
PROGRAM EVALUATION UNIT



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

Fourth Interim Evaluation Report

**Fay Kohn, Belinda Morley, Jane Pirkis,
Grant Blashki, Philip Burgess**

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Executive summary

Background

The 2001-2002 Federal budget initiative Better Outcomes in Mental Health Care seeks to improve the mental health care available to Australians. A key component of the initiative is the Access to Allied Health Services component, which 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 with a following six sessions available upon GP review. Since the initiative began, 102 Access to Allied Health Services projects have been funded in three major funding rounds. In Round 1, 15 pilot projects received funding between June and August 2002, and a further 14 supplementary projects received funding between January and March 2003. In Round 2, 40 additional projects received funding after July 2003. A third funding round saw the commencement of 33 further projects in July 2004.

Method

The current report is the fourth, and most comprehensive to date, in a series of interim evaluation reports.¹⁻³ It synthesises evaluation evidence from the Round 1 and 2 projects. Specifically, it draws on information from the local evaluation reports of these projects and data from a purpose-designed minimum dataset. It considers the achievements of the projects via the following questions:

- What models of service delivery are being used by the projects?
- What is the level of uptake of the projects?
- Who is accessing services through the projects?
- What services are consumers receiving through the projects?
- What are the benefits and barriers associated with the projects?
- What lessons have been learned from the early experiences of the projects?

Overview of achievements of the Round 1 and 2 projects

By the end of 2004, the Round 1 pilot projects had been running for at least 28 months, the Round 1 supplementary counterparts for at least 21 months, and the Round 2 projects for at least 18 months. Most projects took a number of months to establish the infrastructure and garner the support necessary to ensure their smooth implementation, but all are now well-established in terms of service delivery. Earlier projects have been modified along the way in response to stakeholder concerns, and later projects have learnt lessons from their earlier counterparts. As a consequence, the projects are operating under a range of different models which vary in terms of means of retaining allied health professionals, location of allied health professionals, and referral mechanisms.

The stakeholders involved in the conduct of the projects have much to be proud of in the way of achievements. Divisions have engendered considerable enthusiasm for the initiative on the part of GPs and allied health professionals, developed models of service delivery tailored to local needs, put in place increasingly sophisticated systems to manage service delivery, provided support and resources for participating GPs and allied health professionals, and engaged in monitoring and evaluation activities. The involvement of GPs and allied health professionals has mushroomed, with both parties adapting well to new systems, ways of working and professional relationships. As a consequence, the Access to Allied Health Services projects are realising what they set out to achieve: providing high quality mental health care to consumers who would otherwise face barriers to accessing such care.

The uptake of the Round 1 and 2 projects is high. Using the minimum dataset as the gold standard, 1,771 GPs had referred 12,758 consumers to 569 allied health professionals by 31 December 2004. This represents a 2.5-3.5 fold increase in the equivalent figures reported in the Second Interim Evaluation Report,² where the data cut-off was 31 May 2004 and Round 2 projects were not included. It is clear that there has been significant growth as time has passed and the Round 2 projects have developed.

The Round 1 and 2 projects are reaching the consumers that they are intended to target. For example, the majority (62%) are on low incomes, most have been diagnosed with depression (76%) and/or anxiety disorders (56%) by their GP, and 46% have no previous history of specialist mental health care, indicating that access may previously have been problematic for them.

There are good indications that the Round 1 and 2 projects are being delivered in the way in which was envisaged when the Better Outcomes in Mental Health Care initiative was first conceived – i.e., providing free or low-cost evidence-based mental health care to consumers through structured sessions. In total, the number of sessions of therapy received to date by consumers in the Round 1 and 2 projects is 45,823 (a mean of 3.6 sessions per consumer). Most sessions (75%) are an hour in length, and 98% involve individual, rather than group-based, treatment. The most common interventions delivered through these sessions are CBT-based cognitive (61%) and behavioural (45%) interventions. In 63% of all sessions, consumers are not required to contribute to the cost of care; in the remainder of cases they are asked to make a co-payment, usually of not more than \$20.

Focus group, interview and survey data from the local evaluation reports suggest that participating GPs, allied health professionals and consumers are very satisfied with the Round 1 and 2 projects. Benefits observed by GPs include upskilling opportunities, improved capacity to deliver high quality care, and the range of referral options. Advantages observed by allied health professionals include improved relationships with GPs, and an increased referral base. Both sets of providers have commended the structured approach and the level of support provided by Divisions. Consumers appreciate the improved access to psychological services and the high quality of care, expressing satisfaction with many aspects of service delivery. There is also evidence that many consumers are achieving positive mental health outcomes as a result of the care they are receiving.

In spite of this, GPs and allied health professionals have experienced some barriers to participation. Some GPs have viewed the education and training and the paperwork as hurdles, and have noted that the benefits do not outweigh these costs since their referral capacity is limited, feedback from allied health professionals is not always optimal, and there are issues with payment. Some allied health professionals have expressed frustration at their lack of decision-making power, and have experienced issues related to the streamlining of the referral process, remuneration and travel. For some consumers, there are equity issues and issues related to the number and format of sessions.

Having said this, it should be noted that a number of the issues that were apparent in earlier local evaluation reports are less relevant in later ones. So, for example, 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', removing barriers for both allied health professionals and consumers.

Conclusion

The Access to Allied Health Services projects are continuing to go from strength to strength in terms of providing access to high quality mental health care for consumers who would otherwise have experienced difficulty accessing such care. Participating GPs, allied health professionals and consumers express high levels of satisfaction with the projects, and a number of the barriers to participation that previously existed have been removed as the projects have developed. The success of the initiative may be due, at least in part, to the balance that has been struck between an over-arching vision that defined the parameters within which projects would operate on the one hand, and a degree of flexibility that has allowed Divisions to tailor projects to suit the local environment, on the other. The continuation and expansion of the initiative should be a high priority for future funding.

Chapter 1: Background

The Better Outcomes in Mental Health Care initiative

The Better Outcomes in Mental Health Care initiative aims to improve the mental health care available to Australians. It is a four-year initiative, which received funding totalling \$120.4 million in the 2001-2002 Federal budget. The initiative has five inter-related 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 report focuses specifically on the Access to Allied Health Services component of the Better Outcomes in Mental Health Care initiative. This component 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 Better Outcomes in Mental Health Care initiative.

Since the initiative began, 102 Access to Allied Health Services projects have been funded in three major funding rounds (see Appendix 2 for a complete list). In Round 1, 15 pilot projects received funding between June and August 2002, and a further 14 supplementary projects received funding between January and March 2003. In Round 2, 40 additional projects received funding after July 2003. A third funding round saw the commencement of 33 further projects in July 2004.

Evaluating the Access to Allied Health Services component

Evaluative efforts related to the Better Outcomes in Mental Health Care initiative in general, and the Access to Allied Health Services component specifically, are overseen by an Evaluation Working Group, chaired by Professor Ian Hickie.

In May 2003, on the recommendation of the Evaluation Working Group, the Program Evaluation Unit of The University of Melbourne's School of Population Health was appointed to undertake national evaluation work in regard to the Access to Allied Health Services projects. The Program Evaluation Unit'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 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 Program Evaluation Unit is providing support to

^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.

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 Program Evaluation Unit developed a minimum dataset that standardises the basic information collected by Divisions running Access to Allied Health Services Projects, and therefore acts as an important evaluation tool. The minimum dataset is designed to capture de-identified consumer-level information, which is 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.
- **Synthesising evaluation lessons from the Access to Allied Health Services projects:** Periodically, the Program Evaluation Unit is 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 components 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

The current report is the fourth in a series that provides evaluation lessons from the Access to Allied Health Services component.¹⁻³ The First Interim Evaluation Report,¹ produced in December 2003, reported on the progress of the Round 1 pilot projects, and drew only on their local evaluation reports since the minimum dataset had not been 'rolled out' at that stage. It considered the models of service delivery being used by the pilots, the uptake of the pilots, and the advantages and disadvantages of the pilots (for GPs, allied health professionals and consumers).

The Second Interim Evaluation Report,² released in July 2004, provided detail on developments related to the Round 1 pilot projects and supplementary projects, utilising data from local evaluation reports and the minimum dataset. Like the First Interim Evaluation Report, it considered models of service delivery, issues of uptake, and advantages and disadvantages. In addition, it profiled those accessing services through the projects, and described the services they are receiving.

The Third Interim Evaluation Report,³ released in February 2005, provided an in-depth look at the models being adopted by the Access to Allied Health Services projects, using data from an evaluation forum, attended by 17 Victorian Divisions and one Tasmanian Division.

The current report is most similar to the Second Interim Evaluation Report,² in that it draws on data from both local evaluation reports and the minimum dataset. It expands on the Second Interim Evaluation Report, however, by including a focus on the Round 2 projects (Round 3 projects are excluded from the current analysis, since they are at varying stages of implementation). It considers the achievements of the projects via essentially the same evaluation questions as the Second Interim Evaluation Report,² but it also explicitly considers some of the lessons learned from the early experiences of the projects.

Table 1 provides a summary of the focus of each report in the series.

Table 1: Summary of focus of interim evaluation reports

Report	Projects included	Data sources	Evaluation questions
First Interim Evaluation Report ¹	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?
Second Interim Evaluation Report ²	Round 1 pilot and supplementary projects – Australia	<ul style="list-style-type: none"> Local evaluation reports Minimum data 	<ul style="list-style-type: none"> What models of service delivery are being used by the projects? What is the level of uptake of the projects? Who is accessing services through the projects? What services are consumers receiving through the projects? What are the advantages and disadvantages of the projects?
Third Interim Evaluation Report ³	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?
Fourth Interim Evaluation Report (current)	Round 1 pilot and supplementary projects, Round 2 projects – Australia	<ul style="list-style-type: none"> Local evaluation reports Minimum data 	<ul style="list-style-type: none"> What models of service delivery are being used by the projects? What is the level of uptake of the projects? Who is accessing services through the projects? What services are consumers receiving through the projects? What are the benefits and barriers associated with the projects? What lessons have been learned from the early experiences of the projects?

Chapter 2: Method

Evaluation questions

As noted in the previous section, this Fourth Interim Evaluation Report considers the achievements of the Round 1 and 2 projects via the following evaluation questions:

- What models of service delivery are being used by the projects?
- What is the level of uptake of the projects?
- Who is accessing services through the projects?
- What services are consumers receiving through the projects?
- What are the benefits and barriers associated with the projects?
- What lessons have been learned from the early experiences of the projects?

The answers to these questions are considered for the Round 1 (pilot and supplementary) projects and Round 2 projects as a whole, but, wherever possible, consideration is given to the extent to which the earlier projects have changed over time and/or the later projects have drawn on lessons from the earlier ones.

Data sources

To do this, the report draws on information from two sources, namely the local evaluation reports from the Round 1 and 2 projects, and data from the minimum dataset. Each of these data sources is described in more detail below. For each, the cut-off point for inclusion in the current report was 31 December 2004.

Data from local evaluation reports

As at 31 December 2004, 110 local evaluation and project implementation reports had been submitted by 58 (84%) of the 69 Round 1 and 2 projects. Table 2 provides a breakdown of these projects by funding Round. The quality of these reports was variable, and it was not always clear whether a given report constituted an evaluation report or a project implementation report, so, for the purposes of the following analysis, all reports have been subsumed under the banner 'local evaluation reports'.

Some of the data in these reports were quantitative, and took the form of routinely-collected registration and utilisation data. More commonly, the information in these reports was qualitative and took the form of opinions from GPs, allied health professionals and consumers. Such information came from a variety of sources (e.g., focus groups and key informant interviews), but there was an increasing reliance on satisfaction surveys in later reports, reflecting a sharing of evaluation tools by Divisions.

Data from the minimum dataset

As at 31 December 2004, 55 (80%) of the 69 Round 1 and 2 projects were submitting data to the minimum dataset. Table 2 provides a breakdown of these projects, by funding round and state/territory.

Data were extracted from the minimum dataset on consumers accessing services through the projects, in terms of their numbers, their socio-demographic and clinical characteristics, and the services being provided to them. All data were analysed using SPSS (Version 12), and are presented as simple frequencies, percentages and means.

Table 2: Overview of Round 1 and 2 projects submitting local evaluation reports and minimum dataset data as at 31 December 2004 (Round 1 pilot and supplementary, and Round 2 projects)

State	Pilot projects (n=15)	Supplementary projects (n=14)	Round 2 projects (n=40)	Total projects (n=69)
Projects submitting local evaluation reports	8 ^a	13 ^b	37 ^c	58 ^d
Projects submitting data to the minimum dataset	14	9	32	55

- a. Total number of reports: 10
- b. Total number of reports: 18
- c. Total number of reports: 82
- d. Total number of reports: 110

Chapter 3: What models of service delivery are being used by the projects?

Drawing on relevant project documentation, the First and Second Interim Evaluation Reports^{1,2} put forward a framework to describe the models of service delivery being used by the projects, based on different referral mechanisms, different means of retaining allied health professionals, and different locations of allied health professionals. This framework was modified slightly in the Third Interim Evaluation Report,³ on the basis of detailed information provided by the Victorian and Tasmanian Divisions that attended the evaluation forum. The modified framework is described in Table 3.

Table 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. 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.

Source: Morley et al³

The local evaluation reports from the Round 1 and 2 projects suggest that the range of models adopted fits within the framework described above.

Chapter 4: What is the level of uptake of the projects?

Table 4 shows the level of uptake of the Access to Allied Health Services projects, as reflected in participation by referring GPs, allied health professionals providing services, and referred consumers. Specifically, it presents data from the minimum dataset and the local evaluation reports on the numbers participating in the Round 1 and 2 projects, as at 31 December 2004. For comparison purposes, it also presents data on those participating in the Round 1 projects six months earlier.

The minimum dataset shows that, in total, 1,771 GPs have referred 12,758 consumers to 569 allied health professionals. The equivalent figures from the evaluation reports are 1,462, 9,082 and 546, respectively. The higher estimate from the minimum dataset is likely to be more reliable, since the units of counting are common across all projects. Nonetheless, the minimum dataset figures are still likely to represent an underestimate, since 20% of Round 1 and 2 projects have not yet submitted data to the minimum dataset.

Table 4: Number of GPs, allied health professionals and consumers participating in Round 1 and 2 projects, according to the minimum dataset and the local evaluation reports

		Round 1 projects (May/June 2004)		Round 1 and 2 projects (December 2004)	
		Minimum dataset ^a	Evaluation reports ^b	Minimum dataset ^c	Evaluation reports ^d
Referring GPs		710	926	1,771	1,462
Allied health professionals	Psychologists		179		538
	Social workers		8		2
	Occupational therapists		7		3
	Psychiatric nurses		11		3
	Not reported		24		
	Total	160	229	569	546
Referred consumers		3,476	3,656	12,758	9,082

a. Data as at 31 May 2004

b. Data as at 30 June 2004

c. Data as at 31 December 2004

d. Data as at 31 December 2004

If the minimum dataset figures are taken as the gold standard, it is clear that there has been a substantial growth in the initiative since the Second Interim Evaluation Report,² which reported data from 31 May 2004. At that time, 710 GPs had referred 3,476 consumers to 160 allied health professionals. Since then, the Round 2 projects have 'taken off', learning from the early experiences of the Round 1 projects and consequently beginning implementation more quickly and efficiently. The number of referring GPs is 2.5 times greater, and the numbers of referred consumers and participating allied health professionals are both 3.5 times greater.

Chapter 5: Who is accessing services through the projects?

Socio-demographic characteristics

The minimum dataset provided a breakdown of consumers accessing the Round 1 and 2 projects by age/sex, language spoken at home, proficiency with English, Aboriginality, socio-economic status and residential circumstances.

Age/sex

Data on age/sex were available for 11,878 consumers. Of these, 8,665 (73%) were female and 3,213 (27%) were male. These consumers' ages ranged from five to 100 years, with a mean of 40 years. This corresponds with the breakdown observed in the Second Interim Evaluation Report,² and is comparable with the general population average of 35 years, identified in the 2001 Census.⁴

Language

Language has been identified as a particular barrier to accessing psychological services, given that such services rely on good communication skills.

Language spoken at home was recorded in the minimum dataset for 11,448 consumers, and a breakdown of the listed languages is provided in Table 5. Ninety four per cent of all consumers spoke English at home (compared with 87% reported in the Second Interim Evaluation Report²), but almost 50 other languages were spoken by the remainder, with Italian (1%), Chinese languages (0.3%), Greek (0.3%) and Turkish (0.3%) being the most common. Language was recorded as 'unknown' for 3% of consumers. These figures suggest that English-speaking consumers are over-represented in the group accessing services through the projects, since only 80% of the Australian population speak English at home according to the 2001 Census.⁴ Having said this, the pattern of other languages is similar, since the three most common languages spoken at home other than English in the 2001 Census⁴ were Chinese languages (2.1%), Italian (1.9%) and Greek (1.4%).

Simply ascertaining whether a person speaks a language other than English does not indicate how well the consumer will be able to participate in a consultation with a GP or allied health professional. The minimum dataset also collects information on the English proficiency of consumers, as judged by the referring GP. These data were available for 344 of the consumers who spoke a language other than English at home. The majority were considered to speak English 'well' or 'very well' (80%), as judged by their GP. However, 20% spoke English 'not well' or 'not at all'. In the Second Interim Evaluation Report,² the corresponding figures were 88% and 12%.

Table 5: Language spoken at home by consumers receiving services through the Round 1 and 2 projects (n=11,448)

	Frequency	Percent
English	10,718	93.6
Italian	109	1.0
Chinese languages	35	0.3
Greek	35	0.3
Turkish	32	0.3
Other	188	1.6
Unknown	331	2.9
Total	11,448	100.0

Taken together, these figures tell an important story. The fact that a number of languages other than English were spoken at home by consumers is positive, but there is clearly scope for the projects to increase their efforts in this regard, as members of different language groups, relative to the general population, would appear to be under-represented in the above figures.

Aboriginality

Aboriginal and Torres Strait Islander consumers may experience a range of hurdles when trying to access psychological services, particularly cultural barriers. Divisions implementing Access to Allied Health Services projects which are located in catchment areas that have large Aboriginal and Torres Strait Islander populations are tailoring their services to the needs of these consumers in order to reduce these barriers and facilitate access. Thirty five Divisions representing all states/territories except the Australian Capital Territory are providing access to psychological services for consumers who are of Aboriginal or Torres Strait Islander background.

The minimum dataset collects data on whether consumers identify as being from Aboriginal or Torres Strait Islander background, and a response was available for 11,923 consumers. Table 6 shows that, overall, 1.4% of all consumers were classified as being of Aboriginal or Torres Strait Islander background. In the Second Interim Evaluation Report,² the equivalent figure was 1.7%. The new figure is below that of the 2001 Census⁴ count in which 2.2% of the Australian population identified as being of Aboriginal or Torres Strait Islander background. It should be noted, however, that for a substantial proportion of consumers (16%), Aboriginality was recorded as 'unknown'.

Table 6: Aboriginal and Torres Strait Islander background of consumers receiving services through the Round 1 and 2 projects (n=11,923)

	Frequency	Percent
Yes	171	1.4
No	9,852	82.6
Unknown	1,900	16.0
Total	11,923	100.0

Socio-economic status

Financial cost has traditionally been a barrier for many of those attempting to access psychological services, and the Access to Allied Health Services projects have been specifically designed to overcome this barrier. The minimum dataset includes two fields that permit a profile to be constructed of the socio-economic status of consumers who are receiving services through the projects.

The first is a field that asks the referring GP to make a judgement about the income level of the consumer, taking into account comparative levels of income and evidence that the person is a Health Care Card holder or pensioner. Examination of data presented in Table 7 reveals that 62% of those consumers accessing psychological services through the Round 1 and 2 projects were judged by their GP to be low income earners. The equivalent figure reported in the Second Interim Evaluation Report was 58%.

The second is a field that ascertains the level of education achieved by the consumer. Table 8 indicates that 5% of the consumers who have received services through the pilot and supplementary projects have completed some primary education only, and 69% have completed some secondary education. About one quarter have completed some tertiary education. These figures are similar to those reported in the Second Interim Evaluation Report.²

Table 7: Income level of consumers receiving services through the Round 1 and 2 projects (n=11,711)

	Frequency	Percent
Low income earner	7,278	62.1
Not low income earner	2,504	21.4
Unknown	1,929	16.5
Total	11,711	100.0

Table 8: Level of education achieved by consumers receiving services through the Round 1 and 2 projects (n=8,926)

	Frequency	Percent
Primary or below	452	5.1
Secondary	6,186	69.3
Tertiary	2,288	25.6
Total	8,926	100.0

Together, these findings suggest that the Access to Allied Health Services projects are targeting consumers who would otherwise encounter difficulty in accessing psychological services due to the barrier of cost. This is positive, as it suggests that the projects are meeting the needs of those they are targeting.

Residential circumstances

The minimum dataset includes a field that describes the consumer's residential circumstances, in terms of whether he or she lives alone. This was intended as a proxy measure of whether the consumer has care or support at home, but it is acknowledged that the availability of support does not guarantee that such support is provided nor the quality and benefit of such support. Information on residential circumstances was available for 11,734 consumers, of whom 16% were found to live alone (see Table 9). This figure compares with 14% reported in the Second Interim Evaluation Report,² and is higher than that of the 2001 Census⁴ which indicated that 9.1% of the general population reside in lone person households.

Table 9: Residential circumstances of consumers receiving services through the Round 1 and 2 projects (n=11,734)

	Frequency	Percent
Lives alone	1,873	16.0
Does not live alone	8,100	69.0
Unknown	1,761	15.0
Total	11,734	100.0

Clinical characteristics at the point of referral

The minimum dataset collects a range of data on the clinical characteristics of consumers who are accessing psychological services through the Access to Allied Health Services projects, doing so at the point of referral. Available data include diagnosis, current psychotropic medication, psychiatric service history, and focused psychological strategy for which the referral was made.

Diagnosis

All components of the Better Outcomes in Mental Health Care Initiative, including the Access to Allied Health Services component, prioritise access to specialist mental health services for consumers with high prevalence disorders such as depression and anxiety. For the purposes of referring a consumer to a given project, GPs are asked to provide one or more diagnoses within the ICD-10 primary care diagnostic categories: Chapter V Primary Care Version Brief Version (with amended categories).⁵ These diagnoses are recorded in the minimum dataset, with multiple responses permitted.

Table 10 shows that the clear majority of consumers accessing psychological services through the Access to Allied Health Services projects have been diagnosed with depression (76%) and/or anxiety (56%) by their GP at the point of referral. These figures are consistent with those reported in the Second Interim Evaluation Report (77% and 55%, respectively),² and suggest that the projects are correctly targeting consumers to meet the objectives of the initiative and to prioritise access for consumers who will benefit most from psychological services.

Table 10: ICD-10 diagnosis of consumers receiving services through the Round 1 and 2 projects (n=10,541, multiple responses permitted)

	Frequency	Percent
F1 Alcohol and drug use disorders	616	5.8
F2 Psychotic disorders	170	1.6
F3 Depression	7,991	75.8
F4 Anxiety disorders	5,950	56.4
F5 Unexplained somatic disorders	295	2.8

Current psychotropic medication

The Access to Allied Health Services projects are aimed at providing non-pharmacological forms of treatment by non-medical mental health specialists. The minimum dataset collects information on whether consumers are taking psychotropic medication, and if so, what type (with multiple responses permitted). In total, 6,343 consumers (50%) were taking psychotropic medication at the point of referral to the Round 1 and 2 projects, compared with 48% in the Second Interim Evaluation Report.² This suggests that the projects are providing focused psychological strategies both as an adjunct to, and as an alternative to, pharmacological therapies.

Of the 6,343 consumers receiving psychotropic medication, 90% were receiving antidepressants, 14% benzodiazepines and/or anxiolytics, 4% phenothiazines and major tranquillisers, and 5% mood stabilisers. This is consistent with the diagnostic information presented above, suggesting that the majority of consumers who are accessing services through the projects are experiencing depression and anxiety disorders.

Psychiatric service history

The Access to Allied Health Services projects aim to improve access to specialist mental health services for those who have previously been unserved or underserved due to barriers such as cost, language or distance. The minimum dataset collects data on whether consumers have previously accessed specialist mental health care (from public, private, medical and allied health services), thereby permitting an examination of the extent to which the projects are achieving this aim.

Table 11 shows that 46% of consumers had not previously received specialist mental health care (compared with 40% in the Second Interim Evaluation Report²). While some of these consumers may have had no previous need to access mental health care, this finding suggests that the projects are improving access for at least some consumers who would otherwise have experienced barriers.

Table 11: Previous receipt of specialist mental health care by consumers receiving services through the Round 1 and 2 projects (n=11,292)

	Frequency	Percent
Yes	3,878	34.3
No	5,227	46.3
Unknown	2,187	19.4
Total	11,292	100.0

Focused psychological strategy for which referral was made

The minimum dataset collects information on the particular focused psychological strategy for which the consumer was referred, permitting multiple responses. Data were available for 10,049 consumers, and Table 12 shows the results. Specifically, it shows that the most common referral was for cognitive interventions (67%), followed by behavioural interventions (50%), diagnostic assessment (45%), relaxation strategies (42%) and psycho-education (40%). These figures differ from those reported in the Second Interim Evaluation Report,² where the most common referral was for diagnostic assessment (62%), and there were commensurately lower rates of referral for specific psychological strategies.

Table 12: Focused psychological strategy for which referral was made for consumers receiving services through the Round 1 and 2 projects (n=10,049, multiple responses permitted)

	Frequency	Percent
Diagnostic assessment	4,536	45.1
Psycho-education	4,017	40.0
CBT - Behavioural interventions	5,060	50.4
CBT - Cognitive interventions	6,719	66.9
CBT - Relaxation strategies	4,234	42.1
CBT - Skills training	2,964	29.5
Interpersonal therapy	2,273	22.6
Other	20	0.2

Chapter 6: What services are consumers receiving through the projects?

Treatment characteristics

The minimum dataset collects information on the characteristics of care provided to consumers when they are referred by GPs to allied health professionals through the Access to Allied Health Services projects. Specifically, data are provided about the number, duration, format and content of sessions provided by the allied health professional.

Number of sessions

The terms of the Access to Allied Health Services projects stipulate that a consumer can be referred by his/her GP to receive up to six sessions of therapy (in the form of focused psychological strategies) from an allied health professional. Upon review by the GP, an additional six sessions can be provided where it is deemed necessary and appropriate for the consumer.

According to the minimum dataset, the total number of sessions received to date by consumers in the Round 1 and 2 projects was 45,823, a five-fold increase from the number reported in the Second Interim Evaluation Report.² The mean number of sessions per consumer was 3.6 (compared with 2.5 reported in the Second Interim Evaluation Report²). It should be noted that these figures represent an underestimate, as many Divisions do not receive information on a given consumer's sessions until he/she completes the full six.

The number of sessions per consumer varied from one to 24. Of the 12,758 consumers accessing psychological services through the Access to Allied Health Services projects, 12% have been re-referred, following review by their GP, to receive at least a further additional six sessions. Again, this represents an increase from the 6% reported in the Second Interim Evaluation Report.²

Duration of sessions

Data were available from the minimum dataset on the duration of 43,622 sessions. As Table 13 shows, the majority of these (75%) were 46-60 minutes in length. Shorter sessions of 0-30 minutes and 31-45 minutes were provided in 4% and 10% of instances, respectively. Longer sessions in excess of one hour were made available in 11% of cases. These figures are comparable with those reported in the Second Interim Evaluation Report.²

Table 13: Duration of sessions provided through the Round 1 and 2 projects (n=43,622)

	Frequency	Percent
0-30 mins	1,860	4.3
31-45 mins	4,219	9.7
46-60 mins	32,801	75.1
>60 mins	4,742	10.9
Total	43,622	100.0

Format of sessions

Data were available on the format of 43,909 sessions. As was the case in the Second Interim Evaluation Report,² the vast majority of these sessions involved the provision of individual treatment (98%), with only 2% consisting of treatment provided in a group format. Group sessions are currently being provided by 26 Round 1 and 2 projects (one of which is exclusively providing group treatment to consumers).

Content of sessions

The minimum dataset collects data on the content of each session, in terms of the focused psychological strategy, or strategies, provided. Multiple responses are permitted, to cater for the fact that several approaches may be used during the one session.

Data were available on the content of 40,169 sessions. Table 14 shows that the most common interventions were CBT-based cognitive and behavioural interventions, provided at 61% and 45% of all sessions, respectively. The equivalent figures in the Second Interim Evaluation Report² were 55% and 40%.

Table 14: Content of sessions provided through the Round 1 pilot and supplementary projects (n=40,169, multiple responses permitted)

	Frequency	Percent
Diagnostic assessment	7,701	19.2
Psycho-education	11,839	29.5
CBT - Behavioural interventions	18,126	45.1
CBT - Cognitive interventions	24,478	60.9
CBT - Relaxation strategies	10,957	27.3
CBT - Skills training	10,165	25.3
Interpersonal therapy	9,232	23.0

It is worth considering the focused psychological strategies that consumers have been receiving, in the light of those for which they were referred (as shown in Table 12). Of note is the fact that 45% of consumers were referred for diagnostic assessment, whereas only 19% of sessions were devoted to this activity. A likely explanation for this is the fact that diagnostic assessment occurred in the first session, leaving up to five other sessions for therapeutic interventions. In the main, consumers seem to have been delivered the focused psychological strategies for which they were referred, with cognitive and behavioural interventions featuring prominently in the referral data and in the session content data.

Cost to the consumer

Cost is an identified barrier to accessing specialist mental health care, and is one of the key impediments that the Access to Allied Health Services projects are designed to address. Balanced against this is a view expressed in some of the local evaluation reports of the Round 1 and 2 projects that consumers are more likely to commit to treatment if they contribute a small co-payment. In some projects, a co-payment is collected (usually by the allied health professional at each session); in other projects, services are provided at no cost to the consumer.

Information on co-payments was available from the minimum dataset for 21,297 sessions. Table 15 shows that in the majority of these sessions (63%), a co-payment was not collected (this compares with 76% in the Second Interim Evaluation Report²). Where a co-payment was collected, the minimum was \$5 and the maximum was \$80.

Most commonly, co-payments were at the lower end of this scale, with 20% of all sessions costing the consumer \$10 or less, and 10% costing between \$11 and \$20. This clearly suggests that the Access to Allied Health Services projects is effectively removing financial barriers to specialist mental health care.

Table 15: Consumer co-payments for sessions provided through the Round 1 and 2 projects (n=21,297)

	Frequency	Percent
No co-payment	13,481	63.3
\$5	1,224	5.7
\$6-\$10	2,965	13.9
\$11-\$15	503	2.4
\$16-\$20	1,680	7.9
\$21-\$25	959	4.5
\$26-\$30	309	1.5
\$31-\$40	93	0.4
\$41-\$50	35	0.2
\$51-\$60	29	0.1
\$61-\$80	19	0.1
Total	21,297	100.0

Chapter 7: What are the benefits and barriers associated with the projects?

The majority of evaluation reports from the Round 1 and 2 projects included qualitative information about the benefits and barriers associated with the projects from the perspective of GPs, allied health professionals and consumers. Key themes from the qualitative data are explored and elaborated here.

Benefits for GPs

Upskilling of GPs in mental health

In order to participate in the Access to Allied Health Services projects, GPs must complete Level 1 Training (see Appendix 1 for more detail). The local evaluation reports that provided the basis for the First and Second Interim Evaluation Reports^{1,2} suggested that many GPs felt that this training increased their knowledge and understanding of psychological issues, and their confidence in managing mental health problems. Less emphasis is placed on the benefits of training in more recent local evaluation reports, presumably because many participating GPs are now trained. However, those which do include such a focus tend to continue to report that many GPs feel that the training component of the initiative has enhanced their mental health skills.

Opportunities to provide high quality care for consumers who could otherwise not access such care

In general, GPs applaud the Access to Allied Health Services projects for presenting them with opportunities to provide specific and high quality counselling services to consumers who could otherwise not access such care. In the past, these consumers were treated primarily with medication by the GP, or were referred to services or providers that are not necessarily the most appropriate. Typical comments from participating GPs include statements like, '*I have previously sent people to a psychiatrist, when they didn't really need a psychiatrist and now that we can refer to a psychologist it is a lot more direct, plus the patient can afford and that is a great change.*' GPs find it satisfying to be able to broker a more appropriate service for consumers.

A structured approach

In the main, GPs continue to be positive about the structured approach of the Better Outcomes in Mental Health Care initiative in general, and the Access to Allied Health Services projects in particular. In general, GPs are positive about these structural arrangements like the referral processes and the concept of a time-limited number of sessions, finding that they offer direction and guidance. So, for example, many GPs have indicated that they find the initial assessment and development of a treatment plan valuable in educating consumers and preparing them for their first session with the allied health professional. The assessment and plan are perceived as providing an opportunity to help the consumer understand his or her condition, focus on specific problems or behaviours to be addressed in treatment, and identify treatment goals. They are also viewed as providing an opportunity to identify and clarify areas for future monitoring by the GP.

Range of referral options

Consistent with the findings reported in the First and Second Interim Evaluation Reports,^{1,2} GPs are positive about the range of referral options available to them via the projects. They appreciate the fact that in referring a consumer to an allied health

professional, they can be confident that the consumer will receive high quality, affordable care. In particular, they have commented on the mix of skills, qualifications and areas of expertise offered by the allied health professionals associated with the projects. For example, many have stressed that the availability of allied health professionals from different cultural backgrounds and language groups is an extremely positive aspect of the initiative, and fills a gap in mental health care service provision in some areas.

Allied health professionals' location

Consistent with the First and Second Interim Evaluation Reports,^{1,2} GPs continue to express support for allied health professionals providing services to consumers in their practices. The co-location model fosters ease of referral, mutually satisfying professional relationships and good communication. Many GPs have indicated that this is their preferred option.

Having said this, some GPs have noted that there are benefits to having allied health professionals working from their own rooms or another location. The latter arrangement does not place a demand on rooms within the practice, and means that a broader range of allied health professionals may be available to any given referring GP. As noted above, the mix of skills, qualifications and areas of expertise of the allied health professionals is one of the factors that makes the Access to Allied Health Services projects attractive to participating GPs.

Divisional support

Increasingly, GPs have expressed satisfaction with the support offered by Divisions regarding the projects. Most GPs approve of the role that Divisions play. Many also appreciate the approachability of Divisional staff and their willingness to assist, finding them to be prompt, knowledgeable and courteous.

In particular, GPs are positive about the infrastructure and resources provided by Divisions. Those GPs who are involved in projects that have adopted a register system, for example, are generally very pleased to be given a list of allied health professionals to whom they can refer (particularly when the list details the allied health professionals' areas of interest, since this assists them in matching consumers to the most appropriate service providers). Those GPs who have received Divisional support in the form of information kits have also responded positively, finding that such resources enable them to confidently provide consumers with information regarding the referral process.

Consideration of the evaluation reports over time suggests that the role of Divisions has shifted in parallel with a growing confidence and clarity regarding the goals of the Access to Allied Health Services projects. From the GPs' perspective, Divisions have grown in strength, and are now able to offer far greater support.

Barriers for GPs

Barriers to participating in education and training

Consistent with the findings of the First and Second Interim Evaluation Reports,^{1,2} the current analysis found that the training required by GPs in order for them to be registered to refer consumers is a contentious issue. Having said above that many GPs are appreciative of the training, believing it to enhance their mental health skills, there are certainly a number who are less positive. According to focus groups, interviews and surveys, certain GPs are *'totally put off by the training'*, considering it to have *'no impact on clinical knowledge of mental health issues or on clinical skills.'* These sentiments are summed up in the comments of one GP, who said, *'[There is] ... too much training when all I want to do is refer to a psychologist in the medical interests of the patient'*.

Onerous paperwork requirements

Balanced against the structure provided by the Access to Allied Health Services projects (noted as a benefit in the previous section), is a perceived burden of the paperwork required by the initiative. Many GPs describe the paperwork associated with referral (particularly that involved in completing the mental health assessment and mental health plan, but also that involved in the mechanics of referral) as 'excessive', and indicate that this acts as a disincentive to participation. These views are summarised by the comments of one GP: 'GPs just don't have the time to fill out forms and then recall patients.'

Limited referral capacity

As noted in Second Interim Evaluation Reports,² GPs have expressed concerns about the number of referrals available to any individual GP. According to the data from the minimum dataset presented in Chapter 4, 1,771 GPs had referred 12,758 consumers to the Access to Allied Health Services projects as at 31 December 2004. This equates to 7.2 consumers per GP, which is higher than the figure reported in the Second Interim Evaluation Report² of 4.9, but still indicates that the average number of referrals is limited.

Focus group, survey and interview data from the local evaluation reports suggest that GPs still consider their limited referral capacity to be a significant issue. It has ramifications for the ongoing commitment of GPs, many of whom feel that the reality does not correspond to what was initially promised.

Feedback from allied health professionals

A number of GPs have observed that feedback from allied health professionals is sometimes slow, and not always sufficiently informative. In particular, these GPs feel that communication from the allied health professionals regarding consumers' progress and outcomes is sub-optimal. They contrast this with their experiences in referring consumers to other specialists, where a letter is usually forwarded to the GP as soon as the consumer is seen, and ongoing updates often are provided. Their expectations of the allied health professionals are similar.

Issues with Service Incentive Payments

Service Incentive Payments are triggered by the consumer returning to the GP for a review after six sessions with the allied health professional. The First and Second Interim Evaluation Reports^{1,2} both identified issues with Service Incentive Payments as being among the concerns of GPs who commented that if the consumer fails to return for the review session, they face loss of income.

In some instances, the earlier concerns have been addressed by projects putting in place specific measures to encourage consumers to return for the review session (e.g., allied health professionals highlighting the importance of this session to consumers, or GPs bulk-billing for the review session to remove any financial barriers for consumers). However, in other instances, consumers are still not returning to the GP for review. This may occur if the consumer feels that he or she has fully benefited from seeing the allied health professional, and has no need to return to the GP, or if he or she does not begin or discontinues treatment. It may also occur in circumstances where a GP who is not registered with the Better Outcomes in Mental Health Care initiative requests that a GP who is registered refer a consumer on his or her behalf, and the consumer ultimately returns to the original GP. Whatever the cause, inability to access Service Incentive Payments causes frustration on the part of GPs: *I can't stand it. I haven't claimed for any of the Service Incentive Payments.'*

Benefits for allied health professionals

Improved relationships with GPs

Consistent with the findings of the First and Second Interim Evaluation Reports, one of the key benefits of the Access to Allied Health Services projects for allied health professionals continues to be improved relationships with GPs. Data from focus groups, interviews and surveys conducted by Divisions in the process of compiling their local evaluation reports suggest that allied health professionals are positive about the mutual benefits of working with GPs.

Allied health professionals reiterate that their involvement with the Access to Allied Health Services projects has provided the opportunity for them and the GPs *'to work as a team.'* Allied health professionals have found such collaboration to combat professional isolation, in that it develops and strengthens their relationships with local GPs. In turn, this has led to improved mutual understanding of the way each professional group operates, and their respective roles in mental health care.

Increased (appropriate) referral base

In the First and Second Interim Evaluation Reports,^{1,2} there was evidence that allied health professionals were positive about the increased referral base created by their involvement in the Access to Allied Health Services projects, but that they cautioned that some referrals were inappropriate. As time has gone by, allied health professionals would appear to be satisfied with the quality as well as the quantity of referrals. GPs have become more familiar with the referral process, with the stipulations of the initiative, and with the skills of given allied health professionals, and as a result there are now far fewer inappropriate referrals.

A structured approach

On the whole, allied health professionals appear to appreciate the structured approach of the Access to Allied Health Services projects. For example, many have observed that the systematic referral process results in their receiving more information than they normally would from a referring GP, and equips them well to deliver an optimal service. Similarly, many have commented that the six session format is well-suited to the majority of referred consumers, and achieves positive outcomes (but are reassured by the option of a further six sessions in appropriate cases).

Allied health professionals' location

As noted in, the First and Second Interim Evaluation Reports,^{1,2} service location is an important aspect of the initiative from the allied health professional's point of view. Like GPs, allied health professionals favour different approaches, depending on the circumstances. On the one hand, they see considerable benefits to being co-located with the GP, since it enhances the professional relationship and fosters good communication between providers. On the other hand, offering services from their own premises creates fewer problems in terms of suitability of accommodation, and sometimes travel.

Divisional support

According to allied health professionals consulted during the course of local evaluations, the level of Divisional support provided through the Round 1 and 2 projects has been high. Allied health professionals have praised Divisions for their role in co-ordinating the projects, viewing this role as *'facilitating links between players and not just administrative.'* Many Divisions have developed specific resources, such as kits containing relevant information and forms to assist the allied health professional to deliver services. Other support has taken the form of professional development, regular meetings with project management, debriefing groups, and clinical supervision.

Barriers for allied health professionals

Lack of decision-making power

Local evaluation reports from the Round 1 and 2 projects suggest that, despite being generally positive about their involvement, some allied health professionals feel that they do not have sufficient decision-making power. This finding was reported in the First and Second Interim Evaluation Reports,^{1, 2} and continues to manifest itself in the same way. For example, many allied health professionals object to the fact that the decision to offer a consumer additional sessions beyond the original six rests with the GP. There have been calls to *'leave the decision about additional sessions (after six) to the therapists, rather than going through the re-referral process.'* Some projects have attempted to overcome this by arranging for the allied health professional to be present at the review and/or for the decision about further sessions to be made jointly by the allied health professional and the GP.

Insufficient streamlining

Having noted above that many allied health professionals appreciate the structured approach to service delivery afforded by the Access to Allied Health Services projects, it must be said that a minority still have some concerns about whether the model could be more streamlined. For example, although most allied health professionals applaud the way in which GPs prepare consumers for what to expect, a small number have observed that some consumers are unclear about why they have been referred, the number of sessions available to them, and whether payment is required. Similarly, some allied health professionals have questioned whether the six session norm is appropriate for some of the conditions that the projects are targeting. These sorts of factors create frustrations for some allied health professionals.

Remuneration issues

In the past, allied health professionals have observed time lags between delivery of service and payment (particularly under voucher systems) and loss of income due to consumer non-attendance at sessions. Later local evaluation reports suggest that many of these issues have been resolved as Divisional systems have become more sophisticated. Current issues regarding remuneration relate more to a feeling on the part of allied health professionals that they are not adequately recompensed, since their payment does not cover the paperwork requirements of their participation (e.g., provision of data for the minimum dataset, administration of outcome measures, and feedback to GPs). Even this concern is expressed only by a minority.

Distance and travel time for rural and remote allied health professionals

The distances and travel time required by rural and remote allied health professionals, identified as a problem in the First and Second Interim Evaluation Reports,^{1, 2} continues

to be an issue for some allied health professionals participating in Round 1 and 2 projects in non-metropolitan areas.

Benefits for consumers

Improved access to psychological services

Consistent with the findings of the First and Second Interim Evaluation Reports,^{1, 2} stakeholders who have been consulted as part of the ongoing evaluation process unanimously agree that the Round 1 and 2 projects are improving access to psychological services for consumers who otherwise might face barriers of high costs or long waiting times.

The projects have clearly removed financial barriers to accessing care, providing free or low-cost services (see Chapter 6). Consumers are extremely positive about this aspect of the initiative, and frequently make comments like, *'I feel I've benefited greatly from these sessions and there is no way I could have afforded them with my own finances'* and *'It meant that I didn't feel like a burden on the family because I was having therapy.'*

Likewise, consumers are sanguine about the waiting time between being referred by the GP and seeing the allied health professional. According to survey data, this period is typically no longer than two weeks, although there have been some reports of referrals taking longer than expected.

High quality care

There is continuing evidence from the Round 1 and 2 local evaluation reports that the mental health care being delivered to consumers is of high quality, in the sense that projects have taken steps to make sure that allied health professionals are well qualified and skilled (e.g., in general, psychologists must be registered with at least two years' postgraduate clinical experience, extensive training and experience in the use of evidence-based therapies) and well-supported (e.g., with clinical supervision).

Satisfaction with care

A recurrent theme in the local evaluation reports from the Round 1 and 2 projects is that consumers are satisfied with the care they are receiving through the projects. Through focus groups, interviews and surveys, consumers have commented on different aspects of their care.

They are positive about the co-ordinating role of the GP. Some have commented that they would have not been aware of the service had the GP not mentioned it: *'Without the GP telling me about the service, I would not know.'* Others have noted that having a familiar, trusted provider guide them through the process is reassuring. Still others have commended the GPs for providing them with information about the reasons for referral, potential benefits and (if relevant) costs, noting that this helped build up their confidence about participating. Only a minority have expressed concern that they were left with only a vague understanding of what was involved at the point of referral.

Consumers are generally satisfied with the allied health professional to whom they are referred, and many report that they would return to the same person should they experience a need in the future. Even those who would not be keen to return to the same provider generally indicate that they would be prepared to give another allied health professional a try, suggesting that the experience for most is positive.

Consumers are also pleased with the communication between the GPs and the allied health professionals involved in the Round 1 and 2 projects. They appreciate the fact

that their care is co-ordinated and shared between the two providers, and make comments like, *'The care I received from both the doctor and the counsellor was excellent. I would not have coped with life during this time without them.'* Good communication between the two parties has reduced the often-frustrating requirement that consumers 'retell their story' to different providers. This has not occurred at the expense of consumer confidentiality; indeed, most consumers have expressed the opinion that their privacy was respected at all times.

Perhaps even more important than their satisfaction with the individual and combined efforts of the GPs and allied health professionals, is consumers' satisfaction with their own involvement in treatment. The Round 1 and 2 local evaluation reports indicate that consumers are pleased to be involved in decisions about their own treatment, and feel a *'sense of ownership.'*

The views of consumers regarding the location of allied health professionals vary, depending on the model to which they have been exposed. In the main, those who have seen the allied health professional on the GP's premises have found that this model reduces stigma, since it is not evident that the consumer is visiting a mental health specialist. Typical comments in the local evaluation reports include, *'Having seen my counsellor at the doctor's surgery was as private as possible. No-one knew why you were there except staff'* and *'You could have just been seeing a doctor as far as anyone knew.'* On the other hand, those who have seen allied health professionals in their own premises have appreciated the choice this affords, making comments like, *'It was easy to access ... I was presented with a choice of male and female therapists and locations.'* Either way, ease of access to the location is important.

In addition to expressing satisfaction with the individual sessions that make up the overwhelming majority of sessions (see Chapter 6), those who have participated in group sessions are positive about their content, format and delivery. For example, one consumer commented on the allied health professionals conducting a local group, noting *'I have found both leaders to be extremely sensitive to each individual's needs, and willing to answer questions or find the answer.'*

Improved outcomes of care

The First and Second Interim Evaluation Reports noted that, at least in their early stages, the Round 1 pilot and supplementary projects did not systematically assess clinical outcomes for consumers in terms of improvements on standardised instruments. As time has gone on, however, these and the Round 2 projects have begun to draw more heavily on outcome measurement in their local evaluation reports. Numerous instruments are being used,⁶ with the most common being the Kessler 10 (K10),⁷ followed by the Depression Anxiety Stress Scales (DASS)⁸ and then the Health of the Nation Outcome Scales (HoNOS).⁹ Where these instruments have been used, they have demonstrated significant reductions in psychological distress, depression and anxiety over the six sessions of therapy. This is evidenced by summary comments like, *'There were statistically significant reductions in the overall score and in each subscale score ... The average group scores for the three subscales started in the severe group range. After intervention, the group mean for stress reduced to mild, and [that for] anxiety and depression to moderate.'*

The qualitative responses from consumers corroborate these findings, with many reporting that their mental health has improved as a consequence of the sessions with the allied health professional. Consumers have variously made comments like:

'It has given me a new way of looking at things, a better understanding of my situation, and strategies to deal with problems on an ongoing basis.'

'Having access to this counselling has been wonderful and has made all the difference to my recovery.'

'I was able to clarify issues by talking about them. The therapist helped me take one step at a time. I learnt that the problem was real and that I could do something about it. I'm very grateful for the opportunity. The therapist gave me a much better concept of realistic goals and the importance of looking after my emotional needs. I learnt to trust someone with my feelings and not be afraid to speak up. Since therapy, I feel I have completely turned my life around. I am finally comfortable with who I am and what I am. Thank you so much. I have got a life and it is good.'

'This project between my GP and my clinical psychologist has been helpful in managing my problem.'

Barriers for consumers

Inequity of access for consumers

As noted in the First and Second Interim Evaluation Reports,^{1, 2} one of the flip-sides of the structured approach to the Access to Allied Health Services projects that requires participating GPs to be trained and registered in order to refer consumers, is that consumers of non-trained and non-registered GPs may miss out on services. Anecdotal evidence from the local evaluation reports suggests that some non-registered GPs are referring consumers on to registered GPs, in order that they can then be referred to an allied health professional. There are disincentives for non-registered GPs to refer on, however, since they may 'lose' the consumer. There are also disincentives for registered GPs to receive such referrals, since they may miss out on Service Incentive Payments (see above). Consumers themselves have no way of knowing which GPs are registered, since Divisions will not divulge this information. Consequently, there is an inequity of access to services, based on consumers' affiliation with individual GPs or practices.

Issues with session number and format

Some consumers have raised concerns about the format of sessions. Although most who have undergone individual therapy feel that six sessions is appropriate (particularly given the option for further sessions if required), a number have indicated that they would have benefited from further follow-up sessions. Typical comments include, *'I feel like I need to be monitored once a month on the scheme'* and *'I've grown so much since I started and would like a follow-up down the track.'* Some have also noted that individual sessions *'could be longer.'* Similarly, several consumers who have taken part in group therapy sessions have suggested that eight weeks might be more suitable than six weeks, and that additional one-to-one sessions to complement the group sessions might be beneficial.

Chapter 8: What lessons have been learned from the early experiences of the projects?

As the Access to Allied Health Services component of the Better Outcomes in Mental Health Care initiative has matured, earlier projects have modified their approaches in response to observed issues, and later projects have learnt from the experiences of earlier projects. As a consequence, the conduct of the projects has become smoother over time. This is evident when comparing the barriers identified in the previous chapter of the current report to those identified in the equivalent chapters in the First and Second Interim evaluation reports.^{1,2} Although some barriers are ongoing, some have been rectified and are no longer problematic. For example, GPs are less likely to experience confusion about how the projects operate and barriers related to education and training than they were in the past. Allied health professionals seem to be less concerned about the uncertainty of guaranteed work, since the initiative is now well established. Problems with inappropriate referrals have generally been 'ironed out', removing barriers for both allied health professionals and consumers themselves.

It is worth considering some of the difficulties encountered in the course of conducting the projects, and the solutions that have been put in place to address them. Some projects have resolved identified issues in quite innovative ways. Tables 16, 17 and 18 draw on the local evaluation reports to describe some of the difficulties encountered and solutions identified by those providing services under the projects (Divisions, GPs and allied health professionals, respectively). The difficulties vary in magnitude from small but significant problems to major issues that could have potentially jeopardised the given project's successful implementation.

The difficulties and their solutions are presented here, in order to provide potential lessons for other projects, particularly those funded in later funding rounds

Table 16: Selected difficulties encountered by Divisions, and some solutions

Difficulties	Solutions
Community confusion about the initiative.	Education campaigns conducted.
Poor GP attendance at initial project meetings.	Practices of non-attending GPs visited and information kits distributed.
Problems with timely identification of which GPs have completed Level 1 Training and are registered with the Better Outcomes in Mental Health Care initiative.	Data sought from the General Practice Mental Health Standards Collaboration, and through local surveys of GPs.
Difficulties recruiting allied health professionals and matching skills and qualifications to profiles of need (particularly in rural areas).	Protocols broadened to include additional suitable providers (e.g., student psychologists, working under supervision).
GP confusion re. More Allied Health Services initiative and Better Outcomes in Mental Health Care initiative.	Differences between the two initiatives clarified, and roles of relevant Divisional project staff delineated.
Poor systems for tracking referrals.	Increasingly sophisticated systems developed that involve timely notification to the Division that a referral has been made.
Initial low rates of referral from GPs.	Referral systems modified and simplified (e.g., one page document completed by GP).
'No shows'.	Strategies to encourage attendance implemented (e.g., time limit within which consumer must make initial appointment; reminder phone calls and letters; requirement that consumer return to GP for re-referral if he/she fails to attend more than a certain number of appointments). Importance of

Difficulties	Solutions
	attendance stressed to consumers. Careful selection and preparation of consumers for referral on the part of GPs encouraged.
Lack of support for specific consumer groups (e.g., people from culturally and linguistically diverse communities).	Partnerships forged with relevant organisations (e.g., transcultural mental health services).
Low uptake of group sessions.	Information provided to GPs and consumers re. the benefits of group therapy.
Difficulties with administering outcome measures, particularly at review session.	Strategies to encourage completion of outcome measures implemented (e.g., allied health professional administers instrument at sixth session; pre-paid envelopes provided for self-completion instruments; GP provided with incentives for administering instruments at review).
Data entry issues.	Provision of on-line access for allied health professionals to enter data; employment of Divisional staff.

Table 17: Selected difficulties encountered by GPs, and some solutions

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

Table 18: Selected difficulties encountered by allied health professionals, and some solutions

Difficulties	Solutions
Lack of suitable accommodation at GPs' premises.	Alternative accommodation arrangements sought (e.g., own rooms, room at Division, or room at a third location such as a community health centre).
Some inappropriate referrals (e.g., for 'crisis management' and 'chronic mental illness')	GP education re. parameters of initiative.
Travel time and costs higher than expected (particularly in rural areas).	Single central location, or several suitable locations, sourced to minimise travel requirements for allied health professional.
Loss of income associated with 'no shows'.	Strategies implemented to encourage consumers to attend initial and subsequent appointments (e.g., GP makes the initial appointment while the consumer is present, providing advice about what the sessions will entail, and giving directions to the location).
Delays in payment due to the period elapsing between referral being made and sessions being completed.	Strategies to streamline 'tracking' of consumers (e.g., electronic or carbon-based systems, additional Divisional staff).
High caseloads.	Additional allied health professional(s) recruited to help meet demand and reduce waiting times.

Chapter 9: Discussion and conclusions

An overview of the achievements of the Round 1 and 2 projects

By the end of 2004, the Round 1 pilot projects had been running for at least 28 months, the Round 1 supplementary counterparts for at least 21 months, and the Round 2 projects for at least 18 months. Most projects took a number of months to establish the infrastructure and garner the support necessary to ensure their smooth implementation, but all are now well-established in terms of service delivery. Earlier projects have been modified along the way in response to stakeholder concerns, and later projects have learnt lessons from their earlier counterparts. As a consequence, the projects are operating under a range of different models which vary in terms of means of retaining allied health professionals, location of allied health professionals, and referral mechanisms.

The stakeholders involved in the conduct of the projects have much to be proud of in the way of achievements. Divisions have engendered considerable enthusiasm for the initiative on the part of GPs and allied health professionals, developed models of service delivery tailored to local needs, put in place increasingly sophisticated systems to manage service delivery, provided support and resources for participating GPs and allied health professionals, and engaged in monitoring and evaluation activities. The involvement of GPs and allied health professionals has mushroomed, with both parties adapting well to new systems, ways of working and professional relationships. As a consequence, the Access to Allied Health Services projects are realising what they set out to achieve: providing high quality mental health care to consumers who would otherwise face barriers to accessing such care.

The uptake of the Round 1 and 2 projects is high. Using the minimum dataset as the gold standard, 1,771 GPs had referred 12,758 consumers to 569 allied health professionals by 31 December 2004. This represents a 2.5-3.5 fold increase in the equivalent figures reported in the Second Interim Evaluation Report,² where the data cut-off was 31 May 2004 and Round 2 projects were not included. It is clear that there has been significant growth as time has passed and the Round 2 projects have developed.

There is evidence that the Round 1 and 2 projects are reaching the consumers that they are intended to target. For example, the majority (62%) are on low incomes, most have been diagnosed with depression (76%) and/or anxiety disorders (56%) by their GP, and 46% have no previous history of specialist mental health care, indicating that access may previously have been problematic for them.

There are good indications that the Round 1 and 2 projects are being delivered in the way in which was envisaged when the Better Outcomes in Mental Health Care initiative was first conceived – i.e., providing free or low-cost evidence-based mental health care to consumers through structured sessions. In total, the number of sessions of therapy received to date by consumers in the Round 1 and 2 projects is 45,823 (a mean of 3.6 sessions per consumer). Most sessions (75%) are an hour in length, and 98% involve individual, rather than group-based, treatment. The most common interventions delivered through these sessions are CBT-based cognitive (61%) and behavioural (45%) interventions. In 63% of all sessions, consumers are not required to contribute to the cost of care; in the remainder of cases they are asked to make a co-payment, usually of not more than \$20.

Focus group, interview and survey data from the local evaluation reports suggest that participating GPs, allied health professionals and consumers are very satisfied with the Round 1 and 2 projects. Benefits observed by GPs include upskilling opportunities,

improved capacity to deliver high quality care, and the range of referral options. Advantages observed by allied health professionals include improved relationships with GPs, and an increased referral base. Both sets of providers have commended the structured approach and the level of support provided by Divisions. Consumers appreciate the improved access to psychological services and the high quality of care, expressing satisfaction with many aspects of service delivery. There is also evidence that many consumers are achieving positive mental health outcomes as a result of the care they are receiving.

In spite of this, GPs and allied health professionals have experienced some barriers to participation. Some GPs have viewed the education and training and the paperwork as hurdles, and have noted that the benefits do not outweigh these costs since their referral capacity is limited, feedback from allied health professionals is not always optimal, and there are issues with payment. Some allied health professionals have expressed frustration at their lack of decision-making power, and have struck issues related to the streamlining of the referral process, remuneration and travel. For some consumers, there are equity issues and issues related to the number and format of sessions.

Having said this, it should be noted that a number of the issues that were apparent in earlier local evaluation reports are less relevant in later ones. So, for example, 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', removing barriers for both allied health professionals and consumers.

Suggested future directions

As the original four-year funding period of the Better Outcomes in Mental Health Care initiative draws to a close, it is timely to consider how the current findings might guide future funding decisions. Indeed, many of the local evaluation reports that formed the basis for the current report made recommendations about what might change and what might stay the same if the Access to Allied Health Services component of the initiative was to operate optimally.

At the outset, it should be said that continuation and expansion of the initiative should be a high priority for ongoing funding. The uptake of the projects by GPs, allied health professionals and consumers is impressive by any standards. The projects are reaching consumers whose needs were previously unmet, and providing them with evidence-based care that is resulting in positive mental health outcomes.

One of the reasons for the success of the projects may be the fact that the approach is structured and visionary, but at the same time allows Divisions to develop specific models that are tailored to their local contexts. In addition, the 'roll-out' of the projects has been systematic, and has allowed for early learnings to be built upon over time.

It would clearly be desirable for future funding efforts to maintain the balance between structure and flexibility, and to foster the sharing of information across projects. Having said this, there are areas that warrant particular consideration. Key among these is the issue of the limited number of referrals available to GPs, created by the effective cap on services that results from finite project budgets. Also worthy of consideration are particular at-risk groups who are as yet not optimally served by the projects – two clear examples are people from culturally and linguistically diverse communities and young people. Emphasis should also be given to mechanisms that might encourage group therapy sessions. Issues of support and remuneration for GPs and allied health professionals also warrant further consideration.

Ongoing evaluation efforts

As noted in Chapter 1, the current report is the fourth, and most comprehensive to date, in a series of interim evaluation reports. It focused on Round 1 and 2 projects, on the rationale that these had all been running for sufficiently long to have reached the point of service delivery. It drew on local evaluation reports from 84% of these projects, and on minimum dataset statistics from 80% of them. The next interim evaluation report will incorporate data from the Round 3 projects, when these projects collectively reach maturity in terms of implementation.

Although the current report was able to include a greater focus on consumer outcomes than its predecessors (because many more local evaluation reports incorporated data from standardised outcome measures), there is still a clear need to do this more systematically. A set of fields is in the final stages of completion for incorporation into the minimum dataset, which will allow outcome data to be collected routinely to inform future interim evaluation reports. Outcome measurement is not the be-all and end-all of evaluation, but it will provide a common metric against which to assess the effectiveness (and cost-effectiveness) of projects in terms of impacts for consumers.

Conclusion

The Access to Allied Health Services projects are continuing to go from strength to strength in terms of providing access to high quality mental health care for consumers who would otherwise have experienced difficulty accessing such care. Participating GPs, allied health professionals and consumers express high levels of satisfaction with the projects, and a number of the barriers to participation that previously existed have been removed as the projects have developed. The success of the initiative may be due, at least in part, to the balance that has been struck between an over-arching vision that defined the parameters within which projects would operate on the one hand, and a degree of flexibility that has allowed Divisions to tailor projects to suit the local environment, on the other. The continuation and expansion of the initiative should be a high priority for future funding.

References

1. Pirkis J, Blashki G, Headey A, Morley B, Kohn F. *Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: First Interim Evaluation Report*. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne; 2003.
2. Morley B, Kohn F, Pirkis J, Blashki G, Burgess P. *Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: Second Interim Evaluation Report*. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne; 2004.
3. Morley B, Kohn F, Pirkis J, Blashki G, Burgess P. *Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: Third Interim Evaluation Report: Benefits and Barriers Associated with Different Models of Service Delivery*. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne; 2005.
4. Australian Bureau of Statistics. <http://www.abs.gov.au/>.
5. World Health Organization. *Diagnostic and management guidelines for mental disorders in primary care: ICD-10 Chapter V Primary Care Version*. Gottingen: Hogrefe and Huber Publications; 1996.
6. Pirkis J, Kohn F, Morley B, Burgess P, Blashki G. Better Outcomes in Mental Health Care? *Primary Care Mental Health*. In press.
7. Kessler RC, Andrews G, Colpe LJ, et al. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*. Aug 2002;32(6):959-976.
8. Lovibond PF, Lovibond SH. The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*. 1995;33:335-343.
9. Wing JK, Beevor AS, Curtis RH, Park SB, Hadden S, Burns A. Health of the Nation Outcome Scales (HoNOS). Research and development. *British Journal of Psychiatry*. Jan 1998;172:11-18.

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 Better Outcomes in Mental Health Care 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 Better Outcomes in Mental Health Care 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 Better Outcomes in Mental Health Care 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 Better Outcomes in Mental Health Care initiative.

Component 5: Access to Psychiatrist Support

The Access to Psychiatrist Support component of the Better Outcomes in Mental Health Care 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)
1 (Pilot)	NSW	NSW Outback Division of General Practice
1 (Pilot)	NSW	NSW Central West Division of General Practice
1 (Pilot)	NT	Top End Division of General Practice
1 (Pilot)	QLD	Toowoomba and District Division of General Practice
1 (Pilot)	QLD	Logan Area Division of General Practice
1 (Pilot)	QLD	Sunshine Coast Division of General Practice
1 (Pilot)	QLD	Brisbane Inner South and Bayside Divisions of General Practice
1 (Pilot)	SA	Adelaide Northern Division of General Practice
1 (Pilot)	Vic	Bendigo and District Division of General Practice
1 (Pilot)	Vic	Dandenong and Greater South Eastern Divisions of General Practice
1 (Pilot)	Vic	North West Melbourne Division of General Practice
1 (Pilot)	Vic	East Gippsland, Central West Gippsland and South Gippsland Divisions of General Practice
1 (Pilot)	Vic	Knox Division of General Practice
1 (Pilot)	WA	Fremantle Regional Division of General Practice
1 (Pilot)	WA	Perth and Hills Division of General Practice
1 (Supplementary)	ACT	ACT Division of General Practice
1 (Supplementary)	NSW	Mid North Coast (NSW) Division of General Practice
1 (Supplementary)	NSW	Hastings Macleay Division of General Practice
1 (Supplementary)	NSW	Riverina Division of General Practice
1 (Supplementary)	NSW	NSW Central Coast Division of General Practice
1 (Supplementary)	NSW	Canterbury Division of General Practice
1 (Supplementary)	QLD	Northern Queensland Division of General Practice and Western Queensland Primary Health Care
1 (Supplementary)	SA	Adelaide Southern Division of General Practice
1 (Supplementary)	Vic	Central Highlands Division of General Practice
1 (Supplementary)	Vic	Mornington Peninsula Division of General Practice
1 (Supplementary)	Vic	Ballarat and District Division of General Practice
1 (Supplementary)	Vic	Geelong and Otway Divisions of General Practice
1 (Supplementary)	Vic	North East Victorian Division of General Practice
1 (Supplementary)	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
2	NSW	Nepean and Hawkesbury Divisions of General Practice

Round	State	Division(s)
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
3	NSW	Barrier Division of General Practice Ltd.
3	NSW	Barwon Division of General Practice Inc.
3	NSW	Central Sydney Division of General Practice
3	NSW	Eastern Sydney Division of General Practice Ltd (includes South Eastern Sydney Division)
3	NSW	Hornsby Ku-Ring-Gai Division of General Practice Ltd.
3	NSW	Hunter Rural Division of General Practice Ltd.
3	NSW	Hunter Urban Division of General Practice Ltd.
3	NSW	Macarthur Division of General Practice Ltd.
3	NSW	Northern Rivers Division of General Practice (NSW) Ltd.
3	NSW	St George District Division of General Practice Inc.
3	NSW	The Northern Sydney Division of General Practice Inc.
3	NSW	The Shoalhaven Division of General Practice Inc.
3	NSW	The South East NSW Division of General Practice Ltd.
3	NSW	The Western Sydney Division of General Practice Inc.

Round	State	Division(s)
3	QLD	Brisbane North Division of General Practice Association Inc.
3	QLD	Southern Queensland Rural Division of General Practice Association Inc.
3	QLD	Wide Bay Division of General Practice
3	SA	Eyre Peninsula Division of General Practice
3	SA	Flinders and Far North Division of General Practice Inc.
3	SA	Mid North Rural SA Division of General Practice
3	SA	Riverland Division of General Practice Inc.
3	SA	The Barossa Division of General Practice Inc.
3	SA	Yorke Peninsula Division of General Practice Inc.
3	VIC	Central West Victoria Division of General Practice Inc.
3	VIC	Goulburn Valley GP's
3	VIC	Eastern Ranges Division of General Practice
3	VIC	Mallee Division of General Practice
3	VIC	Northern Division of General Practice , Melbourne
3	VIC	The Border GP Division of Pty Ltd.
3	VIC	West Vic Division of General Practice
3	WA	Central Wheatbelt Division of General Practice
3	WA	Eastern Goldfields Medical Division of General Practice Ltd.
3	WA	Mid West Division of General Practice Inc.
3	WA	Rockingham Kwinana Division of General Practice Ltd.