



Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program

Eleventh Interim Evaluation Report

Utilisation of evaluation findings

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Executive summary

Background

One hundred and eleven Access to Allied Psychological Services (ATAPS) projects have been funded under the Better Outcomes in Mental Health Care (BOiMHC) program since July 2001. These projects, run by Divisions of General Practice, enable GPs to refer consumers to allied health professionals for 6-12 sessions of evidence-based care. The projects have improved access to high quality psychological care for people whose access might otherwise have been restricted by barriers such as cost.

For the past five years, the Centre for Health Policy, Programs and Economics (formerly the Program Evaluation Unit) in the University of Melbourne's School of Population Health has been conducting an evaluation of the ATAPS projects. As part of this role, the Centre for Health Policy, Programs and Economics has produced ten evaluation reports addressing different evaluation questions.

The current report examines the utilisation of the first eight of these reports by a range of stakeholders.

Method

In June/July 2006, semi-structured interviews were conducted with ten purposively-sampled stakeholders who, together, represented the groups that have been the primary audiences for the evaluation. The interviews explored the use to which the evaluation reports have been put.

Key findings

The findings from the evaluation have been put to a range of uses by different stakeholder groups. Most notably, the findings have been put to instrumental use.¹⁻³ For example, they have influenced decisions by Divisions to modify (or retain) the way in which individual projects are operating and decisions by the Department of Health and Ageing about contractual arrangements. The findings have also been put to conceptual use,¹⁻⁴⁻⁶ in the sense that they have contributed to the knowledge base regarding the delivery of primary mental health care. In addition, the findings have been put to symbolic or legitimative use.⁵⁻⁹ This latter form of use is sometimes viewed negatively, but in this case it has been valuable in confirming the original philosophy behind the BOiMHC program and underpinning lobbying and advocacy exercises related to Australia's new mental health reforms.

Conclusion

The evaluation reports are being well utilised for a range of purposes by a range of stakeholders. This is positive, because it suggests that the evaluation work associated with the ATAPS projects is helping to shape an initiative which has no precedents internationally and is having a major impact on mental health care delivery in Australia.

Chapter 1: Background

Evaluation of the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program

For the past five years, the Centre for Health Policy, Programs and Economics (formerly the Program Evaluation Unit) in the University of Melbourne's School of Population Health has been conducting an evaluation of a key component of a major Australian primary mental health care initiative known as the Better Outcomes in Mental Health Care (BOiMHC) program (see Appendix 1). Specifically, the evaluation has considered the processes, impacts and outcomes of the Access to Allied Psychological Services (ATAPS) component of the BOiMHC program. This component involves 111 projects being conducted across the country by Divisions of General Practice (see Appendix 2). The projects have been funded in four funding rounds since June 2002. Through these projects, local general practitioners are able to refer consumers to allied health professionals (predominantly psychologists) for 6-12 free or low-cost sessions of evidence-based psychological care (i.e., interventions with proven efficacy, such as cognitive behavioural therapy). Both the BOiMHC program and its evaluation have been funded by the Australian Government Department of Health and Ageing.

The evaluation role of the Centre for Health Policy, Programs and Economics has involved synthesising information from a range of sources, with the overall aim of providing ongoing lessons about how the projects are going, who they are reaching, the type of care they are providing and whether specific models of service delivery seem to be effective in particular circumstances. The specific data sources have included the projects' local project evaluation reports, a purpose-designed minimum dataset (a web-based national database which captures de-identified socio-demographic, clinical, treatment and outcome information on consumers), and several topic-specific surveys completed by Divisional project officers (one on models of service delivery, one on outcome measurement and one on demand management).

The above evaluation information has been presented in ten evaluation reports, which have drawn on different data sources and dealt with different evaluation questions.¹⁰⁻¹⁹ An overview of the reports is provided in Table 1.

Table 1: Summary of focus of evaluation reports

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
First Evaluation Report ¹⁰	Round 1 pilot projects – Australia	<ul style="list-style-type: none"> Local evaluation reports 	<ul style="list-style-type: none"> What models of service delivery are being used by the pilots? What is the uptake of the pilots? What are the advantages and disadvantages of the pilots? 	<ul style="list-style-type: none"> The ATAPS pilots are operating under a range of models. The models differ in terms of referral mechanisms (ranging from simple voucher systems to more complex brokerage systems), means of retaining allied health professionals (with most retaining them under some sort of contract and some employing them directly), and location of allied health professionals (with most providing services in GPs' rooms but some providing them in their own rooms or in a third location). The ATAPS pilots have recruited 136 individual allied health professionals (primarily psychologists) and ten agencies. In total, 387 GPs have referred 2036 consumers to these allied health professionals. For participating GPs, advantages of the ATAPS pilots included: savings in terms of time and cost and feedback from allied health professionals, and disadvantages included opportunity costs and other risks. For participating allied health professionals, advantages included an increased referral base and improved relationships with GPs, and disadvantages included payment anomalies and communication difficulties. For consumers, advantages included access to psychological services although some noted barriers to attendance.
Second Evaluation Report ¹¹	Round 1 pilot and supplementary projects – Australia	<ul style="list-style-type: none"> Local evaluation reports Minimum dataset 	<ul style="list-style-type: none"> What models of service delivery are being used by the projects? What is the level of uptake of the projects? Who is accessing services through the projects? What services are consumers receiving through the projects? What are the advantages and disadvantages of the projects? 	<ul style="list-style-type: none"> A range of models are being used from simple voucher systems to more complex brokerage models. Intermediate models are now available which provide GPs with registers that profile allied health professionals in terms of their skills and competencies, thereby enabling GPs to make informed referral decisions. Depending on whether the minimum dataset of the local evaluation reports are used as the authoritative data source, the ATAPS projects have involved between 710 and 926 GPs and between 160 and 229 allied health professionals. Together, these providers have enabled between 3,476 and 3,656 consumers to access mental health care which would otherwise have been out of their reach. The ATAPS projects appear to be reaching the consumers that they are supposed to be targeting – e.g., the majority are on low incomes (58%) and have not completed secondary education (56%), most have been diagnosed with depression (77%) and/or anxiety (55%) by their GP, and 40% have no previous history of specialist mental health care, indicating that their access may have previously been problematic. The number of sessions of therapy received to date is 8,678. Most sessions tend to be close to an hour in length (71%), and involve individual treatment (99%). The most common interventions delivered through these sessions are cognitive and behavioural interventions (55% and 41%, respectively). In 76% of all sessions, no co-payment is required; in the remainder of sessions a

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
				<p>co-payment of not more than \$10 is charged.</p> <ul style="list-style-type: none"> • GPs and allied health professionals involved in ATAPS projects are now feeling more satisfied that the initiative is viable and ongoing. Benefits observed by GPs include new skills and knowledge in the area of mental health and new referral options. Benefits observed by allied health professionals include improved relationships with GPs and an increased referral base. Consumers are benefiting from ready access to high quality care. Despite these positives, GPs and allied health professionals have experienced some attitudinal and logistical barriers, and consumers have experienced some inequities in referral.
Third Evaluation Report ¹²	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects – Victoria and Tasmania	Evaluation forum	<ul style="list-style-type: none"> • Do models of service delivery differ from the conceptualisation outlined in the First and Second Evaluation Reports? • What are the benefits and barriers associated with the means of retaining allied health professionals? • What are the benefits and barriers associated with the various locations from which allied health professionals deliver services? • What are the benefits and barriers associated with the different referral mechanisms? 	<ul style="list-style-type: none"> • The evaluation forum provided support for the validity of the conceptualisation of the different models of service delivery put forward in the early evaluation reports. • The major focus of the evaluation forum was in determining the benefits and barriers associated with the dimensions of the models. Often, the benefits of one model address barriers to another, and vice versa. So, for example, ATAPS projects in which the allied health professionals operate from their own rooms may have benefits for GPs in terms of access to a range of providers, but may present problems associated with reduced opportunities to collaborate. Conversely, ATAPS projects in which the allied health professionals are co-located with GPs may have advantages for GPs in terms of communication, collaboration and potential for knowledge transfer, but the downside may be a reduced range of providers to whom referrals can be made.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Fourth Evaluation Report ¹³	Round 1 pilot and supplementary projects, Round 2 projects – Australia	<ul style="list-style-type: none"> • Local evaluation reports • Minimum dataset 	<ul style="list-style-type: none"> • What models of service delivery are being used by the projects? • What is the level of uptake of the projects? • Who is accessing services through the projects? • What services are consumers receiving through the projects? • What are the benefits and barriers associated with the projects? • What lessons have been learned from the early experiences of the projects? 	<ul style="list-style-type: none"> • Earlier ATAPS projects have been modified along the way in response to stakeholder concerns, and later projects have learnt lessons from their earlier counterparts. As a consequence, the projects are operating under a range of different models which vary in terms of means of retaining allied health professionals, location of allied health professionals, and referral mechanisms. • The uptake of the Round 1 and 2 ATAPS projects is high. Using the minimum dataset as the gold standard, 1,771 GPs had referred 12,758 consumers to 569 allied health professionals by 31 December 2004. There has been significant growth as time has passed and the Round 2 projects have developed. • The Round 1 and 2 ATAPS projects are reaching the consumers that they are intended to target. For example, the majority (62%) are on low incomes, most have been diagnosed with depression (76%) and/or anxiety disorders (56%) by their GP, and 46% have no previous history of specialist mental health care, indicating that access may previously have been problematic for them. • There are good indications that the Round 1 and 2 ATAPS projects are providing free or low-cost evidence-based mental health care to consumers through structured sessions. In total, the number of sessions of therapy received to date by consumers in the Round 1 and 2 projects is 45,823. Most sessions (75%) are an hour in length, and 98% involve individual, rather than group-based, treatment. The most common interventions delivered through these sessions are CBT-based cognitive (61%) and behavioural (45%) interventions. In 63% of all sessions, consumers are not required to contribute to the cost of care; in the remainder of cases they are asked to make a co-payment, usually of not more than \$20. • Participating GPs, allied health professionals and consumers are very satisfied with the Round 1 and 2 ATAPS projects. GPs, allied health professionals and consumers appreciate up skilling opportunities, the increased referral base and the high quality of care, respectively. In spite of this, there have been some barriers to participation – e.g., paperwork hurdles for GPs, frustration at a perceived lack of decision-making power for allied health professionals, and equity issues for consumers. • Having said this, it should be noted that a number of the issues that were apparent in earlier local evaluation reports are less relevant in later ones – e.g., GPs are now less likely to experience confusion about how the ATAPS projects operate, allied health professionals seem to be less concerned about the uncertainty of guaranteed work, and problems with inappropriate referrals have generally been “ironed out”.
Fifth Evaluation Report ¹⁴	Round 1 pilot and supplementary projects,	<ul style="list-style-type: none"> • Survey of models of service delivery. 	<ul style="list-style-type: none"> • What is the profile of models of service delivery across the ATAPS projects? 	<ul style="list-style-type: none"> • In 76% of ATAPS projects, allied health professionals are retained under contractual arrangements; in 28% through direct employment; and in 7% by other means (e.g., arrangements with supervised postgraduate psychology students); in 63%, allied health professionals provide services from GPs’ rooms; in 63% they do so from their own rooms; and in 42% they do so from

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
	Round 2 projects – Australia		<ul style="list-style-type: none"> • Are particular models associated with differential levels of consumer access to services? 	<p>some other location (e.g., Divisional rooms, community health centres, hospitals and other general health and mental health facilities, other community agencies, and universities); and in 27%, voucher systems are used; in 24% brokerage systems are used; in 25% register systems are used; and in 51% direct referral systems are used.</p> <ul style="list-style-type: none"> • All models appear to be performing equally well in terms of enabling consumers to receive free (or low cost), evidence-based mental health care.
Sixth Evaluation Report ¹⁵	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects – Australia	<ul style="list-style-type: none"> • Local evaluation reports. • Minimum dataset 	<ul style="list-style-type: none"> • Has participation in the projects by GPs and allied health professionals changed over time? • Have access to and the nature of mental health care for consumers changed over time? • Have the experiences of GPs, allied health professionals and consumers changed over time? • Are the projects achieving positive outcomes for consumers? 	<ul style="list-style-type: none"> • 2,980 GPs have made referrals to 1,040 allied health professionals since the ATAPS projects began. There has been a dramatic increase in participation rates by both GPs and allied health professionals over the life of the projects. • The total number of consumers receiving care through the ATAPS projects is 26,444. The total number of sessions provided to these consumers is 102,120. Both the number of consumers and the number of sessions have increased substantially over time. In the main, the profile of these sessions has not changed over time, with the majority being individually-based, an hour in length, and consisting of CBT-based cognitive and behavioural therapies. The only notable fluctuation over time relates to the charging of a co-payment. Early sessions rarely incurred a co-payment, and where they did it was usually \$10 or less; subsequent sessions more commonly involved a co-payment, sometimes of as much as \$20 or more; and more recent sessions have been less commonly associated with a co-payment although the situation has not returned to the original low. • Some experiences for stakeholders have remained constant over time, while others have changed. • In 88% of cases, consumers who have contact with allied health professionals through the ATAPS projects get better.
Seventh Evaluation Report ¹⁶	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects – Australia	<ul style="list-style-type: none"> • Minimum dataset • Survey of models of service delivery • Project case studies 	<ul style="list-style-type: none"> • What models of service delivery are being used by the rural and urban projects? • What is the level of uptake of the rural and urban projects? • Who is accessing services through the rural and urban 	<ul style="list-style-type: none"> • Both rural and urban projects are using a mix of models. There are some notable differences in each of the domains on which models of service delivery differ, however. For example, rural ATAPS projects are more likely than urban ATAPS projects to directly employ allied health professionals, with 37% of the former doing so compared with only 21% of the latter. Rural projects are also less likely to have allied health professionals providing services from their own rooms (53% versus 72%). In addition, rural projects are more likely to implement direct referral systems (64% versus 38%), and less likely to use register systems (17% versus 32%). • As at 31 December 2005, 1,587 GPs had referred 14,137 consumers to 359 allied health professionals via the rural ATAPS projects. The equivalent figures for the urban projects are 1,639, 16,649 and 770, respectively.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
			<p>projects?</p> <ul style="list-style-type: none"> • What services are consumers receiving through the rural and urban projects? • What are the outcomes for consumers through the rural and urban projects? • What are the issues associated with the rural and urban projects? 	<ul style="list-style-type: none"> • The socio-demographic profiles of rural and urban consumers display some important differences, as well as some similarities – e.g., although the majority of consumers in both rural and urban locations are female, there are proportionally more male consumers in rural settings (28% versus 26%). Similarly, the clinical profiles of rural and urban consumers show some differences, but also certain commonalities – e.g., although the majority of each have depression and/or anxiety disorders, a lower proportion of rural consumers have the latter (55% versus 60%). • The services consumers are receiving through rural and urban ATAPS projects are similar in many respects, but also show some differences – e.g., the majority of sessions in both settings are 46-60 minutes in length, although a smaller proportion are of this duration in rural settings (75% versus 80%) and no co-payment is charged in 82% of rural sessions, compared with only 68% of urban sessions. • Both rural and urban ATAPS projects are achieving positive consumer outcomes. • Rural ATAPS projects have struck problems to do with: distance; attracting qualified staff; lack of training and support for GPs; limited services; large Indigenous populations; high levels of unemployment; and stigma. By contrast, the issues for urban ATAPS projects have related more to: uptake and demand; workforce shortages; and availability of and co-ordination with other services. Both rural and urban projects have addressed these problems in novel and innovative ways, seeking solutions that are responsive to the local context.
Eighth Evaluation Report ¹⁷	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects – Australia	<ul style="list-style-type: none"> • Minimum dataset • Survey of models of service delivery 	<ul style="list-style-type: none"> • What is the level of consumer outcomes within and across projects? • Does the level of consumer outcomes vary depending on the model of service delivery? 	<ul style="list-style-type: none"> • The ATAPS projects are achieving positive effects, mostly of large or medium magnitude. This suggests that the projects are effective in improving the mental health of consumers who are receiving psychological services. • ATAPS projects do not differ markedly in terms of the consumer outcomes they are achieving, despite their differences in models of service delivery. Only one variable emerged as significant: projects implementing direct referral systems are tending to achieve greater levels of consumer outcomes. In addition, there were non-significant trends toward employment of allied health professionals being predictive of greater consumer outcomes and delivery of services from allied health professionals' own rooms being predictive of lesser consumer outcomes.
Ninth Evaluation Report ¹⁸	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4	<ul style="list-style-type: none"> • Survey of demand management strategies 	<ul style="list-style-type: none"> • How many projects are using demand management strategies? • What demand management strategies are being used within 	<ul style="list-style-type: none"> • 85% of ATAPS projects are using at least one demand management strategy. • There is considerable activity across ATAPS projects with respect to demand management. The most commonly-used demand management strategies are: informing/training GPs (used in 82% of projects), putting in place systems and/or administrative procedures (used in 76%), and monitoring and limiting referrals (used in 61%). The majority of projects are using a combination of broad demand management strategies (5.6 per project, on average). They are also employing a range of approaches within each demand management strategy. So, for example, within the general

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
	projects – Australia		<p>projects?</p> <ul style="list-style-type: none"> • Which demand management strategies have been found to be most useful? • What features of any demand management strategy have worked well and not worked well? 	<p>strategy of monitoring and limiting referrals, a given project might adopt pre-numbered vouchers, track referral numbers, recall and re-allocate unused or partially-used vouchers, and cap the number of referrals available to each GP.</p> <ul style="list-style-type: none"> • Monitoring and limiting referrals and putting in place systems and/or administrative procedures are ranked as the most useful demand management strategies, with 29% of project officers endorsing the former and 24% the latter. • Different features of these demand strategies appear to work well for different projects, but a common theme is that they need to be underpinned by strong partnerships and solid infrastructure. There is concern that the need for demand management reflects the fact that projects are insufficiently resourced, and that as a consequence demand management strategies such as limiting referrals can have a negative effect on stakeholder perceptions.
Tenth Evaluation Report ¹⁹		<ul style="list-style-type: none"> • Minimum dataset • Medicare Benefits Schedule data 	<ul style="list-style-type: none"> • Has participation in the projects by GPs and allied health professionals changed over time? • Has the profile of consumers varied over time and has the care they are receiving changed? • Are the projects achieving positive outcomes for consumers? • Have there been changes in the level of uptake of services provided by the projects following the introduction of the Better Access program? 	<ul style="list-style-type: none"> • The current report indicates that the ATAPS projects have gained considerable momentum over time. Collectively, they are attracting far more GPs and allied health professionals and are providing access to high quality mental health care than was the case originally. In the main, the profile of consumers they are treating and the nature of sessions they are providing have both reached a point of consistency. They are achieving positive outcomes for these consumers. • Overall, the introduction of the Better Access program does not seem to have reduced the demand for psychological services provided through the ATAPS projects, although there has been a slight shift to Better Access in urban Divisions.

The reports have been distributed to key stakeholders, including general practitioners and allied health professionals and their respective professional bodies (the Royal Australian College of General Practitioners and the Australian Medical Association in the case of the former and the Australian Psychological Society in the case of the latter), project officers responsible for the management of the ATAPS projects, staff of the Department of Health and Ageing, Divisional Liaison Officers (employed by state-based organisations to provide support to Divisions), and representatives from Australian Divisions of General Practice (the peak national body representing Divisions across Australia). Hard and soft copies of each report have been made available via physical and electronic mail-outs. Each report has also been made available on a purpose-designed Better Outcomes in Mental Health Care website, on the website of the Centre for Health Policy, Programs and Economics, and on a website hosted by the Primary Mental Health Care Australian Resource Centre (an organisation based at Flinders University which, until recently, provided knowledge management, research, evaluation and information services to support Australian primary mental health care). The release of each report has been accompanied by a range of strategies designed to alert stakeholders to its contents, including presentations at relevant meetings and conferences and brief articles in several newsletters that are regularly accessed by stakeholders.

To date, there has been no systematic examination of the way in which the evaluation reports have been utilised by relevant stakeholders.

Utilisation focussed evaluation

Over the last 25 years, many experts have debated theories of evaluation utilisation and considered particular factors that affect utilisation. There is an abundance of such theoretical literature, but very little practical data from studies that have investigated utilisation practice.

According to Patton,⁸ utilisation focussed evaluation is done with specific, intended uses for specific, intended primary users. Patton and various other authors have considered in detail both the nature (and types) of these uses, and the way in which primary users might best be engaged.

Different authors use different nomenclature, but essentially identify three main types of use:

- “Instrumental use” takes place when evaluation findings are acted on in specific and direct ways, such as when evaluation results are used to reshape a given health program. Sometimes this occurs in the context of “judgement-oriented evaluations”, where the findings of an evaluation are synthesised into a value statement or an assessment of merit or worth; sometimes it occurs in “improvement-oriented evaluations”, where information is used for “reflection and innovation”.¹⁻³
- “Conceptual use” is more indirect, and relates to “enlightenment” or generating knowledge in a given area.^{1 4-6}
- “Symbolic use” or “legitimative use” involves drawing on research to justify a position or action that has already been taken for another reason,⁵⁻⁸ or to garner additional support for a program.⁹

Irrespective of the type of use to which the evaluation findings are to be put, an evaluation which is “utilisation-minded” engages potential users (i.e., relevant stakeholders) at the outset.⁸ King²⁰ notes that “It’s the users, not the report, that play ... a critical role in the evaluation process.” Engaging these users involves establishing who these users are and understanding the use to which they might put the findings. Different types of evaluation may be geared towards different users. So, for example, Patton⁸ suggests that although both funders and program staff/participants may make instrumental use of evaluation findings, funders may be more likely to do so in the context of making judgements and staff may be more likely to do so in the context of making improvements.

Once potential users are identified, they must be “brought on board” in order to maximise the likelihood of the findings of the evaluation being utilised²¹. This involves garnering their support

and giving them some “ownership” of the process. It also involves establishing their needs and determining how best to meet them, particularly given that they (and the evaluation questions associated with them) may change during the course of the evaluation. Stufflebeam¹ points out that the importance of deliberately involving stakeholders is to give “them the information they need to fulfil their objectives” which involves “gear[ing] a defensible program evaluation to the targeted users’ evolving needs.” Utilisation focussed evaluation has been called “active-reactive-adaptive and situationally responsive” because of the way it evolves through ongoing deliberation with stakeholders.⁸

Having said this, it must be acknowledged that there is some debate about the extent to which potential users of the evaluation should drive its design and implementation, which potential users should be involved, and what the nature of their involvement should be.²² Stufflebeam and Shinkfield²³ warn that although the “participant-oriented” approach of utilisation focussed evaluation is of prime importance, the evaluator must still adhere to professional standards with regard to designing the evaluation in the most methodologically-rigorous manner and reporting relevant findings in an unbiased fashion. Stufflebeam and Shinkfield²³ also note that this potential conflict may be exacerbated by the fact that identified stakeholders may not be representative of all users, and the process may give undue weight to the views of some. House²⁴ calls for a distinction between depth and breadth of involvement, where depth refers to the level of stakeholder involvement and breadth refers to the number of stakeholders. It may be difficult to satisfy both, and the ultimate profile of stakeholder involvement may impact on the extent and nature of the utilisation of the evaluation findings. Evaluators will be required to negotiate these roles and make choices about stakeholder involvement.^{8 23 24}

Communicating with relevant stakeholders in a meaningful and timely manner is also crucial in utilisation focussed evaluation. Patton⁸ summarises this by stating that getting the right information to the right people ... [in the right way] ... is the challenge. Owen and Rogers⁵ also flag the relationship between good communication and likelihood of utilisation, noting that stakeholders need to be informed about progress and given preliminary results as the evaluation moves through its various stages. Dibella²⁵ also refers to this point in a more specific discussion about evaluation reports, explaining that these require careful crafting and personal promotion if their findings and recommendations are to be translated into agenda items for program managers.

Ideally, communication with stakeholders should not end once the final evaluation report is submitted, but rather should be continuous.²⁰ Posavac and Carey²⁶ stress the importance of working with stakeholders once the evaluation is completed to implement changes, although they acknowledge that this may be easier for internal evaluators than external ones. Sonnichsen²⁷ similarly argues for keeping the findings of an evaluation on stakeholders’ agendas, since they may be of maximal relevance some time after they are first presented.

Familiarity with the context within which the evaluation is occurring is also important. In particular, is important to understand the relevant decision-making systems. Weiss⁶ argues that program and policy decisions are influenced by many factors, and that it is not realistic to expect any evaluation to be solely responsible for bringing about change. Even very good evaluations that have identified and involved all of the relevant players and have optimally communicated their findings will not influence decisions in the absence of other factors, such as political will and available resources.

The current report

The current report examines the nature and extent of utilisation of the evaluation reports associated with the ATAPS projects. It considers the utilisation of these reports in aggregate, rather than individually, on the grounds that they represent iterative findings from an ongoing evaluation.

Chapter 2: Method

In June/July 2006, ten respondents were invited to take part in a semi-structured 30-minute interview. These respondents were purposively sampled. Specifically, they were selected on the basis that they provided broad representation from key stakeholder groups who might make use of the evaluation findings in different ways (e.g., to guide service delivery, to inform policy or funding decisions, to advise constituents about the ATAPS projects etc.). They can be regarded as representing the groups that have been the primary audiences for the evaluation.

Respondents comprised three Divisional project officers (selected to ensure coverage of projects that had been funded for different durations, guaranteeing a balance in terms of exposure to the evaluation reports), one Divisional Liaison Officer, and one representative from each of the following organisations: 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.

At the time of interviewing, eight evaluation reports had been released. During the course of the interviews, respondents were asked a series of open-ended questions to determine the extent and nature of use of these evaluation reports, and, where relevant, the impact of this use. The structure and nature of the questions varied slightly, depending on the given stakeholders' role, but all were asked:

- What have the evaluation reports been used for?
- What have the reports confirmed?
- What aspects of the reports have been the most useful?
- Have the reports affected any decisions or led to any changes?
- Was new knowledge regarding the program produced in the evaluation reports?

The questions were emailed to all respondents prior to the scheduled interview. One respondent preferred to provide a written response, but the remainder were interviewed by telephone. All interviews were audio-taped and transcribed.

A content analysis of the interviews was conducted. This involved identifying key themes as they related to each of the above research questions. The themes effectively became category labels, and interview segments or quotations were sorted by these category labels. In instances where separate themes within a category emerged, the categories were further divided into sub-categories. No attempt was made to count the frequency of responses as this was felt to be inappropriate for a qualitative study.²⁸

Chapter 3: Results

What have the evaluation reports been used for?

The evaluation reports have been used for different purposes by different stakeholders. Most commonly, respondents commented on their usefulness in describing what was occurring in the field in terms of uptake (by general practitioners, allied health professionals and consumers), models of service delivery and referral pathways. This descriptive information has been used by the Australian Division of General Practice and by state-based Divisional Liaison Officers to promote the program and update Divisional staff on the progress of the projects, and in turn by Divisional project officers to inform general practitioners and allied health professionals about patterns of service delivery. The latter feedback has been useful in informing these providers of their contribution to improved mental health service delivery.

In some instances, the reports have led to program modification. One respondent observed, *“It’s been interesting ... I certainly intend making more use of it in terms of the further development of our program.”* Other respondents commented that the reports enabled them to *“get a handle on things”* and *“modify aspects of their program”*. Yet another noted, *“[the reports have] ... meant that they’ve been able to make positive adjustments to their model to make it work better as they’ve gone along. Fabulous.”*

The reports have not always led to program modification, however. Sometimes they have reassured project staff that their projects are operating as well as or better than others across the nation, and have resulted in their maintaining the status quo. One respondent noted, for example, that it was useful to *“... see how the programs are operating nationally and where we sit within that. It’s actually really good to read the national – you know, the outcomes and what’s happening nationally – so that we can see we fit in with that ... It’s affirming what we’re doing.”*

The reports have also been used to assist with documentation related to the projects, including procedure manuals and media releases, being viewed as *“... an important reference for information about the projects.”* For example, the Australian Psychological Society has used the reports to prepare a procedure guidance manual (as yet unreleased) for allied health professionals involved in the ATAPS projects. The relevant respondent noted *“...we did include a lot of information from the evaluation reports in that. It helped us to be able to tell the allied health practitioners all the different models of care [and] which ones are the more popular ... They were particularly interested in the feedback from the field, ... the numbers of people that had been seen, the data showing the people that the program is intended for are actually the ones that are being reached ... That always helps to make people feel like they’re being involved in something worthwhile.”*

The reports have been used by a variety of stakeholders for lobbying and advocacy purposes. In 2006, \$AUD1.9 billion was set aside for mental health care reform, and submissions were made to relevant authorities regarding funding priorities. The Australian Divisions of General Practice and several of the professional bodies made submissions during this process, and drew on the reports to put forward a case for the value of the ATAPS projects, particularly in rural areas and areas of low socio-economic status where there are few alternative mental health care providers.

Relatedly, the reports have been used to make a case for better evaluation of the other components of the BOiMHC program. There is an acknowledgement that evaluation efforts to date have focussed heavily on the ATAPS component, and that this has occurred at the expense of evaluation of some of the other components. The reports have been cited at various forums designed to promote stronger evaluation of components related to general practitioners’ direct delivery of mental health care.

What have the reports confirmed?

According to many respondents, the reports have confirmed that the original thinking behind the BOiMHC program in general and the ATAPS projects in particular is appropriate. As one respondent put it, *"I think they've confirmed that the original philosophy around the Better Outcomes initiative – collaborative care – works. I think ... it's confirming that [the] collaborative way of working is professionally satisfying for them [general practitioners and allied health professionals], but also it works for the patients."*

At a more practical level, the reports have confirmed for individual Divisions that the approach they are taking is right. In the words of one respondent, *"From the Division's [point of] view, the reports have confirmed what we had thought we were doing, you know, was going really well and the reports have confirmed that ... It was having a sense of place in the broader scheme of things."*

In addition, the reports have confirmed the *"... value of collecting data and information about programs for evaluation purposes at a local and national level."*

What aspects of the evaluation reports have been the most useful?

Several respondents found it difficult to hone in on the "most useful" aspects of the reports, making statements like, *"It's all helpful in terms of being a resource for me for the program ..."* They commented on the reports' overall quality instead, noting that this was "rare". One respondent summed this up in the following way, *"There's a lot of things rolled out in the Divisions network which don't have this calibre of evaluation attached to [them]. I think it's unique in that sense."*

When respondents were asked to comment on what aspects of the reports had been the most useful, however, they tended to focus on specifics like the uptake data on the number of general practitioners and allied health professionals who had been involved, and the number of consumers who had received care. The data which profiled the socio-demographic and clinical characteristics of consumers and detailed the services provided to them was also viewed as useful. In particular, respondents valued the fact that the reports *"point[ed] out national trends."*

Beyond this purely descriptive data, some respondents valued information on the projects' impacts. One respondent noted, for example, *"... there's been a degree of patient satisfaction that seems to have been picked up through a number of the reports."*

Some respondents felt that more process-oriented information was of the greatest value, particularly for the purposes of lobbying for funding and/or justifying the program. Comparative information about different service delivery models was viewed as useful in this regard.

Still other respondents valued the interpretation of the data more than the data itself, commenting on the utility of the *"semantic analysis"*.

Have the reports affected any decisions or led to any changes?

As noted above, the reports have been viewed as a *"good resource"* and have been instrumental in guiding program modification (or non-modification) at a Divisional level. One project officer commented, *"It gave me a lot of ideas. I started jotting down ideas, certain things that can be changed or certain things that can be done. The reason it's a good resource is that it's about what's happening now all around us and we're part of, rather than something that was written about something that happened somewhere else."*

According to respondents, the reports have influenced decisions about the ATAPS program at other levels too. For example, the rulings about co-payments have been guided by the reports. The original contracts between the Department of Health and Ageing and Divisions left decisions about charging co-payments to the discretion of Divisions. The evaluation reports have

documented the degree to which co-payments are charged and have demonstrated that the proportion of consumers who are charged a co-payment has increased over time, as has the average co-payment amount. This has occurred in response to high levels of demand, and the reports have been useful in providing benchmarking information. As a direct consequence, the Department has capped the level of co-payment that can be charged: *“Yes. The Department has specified a maximum [patient] co-payment that can be charged through the projects (\$30) in the new Funding Agreements with Divisions.”*

Respondents thought that the reports might have influenced changes at the policy level beyond the current ATAPS program. Specifically, they commented that the reports may have impacted on some of the mental health reforms that are currently under discussion in Australia. One respondent, for example, noted that *“... some of the decisions on the new [mental health] measures – particularly to expand the ATAPS type model or to put some additional funding into that model in rural and remote communities – have been supported by findings from the evaluation.”*

Was new knowledge regarding the program produced in the evaluation reports?

Respondents indicated that the evaluation reports had contributed to new knowledge in the field of primary mental health care. The literature in this area has tended to focus on the efficacy of interventions provided by psychologists alone, rather than by psychologists working in co-operation with other key primary care providers such as general practitioners. Respondents felt that the reports had furthered understanding about *“what works, for whom, and in what circumstances.”*

In terms of *“what works”*, respondents were confident that the collaborative approach fostered through the ATAPS projects had demonstrated efficacy, on the basis of outcome data presented in the evaluation reports. Divisions are collecting outcome data via a range of measures – e.g., the Kessler-10 (K-10), the Depression Anxiety Stress Scales (DASS) and the Health of the Nation Outcome Scales (HoNOS). Data from these measures has been aggregated and presented in several of the evaluation reports. Various respondents commented on the fact the reported outcome has demonstrated that such collaborative primary mental health care can result in positive changes in consumers’ mental health status and quality of life. One respondent commented, for example, that *“...it showed the K-10 scores ... can change when you do this program and that’s an interesting thing ...”*

With respect to *“for whom”*, respondents praised the reports for providing data that profiled the consumers who have been accessing care through the ATAPS projects. One respondent noted that this overall profile was useful because *“...we didn’t really know who would use this service.”*

With regard to *“under what circumstances”* respondents made reference to the wealth of information in the reports about the strengths and weaknesses of the different models of service delivery. The reports have generally concluded that different models are appropriate in different circumstances and that a “one size fits all” approach would be unlikely to work. Respondents noted that this has contributed to knowledge about the processes that might facilitate good primary mental health care in other settings as well as in the current context.

Chapter 4: Discussion and conclusions

The findings from the evaluation of the ATAPS projects have been put to a range of uses by different stakeholder groups. Most notably, the findings have been put to instrumental use.¹⁻³ For example, they have influenced decisions by Divisions to modify (or retain) the way in which individual projects are operating and decisions by the Department of Health and Ageing about contractual arrangements. The findings have also been put to conceptual use,¹⁻⁴⁻⁶ in the sense that they have contributed to the knowledge base regarding the delivery of primary mental health care. In addition, the findings have been put to symbolic or legitimative use.⁵⁻⁹ This latter form of use is sometimes viewed negatively, but in this case it has been valuable in confirming the original philosophy behind the BOiMHC program and underpinning lobbying and advocacy exercises related to Australia's new mental health reforms.

There may be several reasons for this wide range of uses. Every effort has been made to identify all relevant stakeholders,^{8,20} garner their support for the evaluation from the outset,^{1,21} and communicate the evaluation findings to them in a relevant manner.^{5,8,20,25,26} The original evaluation framework was informed by an evaluation advisory group that comprised representatives from the majority of the stakeholder groups mentioned in the current report. In addition, ongoing dialogue has occurred between the evaluators and various stakeholders with regard to what information they require from the evaluation (e.g., at the Divisions' request, the minimum dataset has been designed in such a way that reports can be automatically generated which allow individual projects to track their own progress). A tailored communication strategy has also been developed to ensure that key messages from the reports are repeated in a variety of ways to a variety of audiences. So, for example, the evaluation team has worked closely with Divisional Liaison Officers and project officers to disseminate the findings of each report once it has been released. This has involved highlighting the findings and explaining their applications, via avenues like seminars and summary articles in newsletters.

The current investigation had several limitations, which should be acknowledged here. Firstly, it was restricted to the views of ten stakeholders, and it should be acknowledged that if a different ten stakeholders had been interviewed, or if the total number of stakeholders was larger, different views about the utility of the evaluation reports might have been expressed. Having said this, the stakeholders were specifically selected because of their key role in each of the organisations they represented, and it would not have been possible or appropriate to randomly select them. It is also fair to say that the selected stakeholders were likely to have a comprehensive view of the way in which the evaluation reports have been "rolled out" and their findings taken up. For this reason, the results of the current study are encouraging because they suggest that the evaluation work surrounding the ATAPS projects is having a significant impact "on the ground".

A second limitation is that the interviews were restricted to 30 minutes and sought relatively high-level information. In an ideal world, longer interviews might have been conducted, and more specific details about the utilisation of the findings in the evaluation reports might have been sought. However, conducting longer interviews with the majority of the chosen respondents would not have been feasible, due to their competing time commitments. In addition, the evaluation team's own time and resource constraints precluded longer, more in-depth interviews.

These limitations aside, the current report provides empirical evidence of the fact that evaluation findings are being well utilised for a range of purposes by a range of stakeholders. This is positive, because it suggests that the evaluation work associated with the ATAPS projects is helping to shape an initiative which has no precedents internationally and is having a major impact on mental health care delivery in Australia.

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

Education and training for GPs (Component 1)

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

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

To complete Familiarisation Training, GPs attend a two-hour session provided by local Divisions of General Practice, supplemented by a Familiarisation Training E-learning CD-ROM. To qualify for completion of both Level 1 and Level 2 Training, GPs must either apply for recognition of prior learning (RPL) or complete a recognised educational activity, delivered by an eligible provider. The General Practice Mental Health Standards Collaboration¹ sets and administers the education and training standards that govern which previous and current activities satisfy the requirements of Level 1 and Level 2 Training.

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

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

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

The GP Mental Health Care Plan was included in the Better Outcomes in Mental Health Care program to provide a framework for the management of mental health problems and mental illness in a primary care setting, by encouraging effective and longitudinal care of consumers. Originally known as the 3 Step Mental Health Process, it included: (a) an assessment (Step 1); (b) preparation of a mental health plan (Step 2); and (c) a review of the mental health plan (Step 3). GPs were reimbursed for providing the 3 Step Mental Health Plan via a blended mechanism of payment. When they registered with Medicare Australia, they were paid a sign-on Service Incentive Payment of \$150. The GP then billed Medicare Australia under normal attendance items

¹ The General Practice Mental Health Standards Collaboration is a collaboration of the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine, the Royal Australian and New Zealand College of Psychiatrists, the Australian Psychological Society, and the Mental Health Council of Australia.

(Level C or D) for the assessment and the mental health plan. He or she used a specific item number to bill Medicare Australia for the review (Items 2574, 2575, 2577, 2578, 2704, 2707, 2705 or 2708), and this triggered the payment of a Service Incentive Payment (\$150 per 3 Step Mental Health Process per consumer per year) in addition to attracting a Medicare rebate for the consumer.

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

Focussed Psychological Strategies (Component 3)

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

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

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

Access to Allied Psychological Services (Component 4)

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

Access to Psychiatrist Support (Component 5)

The Access to Psychiatrist Support component of the Better Outcomes in Mental Health Care program has two sub-components, both of which broaden the role of psychiatrists in providing mental health care. The first involves a series of Medicare Benefits Schedule rebates which enable psychiatrists to organise or take part in case conferences on a consumer's behalf (Items 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838, 855, 857, 858, 861, 864 and 866). The second involves the provision of consultancy assistance to GPs by psychiatrists via GP Psych Support, a service that was originally provided by McKesson and Educational Health Solutions and

is now being provided by the Royal Australian College of General Practitioners. GP Psych Support provides GPs with telephone, fax and email access to quality management advice from a psychiatrist within 24 hours, seven days a week.

Appendix 2: Access to Allied Psychological Services projects

Round	Division(s)	State	Urban/Rural
1 (pilot)	Central Coast	NSW	Urban
1 (pilot)	NSW Central West	NSW	Rural
1 (pilot)	NSW Outback	NSW	Rural
1 (pilot)	Top End Div of GP	NT	Rural
1 (pilot)	Logan Area	QLD	Urban
1 (pilot)	SE Alliance of GP Bris (Ass of Bayside)	QLD	Urban
1 (pilot)	Sunshine Coast	QLD	Rural
1 (pilot)	Toowoomba & District (Now GP Connections)	QLD	Rural
1 (pilot)	Adelaide Nth Div of GP	SA	Urban
1 (pilot)	Bendigo & District	Vic	Rural
1 (pilot)	Dandenong Div of GP(Greater SE Div)	Vic	Urban
1 (pilot)	East Gippsland Div of GP (fund holder for Sth Gipp & Central West Div)	Vic	Urban
1 (pilot)	General Practice Alliance - South Gippsland Limited	Vic	Rural
1 (pilot)	Knox	Vic	Urban
1 (pilot)	NW Melbourne	Vic	Urban
1 (pilot)	Central West Gippsland	Vic	Rural
1 (pilot)	Fremantle	WA	Urban
1 (pilot)	Perth & Hills	WA	Urban
1 (supplementary)	ACT Division of GP	ACT	Urban
1 (supplementary)	Hastings Macleay	NSW	Rural
1 (supplementary)	Mid North Coast	NSW	Rural
1 (supplementary)	Riverina	NSW	Rural
1 (supplementary)	Nth & West QLD Primary Health Care	QLD	Rural
1 (supplementary)	Southern Division of GP SA	SA	Urban
1 (supplementary)	Ballarat & District	Vic	Rural
1 (supplementary)	Central Highlands	Vic	Urban
1 (supplementary)	General Prac Ass of Geelong (fund holder for Otway Div of GP)	Vic	Urban
1 (supplementary)	Mornington Peninsula	Vic	Urban
1 (supplementary)	NE Victoria	Vic	Rural
1 (supplementary)	Otway	Vic	Rural
1 (supplementary)	GP Down South (Peel SW)	WA	Rural
1 (supplementary)	Greater Bunbury (split from Peel SW 01.07.04)	WA	Rural
2	Blue Mountains	NSW	Urban
2	Canterbury	NSW	Urban
2	Dubbo / Plains	NSW	Rural
2	Illawarra	NSW	Urban
2	Murrumbidgee	NSW	Rural

Round	Division(s)	State	Urban/Rural
2	Nepean Div of GP	NSW	Urban
2	New England	NSW	Rural
2	NW Slopes	NSW	Rural
2	Sthrn Highlands	NSW	Rural
2	Sutherland	NSW	Urban
2	Sydney South West GP Network Ltd (Fairfield)	NSW	Urban
2	Brisbane South	QLD	Urban
2	Capricornia	QLD	Rural
2	Central QLD Rural	QLD	Rural
2	Far Nth QLD Rural	Qld	Rural
2	Gold Coast/Tweed Valley Div of GP	QLD	Urban
2	Ipswich/West Moreton	QLD	Urban
2	Mackay	QLD	Rural
2	Townsville	QLD	Rural
2	Adelaide Central and Eastern Div of GP	SA	Urban
2	Adelaide Hills Div of GP	SA	Rural
2	Adelaide NE Div of GP	SA	Urban
2	Adelaide Western Div of GP	SA	Urban
2	Limestone Coast Div of GP	SA	Rural
2	Murray Mallee Div of GP	SA	Rural
2	GP North (Nth Tas)	Tas	Rural
2	NW Tasmania	Tas	Rural
2	Southern Tasmania	Tas	Urban
2	Central Bayside	Vic	Urban
2	Inner Eastern Melbourne DGP	Vic	Urban
2	Melbourne	Vic	Urban
2	Monash (Moorabbin)	Vic	Urban
2	Murray Plains	Vic	Rural
2	NE Valley	Vic	Urban
2	Southcity GP Services (Inner SE Melb)	Vic	Urban
2	Western Melbourne	Vic	Urban
2	Westgate	Vic	Urban
2	Whitehorse Div of GP (Inner East Melb)	Vic	Urban
2	Canning	WA	Urban
2	GP Coastal (Perth Central Coast)	WA	Urban
2	Great Southern	WA	Rural
2	Osborne	WA	Urban
3	Barrier	NSW	Rural
3	Barwon	NSW	Rural
3	Central Sydney	NSW	Urban
3	East Sydney Div of GP (SE Div)	NSW	Urban
3	Hornsby Ku-ring-gai Ryde	NSW	Urban
3	Hunter Rural	NSW	Rural

Round	Division(s)	State	Urban/Rural
3	Hunter Urban	NSW	Urban
3	Macarthur	NSW	Urban
3	Northern Rivers	NSW	Rural
3	Nth Sydney	NSW	Urban
3	SE NSW	NSW	Rural
3	Shoalhaven	NSW	Rural
3	St George	NSW	Urban
3	Went West	NSW	Urban
3	GP Partners (Bris Nth)	QLD	Urban
3	Sthrn QLD Rural	QLD	Rural
3	Wide Bay	QLD	Rural
3	Barossa Div of GP	SA	Rural
3	Eyre Peninsula Div of GP	SA	Rural
3	Flinders and Far Nth	SA	Rural
3	Mid Nth Rural Div of GP	SA	Rural
3	Riverland Div of GP	SA	Rural
3	Yorke Peninsula Div of GP	SA	Rural
3	Border	Vic	Rural
3	Central West Victoria	Vic	Rural
3	Eastern Ranges GP Association	Vic	Urban
3	Goulburn Valley	Vic	Urban
3	Mallee	Vic	Rural
3	Northern	Vic	Urban
3	Central Wheatbelt (Wheatbelt GP Network)	WA	Rural
3	Eastern Goldfields	WA	Rural
3	Mid West	WA	Rural
3	Rockingham Kwinana	WA	Urban
4	Bankstown	NSW	Urban
4	Hawkesbury Hills	NSW	Urban
4	Liverpool	NSW	Urban
4	Central Aust Div of Primary Health	NT	Rural
4	Cairns	QLD	Rural
4	Redcliffe Bribie Caboolture	QLD	Urban