	0.3
Italian	73	0.7	164	0.8	204	0.6	138	0.4	92	0.3	99	0.3	103	0.3	89	0.2	106	0.2	38	0.1	1,106	0.3
Mandarin	7	0.1	25	0.1	41	0.1	35	0.1	20	0.1	23	0.1	16	0.0	34	0.1	169	0.3	92	0.3	462	0.1
Vietnamese	6	0.1	16	0.1	24	0.1	86	0.3	63	0.2	80	0.2	168	0.4	164	0.4	163	0.3	73	0.3	843	0.3
Unknown	433	4.3	390	2.0	801	2.5	986	3.1	1,120	3.7	1,518	4.2	2,075	5.3	2,441	5.6	2,583	4.9	1,496	5.4	13,843	4.3
Missing	1,441	14.3	2,057	10.5	4,009	12.3	4,344	13.6	4,665	15.2	4,592	12.6	5,318	13.5	4,490	10.3	4,264	8.1	2,127	7.7	37,307	11.5
TOTAL	10,104	100	19,561	100	32,524	100	31,987	100	30,592	100	36,518	100	39,332	100	43,513	100	52,682	100	27,512	100	324,325	100
English comprehension level*																						
Not at all	6	0.1	13	0.1	15	0.0	40	0.1	26	0.1	46	0.1	44	0.1	80	0.2	156	0.3	70	0.3	496	0.2
Not well	63	0.6	129	0.7	171	0.5	218	0.7	202	0.7	242	0.7	298	0.8	391	0.9	685	1.3	354	1.3	2,753	0.8
Well	102	1.0	283	1.4	771	2.4	626	2.0	1,056	3.5	1,374	3.8	2,217	5.6	3,235	7.4	5,242	10.0	3,213	11.7	18,119	5.6
Very well	1,402	13.9	3,876	19.8	6,292	19.3	6,986	21.8	5,891	19.3	8,451	23.1	8,569	21.8	16,789	38.6	28,735	54.5	15,893	57.8	102,884	31.7
Unknown	560	5.5	460	2.4	452	1.4	769	2.4	607	2.0	1,180	3.2	1,483	3.8	2,079	4.8	2709	5.1	1,574	5.7	11,873	3.7
Missing	7,971	78.9	14,800	75.7	24,823	76.3	23,348	73.0	22,810	74.6	25,225	69.1	26,721	67.9	20,939	48.1	15,155	28.8	6,408	23.3	188,200	58.0
TOTAL	10,104	100	19,561	100	32,524	100	31,987	100	30,592	100	36,518	100	39,332	100	43,513	100	52,682	100	27,512	100	324,325	100

*As these are stable demographic characteristics, the Frequencies (Freq.) and Percentages (%) are reported on the basis of the total number of unique persons in receipt of services across each financial year, rather than the number of referrals, since one person can have more than one referral within a financial year. Note that because a unique person can have more than one referral across financial years, the overall column total (unique persons across time) does not represent the sum of the row totals. For all other demographics the referral total has been used

Table 11: Diagnostic characteristics of consumers by ATAPS initiative, July 2003–December 2012*

Diagnosis	Tier 1		Tier 2																		OVERALL	
			Aboriginal and Torres Strait Islander		Bushfire		Child		Floods and cyclone Yasi		Homelessness		Perinatal depression		Rural and remote		Suicide prevention		T-CBT			
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Alcohol and drug use disorders	16,734	5.3	283	12.8	110	4.7	18	0.3	32	3.4	465	20.9	117	1.5	98	5.1	734	7.6	2	2.8	18,593	5.3
Psychotic disorders	5,191	1.6	54	2.4	28	1.2	28	0.5	57	6.1	148	6.6	65	0.8	51	2.6	319	3.3	0	0.0	5,941	1.7
Depression	173,809	54.5	1,273	57.4	1,193	51.4	1,138	20.2	310	33.1	1,297	58.2	4,866	61.9	1,115	57.7	5,827	60.1	61	84.7	190,889	54.3
Anxiety disorders	132,479	41.6	938	42.3	1,177	50.7	2,365	42.0	197	21.0	830	37.3	2,404	30.6	888	45.9	2,928	30.2	47	65.3	144,253	41.0
Unexplained somatic disorders	4,987	1.6	36	1.6	33	1.4	132	2.3	7	0.7	30	1.3	47	0.6	21	1.1	100	1.0	0	0.0	5,393	1.5
No formal diagnosis	1,358	0.4	11	0.5	0	0.0	18	0.3	30	3.2	4	0.2	63	0.8	4	0.2	235	2.4	0	0.0	1,723	0.5
Unknown	6,109	1.9	67	3.0	46	2.0	373	6.6	40	4.3	37	1.7	98	1.2	50	2.6	376	3.9	1	1.4	7,197	2.0
Other diagnosis	51,780	16.2	438	19.7	1,120	48.3	1,936	34.4	433	46.2	601	27.0	2,312	29.4	404	20.9	2,089	21.5	7	9.7	61,120	17.4
Missing	65,420	20.5	341	15.4	113	4.9	997	17.7	150	16.0	248	11.1	1,051	13.4	188	9.7	1,782	18.4	1	1.4	70,291	20.0

Note. Consumers can be assigned more than one diagnosis, so total diagnoses will equal more than the number of consumers, and percentages will total more than 100%. For this reason, no totals are provided.

Table 12: Diagnostic characteristics of ATAPS consumers by financial year, July 2003–December 2012*

Diagnosis	2003-4		2004-5		2005-6		2006-7		2007-8		2008-9		2009-10		2010-11		2011-12		2012-13		Overall	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Alcohol and drug use disorders	454	4.5	1,080	5.5	1,720	5.2	1,698	4.9	2,003	6.0	2,158	5.4	2,215	5.2	2,418	5.1	3,056	5.2	1,791	5.7	18,593	5.3
Psychotic disorders	132	1.3	279	1.4	482	1.5	486	1.4	615	1.8	629	1.6	709	1.7	762	1.6	1,232	2.1	615	1.9	5,941	1.7
Depression	5,943	58.7	11,630	59.1	18,755	56.5	18,876	54.6	17,843	53.3	20,639	51.7	22,281	52.2	24,931	52.1	32,078	54.8	17,913	56.8	190,889	54.1
Anxiety disorders	4,396	43.4	8,772	44.5	14,554	43.9	14,052	40.7	13,476	40.3	14,978	37.5	16,813	39.4	18,726	39.1	24,678	42.1	13,808	43.8	144,253	41.0
Unexplained somatic disorders	245	2.4	464	2.4	696	2.1	662	1.9	597	1.8	568	1.4	534	1.3	577	1.2	653	1.1	397	1.3	5,393	1.5
No formal diagnosis	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	7	0.0	243	0.5	921	1.6	552	1.7	1,723	0.5
Unknown	306	3.0	359	1.8	489	1.5	449	1.3	406	1.2	442	1.1	471	1.1	778	1.6	2,042	3.5	1,455	4.6	7,197	2.0
Other diagnosis	1,632	16.1	3,482	17.7	5,234	15.8	6,210	18.0	6,439	19.2	6,814	17.1	7,271	17.0	8,277	17.3	10,148	17.3	5,613	17.8	61,120	17.4
Missing	1,594	15.7	3,103	15.8	5,900	17.8	6,758	19.6	7,203	21.5	9,820	24.6	10,309	24.1	11,158	23.3	9,952	17.0	4,494	14.2	70,291	20.0

Note. Consumers can be assigned more than one diagnosis, so total diagnoses will equal more than the number of consumers, and percentages will total more than 100%. For this reason, no totals are provided.

What is the nature of the treatment received by ATAPS consumers?

chapter six

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

OVERALL SESSION CHARACTERISTICS

Tables 13 and 14 describe some of the key characteristics of the 1,432,130 sessions delivered through the ATAPS initiatives overall and by initiative and by financial year, respectively. As noted previously, a number of the variables have a significant amount of missing data, which should be taken into account when interpreting the results, especially in relation to the Tier 2 initiatives that have delivered a smaller number of sessions.

Overall, sessions of 46-60 minutes in duration have been the most common, accounting for 79.9% of sessions. Sessions of over one hour in duration accounted for 9.6% of all ATAPS services. The vast majority (92.0%) of sessions have been delivered to individuals. The majority (92.3%) of all sessions have been delivered face-to-face; sessions have infrequently been delivered by telephone (0.7%) and even less frequently via videoconference or the web. Notwithstanding their relatively low level of use, use of the latter session modalities has been slowly increasing since their inclusion in the ATAPS program guidelines and the minimum dataset.

Nationally, information regarding session copayment was provided for 1,032,531 sessions. The majority (57.9%) of sessions did not incur a copayment. This information was missing for 27.9% of sessions; although not definitive, it is likely that missing copayment data actually represents the absence of a copayment. For the 203,412b sessions where a copayment was incurred (i.e., only sessions with a copayment of $1 or more), the mean copayment amount was $18.15 (S.D. $22.30).

[b]This number is slightly lower than the 204,002 reported as having incurred a copayment in Tables 13 and 14 because it excludes obvious outliers.

The national mean cost to consumers per session (including sessions that did not incur a copayment) for the 1,032,531 sessions where this information was provided was $3.58 (S.D. $12.26).

The most common interventions provided were CBT-based cognitive and behavioural interventions, delivered in 46.7% and 35.0% of sessions, respectively. Across all Tier 1 and 2 ATAPS initiatives 5.0% of sessions involved 'other CBT' strategies and 6.3% of sessions involved 'other' (non-CBT) strategies. Overall, 15.7% of sessions had no information regarding interventions provided. Consumers did not attend 7.1% of all sessions; however, this is likely to be underestimated because at the time of this report, completion of the non-attendance field was not mandatory in the minimum dataset.

Session characteristics by initiative

Tier 1

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

Tier 2

Similarly, across all Tier 2 initiatives, sessions of 46-60 minutes have been the most popular, accounting for 72.3% to 88.3% of sessions across the initiatives. Sessions of less than 30 minutes duration have been more common within several of the Tier 2 initiatives compared with the Tier 1 initiative (2.1%), particularly the *Suicide prevention* (9.7%) and *Homelessness* (9.0%) initiatives. Tier 2 sessions of over one hour in duration were most common in the *Perinatal depression* and *Rural and remote* initiatives (accounting for 17.5% and 16.8% of sessions, respectively). The majority of

Tier 2 initiatives have also delivered sessions to individuals. Group sessions were most commonly delivered in the *Aboriginal and Torres Strait Islander* initiative (9.8%) and the *Perinatal depression* initiative (8.4%).

The majority of all Tier 2 sessions continue to be delivered face-to-face, ranging from 63.6% in the *T-CBT* initiative to 97.2% in the *Bushfire* initiative. However, sessions delivered via other modalities are being utilised as needed. For example, telephone sessions have been delivered most frequently not only via the now completed *T-CBT* pilot but also via the *Suicide prevention* and the *Floods and cyclone Yasi* initiatives (36.4%, 6.3% and 3.5%, respectively).

The majority of Tier 2 sessions did not incur a copayment and were less likely to do so compared with Tier 1 sessions. This copayment information is not a mandatory field and was missing for large proportions of sessions within specific Tier 2 initiatives. The accuracy of recorded copayment data is also questionable. For example, there are infrequent occasions of recorded copayments exceeding $30, which at times may reflect the full cost incurred by the Medicare Local for those sessions rather than just the amount incurred by the consumer, or may represent the total copayment for all of the sessions accessed by the consumer rather the copayment amount for a single sesssion. The mean cost per session for consumers (including sessions which did not incur a copayment) across all Tier 2 initiatives is relatively low.

In the main, CBT-based cognitive and behavioural interventions have been the most common interventions delivered across all Tier 2 initiatives, with the former provided in 29.3% to 64.5% of sessions and the latter in 27.9% to 45.0%. There are, however, some nuances. For example, psycho-education was more commonly utilised than behavioural interventions in the *Rural and remote* initiative (45.5% vs. 30.1%) than in other Tier 2 initiatives. Psycho-education and interpersonal therapy have been frequently delivered across all initiatives, with the former most frequently delivered in the *Rural and remote* and *Bushfire* initiatives (45.5% and 44.6%, respectively)and the latter in the *Bushfire* initiative (41.9%).

The highest rates of unattended sessions were recorded for the *Aboriginal and Torres Strait Islander* and *Homelessness* initiatives (17.0% and 16.7%, respectively). A smaller proportion of sessions were unattended across the remaining Tier 2 initiatives.

Table 13: Summary characteristics of sessions provided to consumers through ATAPS by initiative, July 2003–December 2012

	Tier 1		Tier 2																		OVERALL	
			Aboriginal and Torres Strait Islander		Bushfire		Child		Floods and cyclone Yasi		Homelessness		Perinatal depression		Rural and remote		Suicide prevention		T-CBT			
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Duration																						
0-30 mins	27,181	2.1	296	4.0	56	0.4	237	1.0	153	4.0	755	9.0	1,127	3.4	259	4.3	4,793	9.7	12	3.7	34,869	2.4
31-45 mins	35,570	2.8	130	1.7	81	0.6	285	1.2	11	0.3	173	2.1	547	1.7	141	2.3	861	1.7	14	4.3	37,813	2.6
46-60 mins	1,030,348	80.1	5,650	75.8	12,087	87.6	20,112	84.6	3,375	88.3	6,085	72.3	24,174	73.1	4,512	74.2	37,385	75.3	256	79.0	1,143,984	79.9
60+ mins	121,564	9.5	732	9.8	737	5.3	1,885	7.9	126	3.3	592	7.0	5,799	17.5	1,019	16.8	4,792	9.7	30	9.3	137,276	9.6
Missing	71,087	5.5	643	8.6	838	6.1	1,248	5.3	156	4.1	811	9.6	1,423	4.3	151	2.5	1,819	3.7	12	3.7	78,188	5.5
Total	1,285,750	100	7,451	100	13,799	100	23,767	100	3,821	100	8,416	100	33,070	100	6,082	100	49,650	100	324	100	1,432,130	100
Type																						
Group	23,928	1.9	730	9.8	201	1.5	308	1.3	50	1.3	30	0.4	2,769	8.4	143	2.4	412	0.8	1	0.3	28,572	2.0
Individual	1,197,147	93.1	6,390	85.8	12,788	92.7	7,866	33.1	3,608	94.4	7,363	87.5	29,183	88.2	5,836	96.0	47,484	95.6	323	99.7	1,317,988	92.0
Child*	729	0.1	1	0.0	0	0.0	9,139	38.5	0	0.0	3	0.0	0	0.0	0	0.0	0	0.0	0	0.0	9,872	0.7
Child & parent(s)	189	0.0	2	0.0	0	0.0	3,402	14.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	3,593	0.3
Child in group	18	0.0	0	0.0	0	0.0	776	3.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	794	0.1
Parent(s)*	93	0.0	0	0.0	0	0.0	590	2.5	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	683	0.0
Parent(s) in group	4	0.0	0	0.0	0	0.0	366	1.5	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	370	0.0
Missing	63,642	4.9	328	4.4	810	5.9	1,320	5.6	163	4.3	1,020	12.1	1,118	3.4	103	1.7	1,754	3.5	0	0.0	70,258	4.9
Total	1,285,750	100	7,451	100	13,799	100	23,767	100	3,821	100	8,416	100	33,070	100	6,082	100	49,650	100	324	100	1,432,130	100

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

(table continues)

Table 13: Summary characteristics of sessions provided to consumers through ATAPS by initiative, July 2003–December 2012 (continued)

	Tier 1		Tier 2																		OVERALL	
			Aboriginal and Torres Strait Islander		Bushfire		Child		Floods and cyclone Yasi		Homelessness		Perinatal depression		Rural and remote		Suicide prevention		T-CBT			
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Modality																						
Face-to- face	1,197,479	93.1	5,814	78.0	13,416	97.2	21,408	90.1	3,499	91.6	5,451	64.8	29,239	88.4	5,237	86.1	40,013	80.6	206	63.6	1,321,762	92.3
Telephone	4,864	0.4	63	0.8	47	0.3	113	0.5	132	3.5	22	0.3	792	2.4	145	2.4	3,146	6.3	118	36.4	9,442	0.7
Video*	288	0.0	0	0.0	2	0.0	8	0.0	2	0.1	2	0.0	32	0.1	1	0.0	162	0.3	0	0.0	497	0.0
Web-based	172	0.0	0	0.0	0	0.0	6	0.0	1	0.0	1	0.0	92	0.3	24	0.4	44	0.1	0	0.0	340	0.0
Missing	82,947	6.5	1,574	21.1	334	2.4	2,232	9.4	187	4.9	2,940	34.9	2,915	8.8	675	11.1	6,285	12.7	0	0.0	100,082	7.0
Total	1,285,750	100	7,451	100	13,799	100	23,767	100	3,821	100	8,416	100	33,070	100	6,082	100	49,650	100	324	100	1,432,130	100
Copayment charged																						
No	775,878	60.3	1,989	26.7	1,864	13.5	8,854	37.3	1,141	29.9	3,941	46.8	12,292	37.2	1,703	28.0	20,655	41.6	212	65.4	828,529	57.9
Yes	197,600	15.4	117	1.6	669	4.8	1,751	7.4	96	2.5	111	1.3	2,626	7.9	636	10.5	383	0.8	13	4.0	204,002	14.2
Missing	312,272	24.3	5,345	71.7	11,266	81.6	13,162	55.4	2,584	67.6	4,364	51.9	18,152	54.9	3,743	61.5	28,612	57.6	99	30.6	399,599	27.9
Total	1,285,750	100	7,451	100	13,799	100	23,767	100	3,821	100	8,416	100	33,070	100	6,082	100	49,650	100	324	100	1,432,130	100
Mean copayment and session cost ($)																						
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Copayment	17.76	21.59	-	-	-	-	31.14	36.15	14.99	0.10	10.74	5.98	20.41	26.90	10.17	4.01	11.93	4.61	6.54	2.40	18.15	22.30
Cost per session	3.60	12.06	-	-	-	-	5.14	18.69	1.16	4.01	0.29	2.01	3.59	13.70	2.77	4.98	0.22	1.71	0.38	1.63	3.58	12.26

Note. Copayment and cost per session amounts have not been provided for the *Aboriginal and Torres Strait Islander* or *Bushfire* initiatives due to significant amounts of missing data and questionable accuracy of the recorded data. *Video-conference.

(table continues)

Table 13: Summary characteristics of sessions provided to consumers through ATAPS by initiative, July 2003–December 2012 (continued)

	Tier 1		Tier 2																		OVERALL	
			Aboriginal and Torres Strait Islander		Bushfire		Child		Floods and cyclone Yasi		Homelessness		Perinatal depression		Rural and remote		Suicide prevention		T-CBT			
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Interventions*																						
Diagnostic assessment	205,014	15.9	1,162	15.6	2,311	16.7	4,439	18.7	525	13.7	1,323	15.7	5,276	16.0	772	12.7	9,363	18.9	40	12.3	230,225	16.1
Psycho-education	315,427	24.5	1,683	22.6	6,155	44.6	5,575	23.5	804	21.0	1,831	21.8	9,112	27.6	2,765	45.5	9,945	20.0	91	28.1	353,388	24.7
CBT-Behavioural	452,720	35.2	2,080	27.9	6,208	45.0	8,428	35.5	1,348	35.3	2,742	32.6	11,240	34.0	1,833	30.1	15,157	30.5	108	33.3	501,864	35.0
CBT-Cognitive	605,271	47.1	3,088	41.4	8,147	59.0	8,251	34.7	1,697	44.4	3,643	43.3	14,083	42.6	3,923	64.5	20,139	40.6	95	29.3	668,337	46.7
CBT-Relaxation	239,263	18.6	1,130	15.2	3,862	28.0	3,231	13.6	642	16.8	880	10.5	6,320	19.1	1,098	18.1	6,378	12.8	49	15.1	262,853	18.4
CBT-Skills training	227,584	17.7	998	13.4	4,549	33.0	5,381	22.6	890	23.3	898	10.7	6,444	19.5	1,188	19.5	7,684	15.5	108	33.3	255,724	17.9
Interpersonal therapy	306,903	23.9	1,583	21.2	5,783	41.9	4,322	18.2	744	19.5	2,011	23.9	8,139	24.6	1,716	28.2	8,664	17.5	34	10.5	339,899	23.7
Narrative therapy	8,634	0.7	324	4.3	246	1.8	390	1.6	143	3.7	99	1.2	588	1.8	339	5.6	691	1.4	0	0.0	11,454	0.8
Family therapy	240	0.0	2	0.0	0	0.0	621	2.6	0	0.0	7	0.1	338	1.0	0	0.0	32	0.1	0	0.0	1,240	0.1
Parent training in behaviour management	198	0.0	2	0.0	0	0.0	1,427	6.0	0	0.0	0	0.0	4	0.0	0	0.0	0	0.0	0	0.0	1,631	0.1
Play therapy	422	0.0	0.0	0.0	0.0	0.0	1,114	4.7	0.0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1,536	0.1
Other CBT strategies	64,241	5.0	497	6.7	162	1.2	376	1.6	82.0	2.1	575	6.8	1,604	4.9	474	7.8	3,203	6.5	2	0.6	71,216	5.0
Other strategies	76,428	5.9	669	9.0	381	2.8	1,043	4.4	200	5.2	652	7.7	3,597	10.9	683	11.2	5,927	11.9	9	2.8	89,589	6.3
Missing	200,172	15.6	1,814	24.3	941	6.8	3,290	13.8	892	23.3	2,449	29.1	5,496	16.6	502	8.3	9,257	18.6	119	36.7	224,932	15.7
Unattended sessions																						
Yes	89,905	7.0	1,265	17.0	728	5.3	1,596	6.7	240	6.3	1,409	16.7	2,689	8.1	447	7.3	3,308	6.7	25	7.7	101,612	7.1

*A session can include more than one type of intervention, so total interventions delivered will equal more than the total number of sessions, and percentages will total more than 100 percent. For this reason, no totals are provided.

Profile of sessions by financial year

Table 14 presents some of the key characteristics of the 1,432,130 sessions delivered through the ATAPS program in each financial year. As noted previously, a number of the variables have a significant amount of missing data, which should be taken into account when interpreting the results.

As previously noted, sessions of 46-60 minutes have been the most popular over time, accounting for 79.9% of all sessions. Sessions of 45 minutes duration or less accounted for 12.8% of sessions in 2003-2004 but less than 6% since 2005-2006. Sessions over 60 minutes were most common in 2004-2005 accounting for 12.1% of sessions. The majority of sessions have been delivered to individuals (92.0%). Group sessions have consistently accounted for approximately 2% of all sessions over time.

The majority of all sessions continue to be delivered face-to-face, with little variation over time. The ability to deliver sessions via other modalities was introduced to the program guidelines and the minimum dataset in 2008-2009, with telephone sessions increasing from 0.2% at this time to 1.3% in 2012-2013.

The majority (57.9%) of sessions did not incur a copayment; however, some differences in copayments over time are apparent. The highest proportion of sessions incurring a copayment was in 2004-2005 and 2005-2006, with just over one-quarter of sessions incurring a copayment. In comparison with earlier years, a smaller percentage, 10% or less, of consumers were charged a copayment in recent years. Over time, the mean copayment charged has generally increased, with some variation in this trend observed: with the exception of the current financial year where the mean copayment was $34.29, the mean copayment has been under $30. As previously mentioned, the accuracy of recorded copayment data is questionable, occasionally representing the full cost incurred by the Medicare Local for those sessions rather than just the amount incurred by the consumer. The mean cost per session (including sessions which did not incur a copayment) is relatively low, with the highest mean of $5.12 (SD $18.33) in 2011-2012, and the lowest of $2.22 (SD$8.22) in 2008-2009. It is interesting to note that over time there appears to be greater variation from the mean cost per session, as the standard deviation of mean cost has increased from $8.07 in 2003-2004 to $19.33 in 2012-2013 (with some exceptions to this trend observed), indicating that there is a wider range of copayments being charged over time.

In the main, CBT-based cognitive and behavioural interventions have been the most common interventions delivered over time, accounting for close to half and one-third of all interventions, respectively. Interpersonal therapy and psycho-education were also commonly utilised, accounting for approximately one-quarter of interventions. Narrative therapy, family therapy, parent training in behaviour management and play therapy account for 2% or less of interventions used in financial years since their introduction in 2009-2010, which is not surprising, given that these interventions are limited to use in specific initiatives, such as the use of narrative therapy for Aboriginal and Torres Strait Islander peoples and play therapy in the *Child* initiative. While 0.5% of sessions in 2003-2004 were unattended, since 2008-2009, 8% or more of sessions have been unattended, which may reflect improved data recording (or entry) of unattended sessions or coincide with the introduction of Tier 2 initiatives in which non-attendance is more common (e.g., the *Homelessness* and *Aboriginal and Torres Strait Islander* initiatives).

Table 14: Summary characteristics of sessions provided to consumers through ATAPS by financial year, July 2003–December 2012

	2003-4		2004-5		2005-6		2006-7		2007-8		2008-9		2009-10		2010-11		2011-12		2012-13		Total	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Duration (minutes)																						
0-30	1,369	4.1	2,079	2.8	1,733	1.4	1,890	1.4	2,374	2.0	3,285	2.0	4,685	2.6	7,014	3.4	6,883	2.8	3,557	2.4	34,869	2.4
31-45	2,883	8.7	5,036	6.8	5,331	4.2	5,359	3.9	3,324	2.8	2,982	1.8	4,486	2.5	3,456	1.7	3,465	1.4	1,491	1.0	37,813	2.6
46-60	24,438	73.3	54,662	74.1	96,570	76.8	104,750	76.6	89,252	75.7	131,280	79.6	143,545	79.4	168,728	81.4	201,800	83.4	128,959	86.2	1,143,984	79.9
60+ mins	3,460	10.4	8,940	12.1	14,594	11.6	14,504	10.6	14,150	12.0	15,852	9.6	17,736	9.8	18,467	8.9	19,697	8.1	9,876	6.6	137,276	9.6
Missing	1,176	3.5	3,035	4.1	7,579	6.0	10,192	7.5	8,767	7.4	11,594	7.0	10,402	5.8	9,642	4.7	10,012	4.1	5,789	3.9	78,188	5.5
Total	33,326	100	73,752	100	125,807	100	136,695	100	117,867	100	164,993	100	180,854	100	207,307	100	241,857	100	149,672	100	1,432,130	100
Type																						
Group	621	1.9	1,527	2.1	2,368	1.9	2,980	2.2	3,104	2.6	3,140	1.9	3,282	1.8	4,573	2.2	4,477	1.9	2,500	1.7	28,572	2.0
Individual	31,875	95.6	69,916	94.8	117,852	93.7	126,675	92.7	108,884	92.4	151,167	91.6	164,706	91.1	188,683	91.0	222,181	91.9	136,049	90.9	1,317,988	92.0
Child	0	0.0	0	0.0	0	0.0	0	0.0	63	0.1	133	0.1	81	0.0	1,766	0.9	4,701	1.9	3,128	2.1	9,872	0.7
Child & parent(s)	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	30	0.0	760	0.4	1,552	0.6	1,251	0.8	3,593	0.3
Child in group	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	82	0.0	519	0.2	193	0.1	794	0.1
Parent(s)	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	3	0.0	162	0.1	323	0.1	195	0.1	683	0.0
Parent(s) in group	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	64	0.0	221	0.1	85	0.1	370	0.0
Missing	830	2.5	2,309	3.1	5,587	4.4	7,040	5.2	5,816	4.9	10,553	6.4	12,752	7.1	11,217	5.4	7,883	3.3	6,271	4.2	70,258	4.9
Total	33,326	100	73,752	100	125,807	100	136,695	100	117,867	100	164,993	100	180,854	100	207,307	100	241,857	100	149,672	100	1,432,130	100

(table continues)

Table 14: Summary characteristics of sessions provided to consumers through ATAPS by financial year, July 2003–December 2012 (continued)

	2003-4		2004-5		2005-6		2006-7		2007-8		2008-9		2009-10		2010-11		2011-12		2012-13		Total	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Modality																						
Face-to-face	33,325	100.0	73,752	100.0	125,807	100.0	136,689	100.0	117,850	100.0	162,540	98.5	172,922	95.6	171,040	82.5	203,463	84.1	124,374	83.1	1,321,762	92.3
Telephone	1	0.0	0	0.0	0	0.0	0	0.0	2	0.0	307	0.2	1767	1.0	2,053	1.0	3,338	1.4	1,974	1.3	9,442	0.7
Video- conference	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	7	0.0	81	0.0	135	0.1	211	0.1	63	0.0	497	0.0
Web-based	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	95	0.0	163	0.1	82	0.1	340	0.0
Missing	0	0.0	0	0.0	0	0.0	6	0.0	15	0.0	2,139	1.3	6,084	3.4	33,984	16.4	34,682	14.3	23,179	15.5	100,089	7.0
TOTAL	33,326	100	73,752	100	125,807	100	136,695	100	117,867	100	164,993	100	180,854	100	207,307	100	241,857	100	149,672	100	1,432,130	100
Copayment charged																						
No	14,816	44.5	42,612	57.8	93,919	74.7	106,331	77.8	98,658	83.7	133,592	81.0	96,028	53.1	85,046	41.0	99,269	41.0	58,258	38.9	828,529	57.9
Yes	6,080	18.2	19,928	27.0	31,873	25.3	30,322	22.2	18,987	16.1	22,730	13.8	19,309	10.7	21,224	10.2	24,315	10.1	9,234	6.2	204,002	14.2
Missing	12,430	37.3	11,212	15.2	15	0.0	42	0.0	222	0.2	8,671	5.3	65,517	36.2	101,037	48.7	118,273	48.9	82,180	54.9	399,599	27.9
TOTAL	33,326	100	73,752	100	125,807	100	136,695	100	117,867	100	164,993	100	180,854	100	207,307	100	241,857	100	149,672	100	1,432,130	100
Mean copayment and session cost ($)																						
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Copayment	14.25	9.02	14.04	8.73	14.52	10.00	19.18	21.57	17.21	21.83	15.29	16.27	14.01	15.29	18.69	24.64	26.02	34.12	34.29	41.42	18.15	22.30
Cost per session	4.12	8.07	4.44	8.17	3.66	8.06	4.25	12.91	2.78	10.81	2.22	8.22	2.34	8.15	3.73	13.31	5.12	18.33	4.69	19.33	3.58	12.26

(table continues)

Table 14: Summary characteristics of sessions provided to consumers through ATAPS by financial year, July 2003–December 2012 (continued)

	2003-4		2004-5		2005-6		2006-7		2007-8		2008-9		2009-10		2010-11		2011-12		2012-13		Total	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Interventions																						
Diagnostic assessment	5,921	17.8	12,286	16.7	21,060	16.7	21,087	15.4	17,714	15.0	24,848	15.1	29,378	16.2	32,825	15.8	41,355	17.1	23,751	15.9	230,225	16.1
Psycho-education	8,341	25.0	18,946	25.7	29,320	23.3	31,192	22.8	26,088	22.1	38,283	23.2	44,699	24.7	51,983	25.1	65,150	26.9	39,386	26.3	353,388	24.7
CBT-Behavioural	11,479	34.4	27,088	36.7	46,745	37.2	48,631	35.6	37,639	31.9	55,659	33.7	61,293	33.9	70,583	34.0	86,975	36.0	55,772	37.3	501,864	35.0
CBT-Cognitive	15,928	47.8	36,948	50.1	60,195	47.8	63,062	46.1	51,525	43.7	73,631	44.6	81,432	45.0	99,240	47.9	114,250	47.2	72,126	48.2	668,337	46.7
CBT-Relaxation	7,344	22.0	15,798	21.4	25,024	19.9	23,598	17.3	18,383	15.6	27,920	16.9	31,618	17.5	39,168	18.9	46,667	19.3	27,333	18.3	262,853	18.4
CBT-Skills training	6,338	19.0	14,787	20.0	23,266	18.5	23,419	17.1	19,436	16.5	26,961	16.3	30,419	16.8	37,105	17.9	45,762	18.9	28,231	18.9	255,724	17.9
Interpersonal therapy	7,173	21.5	16,994	23.0	28,334	22.5	32,327	23.6	25,817	21.9	37,873	23.0	43,421	24.0	51,416	24.8	61,205	25.3	35,339	23.6	339,899	23.7
Narrative therapy	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	59	0.0	2,268	1.1	5,548	2.3	3,579	2.4	11,454	0.8
Family therapy	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	41	0.0	213	0.1	537	0.2	449	0.3	1,240	0.1
Parent trainingb	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	4	0.0	215	0.1	697	0.3	715	0.5	1,631	0.1
Play therapy	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	6	0.0	271	0.1	710	0.3	549	0.4	1,536	0.1
Other CBT strategies	1,785	5.4	5,441	7.4	6,896	5.5	6,842	5.0	5,233	4.4	7,978	4.8	9,009	5.0	9,816	4.7	10,208	4.2	8,008	5.4	71,216	5.0
Other strategies	1,542	4.6	4,544	6.2	8,083	6.4	8,513	6.2	7,451	6.3	10,717	6.5	13,533	7.5	13,090	6.3	13,350	5.5	8,766	5.9	89,589	6.3
Missing	4,118	12.4	7,696	10.4	15,974	12.7	20,479	15.0	20,998	17.8	28,850	17.5	28,624	15.8	34,952	16.9	39,203	16.2	24,038	16.1	224,932	15.7
Unattended sessions																						
Yes	168	0.5	701	1.0	4,336	3.4	8,112	5.9	8,587	7.3	14,204	8.6	15,482	8.6	18,070	8.7	19,879	8.2	12,073	8.1	101,612	7.1

[a]Multiple response permitted; [b]Parent training in behaviour management.

Is ATAPS achieving positive outcomes for consumers?

chapter seven

Chapter 7: Is ATAPS achieving positive outcomes for consumers?

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

To be included in the analyses of outcomes, a minimum of 50 consumers within each ATAPS initiative were required to have pre- and post-treatment scores on a given outcome measure. Based on this prerequisite, pre- and post-treatment outcome data were available for 32,792 Tier 1 consumers (13.1% of the 250,001 who received sessions), 303 *Bushfire* consumers (15.4% of 1,965), 139 *Child* consumers (3.0% of 4,648), 77 *Homelessness* (4.0% of 1,926), 930 *Perinatal depression* consumers (14.5% of 6,428) and 831 *Suicide prevention* consumers (10.0% of 8,313). The remaining Tier 2 initiatives did not meet this prerequisite, which is to be expected based on their relative infancy (with the exception of the completed *T-CBT* pilot). Consumers with 'zero' for both pre- and post-treatment scores were excluded from this analysis. It is extrapolated in these cases that an outcome measure was not actually administered.

Table 15 shows the number of different measures used per consumer by each initiative. The majority of consumers included had outcome data from one measure only, but some had outcome data from multiple measures, with instances of three measures often being accounted for by use of the three Depression Anxiety and Stress Scales (DASS)[64] or the subscales of the Strengths and Difficulties Questionnaire (SDQ).[65]

Appendix A describes the 13 most commonly-used outcome measures: the Beck Anxiety Inventory (BAI),[66] the Behaviour and Symptom Identification Scale 32 (BASIS-32),[67] the Beck Depression Inventory (BDI),[68] the DASS,[64] the Edinburgh Post Natal Depression Scale (EPNDS),[69] the Global Assessment of Functioning (GAF),[70] the General Well-Being Index (GWBI),[71] the Hospital Anxiety and Depression Scale (HADS),[72] the Health of the Nation Outcome Scales (HoNOS),[73] the Kessler 10 (K-10),[74] the Modified Scale for Suicidal Ideation (MSSI),[75] the Outcome Rating Scale (ORS),[76] and the SDQ.[65] Although pre- and post-treatment scores were available for the Session Rating Scale (SRS),[77] the results are not reported because it assesses the therapeutic alliance rather than consumer outcomes.[78]

Table 15: Number of outcome measures used per consumer by initiative

Number of measures per consumer	Tier 1		Bushfire		Child		Homelessness		Perinatal depression		Suicide prevention	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
1	18,321	55.9	231	6.2	72	51.8	46	59.7	497	53.4	409	49.2
2	2,958	9.0	32	10.6	3	2.2	3	3.9	39	4.2	17	2.0
3	8,808	26.9	40	13.2	24	17.3	22	28.6	233	25.1	183	22.0
4	2,482	7.6	-	-	12	8.6	6	7.8	137	14.7	161	19.4
5	124	0.4	-	-	4	2.9	-	-	23	2.5	61	7.3
6	73	0.2	-	-	22	15.8	-	-	-	-	-	-
7	12	0.0	-	-	2	1.4	-	-	-	-	-	-
8	5	0.0	-	-	-	-	-	-	1	0.1	-	-
12	1	0.0	-	-	-	-	-	-	-	-	-	-
13	4	0.0	-	-	-	-	-	-	-	-	-	-
14	3	0.0	-	-	-	-	-	-	-	-	-	-
15	1	0.0	-	-	-	-	-	-	-	-	-	-
Total	32,792	100.0	303	100.0	139	100.0	77	100.0	930	100.0	830	100.0

CHANGES ON OUTCOME MEASURES FROM PRE- TO POST-TREATMENT

Table 16 shows the mean difference between pre- and post-treatment scores on the 13 most commonly used outcome measures by initiative. With the exception of the DASS and HADS, the mean differences were based on total scores. In the case of the DASS and HADS, the mean differences were based on scores for each of the respective sub-scales because a total score on these instruments is not regarded as meaningful.[64,72] It is noteworthy that negative mean difference scores for the GAF, GWBI and ORS, and positive mean difference scores across the remaining outcome measures are indicative of improvements. Across all measures, the mean difference between the pre- and post-treatment scores was statistically significant and indicative of clinical improvement.

Table 16: Pre- and post-treatment outcome scores on available outcome measures for consumers receiving care through ATAPS by initiative

Measure	Tier 1							Bushfire							Child						
		Pre-treatment		Post-treatment		Pre-post difference			Pre-treatment		Post-treatment		Pre-post difference			Pre-treatment		Post-treatment		Pre-post difference	
	n	Mean	SD	Mean	SD	Mean	SD	n	Mean	SD	Mean	SD	Mean	SD	n	Mean	SD	Mean	SD	Mean	SD
BAI	564	23.1	12.6	14.4	11.9	8.6**	10.5	-	-	-	-	-	-	-	-		-		-		-
BASIS-32	2,458	1.4	0.6	0.3	0.5	1.2**	0.7	-	-	-	-	-	-	-	-		-		-		-
BDI	777	27.3	11.9	15.4	11.9	11.9**	11.1	-	-	-	-	-	-	-	-		-		-		-
DASS-A	11,544	16.3	9.8	10.5	8.9	5.8**	9.0	-	-	-	-	-	-	-	-		-		-		-
DASS-D	11,640	20.6	11.0	12.5	10.2	8.1**	10.7	-	-	-	-	-	-	-	-		-		-		-
DASS-S	11,577	22.3	9.9	14.8	9.8	7.5**	10.1	-	-	-	-	-	-	-	-		-		-		-
EPNDS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		-		-		-
GAF	1,170	58.1	9.1	69.6	11.1	-11.5**	8.4	-	-	-	-	-	-	-	-		-		-		-
GWBI	325	39.9	15.2	54.8	16.2	-14.9**	17.0	-	-	-	-	-	-	-	-		-		-		-
HADSAnx	59	10.7	4.5	6.3	3.8	4.4**	4.3	-	-	-	-	-	-	-	-		-		-		-
HADSDep	57	10.4	4.1	5.5	3.6	4.9**	3.7	-	-	-	-	-	-	-							
HoNOS	3,955	11.9	5.0	6.5	4.6	5.4**	4.2	-	-	-	-	-	-	-	-		-		-		-
K-10	16,693	31.0	7.9	23.0	8.4	8.0**	8.4	171	31.2	7.4	25.5	7.3	5.8**	6.3	50	26.0	7.4	22.2	8.3	3.7*	8.7
ORS	147	20.0	8.0	28.9	9.4	-8.9**	10.1	-	-	-	-	-	-	-	-		-		-		-
SDQPCTD	80	19.8	7.5	9.3	8.8	10.5**	8.9	-	-	-	-	-	-	-	-		-		-		-

Note. As of October 2011, HADS scores have been recorded by subscale and therefore reported by subscale and not by total. * p < .01,**p < 0.001.

(table continues)

Table 16: Pre- and post-treatment outcome scores on available outcome measures for consumers receiving care through ATAPS by initiative (continued)

Measure	Homelessness							Perinatal depression							Suicide prevention						
		Pre-treatment		Post-treatment		Pre-post difference			Pre-treatment		Post-treatment		Pre-post difference			Pre-treatment		Post-treatment		Pre-post difference	
	n	Mean	SD	Mean	SD	Mean	SD	n	Mean	SD	Mean	SD	Mean	SD	n	Mean	SD	Mean	SD	Mean	SD
DASS-A	-		-		-			389	13.4	9.4	7.0	8.0	6.4**	8.8	403	19.9	10.4	11.3	9.5	8.5**	10.8
DASS-D	-		-		-			400	16.9	10.0	8.2	8.4	8.8**	10.6	412	27.8	10.5	15.2	11.9	12.6**	12.7
DASS-S	-		-		-			404	20.6	9.5	12.0	9.4	8.6**	10.8	404	26.0	10.2	15.8	11.1	10.2**	12.1
EPNDS	-		-		-			503	16.4	5.2	9.4	6.3	7.1**	7.1	-		-		-		-
K-10	51	31.2	9.2	26.8	9.4	4.4	6.5**	207	30.1	7.7	20.5	8.0	9.6**	9.5	324	35.3	7.1	25.8	9.1	9.5**	9.7
MSSI	-		-		-		-	-		-		-		-	375	14.7	10.9	4.6	7.5	10.1**	10.1

** $p < 0.001$

What lessons have been learned about the processes, impacts and outcomes of the ATAPS program?

chapter eight

Chapter 8: What lessons have been learned about the processes, impacts and outcomes of the ATAPS program?

Twenty evaluation reports relating to the evaluation of the ATAPS program have included qualitative evaluation components. This section outlines the major findings of these qualitative evaluations. This chapter is divided into three sections: qualitative evaluation findings related to Tier 1 ATAPS, qualitative evaluation findings relating to the Tier 2 ATAPS initiatives and a final section on the all of ATAPS client satisfaction and mental health professional workforce findings. These three sections are further divided into the following headings:

TIER 1 ATAPS INITIATIVE

- Models of service delivery
- Advantages and disadvantages of the pilots
- Experiences of the Tier 1 ATAPS initiative
- Demand management strategies
- Use of CHPPE evaluation reports

TIER 2 ATAPS INITIATIVES

- Suicide prevention
- Telephone-CBT
- Bushfire
- Floods and cyclone Yasi
- Experiences of Divisions with Tier 2 ATAPS initiatives

OVERALL ATAPS PROGRAM

- Client satisfaction
- ATAPS workforce

A brief summary of the methodology used in data collection is provided at the beginning of each section and includes the number and type of participants included in each evaluation component.

Models of service delivery

What models of service delivery are being used by the projects?

Five ATAPS interim evaluation reports released between December 2003 and February 2010 addressed the current models of service delivery being used by ATAPS projects to deliver ATAPS services.[12 13 15 16 26] 'Service delivery models' is the term used to describe the combination of methods used to:

- retain mental health professionals to deliver psychological services,
- refer the consumer from the GP to the mental health professional, and
- the location of mental health service providers.

Three of these evaluation reports reviewed the content of local implementation and evaluation reports submitted by the ATAPS projects to the Department of Health and Ageing over the years 2003 to 2009.[12 13 15] The local evaluation reports were from the 15 pilot, 14 supplementary, and 40 Round 2, projects. The remaining two reports (June 2005 and February 2010) used surveys completed by Division project managers, project officers, and a Divisional CEO from 97 and 104 projects respectively.[16 26]

Table 17 outlines the service delivery models used to deliver ATAPS since the first interim report in December 2003.[12]

Table 17: Models of service delivery

Means of retaining mental health professionals	**Contractual arrangements**	Mental 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.
	Direct employment	Mental health professionals are directly employed by the Division.
Location of mental health professionals	**GPs' rooms**	Mental health professionals provide services to the projects in rooms at the GPs' practices.
	Own rooms	Mental health professionals provide services at their own premises.
	Other location	Mental health professionals provide services at a third location.
Referral mechanisms	**Voucher system**	The Division distributes vouchers to participating GPs who, in turn, give them to consumers. Consumers then use the vouchers to visit nominated mental health professionals, and the mental 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 mental health professional, sometimes using prioritisation or matching criteria.
	Register system	A system whereby a register that profiles eligible mental health professionals is provided to participating GPs, who can then make their own decisions about referral.

While the types of service delivery models used to deliver ATAPS services have remained relatively constant over time, the evaluation reports have highlighted some fluctuations in the use of the various methods over the history of ATAPS. A multitude of combinations of retention models, locations and referral mechanisms were being used across Divisions.

Referral system

- Direct referral from GP to mental health professional remained the most popular referral mechanism across all reports, being used in more than half of ATAPS projects. Since 2005, this direct referral was assisted by provision of a register in about one-quarter of projects.

- The brokerage system became more popular over time, being used by 40% of projects by 2008-2009, while the use of the voucher system declined markedly over time, being used only by 14% of projects by 2008-2009.

Retention of mental health professionals

- Divisions often employed more than one model of retaining mental health professionals.

- Contractual arrangements for retaining mental health professionals remained the most common arrangement used across all reports, with more than 80% using this method of retention in 2008-2009.

- Direct employment was less common, although this method increased in use over time. In 2008-2009, 40% of projects used this method of retaining mental health professionals.

- Other methods of service delivery, such as contracting a third party organisation to deliver services, were used relatively rarely.

Location of mental health professionals

- ATAPS projects often used more than one location for their mental health professionals providing ATAPS services.

- Use of mental health professionals' own rooms and GP rooms remained the most popular, and equally popular, locations for providing ATAPS services over time. Approximately 60% of ATAPS mental health professionals were operating from each of these locations in 2005 and 2008-2009.

- However, use of these locations did decline slightly over time, accompanied by an increase in the use of other locations such as Divisions rooms (30% in 2008-2009) and community health centres (23% in 2008-2009).

Do the models of service delivery being used in rural and urban projects differ?

The evaluation report from March 2006 reviewed earlier survey findings from 97 projects (from June 2005) to identify a number of differences in the service delivery models used in rural and urban ATAPS projects:[18]

- Compared with urban projects, rural projects were more likely to directly employ mental health professionals (37% vs. 21%).

- Mental health professionals providing ATAPS services in rural locations were therefore less likely to operate from their own rooms (53% vs. 72%) and more likely to provide services from a number of locations.

- Direct referral was far more common (64% vs. 38%), and regis ter systems far less common (17% vs. 32%), in rural areas.

Does the level of consumer outcomes and consumer access vary depending on the model of service delivery?

Statistical analyses of data from 84 local evaluation reports, outlined in the November 2005 ATAPS interim report, concluded that projects did not markedly differ in terms of the consumer outcomes they were achieving, despite their differences in models of service delivery.[17] However, the analyses did suggest that use of direct referral and employment of mental health professionals could relate to better consumer outcomes.

No dimensions of the service delivery model predicted the level of consumer access to services.

Advantages and disadvantages of the different models of service delivery

The third ATAPS interim evaluation report (February 2005) reported on the outcomes of an evaluation forum involving representatives from 17 of 25 Victorian ATAPS projects running at that time, plus one Tasmanian project.[14] Participants were asked to outline the advantages and disadvantages of each of the possible mechanisms of service delivery for each stakeholder group. The results of this forum are outlined in Tables 18-20.

Divisions were reported to benefit most from contracting mental health professionals, while mental health professionals were reported to experience more advantages when directly employed by the Division. Co-location of GP and mental health professionals was seen to benefit both parties as well as consumers, although it did come with added pressures for some mental health professionals. Use of professionals' own rooms was seen to have both significant advantages and disadvantages for GPs, mental health professionals and consumers. While each referral system was seen to have its relative advantages, the register system of referral was seen to offer the fewest disadvantages to all stakeholders, and the voucher system the most disadvantages of all referral systems.

Table 18: Advantages and disadvantages of contractual vs. employment model of retention of mental health professionals

	Mental health professionals	Divisions	Consumers
Contractual arrangement			
Advantages		• increased volume and range of providers with varying skills and expertise • greater access can reduce waiting lists • greater flexibility • significant savings on employment costs: supervision; infrastructure; travel	
Disadvantages	• pay for and arrange own infrastructure, supervision and insurance • can experience a lack of support from the project • no guarantee of regular work and therefore of income	• requires projects to 'ration' number of sessions available within the funding provided • restricts service quality monitoring • reduces opportunities to build a relationship with the mental health professional	
Employment arrangement			
Advantages	• infrastructure, supervision and insurance provided • greater support from the project • guarantee of regular work and regular income		• greater continuity of care

Note. The advantages and disadvantages to consumers were provided by Divisions, GPs and mental health professionals and not consumers themselves.

Table 19: Advantages and disadvantages of co-location vs. use of mental health professionals' own rooms

	GPs	Mental health professionals	Consumers
		Co-location	
Advantages	• greater ease of communication • the opportunity to develop a professional relationship • streamlining of service delivery systems • mental health skill development	• greater ease of communication • the opportunity to develop a professional relationship • streamlining of service delivery systems	• the need for less travel • familiarity with the location • greater shared care
Disadvantages		• increased pressure to skip the referral process or to perform tasks outside the ATAPS remit • limited range of referrals • logistical problems of room use within GP practices	
		Own rooms	
Advantages	• increases range of mental health professionals to whom the GP refers, increasing the pool of skills and expertise	• referrals from a range of GPs increases the breadth of referrals and opportunities for skill development and diversity in practice • greater independence	• greater choice of mental health professionals • can decrease stigma as others are not aware they are accessing psychological services
Disadvantages	• less communication between GP and mental health professional	• less communication between GP and mental health professionals • greater isolation • responsibility for own space	• less continuity of care • can lead to decreased anonymity and increased stigma, especially in small rural communities

Note. The advantages and disadvantages to consumers were provided by Divisions, GPs and mental health professionals and not consumers themselves.

Table 20: Advantages and disadvantages of voucher vs. brokerage vs. register system vs. direct referral systems

	GPs	Mental health professionals	Consumers
		Voucher system*	
Advantages	• minimum amount of paperwork and 'red tape' • seen as flexible and simple • GP does not need to directly contact either the Division or the mental health professional	• control given to consumers can make them more invested in treatment	• the control given to consumers can make them more invested in treatment • flexibility of choosing their mental health professional • can initiate treatment when they are ready • can access a clinician working outside their local area, providing greater anonymity
Disadvantages	• difficulties with tracking referrals can mean GPs do not know if their patient has not attended for mental health care • GPs may not receive feedback on progress through treatment • can encounter difficulties with payment if the consumer does not attend for their review session, which activates a Service Incentive Payment	• GP does not know the skills and expertise of the mental health professional their patient is seeing, sometimes leading to inappropriate referrals • difficulties in estimating workload	• GP does not know the skills and expertise of the mental health professional their patient is seeing, sometimes leading to inappropriate referrals to the mental health professional and subsequent delays in treatment •
		Brokerage system	
Advantages	• saves GPs time involved in locating a mental health professional with specific expertise by placing this responsibility on the broker • provides access to a broader range of expertise • can afford GPs the opportunity to learn from mental health professionals with particular expertise		• matching of consumer and mental health professional could increase quality of care
Disadvantages	• reduces the control of the GP over the referral • reducing GPs' control can reduce the consumer's faith in the GP	• broker can favour some providers over others, regardless of their expertise • a third party can inhibit relationship-building and collaboration with referrers	• reduces the control of the GP over the referral, possibly reducing the consumer's faith in the GP • involvement of a third party can also increase the time from referral to initiation of treatment • might need to provide information to multiple sources, decreasing feelings of anonymity and increasing the burden associated with seeking care

Note. The advantages and disadvantages to consumers were provided by Divisions, GPs and mental health professionals and not consumers themselves.

*Divisions were also seen to experience difficulties in tracking referrals when using the voucher system.

(table continues)

Table 20: Advantages and disadvantages of voucher vs. brokerage vs. register system vs. direct referral systems (continued)

	GPs	Mental health professionals	Consumers
		Register system*	
Advantages	• ability to match needs of the consumer with expertise of the mental health professional	• providing to the GP a list of detailed information about mental health professionals reduces the likelihood of inappropriate referrals • increases opportunity to build a specialist referral base in areas of interest	• appropriate referrals can increase quality of care for consumers • access to a greater range of professionals
Disadvantages			· can increase the need for travel to a specific professional · can decrease anonymity through direct referral from GP to professional
		Direct referral	
Advantages	• increases ease of referral • improves collaboration and communication between the GP and mental health professional	• improves collaboration and communication between the GP and mental health professional	• improves collaboration and communication between the GP and mental health professional • reduced time before initiation of treatment • familiarity between the GP and mental health professional can also increase consumer confidence
Disadvantages	• promotes referral to mental health professionals known to the GP, limiting access to a wider pool of experts	• promotes referral to mental health professionals known to the GP, limiting referrals from some GPs • this can result in inappropriate referrals to the mental health professional	• promotes referral to mental health professionals known to the GP, limiting access to a wider pool of experts • this can result in inappropriate referrals to the mental health professional

Note. The advantages and disadvantages to consumers were provided by Divisions, GPs and mental health professionals and not consumers themselves.

*Providing the GP a detailed register of mental health professionals' experience and expertise often occurred in concert with the voucher system, allowing them to suggest to consumers specific professionals that they might access and increasing the GP's ability to make an informed referral.

What are the advantages and disadvantages of the pilots?

The first two (December 2003 and July 2004), and fourth (April 2005) interim ATAPS evaluation reports analysed local evaluation reports from 15 pilot projects, 14 supplementary projects and 40 second round projects to identify the advantages and disadvantages of the ATAPS projects for the various stakeholders, and the barriers and facilitators to the implementation of ATAPS.[12 13 15] The results of these analyses are outlined in Table 21.

Table 21: Advantages and disadvantages of the ATAPS projects for stakeholders, and barriers and facilitators to program implementation

	GPs	Mental health professionals	Divisions	Consumers
Advantages and facilitators	• time and cost savings through simplified referral to mental health professionals • do not have to conduct long mental health consultations with the patient themselves • appreciation of co-locating mental health professionals, which allows greater interaction between GP and mental health professional • formal and informal feedback from mental health professionals, allowing them to stay involved in the patient's mental health care • greater collaboration with mental health professionals • greater opportunities for learning related to psychological interventions • improved understanding of the role of mental health professionals • structured approach to providing mental health care • greater referral options	• increased referral base, increasing both income and diversity of referrals • greater communication with GPs, reducing isolation and increasing mutual learning opportunities • some Divisions offered clinical supervision opportunities, helping to reduce professional isolation • some Divisions targeted particular 'at-risk' groups and provided alternative modes of delivery - opportunity to diversify their practice • mutual support from referrers		• increased access to mental health care • high consumer satisfaction • access to non-pharmacological treatments • access to low or no cost services • shorter waiting times • access to mental health professionals within GP rooms • collaborative approach from GP and mental health professional • Divisions' outcome data showed a decline in consumer distress, depression and anxiety over six sessions • consumers benefited from ATAPS services and especially practical strategies taught in CBT

(table continues)

Table 21: Advantages and disadvantages of the ATAPS projects for stakeholders, and barriers and facilitators to project implementation (continued)

	GPs	Mental health professionals	Divisions	Consumers
Disadvantages and barriers	• mandatory training • registration delays with General Mental Health Standards Collaboration following training • confusion over aspects of the program: number of available sessions; information required at referral; and referral pathways, particularly related to brokerage models • burdened by paperwork involved • loss of income if patients fail to attend their review session, which is scheduled as a long consultation • some had not had positive communications with mental health professionals, probably due to a lack of time • time spent on completing the 3 Step Mental Health Process • lack of flexibility of ATAPS • limited referral capacity • payment issues • increased caseload	• payment often less than recommended psychologist's fee • some co-location arrangements are sub-optimal, e.g., providing sessions from 'tea rooms' and make-shift offices, particularly in the early days of the pilot • poor communication from GPs and in particular a lack of referral information • payment issues, distance and travel time barriers to service delivery for some • lack of decision-making power as clinicians	• non-attendance of consumers: time and cost of travel, lack of motivation associated with certain mental disorders, and lack of clarity about referral arrangements.	• consumers wanted to be referred to a mental health professional who specialised in their particular problem, but Divisions often felt that GPs referred to providers 'at random' or left the consumer to choose their own provider • getting access to GPs who were registered for BOiMHC and who could therefore provide referrals to ATAPS • different locations of mental health professionals: located in their GP rooms felt discomfort at waiting in the GP waiting room, while some whose provider had their own rooms felt that attending these was associated with stigma and unfamiliarity • restricted number of sessions

What lessons have been learned from the early experiences of the projects?

In the fourth interim ATAPS evaluation report (April 2005), local evaluation reports from 69 pilot, supplementary and Round 2 projects were examined to determine what lessons had been learned from the early experiences of the ATAPS projects.[15] Tables 22 to 24 summarise some of the difficulties in ATAPS implementation encountered by Divisions, GPs and mental health professionals, and some of the solutions implemented by April 2005 to overcome them.

Table 22: Selected difficulties encountered by Divisions, and some solutions

Difficulties	Solutions
Community confusion about the initiative	Education campaigns conducted
Poor GP attendance at initial project meetings	Practices of non-attending GPs visited and information kits distributed
Problems with timely identification of which GPs have completed Level 1 Training and are registered with the BOiMHC initiative	Data sought from the General Practice Mental Health Standards Collaboration, and through local surveys of GPs
Difficulties recruiting mental health professionals and matching skills and qualifications to profiles of need (particularly in rural areas)	Protocols broadened to include additional suitable providers (e.g., student psychologists working under supervision)
GP confusion about More Allied Health Services initiative and BOiMHC	Differences between the two initiatives clarified, and roles of relevant Divisional project staff delineated
Poor systems for tracking referrals	Increasingly sophisticated systems developed that involve timely notification to the Division that a referral has been made
Initial low rates of referral from GPs	Referral systems modified and simplified (e.g., one page document completed by GP)
Unattended sessions	Strategies to encourage attendance implemented (e.g. time limit within which consumer must make initial appointment, reminder telephone calls and letters, requirement that consumer return to GP for re-referral if he/she fails to attend more than a certain number of appointments); importance of attendance stressed to consumers; and careful selection and preparation of consumers for referral on the part of GPs encouraged
Lack of support for specific consumer groups (e.g., people from culturally and linguistically diverse communities)	Partnerships forged with relevant organisations (e.g., transcultural mental health services)
Low uptake of group sessions	Information provided to GPs and consumers about the benefits of group therapy
Difficulties with administering outcome measures, particularly at review session	Strategies to encourage completion of outcome measures implemented (e.g., mental health professional administers instrument at sixth session; pre-paid envelopes provided for self-completion instruments; and GP provided with incentives for administering instruments at review)
Data entry issues	Provision of on-line access for mental health professionals to enter data; employment of Divisional staff

Table 23: Selected difficulties encountered by GPs, and some solutions

Difficulties	Solutions
Confusion about how the initiative operates.	Initial briefings, follow-up face-to-face and telephone assistance, and development of resources by Divisions.
Reverse referrals, whereby mental health professionals refer existing consumers back to the GP for re-referral, so that they can receive care without being out-of-pocket.	Written policies and protocols discouraging such practices.
Limited number of referrals available.	Budget increases sought and consumer co-payments increased.
Amount of paperwork and 'red tape'.	Reduced volume of paperwork required by some Divisions. Systems and resources developed to help guide GPs through the process (e.g., checklists, templates for Medical Director, simplified referral forms). Recruitment of experienced GPs to act as 'coaches' with respect to completion of the 3 Step Mental Health Process.
Inability to 'track' consumers, in order to know whether referral has been acted upon. Tracking is a particular problem in some voucher systems, where the number of vouchers available to any given GP is limited, and unused vouchers could potentially be re-issued to new consumers.	Systems developed to tighten the control over vouchers (e.g., electronic or carbon-based systems).
Insufficient feedback from mental health professionals.	Discussions brokered between GPs and mental health professionals, and resources developed to streamline feedback (e.g., a uniform feedback letter).
Inability to access Service Incentive Payment if consumer does not return to GP for review.	Encouragement of consumers by mental health professionals to return to GP for review. Bulk-billing of review sessions by GP so cost does not act as a barrier.

Table 24: Selected difficulties encountered by mental health professionals, and some solutions

Difficulties	Solutions
Lack of suitable accommodation at GPs' premises.	Alternative accommodation arrangements sought (e.g., own rooms, room at Division, or room at a third location such as a community health centre).
Some inappropriate referrals (e.g., for 'crisis management' and 'chronic mental illness').	GP education about parameters of initiative.
Travel time and costs higher than expected (particularly in rural areas).	Single central location, or several suitable locations, sourced to minimise travel requirements for mental health professionals.
Loss of income associated with unattended sessions.	Strategies implemented to encourage consumers to attend initial and subsequent appointments (e.g., GP makes the initial appointment while the consumer is present, providing advice about what the sessions will entail, and giving directions to the location).
Delays in payment due to the period elapsing between referral being made and sessions being completed.	Strategies to streamline 'tracking' of consumers (e.g., electronic or carbon-based systems, additional Divisional staff).
High caseloads.	Additional mental health professionals recruited to help meet demand and reduce waiting times.

Have the experiences of GPs, mental health professionals and consumers participating in ATAPS projects changed over time?

In the sixth interim ATAPS evaluation report (November 2005), 84 local evaluation reports from pilot, Round 2 and Round 3 projects were analysed to determine how the experiences of GPs, mental health professionals and consumers participating in ATAPS projects had changed over time.[17] A number of barriers to the implementation of ATAPS projects reported earlier (see Tables 18-20) had been overcome by this time:

- While some barriers cited by Round 1 and 2 GPs persisted, remuneration issues, inadequate feedback from mental health professionals and confusion over the operation of the projects had proved less problematic for Round 3 GPs, largely because of the efforts of Divisions to 'iron them out';
- Round 3 mental health professionals did not experience the same degree of difficulty with lack of security of work and inappropriate referrals as their Round 1 and 2 colleagues; and
- The restricted nature of sessions had also been flagged as a concern by all three stakeholder groups.

Do the issues faced by rural and urban projects differ, and do the solutions to these issues vary?

The seventh interim ATAPS evaluation report (March 2006)[18] analysed survey data gained from Division project managers, project officers and a Divisional CEO from 14 pilot, 29 Round 2 and 30 Round 3 projects to identify whether issues faced by rural and urban projects differ and if the solutions used to overcome these also differ:

- Rural projects had problems related to distance, attracting qualified staff, lack of training and support for GPs, limited services, large Indigenous populations, high levels of unemployment, and stigma;
- Urban projects had more difficulties related to higher uptake and demand, workforce shortages, and availability of and co-ordination with other services; and
- As a result of these differences in problems faced, projects developed novel solutions suitable to their local environments.

Demand management strategies

The ninth ATAPS interim report (October 2006) analysed survey data gained from project officers from 89 ATAPS projects.[20] The survey asked questions related to the strategies used by the projects to manage the demand for ATAPS within the allocated budget for services and within other resource constraints, such as the number of providers and available appointments. The survey data showed the following outcomes relating to use of demand strategies:

- Seventy-six projects (85%) were using at least one demand management strategy;
- The majority of projects were using a combination of broad demand management strategies (5.6 per project, on average, with each strategy employing a range of approaches);

- Common demand management strategies were:
  - informing GPs of alternative referral pathways and encouraging GPs to attend Level 2 training (82%);
  - systems and/or administrative procedures such as a centralised point for management of referrals (76%); and
  - monitoring and limiting referrals (61%): pre-numbered vouchers, tracking referral numbers, recalling and re-allocating unused or partially-used vouchers, capping number of referrals available to each GP;
- Monitoring and limiting referrals and putting in place systems and/or administrative procedures (29%) were ranked as the most useful demand management strategies (24%);
- There was general agreement that to be successful, demand management strategies needed to be underpinned by strong partnerships and solid infrastructure; and
- There was a concern that the need for demand management reflected that projects were insufficiently resourced, and that demand management strategies such as limiting referrals could have a negative effect on stakeholder perceptions.

Use of ATAPS evaluation reports

For the eleventh interim ATAPS report (October 2007),[22] 30-minute semi-structured interviews were conducted with three Divisional project officers whose Divisions had been funded in different funding rounds, one Division Liaison Officer, and one representative each from:

- the Australian Medical Association;
- the Royal Australian College of General Practitioners;
- the Australian Psychological Society;
- the Australian Divisions of General Practice;
- the Department of Health and Ageing; and
- the Primary Mental Health Care Australian Resource Centre.

These interviews focused on how these stakeholders were using information reported in CHPPE's evaluation reports and stakeholder suggestions for future evaluations. The findings from these interviews are summarised below.

- Common uses of the evaluation reports were:
  - to describe what was happening 'in the field' in ATAPS projects in relation to uptake, models of service delivery and referral pathways;
  - to promote the program; and
  - to update Division staff, GPs and mental health professionals about patterns of service delivery, and to describe their contribution to improved consumer outcomes.

- Sometimes the reports:
  - led to program modification to improve service delivery;
  - reassured staff that their projects were operating well in relation to others';
  - assisted organisations to create documentation about ATAPS;
  - assisted with organisations' advocacy and lobbying;
  - led to some lobbying for improved evaluation of the BOiMHC initiative;
  - confirmed that the original model of thinking for the ATAPS program - that collaboration between GPs and mental health professionals works best for all parties - was appropriate; and
  - confirmed that collecting data for evaluation purposes is important and useful.
- Several stakeholders thought that all aspects of the evaluation reports were useful and appreciated their overall quality.
- Others identified very specific components of the evaluation reports they found most useful:
  - uptake data and consumer profiles that highlighted national trends;
  - data illustrating outcomes of the projects for consumers;
  - process information such as models of service delivery; and
  - interpretation of the data provided.
- Some stakeholders believed that some higher-level decisions had been based on information from the evaluation reports, such as capping of co-payments at $30 and mental health policy reform being undertaken at the current time, including decisions regarding the expansion of ATAPS funding and additional funding for rural and remote communities.
- Stakeholders believed that the ATAPS evaluation reports had contributed to the broader knowledge base in primary mental health care, and in particular regarding the efficacy of interventions undertaken by psychologists and GPs working together. Stakeholders were confident that the collaborative model fostered through ATAPS was effective, based on the outcome data presented in the reports.
- Stakeholders thought that the consumer profile produced for the reports was of significance in providing new information on who was accessing ATAPS services. They also noted the importance of receiving information on 'what works' in terms of service delivery models, with the conclusion that service models need to be adapted to suit the local environment and that this made a wider contribution to understanding what might work in other primary mental health care settings.

Suicide prevention pilot

Between July 2009 and August 2011, three special evaluation reports were produced on the pilot of the *Suicide prevention* initiative that used qualitative evaluation methods.[39-41] The evaluation methods included a telephone survey of 19 project officers from Divisions delivering the pilot *Suicide prevention* initiative; 15-minute telephone interviews with six GPs, three mental health professionals and three emergency department staff members engaged with the pilot; and structured telephone interviews with 19 Division project officers. These evaluations aimed to identify any difficulties with implementing the pilot initiative, and the experiences of Divisions, consumers and professionals engaged with the pilot initiative. The results of these three evaluation reports are summarised below.

Table 25 outlines the barriers and negative effects of the pilot *Suicide prevention* initiative, the facilitators and positive effects of the initiative and the achievements of the initiative identified by the various stakeholders.

Service delivery models

- Specific requirements of the *Suicide prevention* initiative required many Divisions to re-evaluate their models of service delivery, operating policies and procedures. Management of consumer risk was central to these changes and patient referral pathways were a primary focus.

- To implement the initiative, Divisions either employed additional staff or increased the load of mental health professionals already providing ATAPS.

- Engagement of mental health professionals was difficult for some Divisions, due to reluctance of mental health professionals to work frequently with suicidal clients. To deal with this, some Divisions had strengthened their clinical governance framework or allowed professionals to opt in and out of providing *Suicide prevention* services as their work demands changed over time.

- Direct employment by Divisions of mental health professionals to deliver *Suicide prevention* services was more common than for Tier 1 ATAPS. By 2011, approximately equal numbers of Divisions were directly employing mental health professionals as were using external contracts. Three Divisions had contracted external agencies to deliver services.

- Under the *Suicide prevention* initiative, fewer mental health professionals were working from their own rooms than under Tier 1 ATAPS, with about 40% providing services from GP rooms, about 30% from Division rooms and 20% from community rooms. This resulted from a need to reduce the isolation of providers working with suicidal clients.

- By 2011, there had been a marked decline, from about one-half to one-quarter, in the number of Divisions using a direct referral system. This was accompanied by a simultaneous increase in the number of Divisions using a centralised, Division-based intake system staffed either by administrative staff or by a mental health professional (about three-quarters of Divisions).

Policies and procedures

- After-hours referrals were relatively rare for those Divisions that allowed them to occur. Five Divisions did not provide after-hours services.

- By 2011, 11 Divisions had created a specific policy to refer patients at immediate or acute risk to relevant crisis services. Five Divisions had arrangements with state mental health services for these circumstances and for the remaining Divisions the action taken was at the behest of the GP or mental health professional.

Engagement of referrers

- It was clear that engagement of GPs, emergency departments and mental health services, such as state services, required significant and ongoing effort on the part of the Division. These efforts were not always successful in engaging referrers, and this remained a service delivery barrier for a number of Divisions.

Suggestions for other data collection for the evaluation

Of the twelve Divisions who provided suggestions for the ongoing evaluation of the Suicide prevention initiative:

- eight wanted more information on broader and longer term impacts of the initiative on individual consumers, local suicide rates and presentations to emergency departments;

- two Divisions suggested interviewing mental health professionals; and

- one Division suggested the addition of a 'travel time to provide service' field would more accurately reflect demands on rural providers.

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

- Twelve Divisions reported that their mental health professionals used the MSSI with clients, but eleven Divisions reported negative feedback about the scale including that it did not fit with the counselling approach adopted in the first session, and was 'clumsy' and 'cumbersome'.

- Four Divisions reported that mental health professionals were using alternative tools.

Table 25: Barriers and facilitators, positive and negative effects, and achievements, of the *Suicide prevention* pilot

Barriers and negative effects	Facilitators and positive effects	Achievements
• Need to develop new policies, procedures and service delivery models to comply with operational guidelines • Significant administrative load • Lack of certainty about continuation of *Suicide prevention* initiative • Inability to engage mental health professionals to deliver services • Requirement for mental health professional mandatory training • Delays in availability of training • Poor quality of training • Reluctance of mental health professionals to regularly work with suicidal clients • Difficulties engaging GPs and other referrers to refer to the initiative • Poor communication between Division and GP • Difficulties for mental health professionals providing services within specified timeframe, especially if referral received after-hours • Challenges of service delivery in rural areas. Travel increases session costs • Difficulties with receiving referrals from GPs when clients initially referred by the emergency department - concerns over duty of care or no regular GP • Difficulties in delivering services to Aboriginal and Torres Strait Islander peoples and those who are chronically suicidal • Inability for NGOs to refer to thåe initiative • Inappropriate referrals • Funding limitations restrict use of interpreters	• Pivotal role of mental health professionals who deliver services • Positive response to the initiative of current ATAPS providers • Easy referral process for GPs • Division links made with other mental health services • Strong links with GPs and external referrers • Ability of emergency departments to refer suicidal patients directly for *Suicide prevention* services • GPs confident assessing and referring patients for services • Good communication between GP and mental health professional • GPs who participate highly value the initiative • Positive response from GPs asked to provide formal referrals for clients provisionally referred by the emergency department • Flexibility of initiative allows integration into existing Division services	• Development of new policies, procedures and service delivery models for working with suicidal clients • Filling a service gap for suicidal clients • Development of Division links with other mental health services • Reduced stigma for suicidal clients attending emergency departments • Provision of no-cost service a significant advantage • Immediacy of service response a significant advantage for clients • Referral to initiative allows clients to feel that 'someone cares' • Support provided to GPs to support suicidal patients

T-CBT pilot initiative

Two special reports on the *T-CBT* pilot initiative involving qualitative data collection were produced in August 2009 and February 2010.[36] [37] The earlier evaluation used a survey with 22 Division Project Officers to identify the models of service delivery being used by Divisions to implement the *T-CBT* pilot initiative and any difficulties with implementing the pilot. The second evaluation used an interview with 10 mental health professionals delivering *T-CBT* services to assess the benefits and challenges of providing T-CBT services. The results of these two evaluations are summarised below.

Service delivery commencement

Funding for the *T-CBT* pilot was provided in mid-2008; however, of the 22 projects, 15 commenced *T-CBT* in late 2008. These delays in service delivery were attributed to:

- the delay in availability of the Australian Psychological Society's training and
- slow uptake of the initiative by GPs.

Promotion of T-CBT

A range of strategies were used by Divisions to promote the *T-CBT* initiative, using a range of communication modalities:

- It was common for multiple strategies to be used;
- Provider newsletters and practice visits were most common; and
- No strategies were used to promote to organisations outside of ATAPS.

Facilitators and barriers to implementation of T-CBT pilot

The following were identified as facilitators to the implementation of the *T-CBT* pilot:

- positive provider response;
- flexibility in guidelines around referral mechanisms and mix of face-to-face and T-CBT;
- allowing providers and project officers to make decisions about mode of service delivery, rather than relying on GPs;
- need for psychological services to be provided remotely; and
- embedding *T-CBT* in the broader ATAPS program.

Barriers to implementation of *T-CBT* pilot were:

- low rate of GP referrals;
- preference for face-to-face services;
- telephone equipment and coverage issues; and
- funding issues related to cost of telephone calls and travel for mixed face-to-face/T-CBT.

Impact on Divisions

- Thirteen Divisions stated the impact had been positive.
- The Divisions noted positive effects and increased access for consumers.
- Three Divisions had experienced negative effects from increased workload, although they still acknowledged the benefits to consumers.

Benefits and challenges for mental health professionals

The benefits of the *T-CBT* initiative identified by mental health professionals delivering T-CBT services were:

- that appropriate referrals had been received;
- the ability to service rural and remote areas;
- greater continuity of service for rural and remote consumers;
- the ability to offer service to high-need consumers;
- positive consumer outcomes;
- convenience for consumers accessing services from home;
- quick response for consumers;
- more frequent contact with consumers; and
- the Australian Psychological Society's *T-CBT* training, which was helpful.

Challenges experienced by mental health professionals delivering *T-CBT* services were:

- Five mental health professionals had problems with referral system related to GPs' lack of response;
- Some experienced difficulties building rapport over the telephone, which was overcome by conducting initial sessions face-to-face or by learning to 'listen differently';
- Distractions for the consumer often occurred because the environment is not controlled – the mental health professional discussed strategies with the client to minimise interruptions and maximise privacy;
- Risk was managed either through the referral process or in one case through developing connections with local emergency department or after-hours services or managed solely over the telephone;
- Mental health professionals do not know what happens to consumers who do not answer their telephones, making dropout easier; and
- Negative effects for consumers were noted as arising from poor mobile reception, the need to book appointments far in advance, the paperwork required, and because of a preference for face-to-face sessions.

Low uptake

Low uptake was attributed to the challenges above, but also to: consumers opting for face-to-face sessions, even if long travel was required; staff turnover of project officers and mental health professionals; Division management issues; the need for increased marketing; and the lack of availability for training of further professionals.

Improving the pilot

Project officers felt *T-CBT* could be improved by:

- increased flexibility of guidelines;
- education of stakeholders;
- less paperwork;
- increased funding to increase number of clinicians;
- targeting GP practices where distance is more of an issue; and
- not being a temporary pilot.

Mental health professionals felt that *T-CBT* could be improved by:

- increased education and liaison with GPs as they are not aware of the initiative;
- less paperwork for consumers;
- charging a co-payment for consumers; and
- further support and training, such as making forms for mental health professionals and consumers online, offering a review training sessions to professionals, and the ability to link with others providing *T-CBT*.

Bushfire initiative

A special report on the implementation of the *Bushfire* initiative was submitted in November 2010.[43] Interviews were conducted with 10 Division Project Officers and one CEO from a total of 10 Divisions to determine the models of service delivery used to deliver the *Bushfire* initiative and the associated benefits, issues and challenges. Three mental health professionals, two case management coordinators and one GP involved in delivery of the *Bushfire* initiative also responded to a survey about their experiences with the initiative. The results of this evaluation of the *Bushfire* initiative are summarised in the following pages.

These evaluation activities assessing the *Bushfire* initiative formed part of a larger evaluation of the Australian Federal Government Mental Health Response to the Victorian Bushfires. Several papers have been published that outline the results of this evaluation.[8 79-81]

What models of service delivery are being used by the ATAPS projects delivering services to bushfire-affected consumers?

Methods of retaining mental health professionals

Most mental health professionals delivering Bushfire services were retained via contractual arrangements.

About half of the projects reported that there was no difference in their method of retention of mental health professionals for Bushfire services and Tier 1 ATAPS.

The remaining half recruited new mental health professionals to meet demand and expertise or to cover a wider geographic location.

Location of mental health professionals

- GP rooms and the mental health professionals' own rooms were most commonly used.
- Four projects delivered services at a variety of other locations.

Referral mechanisms

- The brokerage system was the most popular referral mechanism.
- Two projects had made changes to their referral systems to accommodate bushfire-affected consumers; these included a brokerage system with another Division and the use of a brokerage/ voucher system.

What are the benefits and challenges of the services for bushfire affected consumers, from the perspective of GPs/bushfire case managers and mental health professionals?

The response rate to the survey of providers, which was used to address this question, was low; therefore, the findings should be interpreted with this caveat in mind. One GP, two bushfire case management coordinators and three mental health professionals provided their views of the *Bushfire* service. These are summarised in Table 26. More advantages than disadvantages were reported.

Table 26: Advantages and facilitators, and disadvantages and barriers, regarding the *Bushfire* initiative

Advantages/Facilitators	Disadvantages/Barriers
• most appropriate avenue for the provision of primary mental health care to bushfire-affected consumers • an additional referral source • supported bushfire case managers via the accessibility of mental health professionals • offered a range of available providers • facilitated an 'immediate response' • overcame the barrier of cost to consumers • involved an easy referral process • facilitated an assessment of benefit to consumers via the review after six sessions • resulted in good feedback for GPs from providers • fostered strong collaborations with Divisions and other organisations who were easy to contact and flexible > facilitated a more flexible approach to service consumer needs > produced positive health outcomes for consumers > flexibility afforded by the service provision guidelines > opportunity to embed the specialist *Bushfire* service within the pre-existing ATAPS model of care > the responsiveness of the Department of Health and Ageing to the needs of Divisions • the goodwill and expertise of providers	• paperwork but it was conceded that this is a requirement for all areas of service delivery • difficulties associated with the referral process • having to access a GP to initiate the referral • issues in relation to remuneration of mental health professionals • need to conduct of a Division-level needs analysis • need more opportunities for stakeholders to provide the government with feedback • need for all-round enhanced communication • need more flexibility around the types of services permitted • needs increased funding for a range of activities other than direct service provision • early timing of funding was viewed as inconsistent with research evidence showing that suicide-related support needs tend to emerge later

Floods and cyclone Yasi

The results of eight interviews and one survey aimed at evaluating the experiences of Divisions and mental health professionals delivering the Floods and cyclone Yasi initiative were presented in a Special Report on the initiative submitted in August 2012.[44] The results of this evaluation are outlined below.

Initiation of service delivery

- Participating Divisions reported no delays in the commencement of service delivery upon receipt of funding. However, four agencies experienced initial delays in the receipt of funding, with three agencies indicating that early service demand had been absorbed either through Division funds or the Tier 1 ATAPS initiative.

Service delivery models

- The majority of agencies applied the existing service delivery model of Tier 1 ATAPS (in terms of referral mechanisms, the location and means of retaining mental health professionals) in the delivery of the 2010-11 *Floods and cyclone Yasi* initiative. ATAPS response services were predominantly provided by existing mental health professionals at GP rooms, with increasing use of community-based locations noted in Queensland. All Divisions received referrals from GPs, whereas consumer self-referrals and referrals from state mental health services were each received by two Divisions.

- Most Divisions utilised multiple strategies to promote the initiative to relevant stakeholders.

Response of GPs and mental health professionals

- While the GP response to the initiative appeared to be variable, ranging from little uptake to positive responses, the response of mental health professionals was reported to be overwhelmingly positive, with many appreciating opportunities for further work or volunteering assistance. There was some indication that a number of GPs were not necessarily differentiating between ATAPS initiatives, and that some GPs and mental health professionals were themselves affected by the disasters.

Facilitators and barriers to implementation

- Among the key factors facilitating effective operation of the initiative reported by Divisions were local community engagement and education, and the initiative's existing flexibilities.

- Among the reported barriers to effective operation were delays in the availability of funding, difficulties in meeting a need for more informal community-level support services through ATAPS, a lack of demand in less affected areas, as well as destroyed infrastructure, inaccessibility of flood affected areas, and the stigma surrounding mental health particularly in rural areas.

Effects of the initiative

- Overall, the initiative appeared to have had a positive impact on the majority of Divisions in that it increased capacity to provide services in affected areas and raised awareness of mental health and support options in the wider community.

Suggestions for improvement

- Suggestions for improvement raised by Divisions included enhanced flexibility to provide group and community level support and utilise funds towards other extreme climatic events, resourcing of community engagement work, as well as clearer policies, communication and consultation with Divisions in relation to disaster mental health responses.

- Support requirements raised by Divisions partly echoed these suggestions and further included a need for timely funding, the availability of more promotional materials, and facilitation of access to local communities.

Experiences of Divisions with Tier 2 ATAPS initiatives

In August 2012, CHPPE submitted a special report on Division experiences of the Tier 2 ATAPS initiatives.[47] This report summarised the results of a survey completed by 83 project officers and service managers representing 93 Divisions, assessing those Tier 2 initiatives being delivered by Divisions, influences on decisions to either implement or not implement the initiatives, and the service delivery models used. The following summary outlines the main findings from that report.

Which Tier 2 initiatives are being delivered by Divisions?

- The vast majority of Divisions (72%) reported delivering between two and four Tier 2 initiatives, with a very small minority delivering either more than six or less than two.

- The initiatives that have been available for the longest times, namely the *Suicide prevention* and *Perinatal depression* initiatives, show the highest rate of implementation, while the *Bushfire* and *Floods and cyclone Yasi* initiatives have the lowest, due to their availability to only a limited number of Divisions whose populations were affected by these events.

- The number of participants who reported that their Division was planning to deliver new initiatives was relatively low.

Is there a relationship between Division-level social indicators and the delivery of Tier 2 initiatives?

- Division-level data related to Indigenous status, age, fertility rate and avoidable mortality (suicide and self-harm) were identified from the 'Divisions of General Practice Atlas, 2012'[2] and then compared with the Divisions who self-reported delivering the relevant Tier 2 initiatives.

- Of the 20 Divisions who completed the survey and who had the highest proportion of Indigenous people among the local population (as at 2006), 12 reported that they were either currently delivering, or planning to deliver, the *Aboriginal and Torres Strait Islander* initiative.

- Of the 20 Divisions who completed the survey and who had the highest prevalence rates of young people aged 0 to 14 (as at 2010), 11 reported that they were either currently delivering, or planning to deliver, the *Child* initiative.

- Of the 20 Divisions who completed the survey and who had the highest fertility rates (number of births per woman between 2005 and 2007), 19 reported that they were either currently delivering, or planning to deliver, the *Perinatal depression* initiative.

- Of the 20 Divisions who completed the survey and who had the highest average annual number of deaths from suicide and self-inflicted injuries per 100,000 (between 2003 and 2007), 12 reported that they were either currently delivering, or planning to deliver, the *Suicide prevention* initiative.

What factors have influenced Divisions' decisions to implement or not implement each initiative?

Table 27 summarises the main influences on Divisions' decisions to implement or not implement the Tier 2 ATAPS initiatives. Responding to local community need was the primary driver for implementation of the initiatives, while a perceived lack of funding was cited as the primary factor influencing decisions not to implement certain initiatives.

What impact has the implementation of Tier 2 initiatives had on consumers and Divisions?

- The impact of the implementation of Tier 2 initiatives on consumers was almost unanimously rated by Divisions as positive or very positive. Only one participant rated the *Homelessness* initiative as having a negative impact.

- While the majority of Divisions reported that the impact on Divisions was positive or very positive, some reported that the impact had been negative, particularly for the *Suicide prevention* and *Floods and cyclone Yasi* initiatives, with about 20% of participants rating the impact of both of these initiatives as either negative or very negative.

What models of service delivery are being used by Divisions for each initiative?

Compared with Tier 1 ATAPS, where contracted or directly employed mental health professionals and a combination of these two methods were most commonly reported, within Tier 2 there was:

- a great degree of variability between the initiatives;

- a trend away from using contracted mental health professionals;

- a greater use of employed mental health professionals, either alone or in combination with the contract method; and

- minimal use of contracted organisations across all initiatives.

Table 27: Factors influencing Divisions' decisions to implement or not implement Tier 2 initiatives

	Aboriginal and Torres Strait Islander	Bushfire	Flood and cyclone Yasi	Child	Homelessness	Perinatal depression	Rural and remote	Suicide prevention
Primary factors influencing decision to implement								
Existing relationships with other services								
Local need	✓	✓		✓	✓	✓	✓	✓
Ease of integration with other services	✓		✓	✓				
Mental health professionals skilled and available		✓				✓	✓	
Interest of GPs			✓					
Interest of consumers			✓				✓	
Directive by Department of Health and Ageing				✓		✓		✓
Current service models easy to integrate					✓			
Already delivering in Tier 1							✓	
Primary factors influencing decision to not implement								
Lack of specific funding	✓			✓	✓		✓	
Administration capacity	✓			✓	✓			
Service duplication	✓							
Transition to Medicare Locals				✓				
No local need					✓		✓	

Note. Most participants reported that their Divisions were not currently running, nor planning to implement, the *Homelessness* initiative.

Client satisfaction

A Special Report dated March 2012 outlined efforts to understand if and how Divisions were measuring client satisfaction with ATAPS.[45] In April 2009, the evaluation team emailed all Divisions providing ATAPS services requesting information on the processes and measures used to collect client satisfaction data. The response rate to this email was very low, with only nine of the 105 Divisions contacted responding to the request for information. The client satisfaction assessment activities of these nine Divisions are outlined below.

How are Divisions collecting client satisfaction data?

- Mental health professionals most commonly handed out surveys during or soon after the client's last treatment session; less commonly, surveys were posted to clients by the Divisions.

- One Division provided surveys in the fourth or fifth session, another Division sent out surveys at the conclusion of treatment (which included after a last session, if the client failed to attend, or if treatment had ended prematurely).

- The surveys were then returned to the Divisions' administration staff for collation. Surveys were anonymous in each case.

What is the content of client satisfaction surveys being used by Divisions?

A question regarding overall satisfaction with the service and/or the service provider and a specific open-ended question regarding general feedback or comments were commonly included in client satisfaction surveys. However, there were few other commonalities between the surveys.

What are the findings of the client satisfaction surveys?

- There were 1,211 responses to a question related to overall satisfaction with treatment across eight Divisions, with 1,142 (94%) responses being either positive or very positive.

- The total number of surveys and overall response rate is unknown as the total number of surveys disseminated was not provided by the Divisions. However, using the number of referrals data from the minimum dataset, it was calculated that the completion rate for client satisfaction surveys distributed for six Divisions was 32% of referrals.

- Comments provided by clients on the surveys were overwhelmingly positive, commenting on the positive impact of treatment on their lives and symptoms, the quality of their service provider and the availability of the service in general.

- The relatively few negative comments made by clients were mostly regarding access to services, including the need for more than the six or 12 sessions available, long waiting times to access services and the low availability of after-hours services.

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ATAPS mental health professional workforce

In June 2011, 472 ATAPS service providers completed a workforce survey requesting information regarding their demographic and professional characteristics. The aim of this survey was to develop a profile of current ATAPS providers. This information was reported in a Special Report on the ATAPS mental health workforce in February 2013.[46] The results of this survey are summarised below.

How representative of the ATAPS mental health workforce are the survey respondents?

- Survey responses were provided by 472 mental health professionals, representing 21% of the ATAPS mental health workforce in 2010 across 80 Divisions.

- The distribution of survey respondents by state and territory mirrored the distribution of the overall ATAPS workforce, with the majority of providers being from New South Wales and Victoria.

- Survey respondents were also representative of the split between providers in rural and urban areas.

What are the demographic characteristics of ATAPS mental health professionals?

- The majority of mental health professionals were female (79%) and aged between 35 and 64 years (80%), with a mean age of 49 years.

- Mental health nurses were proportionally more likely to be males than the other professional groups.

- On average, clinical psychologists were the youngest group and occupational therapists were the oldest group of professionals.

What is the professional profile of ATAPS mental health professionals?

- The majority of survey respondents (82%) were psychologists (general, 56% and clinical, 26%), with a Master's degree being the most common highest qualification (44%).

- Time elapsed since achieving the highest qualification was on average 12.8 years, and the duration of registration was on average 12.5 years.

- The majority (93%) of respondents indicated that they belonged to the relevant professional body; for example, the Australian Psychological Society, the Australian Association of Social Workers, Occupational Therapy Australia or the Australian College of Mental Health Nurses.

What are the service delivery arrangements of ATAPS mental health professionals?

- The vast majority of mental health professionals reported that their main employment setting was independent private practice (65%).

- Seventy percent of mental health professionals were contracted to the relevant Division, 46% of all respondents provided services on a part-time basis and 38% did so on a casual/infrequent basis.

- There was no copayment charged by 80% of mental health professionals for ATAPS services; where a copayment was charged it was likely to be under $15.

- Fifteen percent of mental health professionals reported that they can deliver services in a language other than English.

- In terms of training specific to pilot/Tier 2 initiatives, 6% had completed *T-CBT* training and 18% had completed *Suicide prevention* training.

- There was substantial variation between professions in terms of the proportion of client load that arises from ATAPS, Better Access and other programs. Most mental health professionals estimated Better Access clients accounted for most of their client load. Mental health nurses and provisional psychologists estimated that the majority of their client load came from other programs.

Discussion

chapter nine

Chapter 9: Discussion

SUMMARY AND INTERPRETATION OF FINDINGS

The current report consolidates the findings of the ATAPS evaluation and the achievements across the various ATAPS initiatives over the 10-year duration of implementation.

Uptake of ATAPS by consumers

Overall, between 1 July 2003 and 31 December 2012, 351,576 (90% Tier 1 and 10% Tier 2) referrals were made to the ATAPS program. Of these referrals 277,307 (79%) resulted in sessions of care. In total, 1,432,130 (90% Tier 1 and 10% Tier 2) sessions of care were delivered via ATAPS, making the average number of sessions per referral 5.2.

The uptake of the ATAPS program overall has incrementally increased for each financial year since its inception, with the exception of a temporary drop in 2007-2008 following the introduction of the Better Access program, possibly attributable to GP confusion about the two programs and whether the latter had replaced the former. Similarly, the uptake of the individual Tier 2 initiatives has increased over time since their respective introductions, with the exception of the time limited T-CBT pilot and the extreme climatic events initiatives. The latter may be explained by the deleterious psychological impacts of natural disasters receding over time.

Participation in ATAPS by professionals

Between 1 July 2003 and 31 December 2012, 32,076 professionals referred consumers to ATAPS, with the number of referrers increasing during each financial year from 1,716 in 2003-2004 to 13,137 in 2011-2012. GPs continue to comprise the vast majority of ATAPS referrers (88%) and are likely to account for much of the unrecorded referrer type data (11%), with GPs comprising 9,416 of 9,637 professionals referring to ATAPS in the current financial year.

Between 1 July 2003 and 31 December 2012, 7,300 mental health professionals delivered ATAPS services to consumers. Like referrers, the number of mental health professionals delivering services has shown an overall pattern of increase, but at a slower rate. There were 609 mental health professionals delivering services in 2003-2004 and around 3,000 in the most recent two financial years, including the current half-complete year.

Sociodemographic and clinical profiles of ATAPS consumers

Sixty-seven percent of consumers of the ATAPS program were female, and the overall mean age was 37 years. Approximately 3% of consumers were reported to be Aboriginal and 0.5% to be Torres Strait Islander, which appears to be a reasonable uptake given that Aboriginal and Torres Strait Islander peoples accounted for 2.5% of the Australian population in the 2011 census.[82] In the context that there are large discrepancies in the mental health and emotional wellbeing of Aboriginal and Torres Strait Islander Australians compared with other Australians,[83] it seems appropriate that their access to ATAPS has increased over time from 2.2% in 2003-2004 to 7.2% in 2013-2013. Children aged zero to 11 years accounted for 3.5% of all referrals. Over half of all consumers (60%) were reported to be on a low income and about one third (36%) had no history of mental health care, suggesting that ATAPS is appropriately targeting disadvantaged people and improving access to mental health treatment for those in need who might not otherwise access psychological care. English was the most commonly reported language spoken at home (83%), with low levels of other languages reported suggesting that ATAPS could better target culturally and linguistically diverse populations. Overall, the most common diagnoses were depression (54%) and anxiety disorders (41%), which is consistent with the intended clinical profile of ATAPS consumers.

The profile of Tier 2 consumers varied significantly between the initiatives. Males were more strongly represented in the *Homelessness* and *Child* initiatives (56% and 51%, respectively). Among currently operating Tier 2 initiatives, the *Bushfire* initiative consumers were the oldest and *Perinatal depression* initiative consumers were the youngest (42 vs. 30 years), with the obvious exception of *Child* initiative consumers (11 years). Consumers of the *Homelessness, Aboriginal and Torres Strait Islander* and *T-CBT* initiatives were most likely to be reported to be on a low income (89%, 74% and 72%, respectively). With the exception of the *Child* initiative, consumers of the *Floods and cyclone Yasi* initiative were least likely, and those of the *Bushfire* initiative most likely, to have previously accessed psychiatric services (30% and 46%, respectively). Not surprisingly, the *Child* initiative reported the highest percentage of referrals for children aged 0 to 11 years (59%), while the *Floods and cyclone Yasi* initiative also reported a relatively high number of referrals for children (8%).

While depression and anxiety disorders were the most common diagnoses across all Tier 2 initiatives, there was some variability in the most common diagnoses across initiatives. For example, the highest prevalence of depression was reported in consumers of *T-CBT* (85%) followed by the *Perinatal depression* (62%) and *Suicide prevention* (60%) initiatives. Anxiety disorders were reported by more than half of the consumers of the *Bushfire* and *T-CBT* initiatives (51% and 65%, respectively), and by 42% or more of consumers of each of the *Aboriginal and Torres Strait Islander, Child*, and *Rural and remote* initiatives. Consumers of the *Homelessness* and *Aboriginal and Torres Strait Islander* initiatives reported a somewhat higher prevalence of alcohol and drug use disorders (21% and 13%, respectively). Psychotic disorders were most prevalent among consumers in the *Floods and cyclone Yasi* and *Homelessness* initiatives (7% and 6%, respectively). Unexplained somatic disorders were reported relatively infrequently across all ATAPS initiatives and were highest among consumers of the *Child* initiative (2%).

While the overall sociodemographic and clinical profiles of consumers have remained relatively stable over time, the introduction of the Tier 2 initiatives has instigated some variability. The proportion of male consumers has increased over time from 25% in 2003-2004 to 33% in 2012-2013. While less than 1% of consumers in 2003-2004 were aged 0-11 years, in 2012-2013 the prevalence of consumers aged 0-11 years has increased to 5%. The proportion of Aboriginal consumers has increased over time, ranging from under 2% in 2005-2006 to around 6% in 2012-2013, with a similar trend apparent in the prevalence of Torres Strait Islander consumers. The prevalence of previous psychiatric care fluctuated, with consumers in 2003-2004 and 2007-2008 the least likely to have previously used psychiatric services (32%) and consumers in 2011-2012 and 2012-2013 most likely to have used services (41% and 40% respectively). The fact that more consumers had previously accessed psychiatric care in recent years is not necessarily negative; it may reflect previous services via ATAPS specifically or improved mental health literacy and reduced stigma associated with seeking mental health care in general among Australians. The prevalence of consumers on a low income also increased over time from 54% in 2003-2004 to 71% of consumers in 2012-2013.

Depression and anxiety disorders were common across all financial years, with depression reported by more than half of all consumers in each financial year. The highest rate of depression was reported in 2004-2005 (59%) and the lowest prevalence in 2008-2009 (52%). Anxiety disorders were reported by 40% or more consumers across most financial years. Psychotic and unexplained somatic disorders were reported relatively infrequently, with the former somewhat increasing and the latter decreasing, across all years.

Nature of the treatment received by ATAPS consumers

Overall and within Tier 1, sessions of 46-60 minutes have been the most common, accounting for 80% of sessions. Similarly, across all Tier 2 initiatives sessions of 46-60 minutes have also been the most popular. Sessions of less than 30 minutes have been more common within several of the Tier 2 initiatives compared with the Tier 1 (2%) initiative, particularly the *Suicide prevention* (10%) and *Homelessness* (9%) initiatives, possibly attributable to immediate and brief crisis interventions that may be more prevalent in these target groups. The majority of Tier 2 initiatives have delivered sessions to individuals; however, group sessions appear to have been particularly common in the *Aboriginal and Torres Strait Islander* and *Perinatal depression* initiatives (10% and 8%, respectively), which may be associated with cultural norms of involving the community in the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples,[84] and the relatively higher homogeneity in the psychological issues with which women with perinatal depression present.

For the 203,412 sessions where a copayment was incurred (i.e., $1 or more), the mean copayment amount was $18.15 (S.D. $22.30). The national mean cost to consumers per session (including sessions which did not incur a copayment) for the 1,032,531 sessions where this co-payment information was provided was $3.58 (S.D. $12.26). The majority of Tier 2 sessions did not incur a copayment and were less likely to do so than Tier 1 sessions. Consistent with the intentions of the ATAPS guidelines to improve access, copayments are not incurred for most services and where a copayment is incurred it is typically less than $30. However, there are some variations in copayment data, the accuracy of which is questionable. For example, there are infrequent occasions of recorded copayments exceeding $30, which at times reflect the full cost incurred by the Medicare Local for those sessions rather than just the amount incurred by the consumer, and at other times reflect the total cost for all sessions incurred by the consumer rather than the cost of an individual session. There are also known data entry errors in this field.

Across Tier 1 and Tier 2, CBT-based cognitive and behavioural interventions continue to be the most common interventions delivered. However, there are some nuances among the Tier 2 initiatives. For example, psycho-education was more common than behavioural interventions in the *Rural and remote* initiative (46% vs. 30%). Psycho-education and interpersonal therapy have been frequently delivered across all initiatives, with both being particularly utilised in the *Bushfire* initiative and the former in the *Rural and remote* initiative.

While the treatment characteristics have remained relatively consistent over time, there are some nuances. For example, sessions of 45 minutes duration or less accounted for 13% of sessions in 2003-2004 but less than 6% since 2005-2006. The ability to deliver sessions via modalities other than face-to-face was introduced to the initiative guidelines and the minimum dataset in 2008-2009, with telephone sessions increasing from 0.2% at this time to 1.3% in 2012-2013. In comparison to earlier years, a smaller percentage, 10% or less, of consumers were charged a copayment in recent years. Narrative therapy, family therapy, parent training in behaviour management and play therapy account for 2% or less of interventions used in financial years since their introduction in 2009-2010, which is not surprising, given that these interventions are limited to use in specific initiatives, such as the use of narrative therapy for Aboriginal and Torres Strait Islander peoples and play therapy in the *Child* initiative.

Outcomes of ATAPS for consumers

Pre- and post-treatment outcome data were available for 32,792 Tier 1 consumers (13% of the 250,001 who received sessions), 303 *Bushfire* consumers (15% of 1,965), 139 *Child* consumers (3% of 4,648), 77 *Homelessness* consumers (4% of 1,926), 930 *Perinatal depression* consumers (15% of 6,428) and 831 *Suicide prevention* consumers (10% of 8,313). The remaining Tier 2 initiatives did not have sufficient data to be included in the analyses, which is expected given their relative infancy. Across all of the 13 most commonly used standardised outcome measures, the mean difference was statistically significant and indicative of clinical improvement. Despite the low rate of available pre- and post-treatment outcome measures, these findings indicate that the Tier 1 initiative is continuing to achieve, and the Tier 2 initiatives for which data were available are achieving, the intended objective of the initiative in which they are embedded, namely better outcomes in mental health.

Lessons learned about processes, impacts and outcomes

In addition to quantitative uptake and outcome data from the minimum dataset, the evaluation has sought qualitative data on the processes, impacts and outcomes of ATAPS in order to highlight the achievements and challenges of implementing the program. Specifically, over the life of ATAPS, we have enquired about the models of service delivery, the early implementation experiences of Tier 1 and selected Tier 2 initiatives, demand management strategies, client satisfaction and the ATAPS mental health professional workforce.

A multitude of combinations of models across three dimensions - retention of mental health professionals, locations of service delivery and referral mechanisms - have been used to implement ATAPS and these have been suited to the local context. Across these three dimensions the most popular models have included direct referral from GP to mental health professionals, contractual arrangements for retention of mental health professionals and use of mental health professionals' and GP rooms for the delivery of services. The models of service delivery have not affected consumers' access to services, nor the positive outcomes achieved. A range of advantages and disadvantages of the various models of service delivery have been identified from the perspectives of Divisions, GPs, mental health professionals and consumers.

The majority of mental health professionals providing treatment via ATAPS are female (79%) and aged between 35 and 64 years (80%), with a mean age of 49 years. The majority (82%) are psychologists (general, 56% and clinical, 26%), with a Master's degree being the most common highest qualification (44%).

Early experiences implementing Tier 1 and Tier 2 ATAPS initiatives have often included early 'teething' issues, such as unfamiliarity with the program and various administrative issues, which seem to generally iron out with time. Furthermore, such challenges seem to be outweighed by the positive impact on professional and/or organisational collaboration to improve consumer access to and outcomes derived from the psychological services offered via ATAPS. Divisions have variably assessed consumer satisfaction, with the available consumer feedback about ATAPS being overwhelmingly positive, particularly with respect to the positive impact of treatment on their lives and symptoms, the quality of their service provider and the availability of the service.

The Tier 1 ATAPS initiative has offered an effective infrastructure in which to embed the newer Tier 2 initiatives. Among the Tier 2 initiatives for which qualitative data have been obtained, the *Suicide prevention* pilot and the extreme climatic events ATAPS initiatives appear to have been particularly well received and to have produced positive results for consumers. While the uptake of the T-CBT pilot was low, the ability to offer sessions by telephone was seen to improve access for consumers and the impact on Divisions was reported as mostly positive, with multi-modal service delivery now integrated in the suite of ATAPS initiatives. To date, qualitative data have not been obtained regarding the remaining Tier 2 initiatives. However, three upcoming

special evaluation reports on the *Suicide prevention*, *Child* and *Aboriginal and Torres Strait Islander* initiatives will incorporate qualitative data collection activities.

Division-level population data related to Indigenous status, age, fertility rate and avoidable mortality (suicide and self-harm) from the 'Divisions of General Practice Atlas, 2012' indicated that more Divisions should be targeting Aboriginal and Torres Strait Islander peoples, children, and people at risk of suicide and self-harm as indicated by having the highest prevalence of these target groups, but that women with perinatal depression were appropriately accessing ATAPS.

Given the capped nature of ATAPS funding, demand management is likely to be an ongoing issue. Potentially effective demand management strategies include educating GPs about the eligibility criteria for ATAPS and alternative treatment pathways, and centralised triage of referrals.

Stakeholders have valued the evaluation outputs and have used interim evaluation reports for a variety of practical purposes, such as promoting the program; and updating Division staff, GPs and mental health professionals about patterns of service delivery and describing their contribution to improved consumer outcomes.

LIMITATIONS

Some caution should be exercised in interpreting the above findings. There are lags in data entry into the minimum dataset, with some Medicare Locals not entering session data until all sessions for a given consumer are complete, which may impact on data reported for the current financial year. Furthermore, the complexities associated with the transition from Divisions to Medicare Locals may have resulted in an underestimate of the data for the 2011-2012 financial year.

The average number of sessions per consumer is likely to be an underestimate, as Medicare Locals (formerly Divisions) differ in their ability to identify re-referrals for the same consumer (i.e., the continuation of sessions following the GP review), which means they may inadvertently assign a given consumer both a new patient identification number and referral number after the initial six sessions.

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

There is also a significant amount of missing data in relation to some variables and some data fields which have been more recently added to the minimum dataset to accommodate the introduction of the Tier 2 initiatives which need to be taken into consideration when interpreting the data. Furthermore, given the 'real-world' nature of the evaluation, Tier 2 service delivery commencement in response to policy changes has often preceded commensurate decisions about, and implementation of, changes to the minimum dataset. Medicare Locals are likely to differ in the way that they manage this challenge, and we are unable to determine whether Medicare Locals that upload their data have kept up with the pace of changes to the minimum dataset in terms of updating their internal data capture systems. Also, despite the achievements of the Tier 2 initiatives, their impact has been reported in isolation from local needs analyses and community profiling, prohibiting comment on the true magnitude of their achievements or their reach within the intended target consumer group.

It was not possible to evaluate the consumer outcomes achieved across all of the ATAPS initiatives because of the insufficient numbers of consumers with pre- and post-treatment outcome data. The proportion of consumers for whom pre- and post-treatment outcome data were available was less than

optimal ranging from about 3% to 15% in six of the ten ATAPS initiatives. It is possible that this may have introduced a systematic bias, such that those for whom no outcome data were available may have had poorer outcomes (if, for example, outcome data were unavailable because they dropped out of treatment). The findings still stand, but they may present a somewhat overly-optimistic picture. At the very least, it is possible to say with certainty that the outcomes of care from the six ATAPS initiatives included in the analyses are excellent for the thousands of patients observed here. From an evaluation perspective, more comprehensive collection and collation of outcome data would be desirable, as would rationalising the number of outcome measures used by Medicare Locals. Strengthening the ATAPS outcome data collection in this way would enable more definitive statements about the achievements of ATAPS to be made.

CONCLUSIONS

The current report indicates that the ATAPS program, delivering services to a substantial number of consumers, continues to be an integral part of the primary mental health care system in Australia. The profile of Tier 1 consumers and the care they are receiving has been relatively consistent over time. The majority are women with high prevalence disorders. Strategies usually involve CBT-based cognitive and behavioural interventions, which are typically delivered to individuals in sessions of one hour in duration. Most importantly, the Tier 1 initiative is continuing to achieve considerable positive clinical outcomes for consumers.

The outcome data, where available, show that the Tier 2 initiatives are also producing significant clinical improvement for consumers. The socio-demographic and diagnostic data indicate that the Tier 2 initiatives have been successful in reaching their intended target consumer groups in that their profiles differ somewhat from Tier 1 consumers. This suggests that Tier 2 ATAPS continues to carve an important niche by successfully addressing the unmet need of specific and/or hard-to-reach consumers and through means that are not available via Tier 1 or the Better Access program.

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Appendix A: Description of most commonly used outcome measures for consumers of ATAPS

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

Measure	Description
HADS	Patient-rated measure developed to detect anxiety and depression in a non-psychiatric hospital setting. Comprises 14 items, seven of which are concerned with anxiety and seven of which are concerned with depression. Each item is scored from 0 to 3, where 0 indicates low levels of symptomatology in the previous week and 3 indicates high levels. Total scores range from 0 to 42. A positive difference between pre- and post-treatment scores indicates improvement.
HoNOS	Clinician-rated measure of severity of symptoms in people with a mental illness which covers the previous two weeks. Comprises 12 items that collectively cover the sorts of problems that may be experienced by people with a mental illness. Each item is rated from 0 (No problem) to 4 (Very severe problem), resulting in a total score that can range from 0 to 48. A positive difference between pre- and post-treatment scores indicates improvement.
K-10	Patient-rated measure developed to assess non-specific psychological distress. Comprises 10 items which ask the patient about symptoms of depression and anxiety in the past four weeks. Each item is rated from 1 (None of the time) to 5 (All of the time), resulting in a total score that ranges from 10 to 50. A positive difference between pre- and post-treatment scores indicates improvement.
MSSI	Clinician-rated measure of suicidal ideation representing a modified version of the Scale for Suicidal Ideation (SSI) developed by Beck and colleagues.85 Comprised of 18 items, 13 from the original SSI and five that are new, the first four of which serve as screening items. Each of the 18 items is rated on a 4-point Likert scale ranging from 0 to 3, which are summed to yield a total score ranging from 0 to 54, with negative items reverse scored so that higher scores indicate higher suicidal ideation. A positive difference between pre- and post-treatment scores indicates improvement.
ORS	Patient-rated measure of general wellbeing, personal wellbeing, family relationships and social relationships since the last contact. Comprises four statements on a visual analogue scale ranging from 'Low' at one end to 'High' at the other. This yields four separate scores between 0 and 100 using a millimetre for scale measurement. A negative difference between pre- and post-treatment scores indicates improvement.
SDQ	There are various versions of this measure; the parent-rated version for children aged 0 to 14 years is the one applicable here. Comprises five scales (emotional symptoms, conduct problems, hyperactivity, peer problems, of 5 items each, which are rated on a three-point scale from 0 (not true) to 2 (certainly true). A total difficulties score, ranging from 0 to 40, is generated by summing the scores from all the scales except the prosocial scale. A positive difference between pre- and post-treatment scores indicates improvement.
SRS	Patient-rated measure of relationships, goals and topics, approach and method, and overall session rating. Comprises four visual analogue scales yielding four separate scores between 0 and 100 using a millimetre for scale measurement. A negative difference between pre- and post-treatment scores indicates improvement in these areas.