



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

Fifteenth Interim Evaluation Report

Current profile of, and innovations in, service delivery of Access to Psychological Services projects

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Table of Contents

Executive summary.....	3
Chapter 1: Background.....	6
Chapter 2: Method.....	9
Chapter 3: What is the level of uptake of the general Access to Allied Psychological Services projects by GPs, allied health professionals and consumers?	11
Chapter 4: What is the sociodemographic and clinical profile of consumers of general Access to Psychological Services projects, and what is the nature of the care they are receiving?	15
Chapter 5: Models of service delivery: Profile.....	19
Chapter 6: Discussion	24
References	28
Appendix A: Summary of focus of evaluation reports.....	31
Appendix B: 2005 Service models survey instrument.....	38
Appendix C: 2009 Service models survey instrument.....	42

Executive summary

Background

The majority of Divisions of General Practice are conducting Access to Allied Psychological Services projects, which have been funded progressively under the Better Outcomes in Mental Health Care (BOiMHC) program, which was introduced in July 2001. These projects, run by Divisions of General Practice, enable GPs to refer consumers to allied health professionals for 6-12 individual sessions of evidence-based care per calendar year (with a further 6 in exceptional circumstances, and the option of up to 12 group sessions). The projects are operating under a range of different service delivery models, varying in terms of how they retain their allied health professionals, where their allied health professionals are located, and how referral to their allied health professionals operates.

For the past six years, the Centre for Health Policy, Programs and Economics (formerly the Program Evaluation Unit) in the University of Melbourne's School of Population Health has been conducting an evaluation of the Access to Allied Psychological Services projects. The current report provides an update of: participation rates by GPs, allied health professionals and consumers; the sociodemographic and clinical profiles of consumers; and the precise nature of the care consumers are receiving. It also explores changes in the models of service delivery being utilised by the projects over time. All of the data presented in this report relates to 'General' Access to Allied Psychological Services projects only and excludes all data related to specialist programs which are reported separately.

Method

The report draws on data from a purpose-designed minimum dataset, which collects consumer and session-based data on the projects. Additionally, data regarding models of service delivery were collected via a purpose-designed survey completed by Divisional project officers between October 2008 and February 2009 and are compared to a similar survey which was completed in April 2005.

Specifically, the report considers the progressive achievements of the Access to Allied Psychological Services projects over time, via the following evaluation questions:

Evaluation Question 1: What is the level of uptake of the general Access to Allied Psychological Services projects by GPs, allied health professionals and consumers?

Evaluation Question 2: What are the sociodemographic and clinical profiles of consumers of general Access to Psychological Services projects, and what is the nature of the care they are receiving?

Evaluation Question 3: Have the models of service delivery being utilised by the general Access to Allied Psychological Services projects changed over time?

Key findings

What is the level of uptake of the general Access to Allied Psychological Services projects by GPs, allied health professionals and consumers?

Between 1 July 2003 and 31 December 2009, 15,251 (9,032, 59% urban; 6,219, 41% rural) GPs referred consumers to 4,042 (2,933, 73% urban; 1,109, 27% rural) allied health professionals through the Access to Allied Psychological Services projects.

Between 1 July 2003 and 31 December 2009, 174,675 consumers were referred to the Access to Allied Psychological Services projects, 135,033 (77%) of whom took up the referrals provided. On a quarterly basis the number of referrals rose from 1,344 in July-September 2003 to a peak of 11,152 in July-

September 2006. After the introduction of the Better Access program (November 2006), there was a temporary reduction in the number of referrals overall and in urban and rural areas, perhaps indicating something of a shift to the newer initiative. From the October-December 2007 quarter, the number of referrals steadily increased overall and in rural areas. In urban areas, referral numbers were variable during 2007, but rose consistently in 2008.

In total, 709,684 sessions of care were provided through the projects, making the average number of sessions provided to consumers 5.3. Overall, the number of sessions has increased over time from 3,842 in July-September 2003 to a peak of 42,222 in July-September 2006. The same pattern was apparent for urban and rural projects; the equivalent figures were 2,074 and 25,220 for urban projects and 1,768 and 17,002 for rural projects. Subsequent to the decline after the introduction of the Better Access initiative the number of sessions delivered in rural areas reached a new peak in July-September 2008 with 17,373 sessions. Whilst the number of sessions in urban areas has steadily increased since October-December 2007, the number has not surpassed the previous peak prior to the introduction of Better Access.

What are the sociodemographic and clinical profiles of consumers of general Access to Psychological Services projects, and what is the nature of the care they are receiving?

The profile of referred consumers has remained relatively consistent over time, and, in the main, is similar across urban and rural projects. Around three quarters of all consumers are female, and their mean age is approximately 39 years. The majority (around two thirds) are on low incomes. About half have no previous history of mental health care. Of those for whom a diagnosis was made by the referring GP, most have been diagnosed with depression (75%) and/or anxiety disorders (57%).

The profile of sessions has not changed greatly since the Access to Allied Psychological Services projects began. Sessions of 46-60 minutes have consistently been the most popular format over time, accounting for around four fifths of all sessions. Almost all of these sessions have been delivered to individuals, rather than groups. The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 44% and 58% of sessions, respectively. In the main, the profiles of sessions in urban and rural projects mirror the profile for all projects, but there are some nuances. For example, although the majority of both urban and rural sessions have consistently been 46-60 minutes in length, a slightly higher proportion of rural sessions have been under 45 minutes.

Nationally 79% of sessions over the life of the Access to Allied Psychological Services projects have not incurred a co-payment. For those sessions that have incurred a co-payment it has been \$30 or less. Sessions in rural areas are more likely to be free of a co-payment (92% compared with 71% of sessions in urban areas). In previous reports we have shown how the inclusion of co-payments in sessions has varied overtime. Anecdotal evidence suggests that these fluctuations over time may represent an attempt to strike a balance between providing a free service to a limited number of people, and a low-cost service to a larger number of people.¹ They may also reflect the view that a small copayment may encourage greater commitment to treatment on the part of the consumer.

Have the models of service delivery being utilised by the general Access to Allied Psychological Services projects changed over time?

The 2008/2009 survey of Access to Allied Psychological Services projects sought to answer the following two research questions:

- What is the profile of models of service delivery across the Access to Allied Psychological Services projects?
- How has the profile of models of service delivery across the Access to Allied Psychological Services projects changed since 2005?

Previous national evaluation work in relation to the Access to Allied Psychological Services projects has shown that the projects are operating under a range of different service delivery models. These models differ in terms of: (a) the means of retaining allied health professionals (i.e., contractual arrangements, direct employment, other); (b) the location of allied health professionals (i.e., GPs' rooms, own rooms,

other); and (c) the referral mechanisms used (i.e., voucher systems, brokerage systems, register systems, direct referral, other).

The 2008/2009 survey of Access to Allied Psychological Services projects showed that the most common form of allied health professional retention was contractual, the most commonly used location was the combination of allied health professionals' own rooms and GP's rooms, and that the most commonly used referral mechanism was direct referral.

In terms of allied health retention, comparisons between 2005 and 2008/2009 suggest a slight increase in the use of contractual arrangements, a more significant increase in the use of direct employment and a decrease in the use of other arrangements. In terms of the location of allied health professionals, there was a small decrease in the use of GPs and allied health professionals own rooms and a significant increase in the use of other locations, most notably the use of Divisions' rooms. In terms of referral mechanisms, comparisons between 2005 and 2008/2009 show a significant increase in the use of brokerage and a significant decrease in the use of a voucher system. The use of a register referral system and direct referral remained approximately constant.

Consistent with the 2005 findings, the survey data findings from 2009 suggests that there continues to be considerable variability across the Access to Allied Psychological Services projects with regard to the combination of models of service delivery being implemented. Many projects reported that they were using various combinations of allied health retention, location of allied health professionals and referral mechanism. This, and the fact that many of the projects report that they have continued to modify their models over time suggests that the projects continue to respond to local needs by seeking models of service delivery that work within their own context.

Conclusions

The current report indicates that the Access to Allied Psychological Services projects continue to be an integral part of the primary mental health care system in Australia. There is continued momentum in gaining additional GPs and allied health professionals to provide services to substantial number of consumers. The profile of consumers and the care they are receiving is very consistent overtime. The majority are women with high prevalence disorders who receive individual sessions mostly involving one hour sessions utilising CBT based cognitive and behavioural interventions.

The models of service delivery survey conducted in 2008/2009 indicates that allied health professionals, the location from which they practice and the way they receive referrals varies considerably from project to project. This indicated that there is not a 'one model fits all' approach to the services being delivered. Further there have been some significant changes to the models projects are using since 2005 when the survey was conducted for the first time. This highlights the flexibility of the projects in being responsive to the changing needs of the community and their ability to recognise when services could be delivered in a more effective way to consumers.

Chapter 1: Background

The Access to Allied Psychological Services projects are a key component of the Better Outcomes in Mental Health Care program, which was introduced in July 2001 in an effort to improve consumers' access to primary mental health care in Australia. These projects, implemented by Divisions of General Practice (Divisions), enable GPs to refer consumers with high prevalence disorders (e.g. depression and anxiety) to allied health professionals for six sessions of evidence-based mental health care, with an option of a further six sessions (or 12 in exceptional circumstances and the option of up to 12 group sessions) following a mental health review by the referring GP.

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

More recently, the Access to Allied Psychological Services projects were extended to provide four specialised services in addition to their mainstream services. Three of these were funded by the Department of Health and Ageing: the National Perinatal Depression Initiative, a trial of Telephone-based Cognitive Behaviour Therapy (CBT), and a trial of Specialist Services for Consumers at Risk of Suicide. All projects are involved in providing services for the Perinatal Depression Initiative, 22 rural Divisions were funded to trial Telephone-CBT as an alternative to face-to-face therapy and 19 Divisions were funded to trial the Specialist Services for Consumers at Risk of Suicide. In addition, funding was provided by the Department of Health and Ageing in early 2009 to nine divisions to provide additional services in response to the Victorian bushfires. Each of these programs (mainstream and specialised) is reported upon independently^{2 3 4 5 1 6-9 10-15 16-19}. The current report focuses on mainstream Access to Allied Psychological Services projects, which are distinguished by the term "General Access to Psychological Services projects".

As the previous 'general' Access to Allied Psychological Services report documented, between 1 July 2003 and 31 March 2009, 153,922 consumers were referred to the Access to Allied Psychological Services projects; 116,782 of whom took up the referrals provided¹⁴. In total, 602,405 sessions of care were provided through the projects, making the average number of sessions provided to consumers 5.1¹⁴. It was noted that consumer and session profiles have remained relatively consistent over time. Around three quarters of all consumers are female, and their mean age is approximately 39 years. The majority (around two thirds) are on low incomes. About half have no previous history of mental health care. Of those for whom a diagnosis was made by the referring GP, most had been diagnosed with depression (75%) and/or anxiety disorders (57%). Sessions of 46-60 minutes have consistently been the most popular format over time, accounting for around four fifths of all sessions. Almost all of these sessions have been delivered to individuals, rather than groups. The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions. The majority of sessions do not incur a consumer co-payment.

In April 2005, (general) Access to Psychological Services project officers were surveyed about the models of service delivery being used by the projects. Findings indicated that the projects were operating under a range of different models. The models varied in terms of how they retained their allied health professionals, where these allied health professionals were located, and how referral to these allied health professionals operated. Table 1 provides a summary of the dimensions on which the models of service delivery differ. In 2005 76% of projects were retaining their allied health professionals under contract; 28% via direct employment. Allied health professionals were providing services from GPs' rooms in 63% of projects; from their own rooms in 63%, and from a third location in 42% of projects. The referral mechanism of choice was direct referral in 51% of projects; a voucher system in 27%, a brokerage system in 24%, and 25% used a register system. Divisions had drawn on

each other's experience in applying these models, and many were using different models in combination (hence the percentages frequently totalling greater than 100%)^{6 20}.

Table 1. Dimensions on which models of service delivery differ

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

Source: Morley et al⁴

In the 2005 analysis, it was found that no models emerged as being associated with particular levels of access. In other words, all models appeared to be performing equally well in terms of enabling consumers to receive free (or low cost) evidence-based mental health care. This suggests that some models may work best in one context, whereas others may work best in another context, and that Divisions have adopted the most appropriate model (or combination of models) for their local environment^{6 20}.

Our previous findings have also indicated that projects did not differ markedly in terms of the consumer outcomes they were achieving, despite their differences in models of service delivery. Only one variable emerged as significant: projects implementing direct referral systems were tending to achieve more positive consumer outcomes. In addition, there were non-significant trends towards employment of allied health professionals being predictive of greater consumer outcomes, and delivery of services from allied health professionals' own rooms being predictive of poorer consumer outcomes.^{9 21}

As noted, our original survey on models of service delivery was conducted in April 2005. Since then, a number of new Access to Allied psychological Services projects have been funded, and existing projects have modified their models of service delivery. For this reason, the survey was re-administered in late 2008 / early 2009 to obtain an up-to-date profile of the models of service delivery currently being used by Access to Allied psychological Services projects.

The current report is the 15th in the series evaluating the 'general' Access to Allied Psychological Services projects and considers the current profile of the projects and innovations in service delivery, for a summary of the previous reports see appendix A. It represents an update of the general Access to Allied psychological Services project uptake data provided in the fourteenth report¹⁴, and service delivery models analysed in the fifth interim report⁶. Specifically, current participation rates by GPs, allied health professionals and consumers are described. In addition, the sociodemographic and

clinical profiles of consumers and the precise nature of the care they are receiving are analysed. Finally, changes in the models of service delivery being utilised by the projects over time are examined.

Chapter 2: Method

Evaluation questions

This report considers the progressive achievements of the 'general' Access to Allied Psychological Services projects over time, via the following evaluation questions:

Evaluation Question 1: What is the level of uptake of the general Access to Allied Psychological Services projects by GPs, allied health professionals and consumers?

Evaluation Question 2: What are the sociodemographic and clinical profiles of consumers of general Access to Allied Psychological Services projects, and what is the nature of the care they are receiving?

Evaluation Question 3: Have the models of service delivery being utilised by the general Access to Allied Psychological Services projects changed over time?

Data sources

The first two evaluation questions were addressed using data from the previously mentioned minimum dataset, which captures de-identified, consumer-level and session-level information. Data from the minimum dataset was available for from 1 July 2003 (when the minimum dataset was first 'rolled out') to 31 December 2009. In total 116 Divisions of General Practice have been involved over the life of the Access to Allied Psychological Services projects and data is included for all of them relevant to the period of time they were involved. Currently there are 111 Divisions involved which were funded in four funding rounds: 18 from June 2002 (Round 1 pilot projects); 15 from January 2003 (Round 1 supplementary projects); 42 from July 2003 (Round 2 projects), (one Division of which is no longer operating and two of which have been absorbed in amalgamations); 33 from July 2004 (Round 3 projects); six from July 2005 (Round 4 projects), (one Division of which is no longer operating and one Division has since amalgamated with a Division in a previous funding round); and a further two were funded in 2007.

Data related to general Access to Allied Psychological Services projects were extracted from the minimum dataset on the numbers of GPs and allied health professionals providing services through the projects (Evaluation Question 1), the number and profile of consumers accessing these services (Evaluation Questions 1 and 2, respectively), and the number and nature of these services (Evaluations Question 1 and 2, respectively).

As noted, our original survey on models of service delivery was conducted in April 2005. In late April 2005, a brief survey was emailed to the person responsible for each of the then 102 Access to Allied Psychological Services projects (usually the Project Manager or Project Officer, but in the absence of these, the Divisional Chief Executive Officer or equivalent). Respondents were asked to complete the survey and return it by email or fax. Reminder phone calls were made as necessary, and the cut-off for returned surveys was late June 2005. The survey sought information on the models of service delivery being utilised by the given project, in line with the conceptualisation presented in the background chapter. Specifically, the survey sought information on the project's method of retaining allied health professionals, the location from which allied health professionals were providing services, and the referral process. Changes in each of these dimensions over time were explored. Appendix B contains the full survey instrument used in 2005.

The most recent models survey was conducted between October 2008 and February 2009. An electronic version of the survey was emailed to project officers (of the then 108 Access to Allied Psychological Services projects) in order to orient them to the questions. A mutually convenient time to interview them by telephone was arranged. The survey was very similar to the one used in 2005 with the addition of a further three options regarding location of allied health professionals (i.e. Division's

rooms, community organisation, and educational setting) and some additional questions regarding costs and funding of the Access to Allied Psychological Services projects which are not being reported here. The survey instrument is provided in Appendix C.

Data analysis

Simple frequencies and percentages were calculated from the general Access to Allied Psychological Services projects data in order to answer Evaluation Questions 1 and 2.

Evaluation Question 3 was analysed using simple descriptive analyses which focused on profiling the current models of service delivery being utilised by the projects. These analyses are presented as simple frequencies and percentages, as appropriate. Qualitative analyses were employed to focus on the open-ended responses provided by participants. Both quantitative and qualitative data from the 2008/2009 models survey are compared with the findings of the 2005 models survey.

Chapter 3: What is the level of uptake of the general Access to Allied Psychological Services projects by GPs, allied health professionals and consumers?

Uptake of Access to Allied Psychological Services projects by General Practitioners and allied health professionals

Between 1 July 2003 and 31 December 2009, 15,251 (9,032, 59.2% urban; 6,219, 40.8% rural) GPs referred consumers to 4,042 (2,933, 72.9% urban; 1,109, 27.4% rural) allied health professionals through the Access to Allied Psychological Services projects. This represents a continued increase in the number of GPs and allied health professionals from March 2009 when the figures were 10,296 (5,914 urban; 4,382 rural) and 3,527 (2,548 urban; 979 rural) respectively.

Overview of referrals and sessions overtime

Between 1 July 2003 and 31 December 2009, 174,675 consumers were referred to the Access to Allied Psychological Services projects, 135,033 (77.3%) of whom took up the referrals provided. In total, 709,684 sessions of care were provided through the projects, making the average number of sessions provided to consumers 5.3. This average is likely to be an underestimate as projects differ in their ability to identify re-referrals because some have systems which preclude a consumer carrying the same identifier across referrals.

Figure 1 shows that the number of consumers referred on a quarterly basis to the projects rose from 1,344 in July-September 2003 to a peak of 11,152 in July-September 2006. Figures 2 and 3 provide a breakdown of this increase by urban and rural projects, where the figures for the same period were 530 to 5,990 and 608 to 4,383, respectively. After the introduction of the Better Access program (November 2006) there was a temporary reduction in the number of referrals overall and in urban and rural areas, perhaps indicating something of a shift to the newer initiative. After the October-December 2007 quarter the number of referrals steadily increased, however after July-September 2008 there was another drop in the number of referrals, which remained consistent throughout 2009. In urban areas referral numbers were variable during 2007, but rose consistently in 2008. It should be noted that the significant drop in the final quarter (October-December 2009) can probably be explained by a lag in data entry.

Figures 1, 2 and 3 also provide a quarter-by-quarter picture of the numbers of sessions overall and in urban and rural areas. Overall, the number of sessions has increased over time from 3,842 in July-September 2003 to a peak of 42,222 in July-September 2006. The same pattern was apparent for urban and rural projects; the equivalent figures were 2,074 and 25,220 for urban projects and 1,768 and 17,002 for rural projects. Again, there was a drop in the number of sessions provided overall and in urban and rural areas after the introduction of the Better Access program. The number of sessions delivered in rural areas reached a new peak in July-September 2008 with 17,373 sessions, possibly reflecting the fact that the uptake of the Better Access Initiative has been considerably less in rural than in urban areas.¹³ Whilst the number of sessions in urban areas has steadily increased since October-December 2007 the number has not surpassed the previous peak prior to the introduction of Better Access. In 2009 the number of sessions in urban areas was quite variable, however in rural areas there was a marked decline in the number of sessions delivered throughout 2009.

Figure 1: Referrals for sessions of care through the Access to Allied Psychological Services projects, by quarter (all projects)

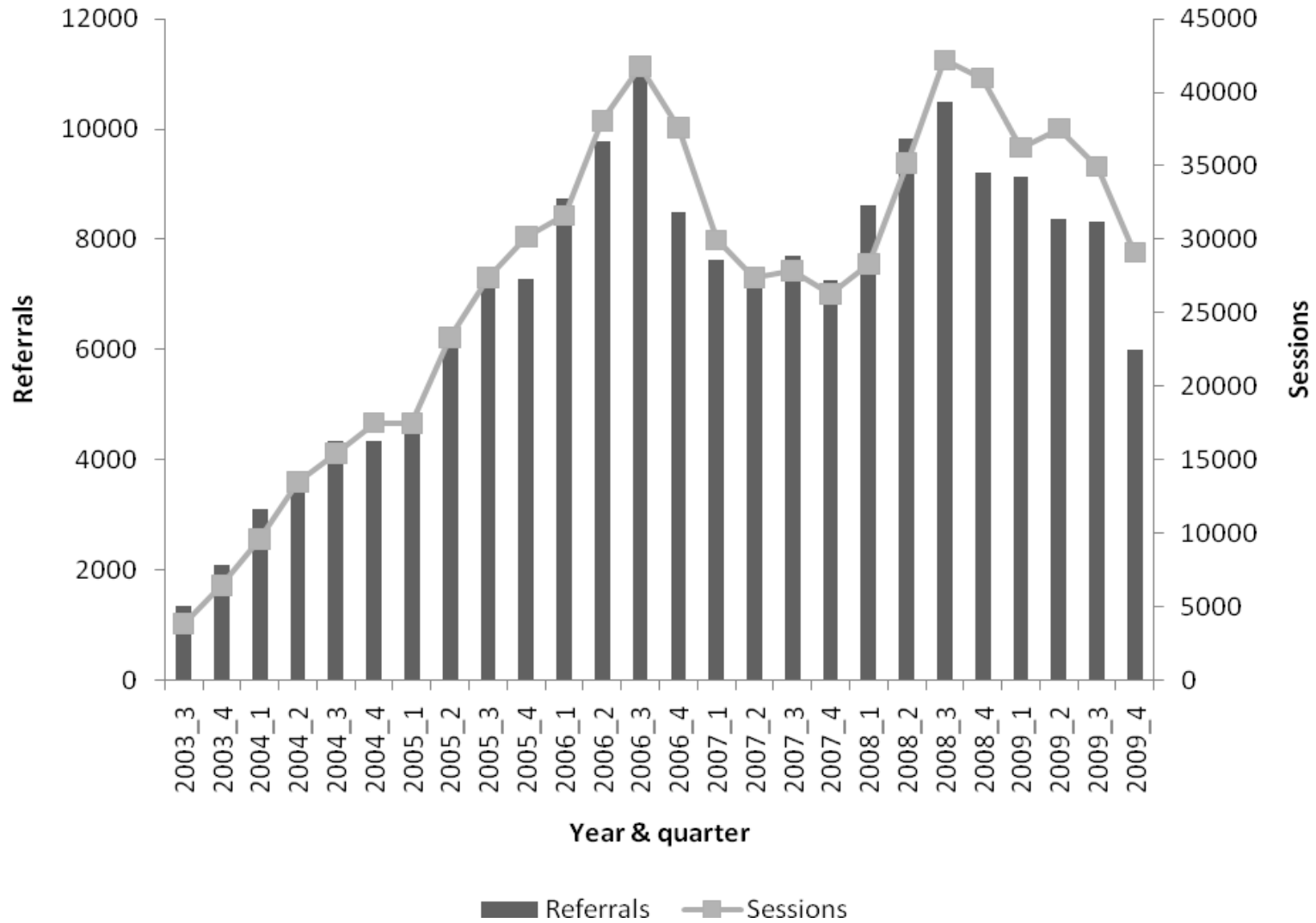


Figure 2: Referrals for sessions of care through the Access to Allied Psychological Services projects, by quarter (urban projects)

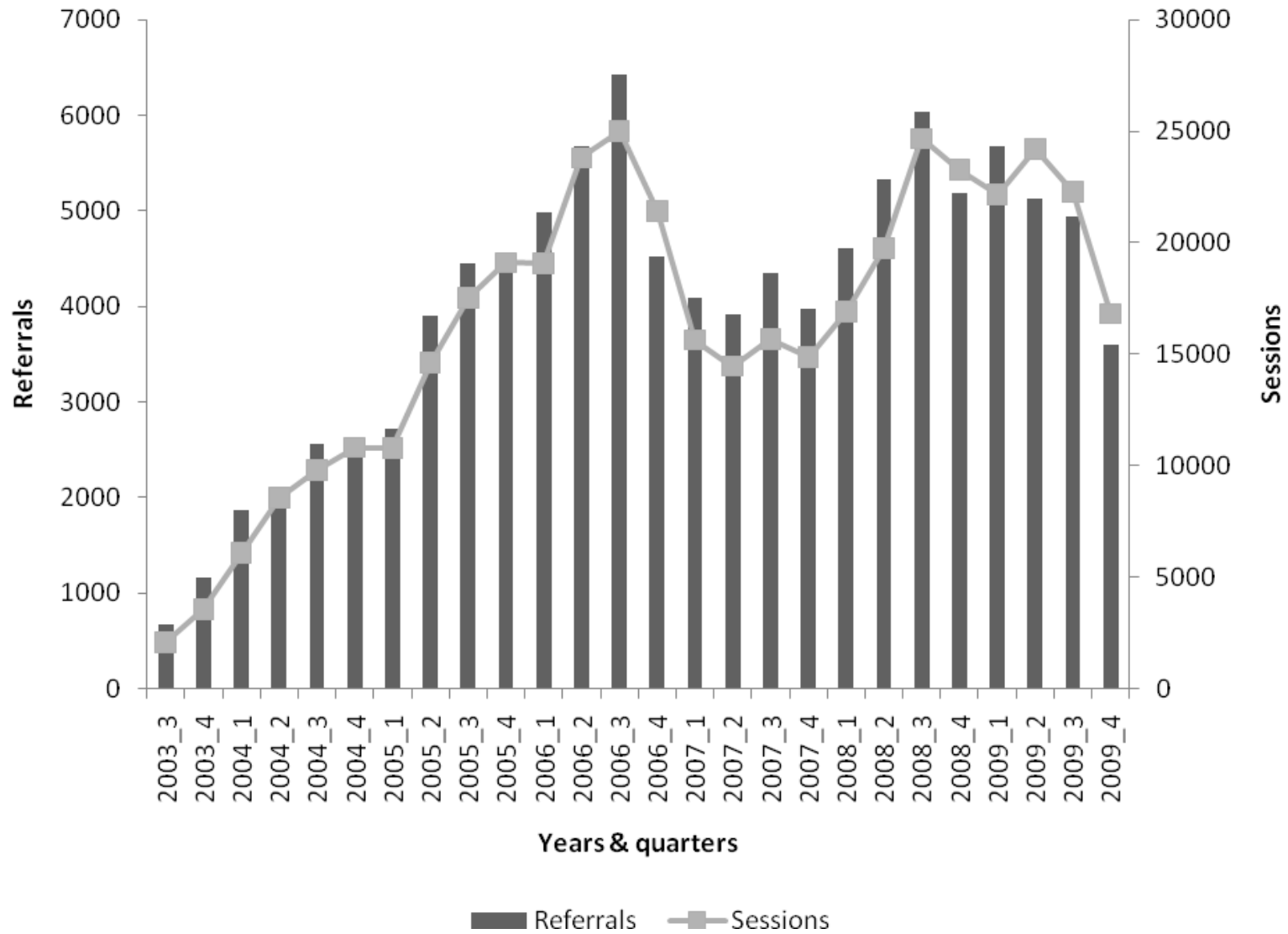
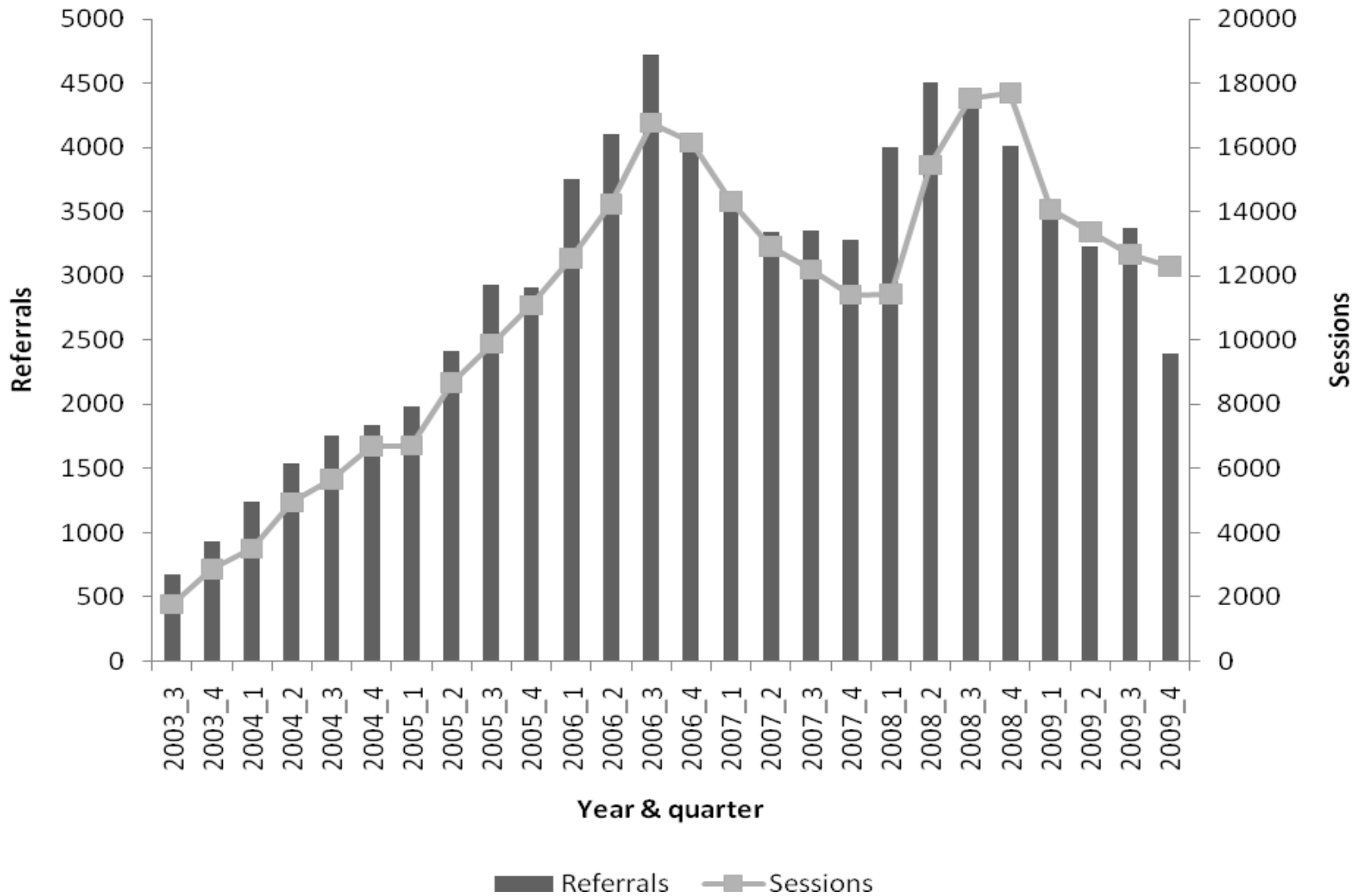


Figure 3: Referrals for sessions of care through the Access to Allied Psychological Services projects, by quarter (rural projects)



Chapter 4: What is the sociodemographic and clinical profile of consumers of general Access to Psychological Services projects, and what is the nature of the care they are receiving?

Profile of consumers

Table 2 summarises some of the key characteristics of the consumers receiving care through the projects, displaying data at the national level and for rural and urban projects. For simplicity, cumulative percentages are presented, rather than quarterly, because the demographic profile of consumers has changed little over time. Around three quarters of all consumers are female, and their mean age is approximately 39 years. Around 3% of consumers are of Aboriginal or Torres Strait Islander descent. The majority (around two thirds) are on low incomes, as judged by their GP. About half have no previous history of mental health care. Of those for whom a diagnosis was made by the referring GP (n=133,181), most have been diagnosed with depression (76%) or anxiety disorders (57%). In the main, the profiles of rural and urban consumers are similar.

Table 2: Summary characteristics of consumers receiving care through Access to Allied Psychological Services projects

	National	Urban	Rural
Gender			
• Female	71 %	71.6%	70.1%
• Male	29%	28.4%	29.9%
Mean age			
	39	39	39
Low income			
• Yes	63.8%	67.4%	59.1%
• No	21.9%	19.5%	25%
• Unknown	14.3%	13.1%	15.9%
Previous psychiatric service use			
• Yes	39.9%	44.9%	39.4%
• No	45.1%	40.2%	45.5%
• Unknown	15.0%	14.9%	15.9%
Aboriginal			
• Yes	2.9%	2.1%	3.9%
• No	87.1%	89.6%	83.8%
• Unknown	10%	8.3%	12.3%
Torres Strait Islander			
• Yes	0.3%	0.3%	0.3%
• No	89.2%	90.9%	87%
• Unknown	10.5%	8.8%	12.7%
Diagnosis ^a			
• Alcohol and drug use disorders	7.4%	7.9%	6.7%
• Psychotic disorders	2.1%	2.2%	2.0%
• Depression	75.5%	75.9%	75.1%
• Anxiety disorders	56.7%	59.1%	53.5%
• Unexplained somatic disorders	2.5%	2.7%	2.2%
• Unknown	2.0%	1.3%	3.0%

a. Multiple responses permitted

Profile of sessions

Table 3 summarises some of the key features of the sessions of care provided to consumers, detailing national, rural and urban data. Again, for the sake of simplicity, aggregated percentages over the life of the project are presented because the profile of these sessions has not changed greatly since the Access to Allied Psychological Services projects began. Sessions of 46-60 minutes have consistently been the most popular format over time, accounting for around four fifths of all sessions, and reflecting the complexity of care provided in these sessions. Almost all of these sessions have been delivered to individuals, rather than groups. The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 57% and 43% of sessions, respectively. These interventions are evidence-based, and widely regarded as appropriate for treating the types of high prevalence disorders with which consumers are presenting (see above

profile of consumers). In the main, the profiles of sessions in rural and urban projects mirror the profile for all projects, but there are some nuances. For example, although the majority of both rural and urban sessions have consistently been 46-60 minutes in length, a slightly higher proportion of rural sessions have been under 45 minutes and over 60 minutes.

Nationally 79.3% of sessions over the life of the Access to Allied Psychological Services projects have not incurred a co-payment, for those sessions that have incurred a co-payment it has been \$30 or less. Sessions in rural areas are more likely to be free of a co-payment (91.7% compared with 71.1% of sessions in urban areas). In previous reports we have shown how the inclusion of co-payments in sessions has varied overtime. Anecdotal evidence suggests that these fluctuations over time may represent an attempt to strike a balance between providing a free service to a limited number of people, and a low-cost service to a larger number of people.¹ They may also reflect the view that a small copayment may encourage greater commitment to treatment on the part of the consumer.

Table 3: Summary characteristics of sessions provided to consumers through the Access to Allied Psychological Services projects

	National	Urban	Rural
Duration ^a			
• 0-30 mins	2.1%	1.3%	3.3%
• 31-45 mins	4.0%	3.1%	5.4%
• 46-60 mins	82.4%	85.2%	78.3%
• Over 60 mins	11.4 %	10.4%	13.2%
Type			
• Group	2.2%	2.6%	1.6%
• Individual	97.8%	97.4%	98.4%
Interventions ^{b, c}			
• Diagnostic assessment	19.5%	20.2%	18.6%
• Psycho-education	29.2%	28.6%	30.1%
• CBT-Behavioural interventions	43.4%	44.4%	42.0%
• CBT-Cognitive interventions	57.4%	58.3%	56.0%
• CBT-Relaxations strategies	22.4%	22.3%	22.0%
• CBT-Skills training	21.9%	22.0%	21.6%
• Interpersonal Therapy	28.6%	28.8%	28.4%

a. Multiple responses permitted

b. Duration & type – proportions exclude missing data (missing n=47,279 & 38,457, respectively)

c. Intervention data was downloaded in February 2010, proportions include missing data as in this case, 'missing' is likely to indicate that the intervention was not delivered in that session

Chapter 5: Models of service delivery: Profile

Availability of data

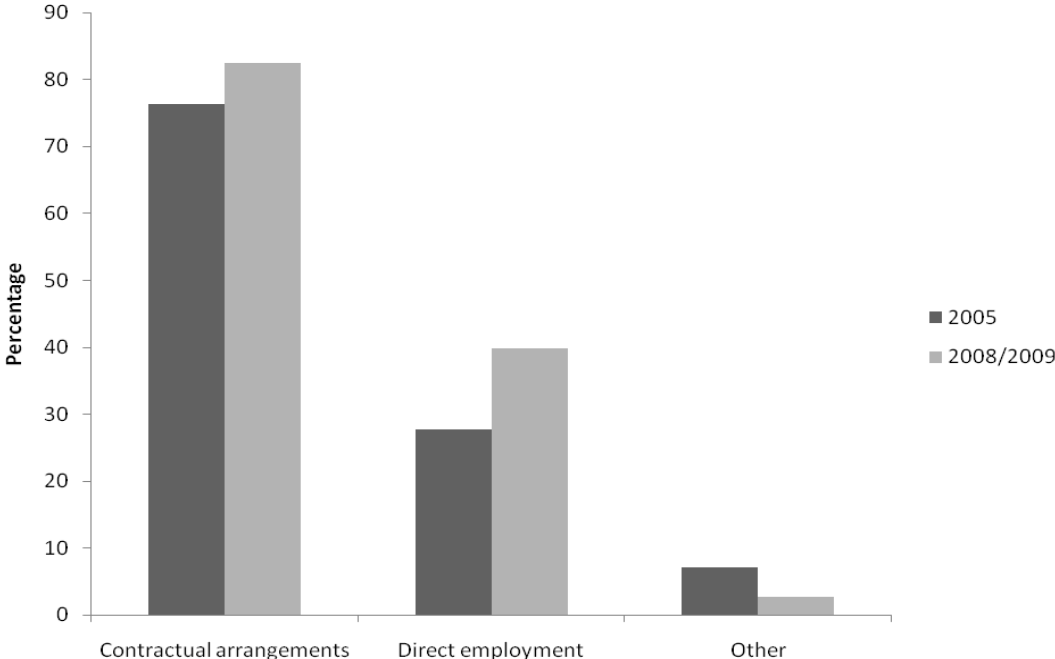
In 2005, survey data on models of service delivery were available from 97 (95%) of the 102 Access to Allied Psychological Services projects. In 2008/2009, survey data were available for 104 (98%) of the 106 Access to Allied Psychological Services projects.

Means of retaining allied health professionals

Figure 4 provides a breakdown of the means of retaining allied health professionals adopted by the projects in 2005 and 2008/2009 (note that some projects are using more than one means, so the total exceeds 100%). In 2005, 74 projects (76%) reported that they were retaining their allied health professionals under contract, compared with 82 projects (82%) in 2008/2009. In 2005, 27 (28%) projects reported that were utilising a direct employment model, compared with 41 projects (40%) in 2008/2009. In 2005, 7 projects (7%) indicated that they are using some other means of retaining their allied health professionals, compared with 4 projects (3%) in 2008/2009. According to free text responses in 2005, the most common 'other' arrangements were with postgraduate psychology students who are neither contracted to, nor directly employed by the Division, but rather provide services in a supervised manner as part of their course requirements. In 2009, only 3 projects reported other methods of retaining allied health professionals. These were: using postgraduate students, contracting of a third party organisation that provides professionals for Access to Allied Psychological Services projects, and contracting a local hospital that provide professionals for Access to Allied Psychological Services projects.

Comparisons between 2005 and 2008/2009 suggest a slight increase in the use of contractual arrangements, a more significant increase in the use of direct employment and a decrease in the use of other arrangements.

Figure 4: Means of retaining allied health professionals in 2005 and 2008/2009



In 2005, the surveys indicated that 11 (11%) of projects had changed their means of retaining allied health professionals since they began. Some had moved from the direct employment model to contracting with individual providers (or external agencies); others had done the reverse. Several had shifted from using postgraduate psychology students to employing or contracting with established providers (e.g., because of low student intakes). Others had introduced greater flexibility (e.g., options for part-time work) or improved working conditions (e.g., additional mentoring and support, study leave and opportunities to develop further skills, above-award wages), in an effort to attract more (and/or better qualified) allied health professionals into the program and improve the quality of care.

In 2008/2009, the surveys indicated that 7(6%) of projects had changed their means of retaining allied health professionals since they began. Three projects reported moving from using only contractual arrangements to only directly employing allied health professionals. One of these projects reported employing psychologist 'interns' as this was more 'cost effective'. Two projects reported moving from only directly employing allied health professionals to only using contractual arrangements. Two further projects reported a move away from the use of contractual professionals, one from sole contractual arrangements to both contractual and employed professionals, and another from the use of both contractual arrangements and employed professionals to the use only of employed professionals.

Some projects in 2008/2009 reported an increase in Access to Allied Psychological Services projects demand that had enabled them to expand their services and engage more allied health professionals.

Location of allied health professionals

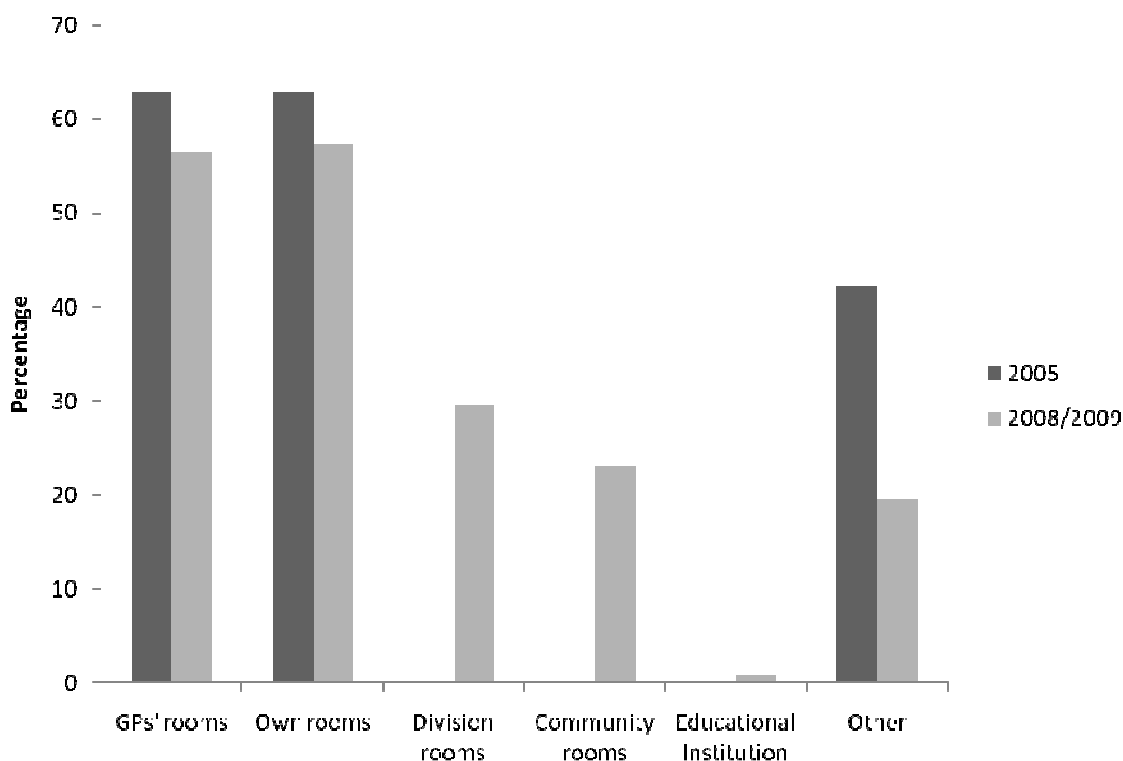
Figure 5 shows the different locations from which allied health professionals were providing services in 2005 and 2008/2009 (again, it should be noted that a given project might be using more than one location, so the total exceeds 100%). In 2005, the allied health professionals in 61 projects (63%) were providing services from GPs' rooms, under co-location arrangements, compared with 56 projects (57%) in 2008/2009. In 2005, 61 projects (63%) reported that allied health professionals were providing services from their own rooms, compared with 59 projects (57%) in 2008/2009. In 2005, 41 projects (42%) reported that allied health professionals were delivering sessions from some other location, compared with 20(19%) in 2008/2009.

In 2005, 'other' locations were many and varied, according to free text survey responses. A number were providing services from Divisional rooms (either located at the Division, or located elsewhere and rented by the Division for this specific purpose). Other commonly-used locations include: community health centres, hospitals and other general health and mental health facilities; other community agencies; and universities. In some projects, allied health professionals were sometimes seeing consumers in their own homes, although this is generally not the norm.

In 2008/2009, the 20 projects who reported using other locations described these most commonly as hospitals (reported by 8 projects). Three of the projects reported using Aboriginal and Torres Strait Island Health Services as a location for their Access to Allied Psychological Services projects allied health professionals. Other locations included: mine sites, community organisations such as women's health centres, youth centres and Headspace. In 2008/2009 extra locations were added to the survey which included; 32 projects (30%) reported that allied health professionals were providing services in Division's rooms, 24 (23%) in community organisations, and 2 (1%) in educational settings.

Comparisons between 2005 and 2009 show a small decrease in the use of GP and own rooms. In contrast, there has been a significant increase in the use of other locations. In 2005, 42% of projects reported their allied health professionals were using other locations. In 2009, further information about the 'other' category was obtained. Divisions' rooms, community organisations, and educational settings were added as their own unique categories, and thus taken out of the 'other' category. If we look at the three new categories and the other category combined for 2008/2009, we can see that in 2008/2009 the use of locations other than GP rooms or allied health professionals own rooms were reported by 73% of Access to Allied Psychological Services projects, an increase of 31%.

Figure 5: Location of allied health professionals in 2005 and 2008/2009



In 2005, 23 projects (24%) reported that the location of service delivery had changed since the project began. Projects reported an effort to expand the service to additional areas or to provide after-hours services, and/or because circumstances had changed. A number of projects that originally provided services exclusively from GPs' practices began offering services from allied health professionals' rooms as well, and vice versa. Several had terminated arrangements with external agencies.

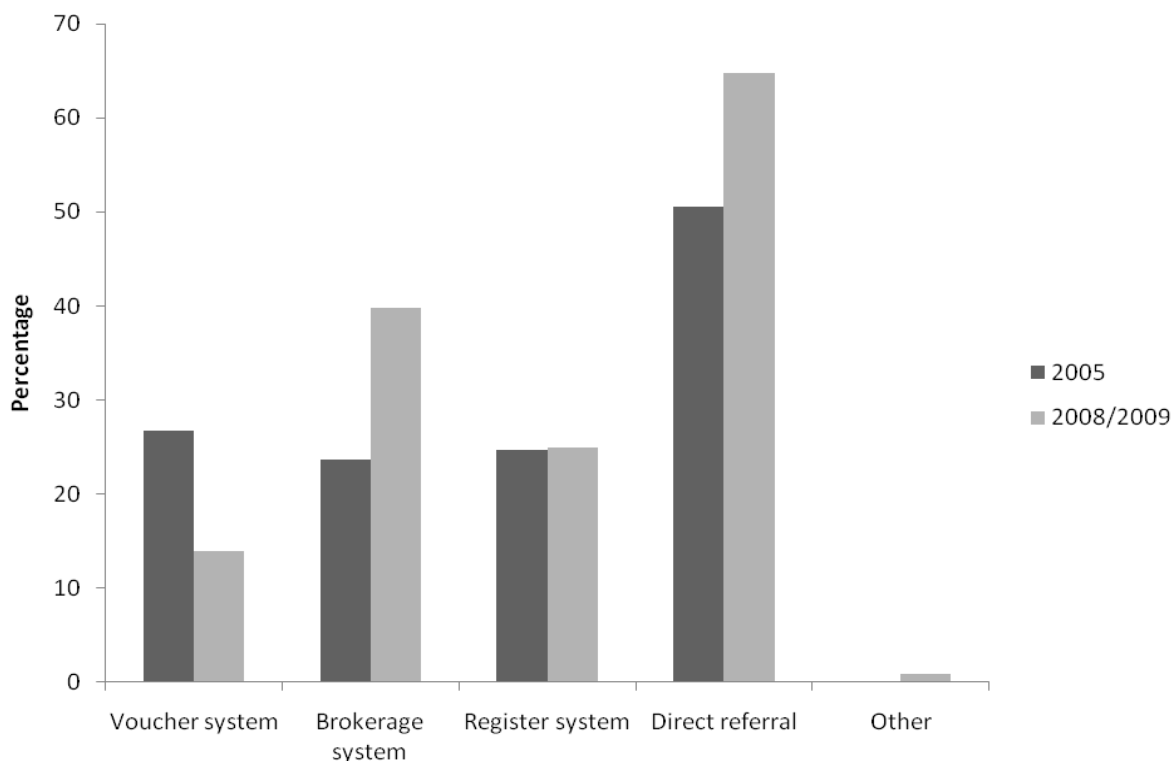
In 2008/2009, only 4 projects (4%) reported a change in the location of service delivery since the project began. Two projects reported they had previously used a combination of allied health professionals' own rooms and GP's rooms, and one project reported they had used only allied health professionals' own rooms. These three projects reported an increased use of Division rooms and also reported a decreased reliance on allied health professionals' own rooms. In addition, one of these projects reported a change to using community organisation rooms. One further Division also reported the inclusion of a community location.

Referral mechanisms

Figure 6 shows the referral mechanisms that are being used in the projects in 2005 and 2008/2009. As with the data on allied health professionals' retention and location, it should be noted that given projects are often using a combination of referral mechanisms, so the total exceeds 100%. The most common referral mechanism, in 2005 and 2008/2009, was direct referral, being used in 49 (51%) projects in 2005 and 51 (53%) in 2008/2009. The voucher system had been taken up in 26 projects (27%) in 2005 and 14 projects (14%) in 2009. The brokerage system was reportedly used in 23 projects (24%) in 2005 and 40 projects (40%) in 2008/2009. The register system was reportedly used in 24 projects (25%) in 2005 and similarly in 26 projects (25%) in 2008/2009.

Comparisons between 2005 and 2008/2009 show a significant increase in the use of brokerage and a significant decrease in the use of a voucher system. The use of a register referral system and direct referral remained relatively constant.

Figure 6: Referral mechanisms in 2005 and 2008/2009



In 2005, survey respondents were given the opportunity to indicate whether any other referral mechanisms are being used in their respective projects, but no new ones were indicated (although several respondents described multiple referral mechanisms being used alongside each other). In 2008/2009 only one ‘other’ referral mechanism was identified.

In 2005, 13 projects (13%) reported that the referral mechanism had changed since the project’s inception. In the main, these changes were fairly minor and involved refining the referral form or the steps involved in the referral process, often with a view to simplifying the tasks required by the GP and/or keeping better track of referrals. More major changes have tended to see projects move from voucher or brokerage systems to direct referral or register systems.

Wherein 2005 most changes to the referral mechanism were reportedly minor, in 2008/2009, 12 projects (11%) reported they had made major changes to the referral mechanism since the project’s inception. The majority of these (10) reported a move away from the use of the voucher system. Two projects provided their rationale for this change, describing the voucher system as ‘disastrous’ and creating an ‘excessive admin load’ because of the ‘difficulty keeping track of paper based vouchers’. However, several projects also reported using the voucher system satisfactorily. Four of these 10 projects reported moving to a brokerage referral system, two moved to a combination of a brokerage and register system, two moved to use only direct referral, one moved to only a register system, and one moved to a combination of brokerage and direct referral. Comments regarding the brokerage system included that whilst it can be useful, it is also administratively draining.

Model combinations

Many of the above models of allied health professional location, retention, and referral mechanism are being used in combination, both within and across dimensions. Table 4 indicates the extent of these combinations. In 2005 there were a wide range of model combinations being implemented with considerable variability. Note that in 2009, Division rooms was added as a new category of location, which would have been captured in 2005 in the ‘other’ category. Also, in the 2009 analysis, only brokerage and

direct referral were analysed as referral mechanisms. It was determined, upon discussion with project officers during the survey that referral mechanisms were described either as brokerage or direct referral and that the voucher system was actually a mechanism by which allied health professionals were paid and identified, and the register system is a list of allied health professionals with their clinical expertise, contact details, and other pertinent information which can be used by the GP or division to aid them in making the most appropriate referral.

In 2009 there continues to be significant variability in model combinations used. Contracted allied health professionals are more commonly used in all combinations of referral and location. Direct referral is more commonly used than brokerage referral in most combinations of location and allied health retention.

Table 4: Number of projects using given model combinations

REFERRAL MECHANISMS	MEANS OF RETAINING ALLIED HEALTH PROFESSIONALS	LOCATION OF ALLIED HEALTH PROFESSIONALS						TOTAL
		GP	OWN	DIVISION	OTHER	GP+OWN	ALL OTHER COMBINATIONS	
BROKERAGE	CON	4	7	3	1	5	2	22
	EMP	1	0	3	0	0	1	5
	CON + EMP	1	0	0	1	1	5	8
DIRECT REFERRAL	CON	6	12	2	2	16	1	39
	EMP	4	0	1	2	1	2	10
	CON+EMP	3	2	1	0	2	6	14
BROKERAGE + DIRECT REFERRAL	CON	0	0	1	0	1	0	2
	EMP	0	0	2	0	0	0	2
	CON + EMP	0	0	0	0	2	2	4
TOTAL		19	21	13	6	27	19	105

LEGEND:

Referral mechanisms
BRK: Brokerage system
DIR: Direct referral

Means of retaining allied health professionals
CON: Contractual arrangements
EMP: Direct employment
CON + EMP: Combination of Contractual and Direct

Location of allied health professionals
GP: GPs' rooms
OWN: Own rooms
DIVISION: Division's rooms
OTH: Other
GP + OWN : Combination of GP and own rooms
ALL OTHER COMBINATIONS: all other combinations of rooms

Additional Comments

When asked for additional comments, a number of projects spoke about funding issues, with eight projects specifically commenting that the Access to Allied Psychological Services projects funding had not been sufficient for their project. Five projects commented that the Access to Allied Psychological Services projects funding does not cover all the costs of running the projects. In particular, funds to 'coordinate and manage the service' and for 'education of GPs' were reported as not being covered. Projects spoke about various demand strategies used to manage the limited funding. Four projects said that they have had to stop GP referrals and close Access to Allied Psychological Services projects services when funding has ran out. Two projects said that they limit Access to Allied Psychological Services projects referrals to low income or pensioner consumers. One other project, using the voucher referral system, limited the number of vouchers available to GPs. Another project reported they were applying to the Department for further funding, and other projects reported that they had received 'top up' funding to cover some of the Access to Allied Psychological Services projects demand. Three projects reported dealing with limited funding by covering administration and management costs through other Division funds.

Chapter 6: Discussion

What is the level of uptake of the general Access to Allied Psychological Services projects by GPs, allied health professionals and consumers?

Between 1 July 2003 and 31 December 2009, 15,251 (9,032, 59% urban; 6,219, 41% rural) GPs referred consumers to 4,042 (2,933, 73% urban; 1,109, 27% rural) allied health professionals through the Access to Allied Psychological Services projects.

Between 1 July 2003 and 31 December 2009, 174,675 consumers were referred to the Access to Allied Psychological Services projects, 135,033 (77%) of whom took up the referrals provided. On a quarterly basis the number of referrals rose from 1,344 in July-September 2003 to a peak of 11,152 in July-September 2006. After the introduction of the Better Access program (November 2006), there was a temporary reduction in the number of referrals overall and in urban and rural areas, perhaps indicating something of a shift to the newer initiative. From the October-December 2007 quarter, the number of referrals steadily increased overall and in rural areas. In urban areas, referral numbers were variable during 2007, but rose consistently in 2008.

In total, 709,684 sessions of care were provided through the projects, making the average number of sessions provided to consumers 5.3. Overall, the number of sessions has increased over time from 3,842 in July-September 2003 to a peak of 42,222 in July-September 2006. The same pattern was apparent for urban and rural projects; the equivalent figures were 2,074 and 25,220 for urban projects and 1,768 and 17,002 for rural projects. Subsequent to the decline after the introduction of the Better Access initiative the number of sessions delivered in rural areas reached a new peak in July-September 2008 with 17,373 sessions. Whilst the number of sessions in urban areas has steadily increased since October-December 2007, the number has not surpassed the previous peak prior to the introduction of Better Access.

What are the sociodemographic and clinical profiles of consumers of general Access to Psychological Services projects, and what is the nature of the care they are receiving?

The profile of referred consumers has remained relatively consistent over time, and, in the main, is similar across urban and rural projects. Around three quarters of all consumers are female, and their mean age is approximately 39 years. The majority (around two thirds) are on low incomes. About half have no previous history of mental health care. Of those for whom a diagnosis was made by the referring GP, most have been diagnosed with depression (75%) and/or anxiety disorders (57%).

The profile of sessions has not changed greatly since the Access to Allied Psychological Services projects began. Sessions of 46-60 minutes have consistently been the most popular format over time, accounting for around four fifths of all sessions. Almost all of these sessions have been delivered to individuals, rather than groups. The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 44% and 58% of sessions, respectively. In the main, the profiles of sessions in urban and rural projects mirror the profile for all projects, but there are some nuances. For example, although the majority of both urban and rural sessions have consistently been 46-60 minutes in length, a slightly higher proportion of rural sessions have been under 45 minutes.

Nationally 79% of sessions over the life of the Access to Allied Psychological Services projects have not incurred a co-payment. For those sessions that have incurred a co-payment it has been \$30 or less. Sessions in rural areas are more likely to be free of a co-payment (92% compared with 71% of sessions in urban areas). In previous reports we have shown how the inclusion of co-payments in sessions has varied overtime. Anecdotal evidence suggests that these fluctuations over time may represent an attempt to strike a balance between providing a free service to a limited number of people, and a low-cost service to a larger number of people.¹ They may also reflect the view that a small copayment may encourage greater commitment to treatment on the part of the consumer.

Have the models of service delivery being utilised by the general Access to Allied Psychological Services projects changed over time?

The 2008/2009 survey of Access to Allied Psychological Services projects sought to answer the following two research questions:

- What is the profile of models of service delivery across the Access to Allied Psychological Services projects?
- How has the profile of models of service delivery across the Access to Allied Psychological Services projects changed since 2005?

Previous national evaluation work in relation to the Access to Allied Psychological Services projects has shown that the projects are operating under a range of different service delivery models. These models differ in terms of: (a) the means of retaining allied health professionals (i.e., contractual arrangements, direct employment, other); (b) the location of allied health professionals (i.e., GPs' rooms, own rooms, other); and (c) the referral mechanisms used (i.e., voucher systems, brokerage systems, register systems, direct referral, other).

The 2008/2009 survey of Access to Allied Psychological Services projects showed that the most common form of allied health professional retention was contractual, the most commonly used location was the combination of allied health professionals' own rooms and GP's rooms, and that the most commonly used referral mechanism was direct referral.

In terms of allied health retention, comparisons between 2005 and 2008/2009 suggest a slight increase in the use of contractual arrangements, a more significant increase in the use of direct employment and a decrease in the use of other arrangements. In terms of the location of allied health professionals, there was a small decrease in the use of GPs and allied health professionals own rooms and a significant increase in the use of other locations, most notably the use of Divisions' rooms. In terms of referral mechanisms, comparisons between 2005 and 2008/2009 show a significant increase in the use of brokerage and a significant decrease in the use of a voucher system. The use of a register referral system and direct referral remained approximately constant.

Consistent with the 2005 findings, the survey data findings from 2009 suggests that there continues to be considerable variability across the Access to Allied Psychological Services projects with regard to the combination of models of service delivery being implemented. Many projects reported that they were using various combinations of allied health retention, location of allied health professionals and referral mechanism. This, and the fact that many of the projects report that they have continued to modify their models over time suggests that the projects continue to respond to local needs by seeking models of service delivery that work within their own context.

Caveats

Some caution should be exercised in interpreting the above findings. Firstly, in relation to data from the minimum dataset, there are lags in data entry specifically some division do not enter session data until all sessions for the consumer are complete therefore this specifically affects the more recent uptake figures. Secondly, in relation to the models of service delivery surveys, the data in 2009 were somewhat limited by the knowledge of the project officers. Some of the interviewed project officers reported that they were relatively new to the role and had limited knowledge regarding the history of their Access to Allied Psychological Services projects and changes over time.

Conclusions

The current report indicates that the Access to Allied Psychological Services projects continue to be an integral part of the primary mental health care system in Australia. There is continued momentum in gaining additional GPs and allied health professionals to provide services to substantial number of consumers. The profile of consumers and the care they are receiving is very consistent overtime. The majority are women with high prevalence disorders who receive individual sessions mostly involving one hour sessions utilising CBT based cognitive and behavioural interventions.

The models of service delivery survey conducted in 2008/2009 indicates that allied health professionals, the location from which they practice and the way they receive referrals varies considerably from project to project. This indicated that there is not a 'one model fits all' approach to the services being delivered. Further there have been some significant changes to the models projects are using since 2005 when the

survey was conducted for the first time. This highlights the flexibility of the projects in being responsive to the changing needs of the community and their ability to recognise when services could be delivered in a more effective way to consumers.

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Appendix A: Summary of focus of evaluation reports

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
First Interim Evaluation Report Dec 2003	Round 1 pilot projects—Australia	<ul style="list-style-type: none"> Local evaluation reports 	<ul style="list-style-type: none"> What models of service delivery are being used by the pilots? What is the uptake of the pilots? What are the advantages and disadvantages of the pilots? 	<ul style="list-style-type: none"> The pilots are operating under a range of models. The models differ in terms of referral mechanisms (ranging from simple voucher systems to more complex brokerage systems), means of retaining allied health professionals (with most retaining them under some sort of contract and some employing them directly), and location of allied health professionals (with most providing services in GPs' rooms but some providing them in their own rooms or in a third location). The pilots have recruited 136 individual allied health professionals (primarily psychologists) and 10 agencies. In total, 387 GPs have referred 2036 patients to these allied health professionals. Advantages for GPs included: savings in terms of time and cost and feedback from allied health professionals, and disadvantages included opportunity costs and other risks. Advantages for allied health professionals included an increased referral base and improved relationships with GPs, and disadvantages included payment anomalies and communication difficulties. Advantages for patients included access to psychological services although some noted barriers to attendance.
Second Interim Evaluation Report July 2004	Round 1 pilot and supplementary projects—Australia	<ul style="list-style-type: none"> Local evaluation reports Minimum dataset 	<ul style="list-style-type: none"> What models of service delivery are being used by the projects? What is the level of uptake of the projects? Who is accessing services through the projects? What services are patients receiving through the projects? What are the advantages and disadvantages of the projects? 	<ul style="list-style-type: none"> A range of models is being used from simple voucher systems to more complex brokerage models. Intermediate models are now available which provide GPs with registers that profile allied health professionals in terms of their skills and competencies, thereby enabling GPs to make informed referral decisions. The projects have involved between 710 and 926 GPs and between 160 and 229 allied health professionals. Together, these providers have enabled between 3476 and 3656 patients to access mental health care, which would otherwise have been out of their reach. The majority (58%) of patients are on low incomes (58%) and have not completed secondary education (56%), most have been diagnosed with depression (77%) and/or anxiety (55%) by their GP, and 40% have no previous history of specialist mental health care, indicating that their access may have previously been problematic. The number of sessions of therapy received to date is 8678. Most sessions tend to be close to an hour in length (71%), and involve individual treatment (99%). The most common interventions are cognitive and behavioural interventions (55% and 41%, respectively). In 76% of all sessions, no co-payment is required; in the remainder of sessions a co-payment of not more than \$10 is charged. GPs and allied health professionals involved in projects are now feeling more satisfied that the initiative is viable and ongoing. Benefits observed by GPs include new skills and knowledge in the area of mental health and new referral options. Benefits observed by allied health professionals include improved relationships with GPs and an increased referral base. Patients are benefiting from ready access to high quality care. Despite these positives, GPs and allied health professionals have experienced some attitudinal and logistical barriers, and patients have experienced some inequities in referral.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Third Interim Evaluation Report Feb 2005	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—Victoria and Tasmania	<ul style="list-style-type: none"> ▪ Evaluation forum 	<ul style="list-style-type: none"> • Do models of service delivery differ from the conceptualisation outlined in the First and Second Interim Evaluation Reports? • What are the benefits and barriers associated with the means of retaining allied health professionals? • What are the benefits and barriers associated with the various locations from which allied health professionals deliver services? • What are the benefits and barriers associated with the different referral mechanisms? 	<ul style="list-style-type: none"> • The evaluation forum provided support for the validity of the conceptualisation of the different models of service delivery put forward in the early evaluation reports. • The major focus of the evaluation forum was in determining the benefits and barriers associated with the dimensions of the models. Often, the benefits of one model address barriers to another, and vice versa. So, for example, projects in which the allied health professionals operate from their own rooms may have benefits for GPs in terms of access to a range of providers, but may present problems associated with reduced opportunities to collaborate. Conversely, projects in which the allied health professionals are co-located with GPs may have advantages for GPs in terms of communication, collaboration and potential for knowledge transfer, but the downside may be a reduced range of providers to whom referrals can be made.
Fourth Interim Evaluation Report April 2005	Round 1 pilot and supplementary projects, Round 2 projects—Australia	<ul style="list-style-type: none"> • Local evaluation reports • Minimum dataset 	<ul style="list-style-type: none"> • What models of service delivery are being used by the projects? • What is the level of uptake of the projects? • Who is accessing services through the projects? • What services are patients receiving through the projects? • What are the benefits and barriers associated with the projects? • What lessons have been learned from the early experiences of the projects? 	<ul style="list-style-type: none"> • The projects are operating under a range of different models that vary in terms of means of retaining allied health professionals, location of allied health professionals, and referral mechanisms. • The uptake of the Round 1 and 2 projects is high. Using the minimum dataset as the gold standard, 1771 GPs had referred 12 758 patients to 569 allied health professionals by 31 December 2004. There has been significant growth as time has passed and the Round 2 projects have developed. • The majority (62%) of patients are on low incomes, most have been diagnosed with depression (76%) and/or anxiety disorders (56%) by their GP, and 46% have no previous history of specialist mental health care, indicating that access may previously have been problematic for them. • There are good indications that the Round 1 and 2 projects are providing free or low-cost evidence-based mental health care to patients through structured sessions. In total, the number of sessions of therapy received to date by patients in the Round 1 and 2 projects is 45 823. Most sessions (75%) are an hour in length, and 98% involve individual, rather than group-based, treatment. The most common interventions delivered through these sessions are CBT-based cognitive (61%) and behavioural (45%) interventions. In 63% of all sessions, patients are not required to contribute to the cost of care; in the remainder of cases they are asked to make a co-payment, usually of not more than \$20. • Participating GPs, allied health professionals and patients are very satisfied with the Round 1 and 2 projects. GPs, allied health professionals and patients appreciate upskilling opportunities, the increased referral base and the high quality of care, respectively. There have been some barriers to participation—e.g., paperwork hurdles for GPs, frustration at a perceived lack of decision-making power for allied health professionals, and equity issues for patients. • GPs are now less likely to experience confusion about how the projects operate, allied health professionals seem to be less concerned about the uncertainty of guaranteed work, and problems with inappropriate referrals have generally been 'ironed out'.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Fifth Interim Evaluation Report June 2005	Round 1 pilot and supplementary projects, Round 2 projects—Australia	<ul style="list-style-type: none"> Survey of models of service delivery 	<ul style="list-style-type: none"> What is the profile of models of service delivery across the ATAPS projects? Are particular models associated with differential levels of patient access to services? 	<ul style="list-style-type: none"> In 76% of projects, allied health professionals are retained under contractual arrangements; in 28% through direct employment; and in 7% by other means (e.g. arrangements with supervised postgraduate psychology students); in 63%, allied health professionals provide services from GPs' rooms; in 63% they do so from their own rooms; and in 42% they do so from some other location (e.g. Divisional rooms, community health centres, hospitals and other general health and mental health facilities, other community agencies, and universities); and in 27%, voucher systems are used; in 24% brokerage systems are used; in 25% register systems are used; and in 51% direct referral systems are used. All models appear to be performing equally well in terms of enabling patients to receive free (or low-cost), evidence-based mental health care.
Sixth Evaluation Report Nov 2005	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—Australia	<ul style="list-style-type: none"> Local evaluation reports Minimum dataset 	<ul style="list-style-type: none"> Has participation in the projects by GPs and allied health professionals changed over time? Have access to and the nature of mental health care for patients changed over time? Have the experiences of GPs, allied health professionals and patients changed over time? Are the projects achieving positive outcomes for patients? 	<ul style="list-style-type: none"> 2980 GPs have made referrals to 1040 allied health professionals since the projects began. There has been a dramatic increase in participation rates by both GPs and allied health professionals over the life of the projects. The total number of patients receiving care through the projects is 26 444. The total number of sessions provided to these patients is 102 120. Both the number of patients and the number of sessions have increased substantially over time. The profile of sessions has not changed over time, with the majority being individually based, an hour in length, and consisting of CBT-based cognitive and behavioural therapies. Early sessions rarely incurred a co-payment, and where they did it was usually \$10 or less; subsequent sessions more commonly involved a co-payment, sometimes of as much as \$20 or more; and more recent sessions have been less commonly associated with a co-payment although the situation has not returned to the original low. Some experiences for stakeholders have remained constant over time, while others have changed. In 88% of cases, patients who have contact with allied health professionals through the ATAPS projects get better.
Seventh Interim Evaluation Report March 2006	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—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 projects? What services are patients receiving through the rural and urban projects? What are the outcomes for patients through the rural and urban projects? What are the issues associated with the rural and urban projects? 	<ul style="list-style-type: none"> Both rural and urban projects are using a mix of models. However, there are some notable differences. Rural projects are more likely than urban projects to directly employ allied health professionals (37% versus 21%). Rural projects are less likely to have allied health professionals providing services from their own rooms (53% versus 72%). Rural projects are more likely to implement direct referral systems (64% versus 38%), and less likely to use register systems (17% versus 32%). As at 31 December 2005, 1587 GPs had referred 14 137 patients to 359 allied health professionals via the rural projects. The equivalent figures for the urban projects are 1639, 16 649 and 770, respectively. The majority of patients in both rural and urban locations are female, however, there are proportionally more male patients in rural settings (28% versus 26%). The majority of rural and urban patients have depression and/or anxiety disorders, a lower proportion of rural patients have the latter (55% versus 60%). The majority of sessions in both rural and urban settings are 46–60 minutes in length, although a smaller proportion are of this duration in rural settings (75% versus 80%). No co-payment is charged in 82% of rural sessions, compared with only 68% of urban sessions. Both rural and urban projects are achieving positive patient outcomes. Rural projects have struck problems to do with: distance; attracting qualified staff; lack of training and support for GPs; limited services; large Indigenous populations; high levels of

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
				unemployment; and stigma. The issues for urban projects have related more to: uptake and demand; workforce shortages; and availability of and coordination with other services.
Eighth Interim Evaluation Report June 2006	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects—Australia	<ul style="list-style-type: none"> • Minimum dataset • Survey of models of service delivery 	<ul style="list-style-type: none"> • What is the level of patient outcomes within and across projects? • Does the level of patient outcomes vary depending on the model of service delivery? 	<ul style="list-style-type: none"> • The projects are achieving positive effects, mostly of large or medium magnitude. This suggests that the projects are effective in improving the mental health of patients who are receiving psychological services. • Projects do not differ markedly in terms of the patient outcomes they are achieving, despite their differences in models of service delivery. Only one variable emerged as significant: projects implementing direct referral systems are tending to achieve greater levels of patient outcomes. In addition, there were non-significant trends toward employment of allied health professionals being predictive of greater patient outcomes and delivery of services from allied health professionals' own rooms being predictive of lesser patient outcomes.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Ninth Interim Evaluation Report October 2006	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects—Australia	<ul style="list-style-type: none"> Survey of demand management strategies 	<ul style="list-style-type: none"> How many projects are using demand management strategies? What demand management strategies are being used within projects? Which demand management strategies have been found to be most useful? What features of any demand management strategy have worked well and not worked well? 	<ul style="list-style-type: none"> 85% of projects are using at least one demand management strategy. The most commonly used demand management strategies are: informing/training GPs (used in 82% of projects); putting in place systems and/or administrative procedures (used in 76%); and monitoring and limiting referrals (used in 61%). The majority of projects are using a combination of broad demand management strategies (5.6 per project, on average). They are also employing a range of approaches within each demand management strategy. Monitoring and limiting referrals and putting in place systems and/or administrative procedures are ranked as the most useful demand management strategies, with 29% of project officers endorsing the former and 24% the latter. Different features of these demand strategies appear to work well for different projects, but a common theme is that they need to be underpinned by strong partnerships and solid infrastructure. There is concern that the need for demand management reflects the fact that projects are insufficiently resourced, and that as a consequence demand management strategies such as limiting referrals can have a negative effect on stakeholder perceptions.
Tenth Evaluation Report Nov 2007	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects—Australia	<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 ATAPS projects have gained considerable momentum over time. Collectively, they are attracting far more GPs and allied health professionals and are providing access to high quality mental health care than was the case originally. The numbers of referring GPs rose steadily from 449 in the July-September 2003 quarter to a peak of 2,451 in the July-September 2006 quarter. 135 allied health professionals, provided services in the July-September 2003 quarter, and 1,225 doing so in the July-September 2006 quarter In the main, the profile of consumers they are treating and the nature of sessions they are providing have both reached a point of consistency. The projects are achieving positive outcomes for consumers. Overall, the introduction of the Better Access program does not seem to have reduced the demand for psychological services provided through the ATAPS projects, although there has been a slight shift to Better Access in urban Divisions.
Eleventh Evaluation Report October 2007	Not applicable	<ul style="list-style-type: none"> Semi structured Interviews 	<ul style="list-style-type: none"> What have the reports been used for? What have the reports confirmed? What aspects of the reports have been the most useful? Have the reports affected any decisions or led to any changes? Was new knowledge regarding the program produced in the evaluation reports? 	<ul style="list-style-type: none"> Most commonly the reports have been used in describing what was occurring in the field. They have also been used with documentation related to the projects. In some cases they have led to program modification. As well the reports have been used for lobbying and advocacy purposes. The reports have confirmed that the original thinking behind the BOiMHC program in general and the ATAPS projects is appropriate. The uptake data and the data that profiled socio-demographic and clinical characteristic of consumers as well as the services provided were very valuable. Others also valued project impact data, process oriented information and data interpretation. The reports have guided program modification or non modification. The reports have influenced decisions about the ATAPS program for example co payments. Some respondents thought that the reports may have influenced changes at the policy level.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
				<ul style="list-style-type: none"> The reports furthered understanding about 'what works, for whom, and in what circumstances.'
Twelfth Evaluation Report April 2008	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects— Australia	<ul style="list-style-type: none"> Minimum dataset 	<ul style="list-style-type: none"> Has participation in the projects by GPs and allied health professionals changed over time? Has the profile of consumers varied over time, and has the care they are receiving changed? Are the projects achieving positive outcomes for consumers? 	<ul style="list-style-type: none"> The uptake of projects continues to be are substantial, with 7,776 GPs referring 100,854 consumers to 2,665 allied health professionals between 1 July 2003 and 31 December 2007 Uptake steadily rose from 2003, with a drop in late 2006 following introduction of Better Access, and continues to be substantial since then. The profile of referred consumers has remained consistent over time, with the majority being females diagnosed with depression or anxiety, on low incomes, and with a mean age of 39 years. About half have no previous history of mental health care. The projects are achieving positive outcomes of large or medium magnitude in 65% of cases.
Thirteenth Evaluation Report March 2009	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects – Australia	<ul style="list-style-type: none"> Minimum dataset Medicare Benefits Schedule data 	<ul style="list-style-type: none"> 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"> In the twenty- one months since the introduction of the Better Access program (1 November 2006), a dramatic uptake of Better Access sessions in urban areas coincided with a temporary reduction in sessions provided in urban areas under ATAPS. Similarly, sessions through rural ATAPS projects temporarily decreased but to a lesser extent. Currently the uptake of sessions through both programs is steadily increasing, suggesting that the two programs are complementary in terms of addressing significant community need.
Fourteenth Evaluation Report June 2009	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects – Australia	<ul style="list-style-type: none"> Minimum dataset 	<ul style="list-style-type: none"> Has participation in the general Access to Allied Psychological Services projects by GPs and allied health professionals changed over time? Has the profile of consumers of general Access to Allied Psychological Services projects varied over time, and has the care they are receiving changed? Are the projects achieving positive outcomes for general Access to Allied Psychological Services consumers? 	<ul style="list-style-type: none"> Since the January-March 2008 quarter the number of GPs has increased steadily to an all time peak in April-June 2008 to 2,616 (1,116 rural; 1,500 urban). Similarly, since October-December 2007 the number of participating allied health professionals also steadily increased to 1218 (390 rural; 891 urban) in the October-December 2008 quarter. The number of GPs and allied health professionals in urban and rural areas has followed a similar pattern to that of the national figures although the impact of Better Access appears to have been much less pronounced in rural areas. The profile of referred consumers has remained relatively consistent over time, and is similar across urban and rural projects. The profile of these sessions has not changed greatly since the Access to Allied Psychological Services projects began. The only notable change over time with respect to the sessions of care provided has been in the charging of a copayment. Relatively small proportions of sessions were associated with copayments The projects were shown to be achieving positive outcomes of large or medium magnitude in 86% of cases.

Report	Projects included	Data sources	Evaluation questions	Evaluation findings
Including Preliminary findings of the Perinatal Depression Initiative		<ul style="list-style-type: none"> • Minimum dataset 	<ul style="list-style-type: none"> • What is the uptake of the Perinatal Depression Initiative by GPs and allied health professionals? • What is the profile of consumers and the care they are receiving? 	<ul style="list-style-type: none"> • 23 divisions have entered data in the minimum-dataset. The majority of referrals and sessions have been in rural areas consistent with the intent of the initiative to target rural and remote locations. • Almost all consumers referred have been female with an average age of 31 years. Eighty-two percent have been diagnosed with depressive disorders and 37% with anxiety disorders. Almost all sessions were individual and an hour in length.

Appendix B: 2005 Service models survey instrument

PROGRAM EVALUATION UNIT



Models of service delivery used in Access to Allied Health Services Projects

As part of our role in synthesising evaluation information from the Access to Allied Health Services projects, we have developed a conceptual framework to describe the models of service delivery being used by the projects. The models differ in terms of means of retaining allied health professionals, location of allied health professionals and referral mechanisms (see Box 1).

Box 2: A framework to describe the models of service delivery being used by the projects

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

To date we have not been able to quantify the extent of variation in the models being used by projects, nor to answer the question of whether some models work better than others in particular contexts. We are not even certain that the framework is exhaustive; there may be other models operating of which we are unaware. In an effort to further clarify the range of models being used, we are conducting a brief survey to establish the models of service delivery that projects are currently implementing.

We would appreciate it if you would spend a few minutes completing the 1-page survey overleaf. Once you have completed the survey, please return it by email or fax to:

Belinda Morley (if you're in Vic, SA, Tas or NT)

Email: bcmorley@unimelb.edu.au

Fax: 03 9348 1174

Fay Kohn (if you're in Qld, NSW, WA or ACT)

Email: fkohn@unimelb.edu.au

Fax: 03 9348 1174

1. Name of Division(s) conducting Access to Allied Health Services project:

2a. Which of the following means of retaining allied health professionals is currently being used in your Access to Allied Health Services project? Please tick appropriate response(s)

- Contractual arrangements:** Allied health professionals are retained under some sort of contract or memorandum of understanding. In most cases, contracts are with individual providers, but some Divisions have elected to enter into contracts with agencies.
- Direct employment:** Allied health professionals are directly employed by the Division.
- Other** [Please specify] _____
-

2b. Has the means of retaining allied health professionals changed since the project began? Please tick appropriate response

- Yes If yes, how? _____
- No _____
-

3a. From which of the following locations are allied health professionals currently providing services in your Access to Allied Health Services Project? Please tick appropriate response(s)

- GPs' rooms:** Allied health professionals provide services to the projects in rooms at the GPs' practices.
- Own rooms:** Allied health professionals provide services at their own premises.
- Other location** [Please specify] _____
-

3b. Has the location of allied health professionals changed since the project began? Please tick appropriate response

- Yes If yes, how? _____
- No _____
-

4. Which of the following referral mechanisms is currently being used in your Access to Allied Health Services Project? Please tick appropriate response(s)

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

4b. Has the referral mechanism changed since the project began? Please tick appropriate response

- Yes If yes, how? _____
- No _____
-

5. Additional comments regarding service delivery models:

Thank you for taking the time to complete this survey.

Appendix C: 2009 Service models survey instrument

CENTRE FOR HEALTH POLICY, PROGRAMS AND ECONOMICS



Models of service delivery used in Access to Allied Health Services Projects

As part of our role in synthesising evaluation information from the Access to Allied Psychological Services projects, we have developed a conceptual framework to describe the models of service delivery being used by the projects. The models differ in terms of means of retaining allied health professionals, location of allied health professionals and referral mechanisms (see Box 1).

Box 3: A framework to describe the models of service delivery being used by the projects

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

In April 2005, as part of our evaluation, we conducted a survey to find out about the various service delivery models being used by ACCESS TO ALLIED PSYCHOLOGICAL SERVICES PROJECTS projects. We found that a range of models were being used and that all models were performing equally in terms of enabling access and improving outcomes for consumers. With the introduction of several new mental health initiatives since 2005, we are interested in whether there have been any changes in ACCESS TO ALLIED PSYCHOLOGICAL SERVICES PROJECTS service delivery models and the cost-effectiveness of these models. In this light, we are conducting interviews with Project Officers / Program Managers.

We will call to arrange a convenient time to interview you. In the meantime, we would appreciate it if you would spend a few minutes preparing responses for the interview questions overleaf.

1. Name of Division(s) conducting Access to Allied Health Services project:

2. Which of the following means of retaining allied health professionals was being used in your Access to Allied Psychological Services project in the 07-08 financial year? Please tick appropriate response(s)

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

3. From which of the following locations were allied health professionals providing services in your Access to Allied Psychological Services project in the 07-08 financial year? Please tick appropriate response(s)

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

3a. Did the Division pay rent for any of the above locations in your Access to Allied Psychological Services project in the 07-08 financial year? Please tick appropriate response

- Yes
- No

4. Which of the following referral mechanisms was being used in your Access to Allied Psychological Services project in the 07-08 financial year? Please tick appropriate response(s)

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

professionals, and the allied health professional redeems the vouchers for payment from the Division.

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

5. Have any aspects of the model of service delivery (i.e., means of retaining allied health professional, location of allied health professional, referral mechanism) changed since the project began? Please tick appropriate response

- Yes If yes, how / when / why?

- No

6. Which of the categories below best describes the amount of funding your ACCESS TO ALLIED PSYCHOLOGICAL SERVICES PROJECTS project received from the Commonwealth for the July 2007 to the June 2008 financial year? Please tick appropriate response

- | | | |
|--|---|--|
| <input type="checkbox"/> less than \$25,000
\$299,999 | <input type="checkbox"/> \$100,000 to \$149,999 | <input type="checkbox"/> \$250,000 to |
| <input type="checkbox"/> \$25,000 to \$49,999 | <input type="checkbox"/> \$150,000 to \$199,999 | <input type="checkbox"/> \$300,000 or more |
| <input type="checkbox"/> \$50,000 to \$99,999 | <input type="checkbox"/> \$200,000 to \$249,999 | |

7. In the financial year from July 2007 to June 2008, did you supplement ACCESS TO ALLIED PSYCHOLOGICAL SERVICES PROJECTS Commonwealth funding with other Division funding? Please tick appropriate response

- Yes
- No

If yes, how much Division funding was used?

- | | | |
|---|---|---|
| <input type="checkbox"/> less than \$2,500 | <input type="checkbox"/> \$10,000 to \$19,999 | <input type="checkbox"/> \$40,000 to \$49,999 |
| <input type="checkbox"/> \$2,500 to \$5,000 | <input type="checkbox"/> \$20,000 to \$29,999 | <input type="checkbox"/> \$50,000 to \$59,999 |
| <input type="checkbox"/> \$5,000 to \$9,999 | <input type="checkbox"/> \$30,000 to \$39,000 | <input type="checkbox"/> \$60,000 or more |

8. In the financial year from July 2007 to June 2008, did you combine ACCESS TO ALLIED PSYCHOLOGICAL SERVICES PROJECTS Commonwealth funding with other Mental Health program funding? Please tick appropriate response

- Yes
- No

If yes, please
describe: _____

9. Additional comments regarding service delivery models:

Thank you for taking the time to complete this survey.