
PROGRAM **E**VALUATION **U**NIT



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

First Interim Evaluation Report

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Executive summary

Background

The Access to Allied Health Services component of the Better Outcomes in Mental Health Care initiative permits eligible GPs to refer consumers to allied health professionals who deliver focused psychological strategies (namely psycho-education, cognitive behavioural therapy and interpersonal therapy) in six sessions. During the first 12 months of the initiative, 69 Access to Allied Health Services projects were funded through Divisions of General Practice. The first 15 were regarded as pilots, and are the focus of this report.

Method

The current report synthesises information from the local implementation and evaluation reports of the pilots in order to provide lessons about how they are going, who they are reaching, the type of care they are providing, and whether specific models of service delivery seem to be particularly effective in given circumstances. In this context, it aims to answer the following questions:

- What models of service delivery are being used by the Access to Allied Health Services pilots?
- What is the uptake of the pilots?
- What are the advantages and disadvantages of the pilots?

Results and discussion

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 different models appear to have advantages and disadvantages. GPs appreciate the simplicity and efficiency of the voucher system, but both GPs and allied health professionals feel that it does not promote good inter-professional communication and consumers argue that it means that they are not always referred to the most appropriate provider. The brokerage system, by contrast, is more likely to cause confusion among GPs, but they are willing to accept a more complex system if the advantages to consumers can be clearly demonstrated. GPs, allied health professionals and consumers believe that the brokerage system promotes high quality care (e.g., because it improves collaboration between professionals and ensures a good 'match' between the consumer and the allied health professional). The key feature of the intermediate model – the co-location of allied health professionals within GPs' practices – combines simplicity with good opportunities for inter-professional communication, but reduces the consumers' choice of allied health professional.

With regard to how the pilots are going, it can be concluded that they have achieved much within a relatively short space of time. They have recruited 136 individual allied health professionals (primarily psychologists) and ten agencies. In total, 387 GPs have referred 2036 consumers to these allied health professionals. Their reach has been significant in terms of the numbers of GPs, allied health professionals and consumers they have involved. Anecdotally, they appear to be reaching their target groups (e.g., consumers on low incomes), but it is not possible to be precise about this without more consistent data.

Likewise, they appear to be providing appropriate services (e.g., cognitive behavioural therapy), but lack of consistent reporting makes it difficult to make definitive statements about this.

For participating GPs, advantages of the pilots included: savings in terms of time and cost; location of service delivery by allied health professionals; feedback from allied health professionals; opportunities for learning; and improved understanding of the role of allied health professionals. Disadvantages included: barriers to participating in education and training; delays in registration with the General Practice Mental Health Standards Collaboration; confusion about how the Access to Allied Health Services component works; opportunity costs and other risks; and sub-optimal communication.

For participating allied health professionals, advantages included: an increased referral base; improved relationships with GPs; clinical supervision; and opportunities to 'do something different'. Disadvantages included: payment anomalies; communication difficulties; and co-location issues.

For consumers referred to allied health professionals, advantages included: access to psychological services; increased satisfaction with care; and improved outcomes of care. Some consumers, however, noted barriers to attendance and inappropriateness of referrals among the disadvantages.

Conclusions

The Access to Allied Health Services component of the BOiMHC initiative has had a high level of uptake, generally proving popular with GPs, allied health professionals and consumers. Like any new initiative, there are some structural and attitudinal barriers that need to be addressed, but its continuation and expansion initiative should be a high priority for ongoing funding. Likewise, rigorous evaluation efforts should be continued.

Background

The Better Outcomes in Mental Health Care initiative

With funding of \$120.4 million over four years, the 2001-2002 budget initiative Better Outcomes in Mental Health Care (BOiMHC) seeks to improve the mental health care available to Australians. It has five key, interconnected components, each of which is described in more detail in Appendix 1:

- Component 1: Education and training for GPs
- Component 2: The 3 Step Mental Health Process
- Component 3: Focused Psychological Strategies
- Component 4: Access to Allied Health Services
- Component 5: Access to Psychiatrist Support

The Access to Allied Health Services component

This evaluation report focuses specifically on the Access to Allied Health Services component. This component of the BOiMHC initiative represents a fundamental reform as it prioritises access for individuals with common mental disorders such as depression and anxiety to non-pharmacological forms of treatment by non-medical mental health specialists. Specifically, it permits eligible GPs to refer consumers to allied health professionals^a who deliver Focused Psychological Strategies, namely (a) psycho-education; (b) cognitive behavioural therapy (including behavioural interventions, cognitive interventions, relaxation strategies and skills training); and (c) interpersonal therapy. These services are deliverable in up to six time-limited sessions with an option for up to a further six sessions following a mental health review by the referring GP. Divisions of General Practice act as fundholders in this component of the BOiMHC initiative.

In the first 12 months of the Initiative, 69 Access to Allied Health Services projects have been funded through divisions (see Appendix 2 for a complete list). Sixteen pilots received Round 1 funding between June and August 2002, and a further 13 supplementary projects received funding between January and March 2003. Forty one additional projects have received Round 2 since July 2003. Priority has been given to rural and regional centres and innovative models.

Evaluating the Access to Allied Health Services component

The Better Outcomes in Mental Health Care initiative has a strong commitment to evaluation, as evidenced by the early establishment of the Evaluation Working Group (chaired by Professor Ian Hickie), which provides advice to the Department of Health and Ageing on evaluation issues concerning the initiative generally and the Access to Allied Health Services projects specifically.

In May 2003, on the recommendation of the Evaluation Working Group, Melbourne University's Program Evaluation Unit (PEU) was appointed as the National Evaluation Team and given the task of undertaking national evaluation work in regard to the Access to Allied Health Services projects. The National Evaluation Team's role involves:

- **Support to local evaluations:** Under the terms of their funding agreements, each project has allocated a portion of its budget to evaluation. Varying arrangements have been pursued with this funding, including the appointment of

^a Allied health professionals have been defined to include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers.

external evaluators. The design and nature of the local evaluations differ, depending on the model of service delivery and the local context. Typically, however, the local evaluations are employing a combination of quantitative and qualitative methods to examine the processes/structures and impacts/outcomes of the different models. The National Evaluation Team is providing support to Divisions with these local evaluations, recognising the different circumstances under which these evaluations are being conducted.

- **The development of a minimum dataset:** On behalf of the Evaluation Working Group, the National Evaluation Team has also been involved in the development of a minimum dataset that will standardise the basic information collected by Divisions running Access to Allied Health Services Projects, and therefore act as an important evaluation tool. The minimum dataset is designed to capture de-identified consumer-level information, which will be invaluable for describing who is accessing allied health care as a result of these projects, as well as for providing a broad overview of the care these people are receiving. The minimum dataset has recently been 'rolled out' to Divisions, which are now entering data in a consistent form.
- **Synthesising evaluation lessons from the Access to Allied Health Services projects:** Periodically, the National Evaluation Team will be drawing together information from the local evaluations (and related local reports) and the minimum dataset to provide ongoing lessons about how the Access to Allied Health Services projects are going, who they are reaching, the type of care they are providing, and whether specific models of service delivery seem to be particularly effective in given circumstances.

The current report

This *First Interim Evaluation Report* represents the first synthesis of evaluation lessons from the Access to Allied Health Services projects. As the minimum dataset has only recently been made available to Divisions, the report draws entirely on information from the local evaluation reports (and implementation reports) of the first 15 pilots.

Method

As noted in the previous section, this report synthesises information from relevant documentation associated with the original 15 pilots funded under the Access to Allied Health Services component of the BOiMHC initiative. It aimed to answer the following questions:

- What models of service delivery are being used by the Access to Allied Health Services pilots?
- What is the uptake of the pilots?
- What are the advantages and disadvantages of the pilots?

As at 30 September 2003, all had been running for 12-15 months. All had submitted at least three quarterly project implementation reports to the Commonwealth Department of Health and Ageing, and 13 had also submitted a fourth quarterly project implementation report. Eight had made evaluation reports available. The quantitative findings (from routinely-collected registration and utilisation data) and qualitative findings (from surveys, interviews and/or focus groups with key informants) in these reports were synthesised for the purposes of the current analysis.

Results

Models of operation

Relevant documentation indicated that the pilots are operating under a range of models, with many drawing on elements from several models. The models differ in terms of referral mechanisms, means of retaining allied health professionals, location of allied health professionals:

- **Referral mechanisms:** The simplest referral mechanisms involve systems whereby the Division distributes vouchers to participating GPs who, in turn, give them to patients. Patients then use the vouchers to visit nominated allied health professionals, and the allied health professional redeems the vouchers for payment from the Division. More complex referral mechanisms involve 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. In between is a model that involves co-location of the allied health professional in the GPs' rooms, and a system whereby GPs can refer consumers to the allied health professional at set times.
- **Means of retaining allied health professionals:** Some allied health professionals are directly employed by the Division, but the majority 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.
- **Location of allied health professionals:** Mostly, allied health professionals provide services to the pilots in rooms at the GPs' practices. Alternatives include the provision of services at the allied health professionals' own practices, or at a third location.

Uptake

Qualitative data from implementation and evaluation reports suggested that many divisions took a number of months to establish the infrastructure necessary to ensure the smooth running of the pilots. Some found the delays frustrating, while others acknowledged that a long lead time was necessary to lay the foundations for the pilots' success.

Utilisation data from implementation and evaluation reports indicated that, to date, the pilots have recruited a total of 136 individual allied health professionals, plus 10 agencies. Of the 136 individual providers, 95 (69%) are psychologists, five (4%) are social workers, five (4%) are occupational therapists, and eight (6%) are psychiatric nurses. Available documentation did not provide details of the professional category of the remaining 23 (17%).

In total, there are 387 referring GPs associated with the Access to Allied Health Services pilots. This is likely to be an underestimate, as there are GPs who are eligible to refer who have not yet done so.

According to the relevant reports, the aggregated number of referred patients is 2036. However, this is likely to be an underestimate because a number of the pilot reports do not document patients until they have completed six sessions.

Table 1: Numbers of allied health professionals, GPs and patients involved in Access to Allied Health Pilots as at 30 September 2003

Allied health professionals	
• Psychologists	95
• Social workers	5
• Occupational therapists	5
• Psychiatric nurses	8
• Professional category not reported	23
• Total	136
Referring GPs	387
Referred patients	2036

Advantages and disadvantages

The majority of evaluation reports included qualitative information from focus groups, key informant interviews and surveys that explored the advantages and disadvantages of the pilots for GPs, allied health professionals and consumers. Key themes from these qualitative data are drawn out below.

Advantages for GPs

(1) Savings in terms of time and cost

GPs in several divisions noted that they had previously conducted lengthy counselling sessions themselves in their own room because they felt the barriers to community counselling services were too great. Some GPs noted that they 'did the best they could', but that these sessions often lasted up to 45 minutes and were often costly to their practice. Hence, some GPs perceived that participation in the pilots saved them time and money.

(2) Location of service delivery by allied health professionals

Many GPs indicated that they appreciated allied health professionals providing services at their practices, as colleagues rather than as more distant referral points. In particular, they noted that this arrangement ensured that they had met the allied health professional in person, which in turn meant that they were able to assure consumers that their treatment would be beneficial. GPs also felt that co-location provided opportunities for informal discussions about a given consumer's care. In sum, GPs observed that providing therapy in GPs' rooms increased both the quantity and quality of referrals.

(3) Feedback from allied health professionals

GPs appreciated feedback from allied health professionals regarding the progress of referred consumers. Formal feedback (e.g., reports quantifying changes in symptomatology through the use of standardised instruments) assisted them in monitoring consumers' progress over time. Less formal feedback (e.g., phone calls or conversations in the GPs rooms) helped to keep GPs 'in the loop', which was seen as particularly important given their case management role.

(4) Opportunities for learning

There was consensus among GPs that the pilots provided opportunities for learning about evidence-based focused psychological strategies, particularly cognitive behaviour therapy. GPs appreciated training that included practical skills, case examples and role plays, and also acknowledged the informal learning that occurred by virtue of their closer association with allied health professionals.

(5) Improved understanding of the role of allied health professionals

GPs in several divisions thought the program helped them better understand the role of allied health professionals in providing therapy to consumers with mental health problems. They attributed this improved understanding to enhanced two-way communication between counsellors and GPs.

Disadvantages for GPs

(1) Barriers to participating in education and training

Some GPs were discouraged from participating in the pilots because they held negative views of the education and training component of the BOIMHC initiative (a pre-requisite for participation in the Access to Allied Health Services component). GPs in several divisions said they did not take part in the training (and therefore remained unaccredited) because they felt that its content was somewhat simplistic and that they did not have the time to devote to it. Some also commented that they felt that it would not equate to tangible benefits for consumers.

(2) Delays in registration with the General Practice Mental Health Standards collaboration

Some GPs reported that they experienced considerable delays in registration with the General Practice Mental Health Standards Collaboration after they had completed training. This resulted in a frustrating 'limbo' period, where they were unable to refer consumers to the pilots.

(3) Confusion about how the Access to Allied Health Services component works

Several evaluation reports noted that GPs were sometimes confused about aspects of the pilots. For example, some GPs were unsure as to whether they could refer patients for an additional six sessions. Others were uncertain about the amount of information required by the allied health professional at referral. Some were also confused about the referral pathway, particularly in the case of more complex, brokerage models.

(4) Opportunity costs and other risks

A number of GPs noted that there were opportunity costs and other risks associated with taking part in the pilots. The amount of paperwork involved was a commonly-expressed general concern. A more specific issue, which was also frequently mentioned, was the problem of consumers missing review appointments. This equates to a direct loss of income (because the review triggers the Service Incentive Payment) as well as an indirect loss of income (because GPs schedule long consultations for the review session, so if consumers do not attend the practice loses potential income from other consumers who could otherwise have been seen).

(5) Sub-optimal communication

Not all GPs experienced the improved relationships with allied health professionals described above. Some commented that communication channels were not optimal. For example, some commented that they wished to be alerted by the allied health professional when a consumer did not attend their first session of therapy, but noted that this rarely happened. The main barrier to professional communication was seen to be a lack of time for both parties. Some divisions indicated that special efforts needed to be made to improve communication between GPs and allied health professionals.

Advantages for allied health professionals

(1) Increased referral base

Participation in the pilots increased the referral base of allied health professionals. Allied health professionals found this satisfying, not only because of the security of income, but also because it increased the diversity of issues they encountered. Many commented that they were particularly pleased to have the opportunity to provide services to those who would not otherwise have been able to access them.

(2) Improved relationships with GPs

Participating allied health professionals were positive about developing professional relationships with GPs. Many typically worked as sole practitioners, and saw their participation as a means of addressing professional isolation. Specifically, they saw these new working relationships as a mutual learning opportunity.

(3) Clinical supervision

Some divisions included clinical supervision of allied health professionals as a key component of their models. Allied health professionals who received such supervision listed this as an advantage of the program, again noting that it addressed the issue of professional isolation.

(4) Opportunities to 'do something different'

A number of allied health professionals commented that they appreciated the opportunity to diversify their practice, particularly in divisions that targeted particular at-risk groups and/or offered different modes of service delivery, such as group therapy programs. Allied health professionals readily grasped new challenges and felt that they had 'something to offer'.

Disadvantages for allied health professionals

(1) Payment anomalies

Some allied health professionals, particularly psychologists, noted that they are regularly paid between \$105 and \$116 per session for work cover clients, which is more than they received on a sessional basis for providing services through the pilots. However, they noted that the reduced fee was offset by the advantage of dealing with a more varied group of consumers and the chance to assist financially disadvantaged consumers.

(2) Communication difficulties

Some allied health professionals noted that there were communication difficulties that needed 'ironing out'. Lack of sufficient information at referral was particularly problematic, and resulted in inappropriate referrals (e.g., consumers whose conditions

were not likely to improve with short term therapy) and referrals for unclear reasons. Allied health professionals commented that many of these difficulties could be overcome by GPs ringing them to discuss the referral at the outset, or, at the very least, completing the 'reason for referral' field on the referral form.

(3) Co-location issues

Although many allied health professionals were positive about their co-location in GPs' practices, some commented that appropriate provision was not always made for them. Some had to provide counselling services in make-shift offices and even tea rooms, particularly in the early stages of the pilots.

Advantages for consumers

(1) Access to psychological services

Stakeholders who were consulted unanimously agreed that the Access to Allied Health Services pilots improved access for consumers who would otherwise miss out. These consumers included those who could not normally afford private sector services provided by allied health professionals or psychiatrists, and those for whom the specialist public mental health sector was not appropriate to their ongoing needs. The pilots were therefore seen as filling a gap in the current mental health care system.

(2) Increased satisfaction with care

Consumers expressed high levels of satisfaction with the care provided through the Access to Allied Health Services pilots, commenting on different aspects of this care. They appreciated the opportunity to receive a non-pharmacological form of treatment and discuss their problems with a mental health specialist; some contrasted the positive experience of seeing an allied health professional with previous negative experiences with psychiatrists. They were pleased to have access to this care at no cost, or at a low cost. Generally, they felt that waiting times were reasonably short. They were positive about the service location, noting that attending the allied health professional in their GP's rooms was convenient and minimised the stigma associated with seeking mental health care. They also appreciated the 'team approach' whereby both the GP and allied health professional combined their unique abilities to help the recovery process.

(3) Improved outcomes of care

Very few of the local evaluations were able to systematically assess clinical outcomes for consumers in terms of improvements on standardised measures. However, those that did demonstrated a significant reduction in psychological distress, depression and anxiety over 6 sessions of therapy, as evidenced by scores on consumer self-rating instruments such as the Kessler-10 (K10), the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and the Depression Anxiety Stress Scale (DASS).

Evaluations more commonly asked consumers directly whether they felt they had benefited from care, or asked GPs and allied health professionals to comment on whether they had observed improvements for consumers. The qualitative responses to these questions were generally positive, with informants noting that the practical skills imparted through cognitive behavioural therapy in particular seemed to better equip consumers to deal with current and ongoing difficulties.

None of the local evaluations were able to make an assessment of whether the benefits observed were sustained in the medium to long term.

Disadvantages for consumers

(1) Barriers to attendance

In several divisions, local evaluations reported problems with non-attendance and noted that there were several barriers to patients attending, including travel time and cost (especially in rural areas), amotivation associated with conditions such as depression, and a lack of clarity about referral arrangements. Key informants suggested that most of these barriers could be overcome by the provision of additional support to consumers to ensure that their specific needs are met. For example, strategies such as requesting that the GP communicate the benefits of attendance, make the appointment, write the time down and follow-up with the consumer as necessary, proved to be beneficial.

(2) Inappropriate referrals

Some consumers felt that their GP selected the name of an allied health professional at random from a list, or simply gave the patient the option of picking their own counsellor. In either case, consumers who reported this problem felt that the choice of counsellor was not based on their specific problem. Consumers placed importance on the GP being familiar with the allied health professional and making a referral on his/her capacity to deal with their difficulties.

Discussion and conclusions

Summary

Despite perhaps taking longer to 'get up and running' than originally anticipated, the pilots are now well-established and operating under carefully considered models, ranging from simple voucher systems to more complex brokerage approaches. They are providing a range of focused psychological strategies, primarily cognitive behavioural therapy. They have involved 137 allied health professionals (primarily psychologists) and 387 referring GPs during the first 12 months of their existence. The pilots have provided access to mental health care for over 2000 patients who would otherwise experienced barriers of cost, language or distance. It would be anticipated that these numbers will continue to increase during the ongoing life of the pilots, and that the subsequent projects will experience similar levels of uptake.

Both the GPs and the allied health professionals are finding the collaborative arrangements satisfying, observing benefits such as opportunities for learning, improved communication, better understanding of the way the other party works and increased capacity to provide services to a broader range of consumers. There is also evidence that the pilots are resulting in improved access, satisfaction and outcomes for consumers.

Despite these positives, GPs and allied health professionals have experienced some barriers to participation. Some of these are attitudinal, and relate to perceptions that the benefits of participation outlined above may not outweigh potential costs in terms of time or money. Others relate to confusion about how the pilots operate, and communication difficulties. For consumers, the barriers relate to structural and other impediments to attendance and a feeling that they are not always referred to the most appropriate allied health professional.

Lessons learned

As noted earlier, the remit of the National Evaluation team provide ongoing lessons about how the Access to Allied Health Services projects are going, who they are reaching, the type of care they are providing, and whether specific models of service delivery seem to be particularly effective in given circumstances. The current report provides some information in this regard, but ongoing evaluation efforts are clearly desirable.

With regard to how the pilots are going, it can be concluded that they have achieved much within a relatively short space of time. Their reach has been significant in terms of the numbers of GPs, allied health professionals and consumers they have involved. Having said this, it should also be acknowledged that their 'set-up' time was not insignificant, and should not be underestimated in future projects.

In terms of who the pilots are reaching, less precision is possible. The evaluation reports provide anecdotal evidence that the majority of consumers who are receiving services are on low incomes. Some pilots are also specifically targeting people whose access to mental health care would normally be limited by other factors, such as distance or language/culture. However, this demographic information has not been consistently collected to date, making it difficult to provide an accurate breakdown. The Minimum Dataset will assist greatly in this regard, and data from it will be incorporated into the *Second Interim Evaluation Report*.

Likewise, it is difficult to be precise about the type of care being provided by the pilots. The evaluation reports are variable in their reporting of these data, although it is fair to say that greatest weight seems to be given to cognitive behavioural therapy. Again, the

Minimum Dataset will provide more detailed information about the nature of services provided by allied health professionals on a session-by-session basis, enabling the *Second Interim Evaluation Report* to be more specific in this regard.

In terms of the effectiveness of different models of care in different circumstances, there is inadequate evidence as yet. What can be described, however, are the advantages and disadvantages of the simplest model (the voucher system), and intermediate model (the system of co-location without triage) and the most complex model (the brokerage system). GPs appreciate the simplicity and efficiency of the voucher system, but both GPs and allied health professionals feel that it does not promote good inter-professional communication and consumers argue that it means that they are not always referred to the most appropriate provider. The brokerage system, by contrast, is more likely to cause confusion among GPs, but they are willing to accept a more complex system if the advantages to consumers can be clearly demonstrated. GPs, allied health professionals and consumers believe that the brokerage system promotes high quality care (e.g., because it improves collaboration between professionals and ensures a good 'match' between the consumer and the allied health professional). The key feature of the intermediate model – the co-location of allied health professionals within GPs' practices – combines simplicity with good opportunities for inter-professional communication, but reduces the consumers' choice of allied health professional.

Implications for ongoing evaluation efforts

The *First Interim Evaluation Report* drew on information from the implementation and evaluation reports from the first 15 Access to Allied Health Services pilots to describe their current status and to provide some lessons for future projects. The national evaluation effort will increase in scope over time, as 69 projects have now been funded under the first two funding rounds and preparations for a third funding round are underway.

The implementation and evaluation reports varied in their structure and content, making the task of synthesising them a difficult one. Some of the differences are unavoidable, and relate to the specific nature of the given divisional model of service delivery. There may be some benefits, however, in considering how to maximise the consistency of both the implementation reports and the evaluation reports. Doing so would increase the extent to which definitive conclusions could be drawn in future national evaluation work.

The Minimum Dataset will also help in this regard. All divisions now have access to the Minimum Dataset and are therefore able to enter consistent consumer-level information, which will enable ongoing national evaluation work to describe in more detail who is accessing allied health care, and what sort of care they are receiving.

The current report focused mainly on processes. This was viewed as appropriate at this stage, given the complexity of the Access to Allied Health Services component of the BOiMHC initiative. It was considered important to describe how individual divisions were interpreting the initiative 'on the ground', and to consider the uptake of the pilots, and to explore the opinions of key stakeholders regarding their advantages and disadvantages. However, it would be desirable for ongoing national evaluation work to move towards considering the impacts and outcomes of the projects, particularly for consumers. By design, the Minimum Dataset is not collecting consumer-level outcome data. Local evaluations should, however, be encouraged to collect these data wherever possible, and to do so in a systematic and consistent manner. Combining outcomes data with cost data will enable the effectiveness and efficiency of different models of service provision to be examined.

Conclusions

The Access to Allied Health Services component of the BOiMHC initiative has had a high level of uptake, generally proving popular with GPs, allied health professionals and consumers. Like any new initiative, there are some structural and attitudinal barriers that need to be addressed, but its continuation and expansion initiative should be a high priority for ongoing funding. Likewise, rigorous evaluation efforts should be continued.

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

Component 1: Education and training for GPs

In order to participate in the BOiMHC initiative, GPs must meet certain training requirements (either by applying for recognition of prior learning (RPL) or completing recognised training activities. Familiarisation Training is designed to familiarise GPs with the initiative in general and Level 1 Training teaches them the skills to perform the 3 Step Mental Health Process (see below). Completion of both is mandatory for GPs wishing to participate in the initiative, and enables them to register with the Health Insurance Commission (HIC) to access Service Incentive Payments for providing a 3 Step Mental Health Process (see below). Level 2 Training promotes skills and knowledge that enable GPs to deliver Focussed Psychological Strategies (see below). Completion of Level 1 and 2 Training, enables GPs to access the new Commonwealth Medical Benefits Schedule for Focussed Psychological Strategies (again, see below).

Component 2: The 3 Step Mental Health Process

The 3 Step Mental Health Process provides a framework for the management of mental health problems and mental illness in a primary care setting, by encouraging effective and longitudinal care of consumers. Specifically, the 3 Step Mental Health Process includes: (a) an assessment (Step 1); (b) preparation of a mental health plan (Step 2); and (c) a review of the mental health plan (Step 3). The process must occur over at least three consultations of more than 20 minutes (at least one for each step), at least two of which must be planned. It must also be documented, and several proformas and a checklist have been developed as resources. GPs are reimbursed for providing the 3 Step Mental Health Plan via a combination of Service Incentive Payments and Medicare Benefits Schedule rebates.

Component 3: Focused Psychological Strategies

The BOiMHC initiative places emphasis on the delivery of Focussed Psychological Strategies, or specific mental health care treatment strategies, derived from evidence based psychological therapies. The strategies approved under the initiative are limited to: (a) psycho-education; (b) cognitive behavioural therapy (including behavioural interventions, cognitive interventions, relaxation strategies and skills training); and (c) interpersonal therapy. These strategies are time limited, normally being deliverable in up to six planned sessions, each lasting a minimum of 30 minutes. In some instances, following review, an additional six planned sessions may be warranted. GPs are paid for providing Focused Psychological Strategies via MBS rebates.

Component 4: Access to Allied Health Services

The Access to Allied Health Services component enables GPs registered who are registered with the BOiMHC initiative to refer consumers to allied health professionals who deliver Focused Psychological Strategies. Allied health professionals have been defined to include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers. The Focussed Psychological Strategies provided by these allied health professionals are the same as those provided by GPs (see above). These services are deliverable in up to six time-limited sessions with an option for up to a further six sessions following a mental health review by the referring GP. Divisions of General Practice act as fundholders in this component of the BOiMHC initiative.

Component 5: Access to Psychiatrist Support

The Access to Psychiatrist Support component of the BOiMHC initiative has two sub-components, both of which broaden the role of psychiatrists in providing mental health care. The first involves the introduction of MBS rebates which enable psychiatrists to take part in case conferencing on a consumer's behalf. The second involves the provision of consultancy assistance to GPs by psychiatrists in emergency situations

Appendix 2: Access to Allied Health Services projects

Round	State	Division(s)
1a	NSW	NSW Outback Division of General Practice
1a	NSW	NSW Central West Division of General Practice
1a	NT	Top End Division of General Practice
1a	QLD	Toowoomba and District Division of General Practice
1a	QLD	Logan Area Division of General Practice
1a	QLD	Sunshine Coast Division of General Practice
1a	QLD	Brisbane Inner South and Bayside Divisions of General Practice
1a	SA	Adelaide Northern Division of General Practice
1a	Vic	Bendigo and District Division of General Practice
1a	Vic	Dandenong and Greater South Eastern Divisions of General Practice
1a	Vic	North West Melbourne Division of General Practice
1a	Vic	East Gippsland, Central West Gippsland and South Gippsland Divisions of General Practice
1a	Vic	Knox Division of General Practice
1a	WA	Freemantle Regional Division of General Practice
1a	WA	Perth and Hills Division of General Practice
1b	ACT	ACT Division of General Practice
1b	NSW	Mid North Coast (NSW) Division of General Practice
1b	NSW	Hastings Macleay Division of General Practice
1b	NSW	Riverina Division of General Practice
1b	NSW	NSW Central Coast Division of General Practice
1b	NSW	Canterbury Division of General Practice
1b	QLD	Northern Queensland Division of General Practice and Western Queensland Primary Health Care
1b	SA	Adelaide Southern Division of General Practice
1b	Vic	Central Highlands Division of General Practice
1b	Vic	Mornington Peninsula Division of General Practice
1b	Vic	Ballarat and District Division of General Practice
1b	Vic	Geelong and Otway Divisions of General Practice
1b	Vic	North East Victorian Division of General Practice
1b	WA	Greater Bunbury Division of General Practice
2	NSW	Blue Mountains Division of General Practice Inc
2	NSW	Division of General Practice Fairfield Health Service Inc
2	NSW	Dubbo/Plains Division of General Practice Ltd
2	NSW	Illawarra Division of General Practice Ltd
2	NSW	Murrumbidgee Division of General Practice Ltd
2	NSW	New England Division of General Practice Ltd
2	NSW	North West Slopes (NSW) Division of General Practice Ltd
2	NSW	Southern Highlands Division of General Practice Inc
2	NSW	Sutherland Division of General Practice Inc

Round	State	Division(s)
2	NSW	Nepean and Hawkesbury Divisions of General Practice
2	QLD	Brisbane Southside Central Division of General Practice Association Inc
2	QLD	Capricornia Division of General Practice Ltd
2	QLD	Central Queensland Rural Division of General Practice Association Inc
2	QLD	Far North Queensland Rural Division of General Practice Association Inc
2	QLD	Gold Coast Division of General Practice Ltd
2	QLD	Ipswich and West Moreton Division of General Practice
2	QLD	Townsville Division of General Practice
2	QLD	Mackay Division of General Practice
2	SA	Adelaide Central and Eastern Division of General Practice
2	SA	Adelaide Hills Division of General Practice Inc
2	SA	Adelaide North East Division of General Practice Inc
2	SA	Adelaide Western Division of General Practice Inc
2	SA	Limestone Coast Division of General Practice
2	SA	Murray Mallee Division of General Practice Inc
2	TAS	Division of General Practice Northern Tasmania Inc
2	TAS	North West Tasmania Division of General Practice
2	TAS	The Division of General Practice (Tasmania -Southern Region) Inc
2	VIC	Central Bayside Division of General Practice Ltd
2	VIC	Melbourne Division of General Practice Inc
2	VIC	Monash Division of General Practice Moorabbin Inc
2	VIC	Murray-Plains Division of General Practice Inc
2	VIC	North East Valley Division of General Practice Pty Ltd
2	VIC	Western Melbourne Division of General Practice Ltd
2	VIC	Westgate Division of General Practice Ltd
2	VIC	South City GP Services Inner South East Melbourne
2	VIC	Whitehorse and Inner Eastern Melbourne Divisions of General Practice
2	WA	Canning Division of General Practice Ltd
2	WA	Great Southern Division of General Practice Ltd
2	WA	Osborne Division of General Practice Ltd
2	WA	Perth Central Coastal Division of General Practice Ltd