Title:

Evaluation of an Australian primary care telephone cognitive behavioural therapy pilot

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Abstract

A telephone-based cognitive behavioural therapy (T-CBT) pilot project was trialled from July 2008 to June 2010, via an Australian Government funded primary mental health care program. A web-based minimum dataset was used to examine: level of uptake; socio-demographic and clinical profile of consumers; precise nature of services delivered; and consumer outcomes. Key informant interviews with 22 project officers and 10 mental health professionals elicited lessons learnt from the implementation of the pilot. Overall, 548 general practitioners referred 908 consumers, who received 6,607 sessions (33% via telephone). The sessions were delivered by 180 mental health professionals. Consumers were mainly females with an average age of 37 years and had a diagnosis of depressive and/or anxiety disorders. A combination of telephone and face-to-face sessions of one hour in duration were conducted, delivering behavioural and cognitive interventions, usually with no cost to consumers. Several implementation issues were identified by project officers and mental health professionals. Although face-to-face treatment is preferred by providers and consumers, the option of the telephone modality is valued, particularly for consumers who would not otherwise access psychological services. Evidence in the form of positive consumer outcomes supports the practice of multimodal service delivery.
The Better Outcomes in Mental Health Care program was introduced in July 2001 by the Australian Department of Health and Ageing in response to low treatment rates for common mental disorders, and has been operating since then. The Access to Allied Psychological Services (ATAPS) component of this program supports general practitioners (GPs) and mental health professionals (psychologists, mental health nurses, occupational therapists, social workers and Aboriginal and Torres Strait Islander health workers) to collaborate to provide optimal primary mental health care. Specifically, the ATAPS component enables GPs to refer consumers with high prevalence disorders (e.g., depression and anxiety) to mental health professionals for six to 12 (or up to 18 in exceptional circumstances) individual and/or group sessions of evidence-based mental health care (predominantly cognitive behavioural therapy, or CBT). Review of the consumer’s treatment progress by the referring GP is essential, particularly if more than six sessions are required. The ATAPS program is implemented nationwide by all 110 General Practice Networks (GPNs), which are primary health care organisations.

Since 2008 several sub-programs have been introduced that focus on particular at-risk populations (e.g., women with perinatal depression, people at risk of suicide, people affected by specific disasters), which are now known as Tier 2 services. The original ATAPS services are now known as Tier 1.

One such Tier 2 program was the telephone-based CBT (T-CBT) pilot, which was funded by the Australian Government in mid-2008. The trial involved substituting and/or combining T-CBT for face-to-face services in 22 GPNs under the existing ATAPS model. This was the first time that the use of the telephone as a treatment modality had been officially approved by the Australian Department of Health and Ageing for GPNs to use. It can be assumed that prior to this the sessions of care delivered through the ATAPS projects were primarily face-to-face. With one exception, the T-CBT pilot projects were implemented in rural and remote GPNs across Australia.
For unknown reasons, GPNs not funded to do so, also commenced delivering sessions by telephone. For the purpose of this paper, which evaluates T-CBT, telephone-related data from these GPNs is included in order to present an accurate picture of the real-world effects of the telephone modality. The Australian Psychological Society was contracted to develop and deliver training, which took the form of a single 3-hour remote facilitator-led webinar delivered on multiple occasions to different providers, to ensure that all participating mental health professionals were adequately equipped to deliver CBT by telephone.

The rationale for the introduction of the T-CBT program was to improve accessibility for selected consumers in rural and remote settings or who for various reasons experienced barriers to seeing a clinician face-to-face. Other advantages of remote psychological treatment include: safety, anonymity, reduced stigma, more options of therapists and affordability (Centore and Milacci, 2008). The decision to implement the T-CBT program was influenced by existing evidence reporting on the efficacy of the telephone modality in the psychological treatment of high prevalence mental disorders (Bee et al., 2008; Lovell et al., 2006; Richards et al., 2008). A UK study found a moderate to large effect of a collaborative care approach to supporting depressed patients in a primary care setting which involved telephone support (Richards et al., 2008). A meta-analysis of psychotherapy mediated by remote communication technologies examined amongst others 10 studies of telephone psychotherapy and concluded that this modality may confer specific benefits but that more rigorous trials are required (Bee et al., 2008). A randomised controlled trial of T-CBT for the treatment of obsessive compulsive disorder reported equivalent outcomes and levels of satisfaction to face-to-face treatment (Lovell et al., 2006).

The University of Melbourne’s Centre for Health Policy, Programs and Economics has been evaluating the Tier 1 ATAPS projects and Tier 2 sub-programs since their respective introductions. This paper describes the findings of the evaluation of the T-CBT pilot in a real-world primary care setting.
program. Specifically, it describes the level of uptake by GPs, mental health professionals and consumers; the socio-demographic and clinical profile of these consumers; and the precise nature of services delivered. In addition the outcomes achieved and lessons from implementation issues are reported.
Method

A web-based minimum dataset was developed early in the life of the broader evaluation of ATAPS. The dataset captures the number of participating providers, de-identified consumer- and session-level information, and pre- and post-treatment scores on standardised outcome measures. Two new T-CBT fields were added to the minimum dataset: a field which flags a given consumer as having been referred for T-CBT and a session modality field which identifies whether a session was delivered face-to-face, by telephone or via videoconference. Data from the minimum dataset for consumers in receipt of at least one session delivered by telephone were extracted on 4 July 2011. The analysis period was from 1 July 2008 (when the T-CBT pilot was first ‘rolled out’) to 30 June 2010 (when the pilot ended).

On receipt of verbal consent, telephone interviews were conducted with one ATAPS project officer from each of the 22 GPNs involved in the T-CBT pilot in June/July 2009. The interviews elicited qualitative data about issues related to implementation, such as: facilitating and hindering factors, impact, benefits and challenges, and suggestions for improvement.

Telephone interviews were also conducted with one mental health professional from 10 of the 22 GPNs involved in the T-CBT pilot in late 2009/ early 2010. The interviews gathered qualitative data about the perceived benefits and challenges of the T-CBT pilot. Mental health professionals were (and GPs were unsuccessfully attempted to be) recruited via project officers from the GPNs participating in the T-CBT pilot on behalf of the evaluators. A random selection of project officers from 11 GPNs was sent an email providing information about the evaluation and a recruitment pack consisting of a plain language statement and consent form, with instructions to invite two mental health professionals each. This was followed up by telephone calls to project officers.
from each of the GPNs for whom at least one mental health professional had not returned a consent form directly to the evaluators.

All interviews were brief (approximately 30 minutes) and structured open-ended questions were asked. Refer to Appendix 1 for the interview protocols. Interviews were conducted by one of two researchers. Responses were recorded in writing by the relevant interviewer during the interviews.

Data analyses

Consumers contributed data to the analyses of data from the minimum dataset if they were identified in the minimum dataset as either having been referred for T-CBT or had received at least one session by telephone. This was considered the most appropriate strategy in order to present an accurate picture of the overall achievements of T-CBT, and the use of the telephone as a session modality in general. Descriptive analyses of the uptake of telephone sessions and consumer- and session-profiles were conducted, with the results presented as simple frequencies and percentages. Trends in the consumer and session-profiles were observed but significance tests were not performed because of the exploratory nature of these findings. Paired t-tests were used to examine the difference between mean pre- and post-treatment scores on selected outcome measures. Consumers who did not have a ‘matched pair’ of pre- and post-treatment scores were excluded.

Qualitative data from the interviews with project officers and mental health professionals were examined using template analysis to organise the data into themes (King, 2004). This involved developing a coding “template” to summarise and organise salient themes as they emerged from the data. As recommended by King (2004), the process began with the identification of some
broad, a priori themes which paralleled the questions asked in the interview. Transcripts were read and re-read with these themes in mind, and segments of text were coded as belonging to these themes. During this process, additional broad themes were identified and portions of text were coded as being relevant to these new themes. Once the final set of broad themes was settled upon, the text relating to each theme was re-examined, and narrower themes were identified and coded. The complete set of broad and narrow themes then formed a template that was applied across all transcripts. This process was iterative, and each transcript was read a number of times. Cross-coding of the transcripts would have been desirable, but this was beyond the scope of the current study. The frequency of respondents generating each theme is presented in order to gauge the extent to which certain issues affected the GPNs and providers conducting the T-CBT pilot.

Results

Uptake of T-CBT

Uptake data were available for 59 GPNs. In the period between 1 July 2008 and 30 June 2010, 548 GPs (63% rural; 37% urban) referred consumers and 180 mental health professionals (65% rural; 35% urban) conducted sessions.

In total, 908 (67% rural; 33% urban) consumers had received at least one telephone session. The total number of sessions delivered to the 908 consumers was 6,607 (67% rural; 33% urban) making the average number of sessions provided to consumers 7.3 (S.D. = 6.3). The majority of these sessions (76%) were delivered via Tier 1 ATAPS and 24% via the different Tier 2 sub-programs including the T-CBT pilot.
Figure 1 presents the number of referrals made and total number of sessions delivered to consumers in receipt of at least one telephone session, by month from 1 July 2008 to 30 June 2010 in rural and urban areas, respectively. The figure shows steady increases in uptake of services by these consumers, with this trend being more pronounced in rural areas.

[SOCIODEMOGRAPHIC AND CLINICAL CHARACTERISTICS OF CONSUMERS]

Table 1 summarises the key characteristics of consumers in receipt of one or more telephone sessions, as well as a comparison of rural and urban consumers. The majority of consumers in both rural and urban areas were females (66%) however males were somewhat more represented in urban areas (31% vs 26%). The average age of consumers was 37 years, with a somewhat younger average age in urban compared to rural areas (34 vs 38 years). Over half were on low incomes as identified by their GPs. Approximately one third of all consumers had not received any previous mental health services. More rural consumers were Aboriginal than their urban counterparts (12% vs 4%). The majority of consumers were diagnosed with depressive (52%) and/or anxiety (34%) disorders; however depression was more common in urban than rural consumers (65% vs 45%). A higher proportion of rural than urban consumers was diagnosed with alcohol and drug, psychotic and unexplained somatic disorders.

[SOCIODEMOGRAPHIC AND CLINICAL CHARACTERISTICS OF CONSUMERS]
Session characteristics

Table 2 describes the characteristics of the overall care received by consumers in receipt of telephone sessions; the session data are separated by both modality (telephone and face-to-face) and rurality. Overall, the majority of sessions (51%) were 46-60 minutes in length; sessions of this duration were least likely when delivered via telephone in urban areas (14%). Telephone sessions were more likely to be less than 30 minutes, particularly if delivered in urban areas (74%). The vast majority of all sessions were delivered to individuals (95%), however group sessions were somewhat more likely if delivered face-to-face than by telephone (2% vs 1%).

Overall, cognitive and behavioural interventions were most frequently used (30% and 25%), particularly if delivered face-to-face and in urban areas (38% and 31%). Psycho-education and interpersonal therapy were more commonly delivered in rural areas irrespective of modality (24% vs 15% and 27% vs 16%, respectively). Skills training and relaxation were least likely if sessions were delivered by telephone and in urban areas (3% and 5%). Although it appears that there is a high proportion of missing data in terms of copayment, it is likely that data was not entered if there was no copayment. The majority (54%) of sessions did not incur a copayment, particularly sessions delivered by telephone in urban areas (81%).

Consumer outcomes

One hundred and sixty (17.6%) consumers had pre- and post-treatment scores on at least one outcome measure. Of these, 18 consumers had been assessed with the Behaviour and Symptom Identification Scale 32 (BASIS-32; Eisen, 1986), 56 with either the Depression Anxiety and Stress
Scales (DASS)- 21 or -42 item version (Lovibond and Lovibond, 1995), 46 with the Health of the Nation Outcome Scales (HoNOS; Wing et al., 1998) 45 with the Kessler-10 (K-10; Kessler et al., 2002) and 40 with the Modified Scale for Suicidal Ideation (MSSI; Miller et al., 1986). Because there were insufficient consumers with pre- and post-treatment scores on each of the outcome measures, it was not considered to be statistically meaningful to compare consumer outcomes according to rurality or the number of sessions received by telephone. However, the majority of consumers included in the outcomes analysis had received between three and 12 sessions overall (mean = 9.0, SD = 5.1), of which between one and 10 sessions had been delivered by telephone (mean = 3.0, SD = 2.9). Consumers excluded from the outcomes analysis on the basis of absence of matched pre-and post-treatment outcomes data had received between one and 12 sessions overall (mean 7.6, SD = 5.9), of which between one and 10 had been delivered by telephone (mean = 2.7, SD = 3.3).

Table 3 shows the mean pre-treatment, mean post-treatment, and mean difference in pre- and post-treatment scores on the BASIS-32, three DASS subscales, HoNOS, K-10 and MSSI. With the exception of the DASS, the mean differences were based on total scores; in the case of the DASS, the mean differences were based on scores for each of the three subscales. A positive difference between pre- and post-treatment is indicative of improvements in symptoms on all of the scales. Across all measures, the mean difference was statistically significant and indicative of clinical improvement.

[INSERT TABLE 3]
Implementation issues identified by project officers in pilot GPNs (N = 22)

Service delivery commencement

Fifteen project officers reported that they commenced T-CBT service delivery in late 2008. Nine project officers reported that there was a delay in the commencement of service delivery, which was most commonly attributed to the corresponding delay in the availability of the Australian Psychological Society webinar training for mental health professionals. Another explanation provided was the slow uptake by GPs, which was problematic in the context of the original guidelines having been perceived to be specifically reliant on GPs suggesting T-CBT to consumers.

Promotion of T-CBT service

Project officers indicated that they used a wide range of strategies to promote the T-CBT service. These strategies made use of all communication modalities – from hardcopy, electronic, telephone, to face-to-face. It was common for multiple strategies to be used, with provider newsletters and practice visits being the most commonly reported promotion strategies (n = 12 and 8, respectively). Interestingly, none of the project officers specifically mentioned promoting the service to other community and health organisations not directly involved in ATAPS.

Factors that facilitate and potentially enhance the T-CBT pilot

Of the 14 project officers who reported on facilitating factors, four indicated that positive provider responses facilitated the T-CBT pilot as demonstrated by this quote: “excellent clinicians who are enthusiastic and GPs who are open minded”. In addition, the flexibility of the guidelines around the referral mechanism and multimodal (i.e., the ability to combine telephone and face-to-face) service delivery was considered to facilitate the T-CBT pilot. In particular, allowing mental health professionals and project officers to make decisions about the (T-CBT) mode of service delivery, rather than relying on GPs to suggest T-CBT to consumers, was regarded as
beneficial. Furthermore, the need for counselling services to be provided remotely and the fact that the service was embedded within ATAPS were reported to facilitate the pilot.

Barriers to the effective operation of the T-CBT pilot

The most commonly mentioned barrier (n = 9) was the low rate of GP referrals, which was attributed to difficulty convincing GPs to use the service, which in turn, was probably attributable to their (and consumers’) preference for face-to-face treatment. This was exemplified by one project officer stating that “patients prefer to wait for face-to-face sessions”. It was expressed that over time patients might increasingly accept the T-CBT service option. Telephone equipment / coverage issues and the additional paperwork were the next most, and equally, frequently cited barriers (n = 5). Funding issues were reported as barriers by three project officers, particularly in terms of the cost of telephone calls and travel costs associated with mixing T-CBT with some face-to-face sessions.

Impact of T-CBT pilot on GPNs

Thirteen project officers indicated that the T-CBT pilot had had positive impacts for the GPN. The flexibility and option of the mode of service delivery, and in turn, its benevolent effect of increasing accessibility for consumers that may otherwise experience difficulties accessing psychological services, was the most frequently mentioned positive impact of the T-CBT pilot for GPNs (n = 11). Three project officers expressed that the T-CBT pilot had had negative impacts for the GPN in terms of additional workload. Nonetheless, the value of the T-CBT pilot was acknowledged as the majority of project officers expressed a desire for the service to continue.
Benefits and challenges of the pilot reported by mental health professionals in pilot GPNs (N = 10)

Of the 10 mental health professionals, representing 10 GPNs, who took part in the purpose-designed interviews, six were psychologists; two were social workers; and one each reported being a psychiatric nurse and a psychotherapist/sociologist/counsellor. Four mental health professionals reported that they had not delivered T-CBT services to any consumers via the pilot, although one of these reported providing telephone services to many consumers external to the T-CBT pilot.

Benefits of T-CBT

Seven professionals reported benefits associated with T-CBT. Overall, mental health professionals reported that the referrals received for T-CBT were suitable for this type of service. Three professionals viewed the ability to service rural or remote areas and provide a greater continuity of service to consumers in these areas who “wouldn’t be seen otherwise” due to access issues as a benefit. The ability to offer high need consumers telephone contact was also perceived positively by two professionals, with one professional stating: “it’s certainly beneficial for those who can’t or don’t want to attend face-to-face”. Three professionals commented that consumer outcomes had been good within the pilot and that consumers were reporting the services to be helpful. Other perceived positive impacts included that the project provided: a convenience for the consumer who can access the services from home, a quick response for consumers, and more frequent contact for consumers. Eight of the ten interviewed professionals said that the mandatory Australian Psychological Society webinar training had been helpful.
Managing challenges associated with T-CBT

Of the seven professionals who provided responses related to the referral process, two reported that the referral process was satisfactory. The other five professionals reported experiencing difficulties with the referral process that were associated with GPs’ lack of response to the T-CBT pilot. It was also noted that the telephone modality was associated with difficulties building rapport, which was attributable to the loss of non-verbal / visual cues. In an effort to overcome this obstacle, five mental health professionals indicated that the initial sessions were conducted face-to-face, or that they adapted by learning “to listen differently...it’s more intense and you compensate with the listening”. Another professional conceded that, “telephone is better than nothing and is very helpful”.

Two professionals commented on the inability to control the environments of their consumers, which led to distractions and frustration. Five mental health professionals reported discussing various strategies with their clients at the initial session to maximise privacy and minimise the risk of interruption of the T-CBT sessions. Risk issues in one instance were managed by developing connections with local emergency and/or after hours services departments or were adequately managed solely via the telephone when the client had been seen for an initial face-to-face consultation. Others managed issues of risk by ensuring that they worked with specific clients that they deemed suitable for T-CBT.

Another challenge cited by three professionals was that they did not know what happened to consumers who did not answer their telephones, making it easier for consumers to drop out of the service. Six mental health professionals perceived negative impacts for consumers such as: the need to book appointments a fortnight in advance, poor mobile reception in some areas, the
paperwork required, and that the consumer does not always feel as connected and “prefers face-to-face attention”.

Project officers from GPNs where a provider was not interviewed indicated that there was low, if any, uptake of the T-CBT pilot. Low uptake was reported to be associated with the types of challenges mentioned above and others including: most clients opt to have face-to-face sessions even if required to travel long distances; staff turnover (of project officers and T-CBT trained mental health professionals); GPN management issues; need for increased marketing; and the lack of availability of further training for new mental health professionals.

**Improving the T-CBT pilot (project officers at GPNs, N = 22 and mental health professionals delivering T-CBT, N = 10)**

Project officers reported that enhanced flexibility of service delivery guidelines, education of stakeholders, and less paperwork would improve the T-CBT pilot. They also noted other potential improvements such as increasing funding to “improve capacity with more clinicians and therefore shorten wait list”; “targeting a GP practice where distance issues (barriers to access) are more relevant”; and T-CBT services “not being a temporary pilot”.

The most common suggestion for improvement of the pilot, made by five mental health professionals, was the need for increased education and liaison with GPs regarding the services. Professionals commented that GPs were not aware of the program and that it “can be difficult to get GPs used to a new idea”. Professionals also suggested that “less paperwork” for consumers, and charging consumers a copayment might improve the services. Four professionals made suggestions for further support and training, including: putting forms for mental health professionals and consumers online, offering a review training session to professionals after they
have conducted some sessions, and providing an opportunity to “link up with other
[professionals] across Australia to discuss patients”. 
Discussion

Evaluation of this pilot program found that T-CBT was usually combined with face-to-face sessions. This mixed modality approach shows promise for the treatment of high prevalence mental disorders and some of our findings offer explanatory insights.

Overall, 908 consumers received 6,607 sessions of mixed modality (33% via telephone). The average number of sessions per consumer is higher than the average number of sessions delivered via Tier 1 ATAPS (7.3 compared with 5.2; Bassilios et al., 2011). This may indicate that sessions of mixed modality are reaching a different group of consumers to those serviced via Tier 1 ATAPS. Another explanation for the higher average number of sessions delivered to consumers in receipt of sessions by telephone may be that some telephone sessions may take place on an ad-hoc basis if mental health professionals contact ‘at-risk’ consumers in between face-to-face sessions. Alternatively, it may reflect compensation for a loss of non-verbal cues during telephone sessions and perceived risk to rapport experienced by mental health professionals (Centore and Milacci, 2008), although others including the mental health professionals in the present study have suggested that the telephone modality results in more ‘intent listening’ (Scharrff, 2012). The uptake of telephone sessions in urban areas was initially slower than in rural areas and this is probably attributable to the fact that the T-CBT pilot itself targeted rural GPNs.

In the main, the profile of consumers in receipt of telephone sessions is similar to that of the Tier 1 ATAPS projects (Bassilios et al., 2011) and to callers to a large Australian telephone counselling centre (Lifeline; Burgess et al., 2008). The exceptions to the former are that T-CBT consumers are three times more likely to be Aboriginal and somewhat more likely to have previously utilised
mental health services and to have a diagnosis of a psychotic disorder than their national counterparts (Bassilios et al., 2011), which supports the proposition that mixed modality sessions allow a more flexible treatment approach that is suited to a more unique, and potentially harder to reach consumer group. The exceptions to the latter are that T-CBT consumers were somewhat younger in age (Burgess et al., 2008). Flexible service modality may also reduce the stigma associated with attending face-to-face psychological treatment (Centore and Milacci, 2008), which may be more salient in some cultural groups than in others.

Mixed modality CBT sessions achieved positive outcomes for consumers as evidenced by statistically and clinically significant levels of improvement across all outcome measures examined. This supports previous findings demonstrating the promise that the telephone modality confers for the delivery of psychological services in general (Bee et al., 2008; Leach and Christensen, 2006; Richards et al., 2008) and CBT in particular as a result of its structured format (Leach and Christensen, 2006; Lovell et al., 2006). In comparison to the larger group of consumers of Tier 1 ATAPS, consumers of mixed modality sessions seemed to have similar pre- and post-treatment outcome scores.

A number of factors were viewed as barriers to the initial uptake of telephone sessions, such as the delay in the availability of the mandatory webinar training, difficulty engaging GPs and an overall preference for face-to-face sessions by providers and consumers alike. However, others have suggested that it is not consumers but clinicians who are opposed to the use of technology more broadly in therapy despite lack of empirical evidence of adverse effects on client-therapist relationships (Anderson et al., 2004). Although a number of challenges associated with delivering sessions by telephone were identified by providers, effective strategies were adopted to manage these; for example having an initial face-to-face session assisted with the development of rapport. Positive provider response to the introduction of telephone sessions via ATAPS and
guidelines which permitted multimodal sessions were considered to optimise service uptake and outcomes. Strategies to improve the engagement of GPs were recommended in order to improve uptake of telephone sessions.

**Caveats**

It is possible that there were sessions being delivered by telephone via ATAPS prior to the introduction of the T-CBT pilot but that these were not being captured as the modality field was added to the minimum dataset in response to the introduction of the pilot in mid-2008. It was beyond the scope of our evaluation to include a non-treatment comparison group. This limits the certainty that treatment was responsible for the improvements in consumer outcomes, although improvements in the absence of treatment are unlikely to match the magnitude of improvements shown here. Although the proportion (18%) of consumers for whom pre- and post-treatment outcome data were available was not optimal, this is not uncommon for studies of this kind (Pirkis et al., 2010). Due to the real-world nature of the evaluation, it was beyond our scope to ensure treatment fidelity, in other words, that consumers received pure T-CBT.

**Conclusions**

The evaluation indicated that the uptake of telephone sessions delivered via ATAPS subprograms has been slowly increasing. However, uptake of the T-CBT pilot itself was slow and this was attributable to a combination of engaging GPs, procedural challenges and a fairly unanimous preference for face-to-face sessions where possible. However, the latter may indicate that the low uptake simply corresponds with the level of consumer need. The fact that mixed modality sessions are reaching consumers with slightly different profiles to Tier 1 ATAPS suggests that the flexibility of the telephone modality is complementing Tier 1 ATAPS.
Despite the preference for face-to-face treatment, providers and consumers value the option of the telephone modality particularly for consumers, both rural and urban, who are unable or prefer not to attend face-to-face sessions for various reasons, or who perhaps require greater support. Use of the telephone, which has long been seen as an accepted form of counselling (Payne et al., 2006; Rosenfield, 1997, 2003), presents a valuable opportunity to reach consumers who prefer not to attend face-to-face psychological services (Goss and Anthony, 2009). Evidence is also emerging to suggest that other forms of technology, such as computers, software programs, virtual reality, the internet and text messaging, also have the potential to improve accessibility to mental health care (Anderson et al., 2004; Callahan and Inckle, 2012; Goss and Anthony, 2009; Williams et al., 2009), and in some instances the lack of nonverbal cues may result in a greater variety of topics discussed (Callahan and Inckle, 2012). This emphasises the importance of mental health professionals being open to the panoply of communication modality options in the modern world (Goss and Anthony, 2009), with consideration to modality-specific advantages and disadvantages and competent and ethical use (Anderson et al., 2004; Williams et al., 2009). Inclusion of multimodal CBT treatment in graduate training programs may improve the competence and receptiveness of clinicians and in turn their potential for reaching consumers in accessible and meaningful ways.

Wider promotion of the availability of the telephone modality to health and welfare organisations and the community may attract more hard to reach consumers, particularly if inability or unwillingness to travel (associated with cost or disability) prevents some consumers even from attending a GP. Importantly, there is evidence that the addition of the telephone modality has achieved positive outcomes for consumers in terms of alleviating symptoms and improving levels of functioning. This, combined with the prevalence of telephone sessions in GPNs not participating in the T-CBT pilot supports the value of multimodal service delivery in general via
ATAPS and has been reflected in consequential ATAPS policy changes that now encourage multimodal service delivery as appropriate in all GPNs.
References


Rosenfield M (1997) *Counselling by telephone*. (Sage, London)


Figure 1: Number of rural and urban T-CBT referrals in receipt of one or more telephone sessions over time\(^a\)

\(^a\)Note that an additional 14 consumers and 56 sessions are not shown in the figure as their referral and session dates were (erroneously) recorded as pre-dating July 2008, the date which telephone sessions were introduced and session modality was added to the minimum dataset. A further 453 sessions are not shown in this figure as they took place post-June 2010 for referrals made during the analysis period.
### Table 1: Characteristics of consumers in receipt of at least one telephone session (N=908)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Rural (n=608)</th>
<th>Urban (n=300)</th>
<th>Overall (N=908)</th>
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</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
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<td></td>
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<tr>
<td>Female</td>
<td>68.1%</td>
<td>63.0%</td>
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<td>Male</td>
<td>26.0%</td>
<td>31.3%</td>
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<td>Missing</td>
<td>5.9%</td>
<td>5.7%</td>
<td>5.8%</td>
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<tr>
<td><strong>Mean age in years (SD)</strong></td>
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<td>34.2 (15.3)</td>
<td>36.7 (15.9)</td>
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<td><strong>Low income</strong></td>
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<td></td>
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<td>Yes</td>
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<td>54.0%</td>
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<td><strong>Previous psychiatric service use</strong></td>
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<td>0.3%</td>
<td>0.2%</td>
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<td>6.1%</td>
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*Percentages are greater than 100% as multiple responses permitted.*
<table>
<thead>
<tr>
<th></th>
<th>Telephone sessions (n = 2,175)</th>
<th>Face-to-face sessions (n = 4,354)</th>
<th>All sessions (N = 6,607)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Rural (n = 1,448)</td>
<td>Urban (n = 727)</td>
<td>All phone (n = 2,175)</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>0-30 mins</td>
<td>34.6%</td>
<td>73.9%</td>
<td>47.7%</td>
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<tr>
<td>31-45 mins</td>
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<td>Over 60 mins</td>
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<td><strong>Type</strong></td>
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<td>97.1%</td>
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<td><strong>Modality</strong></td>
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<td>100%</td>
<td>100%</td>
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<td>-</td>
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<td><strong>Copayment</strong></td>
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<td>8.9%</td>
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<td><strong>No show</strong></td>
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<tr>
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<td>2.3%</td>
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<td>91.9%</td>
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<td>Interventions</td>
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<td>Face-to face sessions (n = 4,354)</td>
<td>All sessions (N = 6,607)*</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-------------------------------</td>
<td>----------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td></td>
<td>Rural (n = 1,448)</td>
<td>Urban (n = 727)</td>
<td>All phone (n =2,175)</td>
</tr>
<tr>
<td>Diagnostic assessment</td>
<td>10.2%</td>
<td>12.2%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Psycho-education</td>
<td>20.0%</td>
<td>7.2%</td>
<td>15.7%</td>
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<tr>
<td>CBT-Behavioural interventions</td>
<td>22.7%</td>
<td>7.8%</td>
<td>17.7%</td>
</tr>
<tr>
<td>CBT-Cognitive interventions</td>
<td>22.9%</td>
<td>8.4%</td>
<td>18.0%</td>
</tr>
<tr>
<td>CBT-Relaxations strategies</td>
<td>13.5%</td>
<td>3.2%</td>
<td>10.1%</td>
</tr>
<tr>
<td>CBT-Skills training</td>
<td>12.6%</td>
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<td>10.1%</td>
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<tr>
<td>Interpersonal therapy</td>
<td>23.4%</td>
<td>7.7%</td>
<td>18.2%</td>
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<td>Narrative</td>
<td>0.3%</td>
<td>0%</td>
<td>0.2%</td>
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<td>Other CBT strategy</td>
<td>5.7%</td>
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<td>8.2%</td>
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<td>Other strategy</td>
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<td>24.2%</td>
<td>16.2%</td>
<td>21.5%</td>
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</tbody>
</table>

*This figure includes data for 16 sessions delivered via videoconference and 62 sessions for which modality was not specified.

b Percentages are greater than 100% as multiple responses permitted.
<p>| Table 3: Pre- and post-treatment outcome scores for consumers in receipt of telephone sessions on available outcome measures, July 2008 to June 2010 |
|-------------------------------------------------|----------------|----------------|----------------|</p>
<table>
<thead>
<tr>
<th>BASIS-32</th>
<th>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.</th>
<th>n</th>
<th>Pre-treatment mean (SD)</th>
<th>Post-treatment mean (SD)</th>
<th>Mean difference (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18</td>
<td>1.4 (0.6)</td>
<td>0.3 (0.5)</td>
<td>1.1 (0.6)*</td>
<td></td>
</tr>
<tr>
<td>DASS_Anxiety</td>
<td>Patient-rated sub-scale of the DASS designed to measure anxiety. Consists of 7 items, 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 raw sub-scale score on the DASS-21 ranges from 0 to 21 but is then doubled so that it can be clinically interpreted. A positive difference between pre- and post-treatment scores indicates improvement.</td>
<td>56</td>
<td>17.4 (10.3)</td>
<td>8.8 (7.6)</td>
<td>8.6 (9.50)*</td>
</tr>
<tr>
<td>DASS_Depression</td>
<td>Patient-rated sub-scale of the DASS designed to measure depression. Consists of 7 items, 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 raw sub-scale score on the DASS-21 ranges from 0 to 21 but is then doubled so that it can be clinically interpreted. A positive difference between pre- and post-treatment scores indicates improvement.</td>
<td>57</td>
<td>23.5 (11.3)</td>
<td>11.0 (10.2)</td>
<td>12.5 (11.2)*</td>
</tr>
<tr>
<td>DASS_Stress</td>
<td>Patient-rated sub-scale of the DASS designed to measure stress. Consists of 7 items, 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 raw sub-scale score on the DASS-21 ranges from 0 to 21 but is then doubled so that it can be clinically interpreted. A positive difference between pre- and post-treatment scores indicates improvement.</td>
<td>56</td>
<td>22.2 (9.5)</td>
<td>13.3 (8.3)</td>
<td>8.9 (10.4)*</td>
</tr>
<tr>
<td>HoNOS</td>
<td>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.</td>
<td>46</td>
<td>12.6 (3.2)</td>
<td>6.7 (3.9)</td>
<td>6.0 (4.34)*</td>
</tr>
<tr>
<td>K-10</td>
<td>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.</td>
<td>45</td>
<td>33.8 (7.7)</td>
<td>25.8 (10.9)</td>
<td>8 (10.4)*</td>
</tr>
<tr>
<td>MSSI</td>
<td>Clinician-rated measure of suicidal ideation representing a modified version of the Scale for Suicidal Ideation (SSI) developed by Beck and colleagues (Beck et al., 1979). Comprises of 18 items, 13 from the original SSI and five that are new, the first four of which serve as screening items. Each of the 18 items is rated on a four point Likert scale ranging from 0 to 3, which are summed to yield a total score ranging from 0 to 54, with negative items reverse scored so that higher scores indicate higher suicidal ideation. A positive difference between pre- and post-treatment scores indicates improvement.</td>
<td>37</td>
<td>14.9 (9.5)</td>
<td>5.1 (6.5)</td>
<td>9.7 (7.2) *</td>
</tr>
</tbody>
</table>

N.B. Each of the DASS subscales is completed as one measure and therefore these represent the same consumers on all three subscales. *p ≤ .001
Appendix 1

Questions for ATAPS project officers involved in the T-CBT project

We are interested in the views of ATAPS project officers from Divisions of General Practice that are involved in the T-CBT project.

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

1. Name of Division(s) conducting T-CBT project:

2. Is your Division a fund holder for another Division which is also conducting the T-CBT project?
   □ Yes
   □ No

   If yes, please specify,

3. How many T-CBT referrals have been received by the Division?

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

4. When was the Division able to start delivering T-CBT services?

4a. If there was a delay starting, what was the reason for the delay?
5. Who has been suggesting T-CBT as a mode of service delivery?

- [ ] GPs
- [ ] Menta; health professionals
- [ ] Both GPs and mental health professionals
- [ ] Division project officer

6. Which of the following means of retaining mental health professionals is being used for your T-CBT project? Please tick appropriate response(s)

- [ ] 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. In some cases, a formal contract may not exist but the mental health professional is paid a ‘fee for service’.

- [ ] Direct employment: Mental health professionals are directly employed by the Division.

- [ ] Other [Please specify]

7. From which of the following locations are mental health professionals providing services in your T-CBT project? Please tick appropriate response(s)

- [ ] 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.

- [ ] Division’s rooms: Mental health professionals provide services to the projects in rooms at Division office.

- [ ] Community organisation: Mental health professionals provide services at Community Centre / organisation.

- [ ] Educational setting: Mental health professionals provide services to the projects at a school / TAFE/ university.

- [ ] Other location [Please specify]

__________________________________________________________
8. Which of the following referral mechanisms is being used in your T-CBT project? Please tick appropriate response(s)

☐ Voucher system: This involves a system whereby the Division distributes vouchers to participating GPs who, in turn, give them to consumers. Consumers then use the vouchers to visit nominated 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: This involves 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.

Direct referral: This involves a system whereby the GP refers the consumer directly to the mental health professional. Often this takes place in the context to the mental health professional being co-located with the GP. However, there are exceptions, where the mental health professional is located elsewhere.

☐ Other [Please specify]

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

☐ Yes
☐ No

9a. If yes, how do they differ?

10. How did the Division promote the T-CBT services to GPs and mental health professionals?

11. How did GPs respond to the introduction of the T-CBT project?
12. How did ATAPS mental health professionals respond to the introduction of the T-CBT project?


13. What factors have facilitated the effective operation of the T-CBT project?


14. What factors have posed a barrier to the effective operation of the T-CBT project?


14a. Were there any difficulties that the evaluation team could support with?


15. Have you found that being able to refer patients via the T-CBT project has had positive impacts for the Division? If so, what have these impacts been?


16. Have you found that being able to refer patients via the T-CBT project has had negative impacts for the Division? If so, what have these impacts been?


17. What would make the T-CBT services work better?


18. Are there any other comments you would like to make about the T-CBT project?
Interview questions for Mental Health Professionals participating in the T-CBT component of the ATAPS projects

Thank you for agreeing to participate in this interview about the new T-CBT project. The interview will take about 20 minutes. Your responses are confidential, and you are free to withdraw from the interview at any stage.

For which Division do you provide most of your T-CBT services to?
This will be confidential and not identified in the report.

What is your mental health profession?

I’d like to ask you some questions about your experience with seeing clients under the T-CBT project.

1a. Approximately how many clients have you had sessions with who have been referred under the T-CBT project? [ ]

1b. Are there clients who were referred and not provided with T-CBT?

How many?

Why?

1c. Approximately how many sessions have you delivered (both telephone and face-to-face) under the T-CBT pilot?

[ ]

1d. Have you had experience delivering telephone CBT prior to your participation in the ATAPS T-CBT pilot?

[ ] Yes
[ ] No

2. Do you also deliver general ATAPS services?

[ ] Yes, if yes;
   a) How long have you been providing general ATAPS services? [ ]
   b) How often (if ever) do you deliver general ATAPS services by phone?

[ ] No, if no;
   a) Were you recruited specifically for the T-CBT pilot?

3. How have you found the referral process?
   [PROMPTS: How appropriate have you found the referrals? In your opinion, how suitable have the clients been for the receipt of the T-CBT service?]
4. How does T-CBT compare with face-to-face treatment?

[PROMPTS: How does the use of telephone modality affect the assessment process?]

[PROMPTS: How do you manage issues of privacy and interruption? E.g. if client lives at home with family]

[PROMPTS: What types of risk issues have you encountered?]

[PROMPTS: How have the loss of body language and other non-verbal cues affected your therapy?]

[PROMPTS: How do you manage ‘failure to attend’ T-CBT sessions?]

[PROMPTS: Has a client ever hung up on you? If so, how have you managed this?]

[PROMPTS: Do you think that T-CBT was more or less effective than face-to-face treatment modality? How?]

[PROMPTS: Are there any types of CBT interventions that you believe can only be delivered face-to-face? If so, what are these and why?]

[PROMPTS: Were there differences in the ways the clients responded to the T-CBT sessions compared to face-to-face sessions?]

5. **Overall have you found that being able to provide services under the T-CBT project has had positive or negative impacts for you?**

[PROMPTS: What were the positive impacts for you?]

[PROMPTS: What were the negative impacts for you?]

6. **Overall have you found that being able to provide services under the T-CBT project has had positive or negative impacts for your clients?**

[PROMPTS: What were the positive impacts for your clients?]

[PROMPTS: What were the negative impacts for your clients?]

7a. **Do you combine T-CBT sessions with other session modalities (i.e., face-to-face or videoconference)?**

   [ ] Yes
   [ ] No

7b. If so, why? If not why not?

8. **What would make the T-CBT service work better?**
10. Did the APS training for the T-CBT project help you in delivering services?

11. What, if any, further support or training would you like regarding T-CBT?

12. Are there any comments you’d like to make about the T-CBT project?

Thank you for participating in the interview.