



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

Interim evaluation report of a trial of telephone-based cognitive behaviour therapy

**Bridget Bassilios, Valeria Zoteyeva, Kylie King,
Justine Fletcher, Fay Kohn, Grant Blashki, Philip Burgess, Jane Pirkis**

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Table of contents

Executive summary	2
Chapter 1: Background	6
Chapter 2: Method.....	7
Chapter 3: What is the uptake of the T-CBT pilot and what are the profiles of consumers and sessions?	8
Chapter 4: What models of service delivery are being utilised by Divisions implementing the T-CBT pilot?	14
Chapter 5: What issues have arisen in implementing the T-CBT trial?	17
Chapter 6: Discussion and conclusions	24
References	28
Appendix 1: Components of the Better Outcomes in Mental Health Care program	30
Appendix 2: Divisions of General Practice involved in Access to Allied Psychological Services projects.....	32
Appendix 3: Divisions of General Practice participating in T-CBT pilot.....	35
Appendix 4: Session information form for T-CBT evaluation.....	36
Appendix 5: Consumer experience survey	37
Appendix 6: Instructions for project officers.....	40
Appendix 7: Instructions for allied health professionals	42
Appendix 8: Questions for Access to Allied Psychological Services project officers participating in the T-CBT pilot	44

Executive summary

Background

In July 2001, the Better Outcomes in Mental Health Care program was introduced in Australia to improve consumers' access to high quality primary mental health care. Pivotal to this program is its Access to Allied Psychological Services component, which encourages collaboration between GPs and allied health professionals to provide optimal mental health care. This collaborative approach to mental health care is occurring nationally through 105 Access to Allied Psychological Services projects being conducted by 111 Divisions of General Practice (Divisions).

Until recently, the sessions of care delivered through the Access to Allied Psychological projects were primarily face-to-face. In mid-2008, the Federal Government extended funding for the Better Outcomes in Mental Health Care program to trial a Telephone-based Cognitive Behaviour Therapy (T-CBT) pilot through 22 rural and remote projects being conducted by 22 Divisions of General Practice. The T-CBT pilot is designed to further enhance consumer access to psychological services, by overcoming barriers such as ability to commute.

The current report provides a preliminary analysis of the uptake of the T-CBT pilot and the characteristics of consumers and sessions. In addition, models of service delivery being utilised by the Divisions involved in the T-CBT pilot and issues related to the implementation of the pilot are considered. Where relevant throughout the report, findings are compared with the rural component of the national Access to Allied Psychological Services projects. The latter is differentiated throughout the report by the use of the terms 'general' and/or 'rural' projects.

Method

The report draws on data from a purpose-designed minimum dataset, which collects consumer- and session-based data on the projects. Additionally, quantitative and qualitative data were analysed from a purpose-designed survey interview of one project officer from each of the 22 Divisions involved in the T-CBT pilot. Specifically, the report considers the uptake and implementation of the T-CBT pilot via the following evaluation questions:

Evaluation Question 1: What is the uptake of the T-CBT pilot and what are the profiles of consumers and sessions?

Evaluation Question 2: What models of service delivery are being utilised by Divisions implementing the T-CBT pilot?

Evaluation Question 3: What issues have arisen in implementing the T-CBT pilot?

Key findings

What is the uptake of the T-CBT pilot and what are the profiles of consumers and sessions?

Data entered on the minimum data set and flagged as being part of the T-CBT pilot, by selecting 'T-CBT' on the 'referral type' field, suggest that the uptake has been very slow. It indicates that to date, 43 consumers have been referred by 21 GPs to 11 allied health professionals, of whom 30 consumers have received 123 sessions of care. However, it is noteworthy that the Divisions involved in the T-CBT pilot have also reported a further 123 sessions of care delivered by telephone but have indicated the associated referrals are for the 'general' Access to Allied Psychological Services projects. Unfortunately, this means that the consumer and session profiles described are not truly representative of all consumers receiving telephone sessions because only data strictly entered on the minimum dataset as being part of the T-CBT pilot was used for these analyses, respectively. Therefore, consumer and session characteristics should be interpreted with caution.

The majority (79%) of consumers are females, aged around 40 years, and are on low incomes as judged by their GPs. Over a third of consumers have not received any previous psychiatric care and for roughly the same proportion this information is unknown. About 2% of T-CBT consumers are Aboriginal and none are Torres Strait Islanders. The vast majority of consumers have been diagnosed with a depressive disorder and/or an anxiety disorder. In the main, T-CBT consumer characteristics are not too dissimilar from consumers of the rural Access to Allied Psychological Services projects, with the following exceptions: T-CBT consumers are more likely to be females, with a diagnosis of a depressive disorder and on low incomes, and less likely to be indigenous.

For the 30 consumers who had session data entered on the minimum dataset, the average number of sessions received is 4. As with the rural Access to Allied Psychological Services projects, the vast majority of sessions are 46-60 minutes in length, delivered to individuals, and rarely incur a copayment. Interestingly, 43% of sessions were delivered face-to-face even though consumers were referred for T-CBT. Compared with the rural Access to Allied Psychological Services projects, T-CBT sessions were more likely to involve diagnostic assessment (42% *cf.* 19%) and psycho-education (48% *cf.* 31%), and never involved CBT-skills training (0% *cf.* 22%). Over one third of T-CBT sessions involved CBT-cognitive interventions and almost two-fifths of sessions involved CBT-behavioural interventions.

What models of service delivery are being utilised by Divisions implementing the T-CBT pilot?

Retention of allied health professionals

The majority (64%) of allied health professionals involved in the T-CBT pilot are retained via contractual arrangements. Project officers reported that their method of retention of allied health professionals for the T-CBT pilot was no different to that of their general ATAPS projects.

Compared to the rural Access to Allied Psychological Services projects, T-CBT pilots are less likely to retain allied health professionals under contractual arrangements (64% *cf.* 87%) but equally likely to directly employ (41% *cf.* 40%).

Location of allied health professionals

The most common locations for allied health professionals delivering T-CBT services included GP rooms, own (allied health professional) rooms and Division sites (in 36%, 32%, and 32% of cases, respectively). Thirty-eight percent of project officers reported that allied health professionals deliver T-CBT sessions from multiple locations. T-CBT Divisions' location of allied health professionals did not vary from the locations of their general Access to Allied Psychological Services projects.

Compared to the rural Access to Allied Psychological Services projects, T-CBT allied health professionals are less likely to deliver services from GP rooms (36% *cf.* 54%), their own rooms (32% *cf.* 46%), and community organisations (18% *cf.* 26%), but are somewhat more likely to utilise other locations (27% *cf.* 22%).

Referral mechanisms

With the exception of one Division, which reported using the voucher system to track T-CBT referrals, the majority of Divisions were using the same referral mechanism for T-CBT as for their general Access to Allied Psychological Services projects. The most commonly utilised referral mechanisms for the T-CBT pilot are direct referral (55%) and brokerage (36%), which is relatively consistent with the pattern observed for the rural Access to Allied Psychological Services projects (63% and 43%, respectively). The register system is less frequently used and this is probably because less allied health providers are available who have been trained to deliver T-CBT.

What issues have arisen in implementing the T-CBT pilot?

Service delivery commencement

The majority of project officers reported that their respective Divisions commenced T-CBT service delivery in late 2008. Nine project officers reported that there was a delay in the commencement of T-CBT service delivery. The most commonly cited reason for this delay was the corresponding delay in

the availability of the webinar training for allied health providers. Another explanation provided was that there was slow uptake by GPs, which was problematic in the context of the original guidelines being perceived to be reliant on GPs suggesting T-CBT to consumers.

Promotion of T-CBT service

Project officers indicated that they were using a wide range of strategies to promote the T-CBT service. These strategies made use of all communication modalities – from hardcopy, electronic, telephone, to face-to-face. It was common for multiple strategies to be used by any one Division, with provider newsletters and practice visits being the most commonly reported promotion strategies. Interestingly, none of the Divisions specifically mentioned promoting the service to other community and health organisations not directly involved in the delivery of Access to Allied Psychological Services.

GP and allied health professional response to T-CBT pilot

GP and allied health professional responses have been varied, with allied health professionals viewing the service as more positive than negative and more positively than GPs. GPs were reported to view the T-CBT pilot favourably as *“it provides a new opportunity to help those who are disadvantaged”*. Importantly, GPs were more likely to engage and refer to the pilot when they received positive feedback about the service from consumers. Despite favourable views of GPs, they were reported to be *“passive in terms of making referrals”* and this was anecdotally attributable to both GP and consumer preference for face-to-face services, if available. Allied health professional responses were reported to be favourable, particularly when *“clients want to engage”*. T-CBT was combined with face-to-face sessions in some instances. Despite an overall positive response by allied health professionals, it was noted that they experienced: difficulty associated with the loss of behavioural cues of patients and disappointment with the low uptake, the webinar training, and the amount of paperwork. The latter may explain why some *“allied health professionals sometimes conduct sessions over the phone with their clients, but not within the T-CBT project”*.

Factors that facilitate and potentially enhance the T-CBT pilot

A substantial number of project officers commented that positive provider responses acted as facilitators of the T-CBT pilot. In addition, the flexibility of the guidelines around the referral mechanism and multimodal (i.e., the ability to combine telephone and face-to-face) service delivery was considered to be a facilitator of the T-CBT pilot. In particular, allowing allied health professionals and Divisions to make decisions about the (T-CBT) mode of service delivery, rather than relying on GPs to suggest T-CBT to consumers was regarded as beneficial. Furthermore, the need for counselling services to be provided remotely and the fact that the pilot operates in conjunction with the Access to Allied Psychological Service projects were reported to facilitate the pilot.

Flexibility, education of stakeholders, and less paperwork emerged as key factors that would improve the T-CBT pilot. Examples of other factors that would improve the T-CBT service included increasing funding to *“improve capacity with more clinicians and therefore shorten wait list”*; *“targeting a GP practice where distance issues (barriers to access) are more relevant”*; and T-CBT services *“not being a temporary pilot”*. The majority of project officers indicated that support from the evaluators of the T-CBT pilot was not required to enhance the operation of the pilot.

Barriers to the effective operation of the T-CBT pilot

The most commonly mentioned barrier was the low rate of GP referrals, which was attributed to difficulty convincing GPs to use the service, which in turn, is probably attributable to their (and consumers') preference for face-to-face treatment. It was expressed that over time clients might increasingly accept the T-CBT service option. Telephone equipment /coverage issues and the additional paperwork were the next most, and equally, frequently cited barriers. Funding issues were reported as barriers by a few project officers, particularly in terms of the cost of telephone calls and travel costs associated with mixing T-CBT with some face-to-face sessions.

Impact of T-CBT pilot on Divisions

A substantial number of project officers indicated that the T-CBT pilot has had positive impacts for the Division. The flexibility and option of the mode of service delivery, and in turn, its effect of increasing accessibility for consumers that may otherwise experience difficulties accessing psychological services, was the most frequently mentioned positive impact of the T-CBT pilot for Divisions. A minority of project officers expressed that the T-CBT pilot has had negative impacts for the Division in terms of

additional workload demand. Nonetheless, the value of the T-CBT pilot was acknowledged as the majority of project officers hoped that the service would continue.

Conclusions

The current report indicates that the uptake of the T-CBT pilot has been underestimated because telephone sessions are being delivered more generally via the Access to Allied Psychological Services projects and not just within T-CBT pilot. As teething issues related to the delivery of T-CBT services and the collection and entry of its data are resolved, a more accurate representation will be facilitated. While some of the teething issues are probably associated with the start-up of any new program, others are specifically related to the telephone modality of the treatment.

Even though there was a reported general consensus among consumers, allied health professionals, GPs, and Divisions that face-to-face treatment is preferred, it is acknowledged that the T-CBT modality is valuable particularly for consumers for whom no other option exists. This is supported by the observation that telephone sessions are being delivered more widely across the various programs comprising the Access to Allied Psychological Services projects rather than solely via the T-CBT pilot. Divisions are definite that they would like the T-CBT service and its flexibility to be sustained, particularly in terms the means of suggesting the option to consumers (i.e., not exclusively relying on GPs) and the ability to deliver a multimodal service (e.g., combine telephone and face-face according to consumer needs).

Promotion of the T-CBT pilot more widely to other community and health organisations and the community in general may attract more consumers who would benefit from T-CBT, particularly if inability to travel (associated with cost or disability) or unwillingness prevents some consumers even from seeing a GP. Consequently, there may also be some merit in considering the integration of the telephone modality option more generally (nationally) under the Access to Allied Psychological Services projects, rather than offering it as a segregated program.

Chapter 1: Background

In July 2001, the Australian Department of Health and Ageing introduced the Better Outcomes in Mental Health Care program. This program aims to improve consumers' access to high quality primary mental health care, through a number of components (described in more detail in Appendix 1).¹ Key among these is the Access to Allied Psychological Services component which supports GPs and allied health professionals to work together to provide optimal mental health care. Specifically, this component enables GPs to refer consumers with high prevalence disorders (e.g., depression and anxiety) to allied health professionals for up to 12 (or 18 in exceptional circumstances) sessions of evidence-based mental health care (predominantly Cognitive Behavioural Therapy), delivered as individual and/or group sessions, with a mental health review by the referring GP after every six sessions. This collaborative approach to mental health care is being implemented via 105 Access to Allied Psychological Services projects being conducted by 111 Divisions of General Practice (58 rural; 53 urban) and progressively funded through four funding rounds. Appendix 2 provides a full list of these projects.

Until recently, the sessions of care delivered through the Access to Allied Psychological Services projects were primarily face-to-face. In mid-2008, the Federal Government funded a trial which involves substituting face-to-face services for Telephone-based Cognitive Behaviour Therapy (T-CBT) in 22 Divisions of General Practice (listed in Appendix 3) under the existing Access to Allied Psychological Services model. This service was implemented to improve accessibility for selected consumers in rural and remote settings or who for various reasons experience barriers to seeing a clinician face-to-face. With one exception, the T-CBT pilots were implemented in rural and remote Divisions. The Australian Psychological Society was contracted to develop and deliver training to ensure that all participating allied health professionals are adequately equipped to deliver T-CBT.

Additionally, the Better Outcomes in Mental Health Care program has been extended to provide services for the National Perinatal Depression Initiative and a Suicide Prevention Pilot in 2008 and to provide services for bushfire affected consumers in Victoria in 2009. These new programs are also being conducted via Access to Psychological Services projects. There have been 19 Divisions funded to trial the Suicide Prevention Pilot and nine Divisions funded to provide services in response to the Victorian bushfires.

Since mid-2003, the University of Melbourne's Centre for Health Policy, Programs and Economics has been conducting an ongoing evaluation of the Access to Allied Psychological Services projects. To date, 14 interim evaluation reports have been produced drawing on a number of data sources, including information from projects' local evaluation and project implementation reports, a purpose-designed minimum dataset, a Division forum, and one-off surveys.²⁻¹⁶ In June 2008, the evaluation contract was varied to incorporate an appraisal of the new T-CBT pilot. Due to the novelty of the T-CBT pilot, there were additional evaluation requirements of the participating Divisions, mainly in terms of some extra session information from allied health professionals (see Appendix 4) and a consumer experience survey (see Appendix 5). To facilitate the collection of this extra data, instructions were developed for project officers and allied health professionals (see Appendices 6 and 7, respectively) and these, along with other resources for the evaluation of the pilot were disseminated to Divisions and posted on the evaluation website (<http://www.boimhc.org>).

The current report is the second to document our progress in evaluating the T-CBT pilot. It represents an update of the first progress report of the T-CBT pilot, which was submitted to the Department of Health and Ageing in November 2008.¹⁷ Specifically, the uptake of the trial and the profiles of consumers and sessions are described. In addition, the models of service delivery being used by the participating Divisions and issues related to the implementation of the T-CBT pilot are examined. Where relevant throughout the report, findings are compared with the rural component of the national Access to Allied Psychological Services projects. The latter is differentiated throughout the report by the use of the terms 'general' and/or 'rural' projects.

Chapter 2: Method

Evaluation questions

This report considers the process of implementing the T-CBT pilot, via the following evaluation questions:

Evaluation Question 1: What is the uptake of the T-CBT pilot and what are the profiles of consumers and sessions?

Evaluation Question 2: What models of service delivery are being utilised by Divisions implementing the T-CBT pilot?

Evaluation Question 3: What issues have arisen in implementing the T-CBT pilot?

Data sources

The first evaluation question was addressed using data from the previously mentioned minimum dataset, which captures de-identified, consumer-level and session-level information. Data from the minimum dataset were available for the 22 Divisions participating in the T-CBT pilot from 1 July 2003 (when the minimum dataset was first 'rolled out') to 16 July 2009. Data related to the T-CBT pilot were extracted from the minimum dataset on the uptake of the pilot, including consumer and session profiles (Evaluation Question 1) on 16 July 2009.

The second and third evaluation questions were examined by conducting a purpose-designed telephone interview with a project officer from each of the 22 Divisions involved in the T-CBT pilot in June/July 2009. The interview gathered quantitative and qualitative data about models of service delivery (Evaluation Question 2) and issues related to implementation (Evaluation Question 3). A copy of the interview questions is included in Appendix 8. The models of service delivery data was also compared to data gathered from similar interviews of the rural Access to Allied Psychological Services projects, conducted between October 2008 and February 2009. Urban data were not considered useful for comparative purposes based on the fact that all but one of the T-CBT pilots are rural.

Data analysis

Simple frequencies and percentages were calculated from the T-CBT pilot data in order to answer Evaluation Question 1.

Evaluation Questions 2 and 3 were examined by manually analysing the qualitative data from the interviews and organising the data into themes. Where appropriate, the frequency of project officers generating each theme is presented in order to gauge the extent to which certain issues affected the Divisions conducting the T-CBT pilot.

Chapter 3: What is the uptake of the T-CBT pilot and what are the profiles of consumers and sessions?

Data from the minimum dataset were extracted in July 2009 and used to address the first evaluation question. Since the introduction of the T-CBT trial, the minimum data set has been amended to capture data for this pilot. Data is available for 22 projects from October 2008, which coincides with the completion of T-CBT training, delivered by the Australian Psychological Society. It is important to note that the findings are most likely an underestimate as it has taken considerable time for some projects to update their data capture systems to incorporate the new pilot. It should also be noted that there are generally lags in data entry, of up to six months, on the minimum dataset because some Divisions enter session data in particular once a consumer has completed treatment.

Evaluation Question 1: What is the uptake of the T-CBT trial and what are the profiles of consumers and sessions?

Data entered on the minimum dataset and flagged as a T-CBT referral, by selecting T-CBT as the 'referral type', suggests that 43 consumers have been referred by their respective GPs to an allied health professional, of whom 30 consumers have had 123 sessions of care entered on the minimum dataset.

Uptake by GPs and allied health professionals

Table 1 shows the number of GPs and allied health professionals who have been involved in the T-CBT trial nationally based on T-CBT referrals identified on the minimum dataset. The table indicates a very modest participation rate, with about twice as many GPs referring consumers as there are allied health professionals delivering sessions.

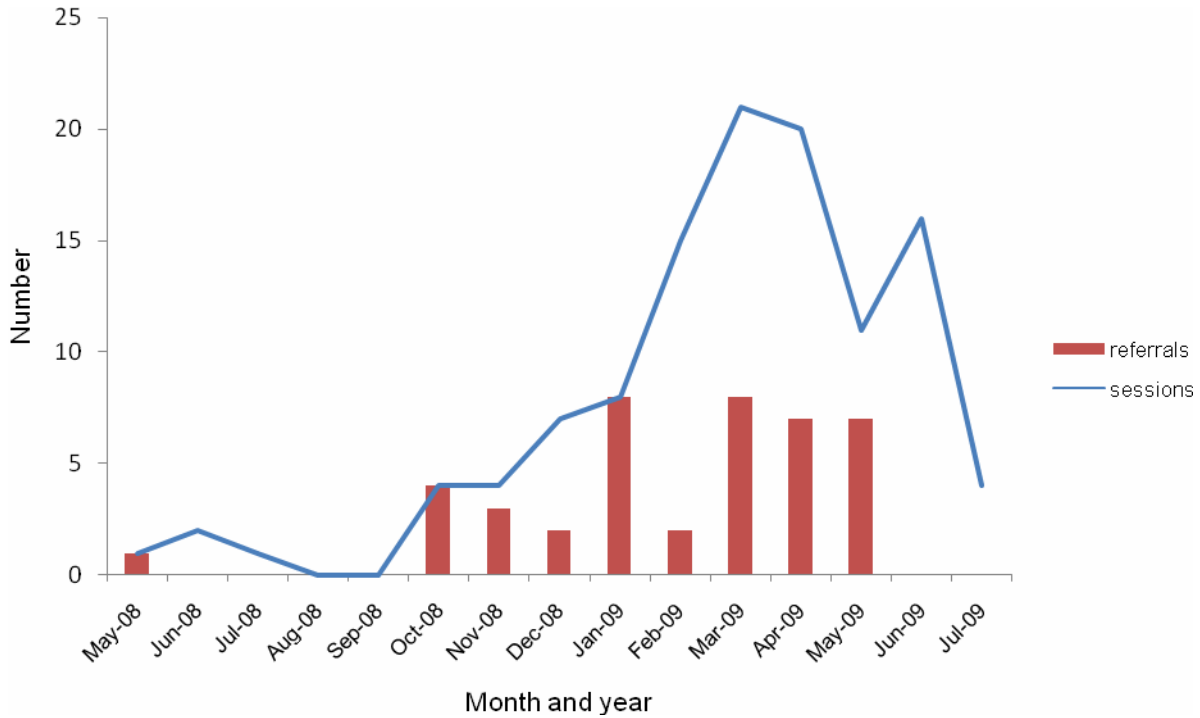
Table 1: Number of GPs and allied health professionals participating in the T-CBT

	Number
General Practitioners	21
Allied health professionals	11

Referrals and sessions identified as part of the T-CBT pilot on the minimum dataset

Figure 1 presents the number of T-CBT referrals made and sessions delivered, respectively, from May 2008 to 16 July 2009 (the date of data extraction). The figure suggests that the uptake of T-CBT services is slow. Not shown in the figure, which tracks uptake from May 2008, is that one referral date was entered on the minimum dataset as October 2007, and another was May 2008. Similarly, 12 sessions occurred prior (from November 2007 to June 2008) to the commencement of training for T-CBT services delivered by the Australian Psychological Society in about September 2008. Anecdotally, this may be reflective of lack of other available options for service delivery (refer Chapter 5) or, alternatively, of errors in entry of dates on the minimum dataset.

Figure 1: Number of T-CBT referrals and sessions over time



Telephone sessions delivered by Divisions under via T-CBT pilot and via ‘general’ Access to Psychological Service projects

Table 2 shows that a total of 123 sessions (70 by telephone and 53 face-to-face) were delivered by the T-CBT Divisions for referrals flagged as T-CBT on the minimum dataset, accounting for 0.8% of all sessions delivered by these Divisions from November 2007 to July 2009. It also shows that an additional 123 sessions were delivered by telephone for referrals that were flagged as ‘general’ Access to Allied Psychological Services. This suggests the uptake of the T-CBT pilot is not being accurately represented because of the way data is being entered on the minimum dataset. It indicates that more than 43 referrals were probably made. It is also probable that more than 246 sessions were delivered via the pilot as there are likely to be additional face-to-face sessions because Divisions often combine modalities under the T-CBT pilot as reported in Chapter 5.

Table 2: Number of T-CBT sessions identified as being for T-CBT referrals, number of all other sessions, and number of telephone sessions recorded under the 'general' Access to Allied Psychological Services projects (ATAPS) by T-CBT Divisions

Division	Number of sessions for T-CBT referrals ^a	Number of sessions for referrals to other ATAPS programs ^b	Total number of sessions	Proportion of T-CBT specific sessions (%)	Number of telephone sessions delivered to general ATAPS referrals
1	0	847	847	0	0
2	0	1050	1050	0	0
3	0	21	21	0	3
4	0	1253	1253	0	17
5	5	840	845	0.6	0
6	0	502	502	0	0
7	0	644	644	0	1
8	0	403	403	0	0
9	4	797	801	0.5	5
10	0	49	49	0	0
11	0	129	129	0	2
12	0	558	558	0	46
13	2	1457	1459	0.1	41
14	0	404	404	0	1
15	25	614	639	3.9	2
16	0	1355	1355	0	0
17	0	1093	1093	0	0
18	3	743	746	0.4	0
19	26	780	806	3.2	1
20	24	493	517	4.6	2
21	0	330	330	0	0
22	34	1352	1386	2.4	2
Total	123^c	15,714	15,837	0.78	123

^a From November 2007 to July 2009

^b From October 2008 to July 2009

^c This figure is comprised of all sessions delivered to 'T-CBT' flagged referrals on the minimum dataset including 53 sessions that were delivered face-to-face.

As a result of the above findings, the number of sessions delivered by telephone across all of the Access to Allied Psychological Services programs was investigated. Table 3 shows that a total of 547 sessions were delivered by telephone. Of the 291 sessions delivered by telephone under the general Access to Allied Psychological Services projects, 123 could have been identified on the minimum dataset as sessions delivered under the T-CBT pilot because they were conducted via T-CBT Divisions. The remaining sessions counted under the general Access to Allied Psychological Services projects (n=168) are actually being delivered by Divisions not involved in the T-CBT trial. Interestingly, telephone sessions also appear to be popular under the Suicide Prevention Pilot.

Table 3: Number of telephone sessions delivered across all Access to Allied Psychological Services programs from mid-2008 to July 2009

Program	Number of telephone sessions
General	291 ^a
T-CBT	70 ^b
Suicide prevention pilot	185
Perinatal depression	1
Bushfire	0
Total	547

^a This figure includes 123 sessions delivered by T-CBT Divisions for referrals not flagged as T-CBT on the minimum dataset

^b This figure may include some data from as early as November 2007

In addition, the overall number of sessions provided under the Access to Allied Psychological Services projects and the modality of delivery over the life of the projects was examined and the findings are presented in Table 4. Of the 634,171 face-to-face sessions delivered as shown in Table 4, 130,000 took place from mid-2008, when the T-CBT pilot was rolled out and ‘session modality’ was added to the minimum dataset, to July 2009. This indicates that approximately 0.4% of all Access to Allied Psychological Service projects’ sessions were delivered by telephone since the addition of the modality field on the minimum dataset.

Table 4: Overall number of Access to Allied Psychological Services projects sessions delivered using different modalities over the life of the projects

Session modality	Number of sessions
Face-to-face	634,171
Telephone	547 ^a
Videoconference	36
Total	634,754

^a This figure includes 193 sessions delivered by T-CBT Divisions, 123 of which are not flagged as T-CBT referrals on the minimum dataset

Consumer and session profiles

Consumer and session profiles were developed based on referrals strictly flagged as T-CBT on the minimum dataset. However, as the above data suggests that T-CBT flagged referrals and sessions represent only a fraction of the consumers receiving telephone sessions, the following results should be interpreted with caution. The final report will provide a more representative description of consumers and sessions by integrating the datasets for all of the programs under the Access to Allied Psychological Services projects rather than relying on the T-CBT dataset.

Table 5 describes the characteristics of consumers receiving care through the T-CBT trial and compares them to those of rural consumers of the national Access to Allied Psychological Services projects.¹⁵ It shows that the majority (79%) of consumers are female, and that proportionally there are more females receiving T-CBT compared with the rural Access to Allied Psychological Services projects (71%). The age range of consumers is 12 to 68 years with a mean of 40 years, which mirrors the mean age of the rural Access to Allied Psychological Services projects. The majority of both T-CBT

and rural Access to Allied Psychological Services projects consumers are on low incomes as identified by their GPs. However, proportionally more T-CBT consumers are on low incomes (65% *cf.* 58%). Over a third of consumers have not received any previous psychiatric care and for roughly the same proportion this information is unknown, compared with 46% of rural consumers of the Access to Allied Psychological Services projects who have not received previous psychiatric care. Aboriginal consumers are somewhat less represented, and Torres Strait Islanders are not at all represented, in the T-CBT pilot compared with the rural Access to Allied Psychological Services projects' consumers (2% *cf.* 3% and 0% *cf.* 0.2%). The vast majority of consumers have been diagnosed with a depressive disorder and/or an anxiety disorder. However, a somewhat greater proportion of consumers of T-CBT (83%) are reported to have a depressive disorder than the rural Access to Allied Psychological Services projects (75%).

Table 5: Characteristics of consumers receiving care through the T-CBT trial and the rural Access to Allied Psychological Services projects

	T-CBT Divisions	Rural projects
Gender		
Female	79.1%	70.6%
Male	20.9%	29.4%
Mean age (years)		
	39.7	39
Low income		
Yes	65.1%	58%
No	9.3%	27%
Unknown	25.6%	15%
Previous psychiatric service use		
Yes	27.9%	39.5%
No	37.2%	46.0%
Unknown	34.9%	14.5%
Aboriginal		
Yes	2.3%	3.2%
No	71.4%	72.4%
Unknown	26.2%	24.4%
Torres Strait Islander		
Yes	0%	0.2%
No	75.6%	73.3%
Unknown	24.4%	26.4%
Diagnosis ^a		
Alcohol and drug use disorders	4.9%	6.8%
Psychotic disorders	0%	2.0%
Depression	82.9%	74.9%
Anxiety disorders	57.5%	53.5%
Unexplained somatic disorders	0%	2.4%
Unknown	2.4%	3.1%

a. Multiple responses permitted

Consumer outcomes and experiences will be described in the final report when there is sufficient data available subject to accurate entry of data on the minimum dataset. To date only one consumer experience survey has been sent to Strategic Data, the minimum dataset development and management contractors.

For the 30 consumers who have session data entered on the minimum dataset, the average number of sessions received is 4, with a standard deviation of 3, and a range of 0 to 13. Table 6 highlights the characteristics of the care consumers are receiving via the T-CBT pilot and the rural Access to Allied Psychological Services projects.¹⁵ In summary, the vast majority of sessions are 46-60 minutes in length and always individual, a pattern approximately mirrored by the rural Access to Allied Psychological Services Projects. Interestingly, 43% of sessions were delivered face-to-face even though consumers were referred for T-CBT. Compared with the rural Access to Allied Psychological Services projects, T-CBT sessions were considerably more likely to involve diagnostic assessment (42% *cf.* 19%) and psycho-education (48% *cf.* 31%), less likely to deliver CBT-cognitive interventions (36% *cf.* 56%), and never involved CBT-skills training (0% *cf.* 22%). These differences may be attributable to the nuances associated with the telephone modality of service delivery. The vast majority of both T-CBT and rural Access to Allied Psychological Services projects did not incur a copayment.

Table 6: Characteristics of sessions provided to consumers through the T-CBT trial and the rural Access to Allied Psychological Services projects

	T-CBT	Rural projects
Duration		
0-30 mins	1.8%	3.3%
31-45 mins	4.4%	5.4%
46-60 mins	82.3%	78.2%
Over 60 mins	11.5%	13.1%
Type		
Group	0%	1.8%
Individual	100%	98.2%
Modality		
Telephone	56.9%	-
Face-to-face	43.1%	-
Interventions^a		
Diagnostic assessment	42.1%	19.4%
Psycho-education	47.7%	30.6%
CBT-Behavioural interventions	38.3%	42.1%
CBT-Cognitive interventions	36.4%	56.4%
CBT-Relaxations strategies	15.0%	23.6%
CBT-Skills training	0%	22%
Interpersonal Therapy	16.8%	27.9%
Copayment		
Yes	10.6%	8.0%
No	89.4%	92.0%

^aMultiple responses permitted

In the final report, T-CBT sessions will be described in more detail using the additional session information (Appendix 4), which is currently paper-based and being posted by Divisions or allied health professionals to Strategic Data until the T-CBT component of the minimum dataset is online. To date, approximately 80 session forms have been received, representing about two thirds of all recorded T-CBT sessions (N=123).

Chapter 4: What models of service delivery are being utilised by Divisions implementing the T-CBT pilot?

The purpose-designed interview of project officers implementing the T-CBT pilot received a 100% response rate (i.e., 22 project officers) and was used to answer the second evaluation question.

Evaluation Question 2: What models of service delivery are being utilised by the Divisions implementing the T-CBT trial?

Data obtained from this survey were compared to rural Access to Allied Psychological Services project data obtained from a similar survey of project officers, which received a 98% response rate (N=54), and was conducted between October 2008 and February 2009. The T-CBT projects were included in the earlier survey, which enquired about their general Access to Allied Psychological Services projects. Both surveys explored three dimensions of service delivery models: methods of retaining allied health professionals, location of allied health professionals and referral mechanisms. These are described in Box 1.

Box 1: A framework to describe the models of service delivery being used by the projects

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

Source: Morley et al⁴

Table 7 shows the models of service delivery being used for the T-CBT and the rural Access to Allied Psychological Services projects, and the proportion of projects by which each of these components is utilised.

Table 7: Proportion of T-CBT projects using various service delivery model components compared with rural Access to Allied Psychological Services (ATAPS) projects

Model component	Differences in model component	T-CBT projects N=22 (%)	Rural projects N=54 (%)
Means of retaining allied health professionals	Contractual arrangements	63.6	87.0
	Direct employment	40.9	42.6
Location of allied health professionals	GPs' rooms	36.4	53.7
	Own rooms	31.8	46.3
	Division sites	31.8	33.3
	Community organisation	18.2	25.9
	Educational settings	0.0	1.9
	Other location	27.3	22.2
Referral mechanisms	Voucher system	9.1	9.3
	Brokerage system	36.4	42.6
	Register system	4.5	13.0
	Direct referral	54.5	63.0

NB. Percentages may be greater than 100% because projects may use more than one means under each model component

Retention of allied health professionals

As shown in Table 7, the majority (64%) of allied health professionals involved in the T-CBT project are retained via contractual arrangements. Project officers reported that their method of retention of allied health professionals for the T-CBT pilot was no different to that of their general Access to Allied Psychological Services projects. Compared to the rural Access to Allied Psychological Services projects, T-CBT projects are less likely to retain allied health professionals under contractual arrangements (64% *cf.* 87%) but equally likely to directly employ (41% *cf.* 43%).

Location of allied health professionals

Table 7 demonstrates that the most common locations for allied health professionals delivering T-CBT services included GP rooms, own (allied health professional) rooms and Division sites (in 36%, 32%, and 32% of cases, respectively). One Division delivering T-CBT sessions onsite, was also reported to provide visits to practices depending on community need.

About one fifth of project officers reported that allied health professionals provided T-CBT services from community organisations and over one quarter reported the use of 'other' locations. Other locations were specific to each Division and included: hired rooms; hired rooms by Divisions in remote areas; allied health centre; Relationships Australia; home, in addition to providing fly-in-fly-out service once a month (for consumers combining T-CBT with face-to-face sessions); and a Division operated mental health service.

Thirty-eight percent of project officers reported allied health professionals delivered T-CBT sessions from multiple locations. All project officers reported that the location of allied health professionals delivering T-CBT services did not vary from the locations used for the delivery of their general Access to Allied Psychological Services projects sessions.

Compared to the rural Access to Allied Psychological Services projects, project officers reported that T-CBT allied health professionals are less likely to deliver services from GP rooms (36% *cf.* 54%), their own rooms (32% *cf.* 46%), and community organisations (18% *cf.* 26%), but somewhat more likely to utilise other locations (27% *cf.* 22%).

Referral mechanisms

The proportion of T-CBT Divisions utilising different types of referral mechanisms is illustrated in Table 7. With the exception of one Division, which was reported to use the voucher system to track T-CBT referrals, the majority of Divisions utilised the same referral mechanism for T-CBT services as those used for the delivery of their general Access to Allied Psychological Services projects sessions. The most commonly utilised referral mechanisms for the T-CBT pilot were direct referral (55%) and brokerage (36%), which is fairly consistent with the pattern observed for the rural Access to Allied Psychological Services projects (63% and 43%, respectively). However, both these methods are somewhat less commonly used in the T-CBT pilot. The register system is less frequently used by T-CBT projects (4.5% *cf.* 13%) and this is probably because less allied health providers are available who have been trained to deliver T-CBT.

Chapter 5: What issues have arisen in implementing the T-CBT trial?

The purpose designed interview of project officers implementing the T-CBT pilot was also used to address the third evaluation question.

Evaluation Question 3: What issues have arisen in implementing the T-CBT trial?

Service delivery commencement

The majority of project officers (n=15) reported that their respective Divisions commenced T-CBT service delivery in late 2008, one of which commenced earlier (July 2008) as face-to-face service delivery was “*not an option*” for certain consumers. A minority of Divisions (n=5) commenced T-CBT service delivery in the first half of 2009, while one Division had not yet commenced service delivery at the time of the interview and the date was unknown for another.

Reasons for delay in commencement

Nine project officers reported that there was a delay in the commencement of T-CBT service delivery. The most commonly cited reason for this delay was the corresponding delay in the availability of the webinar training for allied health providers (n=5). The next most common reason for delays was the lack of availability of fully registered allied health professionals, and/or the loss of interest by trained allied health professionals. Other explanations included: delays in acceptance of the service; client refusal; delay in educating GPs about the new service; recent access to videoconferencing facilities; excessive delays in installation of telephone lines; availability of face-to-face service; commencement immediately preceding holiday period; and slow uptake by GPs leading to delays in referrals, particularly when original guidelines were perceived to be reliant on GPs suggesting T-CBT to consumers. However, the subsequent clarification / amendment of the guidelines has enabled allied health professionals and Divisions to recommend T-CBT for suitable consumers. Over one third of project officers (n=8) reported that GPs suggest T-CBT to consumers and an equal number of project officers (n=8) reported that allied health professionals suggest T-CBT to consumers. Four project officers indicated that both GPs and allied health professionals recommend T-CBT to consumers. Almost half of the project officers (n=10) reported they, themselves, suggest T-CBT for appropriate consumers.

Related to delays in commencement, six Divisions had not received any referrals and five Divisions had each received only one referral. Reasons for lack of referrals mirrored those reported for delays in commencement and were attributed to: insufficient allied health professionals and associated lack of service promotion; anecdotal evidence of consumer preference for face-to-face services “*even if long distance travel is required*”; and problems associated with “*bureaucratic GP referral processes*”.

Promotion of T-CBT service

Project officers indicated that they were using a wide range of strategies to promote the T-CBT service. These strategies are summarised in Table 8 and utilised all communication modalities – from hardcopy, electronic, telephone, to face-to-face. It was common for multiple strategies to be used by any one Division, with provider newsletters being the most commonly reported promotion strategy. Strategies related to allied health professionals included: offering them training; encouraging them to discuss T-CBT with GPs; provision of information to a psychologist coordinator to promote T-CBT to psychologists; and involving an allied health professional in the preparation of the funding submission. Promotional forums included professional development events, lectures, and education sessions. Meetings used to promote T-CBT included a chapter meeting, a clinical services business meeting with allied health professionals, and mental health committee meetings. Interestingly, promotion to potential

consumers was one of several least popular strategies and none of the Divisions specifically mentioned promoting the service to other community and health organisations not directly involved in the delivery of Access to Allied Psychological Services. One project officer noted that it “*was difficult to promote because of the novelty*”.

Table 8: Strategies used by Divisions to promote T-CBT services

Strategy	Frequency (n)
Newsletter / e-newsletter	12
Practice visits	8
Allied health provider related	7
Mail	5
Forums	5
Meetings	4
Fax	3
Updated referral forms	3
Email	3
Service brochure	3
Phone	1
Contracts	1
Packages for GPs and psychologists	1
Made squeeze phones for GPs	1
Division website	1
Word of mouth	1
Advertisement	1
Own referral pathways	1
Booklet for patients	1

GP and allied health professional response to T-CBT pilot

Table 9 presents the general flavour of responses of GPs and allied health professionals to the T-CBT pilot, as reported by Division project officers. It can be seen that GP and allied health provider responses have been varied, with allied health professionals viewing the service as more positive than negative and more positively than GPs.

The ways in which GPs were reported to view the T-CBT pilot favourably included: “*good addition to services*”; “*with interest as it provides a new opportunity to help those who are disadvantaged*”; and with comprehension of the purpose of program. Importantly, GPs were more likely engage and refer to the pilot when they received positive feedback about the service from consumers. Other samples of quotes of GP reported views include:

“GPs don’t really mind as long as the patient is getting better”

and

“They [GPs] think it’s great. Some thought initially it was like Lifeline”.

Despite the favourable views of GPs, several project officers stated that GPs were *“passive in terms of making referrals”* and that this is anecdotally attributable to both GP and consumer preference for face-to-face services, if available.

GPs’ negative responses to the T-CBT trial incorporated lack of ‘interest’, ‘response’, and ‘ease’, again with a preference for face-to-face service delivery noted. In addition, one project officer indicated that *“there is a 10-week wait list and GPs thought it would be quicker”* and another stated:

“GPs don’t like it”.

GPs’ ‘mixed’ responses reported by project officers included: *“some welcome access of service for patients while others are initially hesitant about the telephone modality”*; *“no response from city GPs but a good response from remote GPs”*; *“lack of GP response, with the exception of a specific location where the mental health service closed, in which case GPs and clients are happy but this is because no option for service would otherwise exist”*; and *“neutral response - the mode of delivery doesn’t worry them at all, if they have a client who has the need”*.

Table 9: GP and allied health professional response to T-CBT as reported by project officers

Response	Division frequency (n)	
	GPs	Allied health professionals
Positive	8	14
Negative	7	6
Mixed	4	0
Unknown	3	1

Reported favourable allied health professional responses consisted of: *“enthusiasm and excitement”*; *“good, overtly positive”*; *“some interest; initially keen/interested, but then no referrals were received”*; *“great idea”*; *“good idea but consumers prefer face-to-face sessions”*; *“took on whole heartedly, despite other issues, the service itself was embraced”*; *“initially interested”*; *“they responded positively to the T-CBT service itself although the younger providers tend to be reluctant to deliver exclusively T-CBT so they combine it with face-to-face sessions”*; *“providers are happy for it”*; *“they were happy to do the training”*; *“they respond positively when clients want to engage”*; and sole T-CBT provider responded positively but experienced barriers.

Despite an overall positive response by allied health professionals, several project officers noted that a number of challenges to service delivery existed. Challenges entailed: *“initially having to coax allied health professionals and convince them that the additional paperwork would be manageable”*; limited T-CBT trained providers; issues around *“remoteness, privacy, and time without interruption”*; preference for face-to-face service delivery attributable to *“concerns about what to do if a distressed patient hangs up the phone and associated liability issues”*; and loss of body language. Additionally, because T-CBT is considered to be of most benefit in small rural areas and because allied health professionals prefer to complete the initial assessment face-to-face, *“lack of additional salary funding, particularly for travel”*, is experienced as problematic. Conversely others have noted that in their locations, the distance is not great enough for clients to choose T-CBT over face-to-face.

Reported negative allied health professional responses comprised: they “*were not overtly positive*” or they were “*more negative than positive and preferred face-to-face sessions*”; “*there was not too much of an interest as providers are overloaded*”; “*only one provider responded, probably because of the lack of need for this service*”; “*although initially quite keen, they became disillusioned and began losing interest, and they found it hard not seeing the behavioural cues of patients*”; they were “*disappointed with the low uptake*”; there were “*issues around the webinar training*”; and they “*hated the paperwork, so the paperwork is not happening despite their [providers] reports that they have tried to sell the research component to patients*”. The latter may explain why some “*allied health professionals sometimes conduct sessions over the phone with their clients, but not within T-CBT project*”.

Factors that facilitate and potentially enhance the T-CBT pilot

Four project officers did not provide a response to the question about factors that facilitate the effective operation of the T-CBT pilot. An additional three project officers indicated that they either did not know, or that it was too early to identify factors that facilitate the effective operation of the T-CBT pilot. Of the remaining (n=15) project officers that provided a response, a substantial number (n=4) commented that positive provider responses acted as facilitators of the T-CBT pilot. Specifically, the facilitators described were: strong relationships between GPs and allied health professionals; existing allied health professionals are skilled in the use of the telephone as a mode of service delivery due to experience in other programs; allied health professionals promoting this service option to clients; and “*excellent clinicians who are enthusiastic and GPs who are open minded*.” The next most frequently cited facilitator of the T-CBT pilot pertained to the flexibility of the guidelines around the referral mechanism and multimodal (i.e., telephone and face-to-face) service delivery: “*GPs are not the only source of referrals*”; “*allowing allied health professionals to make decisions about the [T-CBT] mode of service delivery*”; and “*empowering allied health professionals because they still can have the first meeting [session] in person and it is good for both the clinician and the patient*.” Project officers reported other facilitators of the T-CBT pilot ranging from “*good organisational processes*”, “*an organised and passionate practice manager*”, “*communication and availability of information*”, “*good targeting*”, the training, “*the need for counselling services to be provided remotely*”, to the fact that the pilot operates in conjunction with the Access to Allied Psychological Service projects.

In response to what would make the T-CBT service work better, three main themes emerged – flexibility, education of stakeholders, and less paperwork. In terms of flexibility, project officers commented on: the ability of the Division and allied health professional to consult about the decision to offer selected consumers T-CBT based on their circumstances; their preference for “*the criteria to be expanded to offer a more flexible service*”; and their desire for multimodal service delivery to be retained. Education of stakeholders (i.e., GPs, allied health professionals, and consumers) entailed beliefs that the service needs to be better promoted and marketed in order to raise its profile and in turn, increase stakeholders’ “*comfort level with the idea*”. Educating GPs in particular was considered to be important “*because of their [trusted] influence on patients*”, and one project officer stated that the production of “*a single annual CD or document by the Department of Health and Ageing for GPs outlining all programs, with financial incentives may enhance appropriate referrals across the programs*”. Issues related to paperwork mainly revolved around reducing paperwork, substituting it with electronic data collection, and “*improving the perception of allied health professionals about the quantity of data to be collected*”.

There was a range of other suggestions about what would improve the T-CBT service. Two project officers stated that “*effective telephone network services*” and “*having all necessary equipment in place at the commencement of the project rollout*” would improve the service. Other project officers commented on the potential benefits of: capacity building (e.g., “*external third-party arrangements to assist with capacity of existing services, rather than doing things from scratch*”); “*a centralised service*”, although the lack of specific knowledge of different geographic areas was acknowledged as a barrier; “*linking T-CBT with other available services*”; removing the allied health professionals’ training requirement or “*adding it to degree training*”; allowing probationary psychologists to deliver T-CBT services; increasing funding to “*improve capacity with more clinicians and therefore shorten wait list*”; “*targeting a GP practice where distance issues [barriers to access] are more relevant*”; and T-CBT services “*not being a temporary pilot*”. One project officer suggested that using the internet to improve communication about the guidelines and the evaluation of the T-CBT pilot would make the project work

better. It is noteworthy that the Australian General Practice Network has established a list serve (or electronic mailing list) for this purpose and the University of Melbourne has developed an evaluation support website (<http://www.boimhc.org>) with links to T-CBT specific resources related to the evaluation. A further two project officers did not comment – one because she thought that the allied health professionals were better placed to respond and another because the Division had not yet been delivering T-CBT services.

The majority of project officers (n=16) indicated that support from the evaluators of the T-CBT pilot was not required to enhance the operation of the pilot. However, several reported that they would like the evaluators to: mainstream the process; create collective promotional resources; disseminate the findings from the T-CBT project officer interviews to Divisions as soon as the data are collated; liaise with allied health professionals delivering T-CBT services; and *“make the data collection process appear less onerous”*.

Barriers to the effective operation of the T-CBT pilot

There were many barriers to the effective operation of the T-CBT pilot described by project officers and these are summarised in Table 10. The most commonly mentioned barrier (n=9) was the low rate of GP referrals which was attributed to difficulty convincing GPs to use the service; lack of GP engagement; GPs' lack of understanding; GP lack of response in areas where a face-to-face option exists; and a sense that GP reluctance to participate in pilots *“always exists”*. Indeed, one project officer commented that, *“the amount of effort put into the program was quite big, but the response and demand was nil and this Division is not going to proceed with the project”*.

A number of project officers (n=6) commented that consumers prefer face-to-face services, or questioned the need for the T-CBT pilot based on: consumer reluctance to have telephone sessions; consumers choose to travel because of *“region specifics”* (i.e., distance is not great enough); other telephone support services previously existed; and *“patients prefer to wait for face-to-face sessions”*. Although, it was expressed that over time clients might increasingly accept the T-CBT service option. Telephone equipment /coverage issues and the additional paperwork were the next most and equally frequently cited barriers. Telephone equipment /coverage issues comprised: delays in phone line installation and receipt of headsets; lack of telephone network coverage in some areas; and other media and technical difficulties. Remarks related to the additional paperwork (including the requirement that consumers complete and return forms) suggested that: allied health professionals experienced this as *“overwhelming”* and *“massive”*; the partly electronic and partly paper-based data collection was inconvenient; and the paperwork (i.e., the consumer consent form) *“openly highlights that the T-CBT pilot is part of a research project”*.

Funding issues were reported as barriers by a few project officers, particularly in terms of the cost of telephone calls and travel costs associated with mixing T-CBT with some face-to-face sessions. The need to do training, the quality and the content of the training (i.e., apparently strategies to overcome loss of body language were not covered), and lack of training opportunities were the types of barriers grouped under 'training'. Two project officers mentioned that a barrier, which initially existed but has now been addressed, was the guideline interpretation that all sessions had to be delivered via telephone.

Table 10: Barriers to the effective operation of the T-CBT pilot as reported by project officers

Barrier	Frequency (n)
Low rate of referrals	9
Patient preference for face-to-face service	6
Acquiring necessary telephone equipment and/or telephone coverage in some areas	5
The additional paperwork	5
Training	3
Funding issues	3
Lack of flexibility in initial guidelines around multimodal service delivery	2
Lack of staff / capacity (partially attributable to inability to use interns)	2
Long waiting lists for T-CBT (so consumers make the effort to come in)	2
Time and privacy issues	1
Moving premises	1
Mail list is slow	1
Phone support in general is less structured	1

Impact of T-CBT pilot on Divisions

A substantial number of project officers (n=13) indicated that the T-CBT pilot has had positive impacts for the Division. The flexibility and option of the mode of service delivery, and in turn, its effect of increasing the accessibility for remote consumers and consumers that may otherwise experience difficulties accessing psychological services, was overwhelmingly the most commonly (n=11) noted positive impact of the T-CBT pilot for Divisions. For example, one project officer stated that the T-CBT pilot confers the “*ability to offer a psychology service where we wouldn’t have had one before*”. Other positive impacts consisted of: cost saving; expansion of Division services/profile/reputation; and the opportunity to “*liaise with psychologists and support them to extend their own skills and knowledge*”. Other sample related quotes are:

“It’s a really terrific idea; it’s great to be able to offer additional services in very rural/remote areas. We hope it gets re-funded. If we can demonstrate to other GPs that the GPs who are using the service are happy, this may encourage other GPs to refer. We expect the service to expand in time as it is increasingly promoted and its efficacy is demonstrated”.

and

“[The pilot provides] better access for people with lack of finances/access to travel. It’s a huge advantage to have this option available”.

One project officer stated that she could not comment on positive impacts for the Division due to lack of longevity of the T-CBT pilot.

A minority of project officers (n=3) expressed that the T-CBT pilot has had negative impacts for the Division. The T-CBT pilot was perceived to create additional workload demand on professionals, which is assumed to be “*both very time consuming and confusing for allied health professionals*”. In addition,

it was reported that one GP misunderstood the purpose of T-CBT and this required resolution. One project officer expressed concern about the *“liability of clinicians in the event that a patient is distressed and hangs up the telephone”*. Another project officer remarked that the implementation process had been *“slow and painful and now that we are finally getting somewhere, we hope not to lose it”*. Similarly, others noted that it:

“It takes time to get used to T-CBT and to train allied health professionals”

and

“It would be good if the service continues especially for patients that use it and find it beneficial”.

Chapter 6: Discussion and conclusions

Summary of the interim evaluation of the T-CBT pilot

The current report focused on the preliminary uptake and implementation of the T-CBT pilot. Specifically, it aimed to investigate three evaluation questions, the answers to which are summarised below.

What is the uptake of the T-CBT pilot and what are the profiles of consumers and sessions?

Data entered on the minimum data set and flagged as being part of the T-CBT, pilot by selecting 'T-CBT' on the referral type field, suggest that the uptake has been very slow. It indicates that to date, 43 consumers have been referred by 21 GPs to 11 allied health professionals, of whom 30 consumers have received 123 sessions of care. However, it is noteworthy that the Divisions involved in the T-CBT pilot have also reported a further 123 sessions of care delivered by telephone but have indicated the associated referrals are for the 'general' Access to Allied Psychological Services projects. Unfortunately, this means that the consumer and session profiles described are not truly representative of all T-CBT consumers because only data strictly entered on the minimum dataset as being part of the T-CBT pilot was used for these analyses, respectively. Therefore, consumer and session characteristics should be interpreted with caution.

The majority (79%) of T-CBT consumers are females, aged around 40 years, and are on low incomes as judged by their GPs. Over a third of consumers have not received any previous psychiatric care and for roughly the same proportion this information is unknown. About 2% of T-CBT consumers are Aboriginal and none are Torres Strait Islanders. The vast majority of consumers have been diagnosed with a depressive disorder and/or an anxiety disorder. In the main, T-CBT consumer characteristics are not too dissimilar from consumers of the rural Access to Allied Psychological Services projects, with the following exceptions: T-CBT consumers are more likely to be females, with a diagnosis of a depressive disorder and on low incomes, and less likely to be indigenous.

For the 30 consumers who had session data entered on the minimum dataset, the average number of sessions received is 4. As with the rural Access to Allied Psychological Services projects, the vast majority of sessions are 46-60 minutes in length, delivered to individuals, and rarely incur a copayment. Interestingly, 43% of sessions were delivered face-to-face even though consumers were referred for T-CBT. Compared with the rural Access to Allied Psychological Services projects, T-CBT sessions were more likely to involve diagnostic assessment (42% *cf.* 19%) and psycho-education (48% *cf.* 31%), and never involved CBT-skills training (0% *cf.* 22%). Over one third of T-CBT sessions involved CBT-cognitive, and almost two-fifths of sessions involved CBT-behavioural, interventions.

What models of service delivery are being utilised by Divisions implementing the T-CBT pilot?

Retention of allied health professionals

The majority (64%) of allied health professionals involved in the T-CBT pilot are retained via contractual arrangements. Project officers reported that their method of retention of allied health professionals for the T-CBT pilot was no different to that of their general ATAPS projects.

Compared to the rural Access to Allied Psychological Services projects, T-CBT pilots are less likely to retain allied health professionals under contractual arrangements (64% *cf.* 87%) but equally likely to directly employ (41% *cf.* 40%).

Location of allied health professionals

The most common locations for allied health professionals delivering T-CBT services included GP rooms, own (allied health professional) rooms and Division sites (in 36%, 32%, and 32% of cases, respectively). Thirty-eight percent of project officers reported that allied health professionals deliver T-CBT sessions from multiple locations. T-CBT Divisions' location of allied health professionals did not vary from the locations of their general Access to Allied Psychological Services projects.

Compared to the rural Access to Allied Psychological Services projects, T-CBT allied health professionals are less likely to deliver services from GP rooms (36% *cf.* 54%), their own rooms (32% *cf.* 46%), and community organisations (18% *cf.* 26%), but are somewhat more likely to utilise other locations (27% *cf.* 22%).

Referral mechanisms

With the exception of one Division, which reported using the voucher system to track T-CBT referrals, the majority of Divisions were using the same referral mechanism for T-CBT as for their general Access to Allied Psychological Services projects. The most commonly utilised referral mechanisms for the T-CBT pilot are direct referral (55%) and brokerage (36%), which is relatively consistent with the pattern observed for the rural Access to Allied Psychological Services projects (63% and 43%, respectively). The register system is less frequently used and this is probably because less allied health providers are available who have been trained to deliver T-CBT.

What issues have arisen in implementing the T-CBT pilot?

Service delivery commencement

The majority of project officers reported that their respective Divisions commenced T-CBT service delivery in late 2008. Nine project officers reported that there was a delay in the commencement of T-CBT service delivery. The most commonly cited reason for this delay was corresponding delay in the availability of the webinar training for allied health providers. Another explanation provided was that there was slow uptake by GPs, which was problematic in the context of the original guidelines being perceived to be reliant on GPs suggesting T-CBT to consumers.

Promotion of T-CBT service

Project officers indicated that they were using a wide range of strategies to promote the T-CBT service. These strategies made use of all communication modalities – from hardcopy, electronic, telephone, to face-to-face. It was common for multiple strategies to be used by any one Division, with provider newsletters and practice visits being the most commonly reported promotion strategies. Interestingly, none of the Divisions specifically mentioned promoting the service to other community and health organisations not directly involved in the delivery of Access to Allied Psychological Services.

GP and allied health professional response to T-CBT pilot

In general, GP and allied health professional responses have been varied, with allied health professionals viewing the service as more positive than negative and more positively than GPs. GPs were reported to view the T-CBT pilot favourably as *“it provides a new opportunity to help those who are disadvantaged”*. Importantly, GPs were more likely to engage and refer to the pilot when they received positive feedback about the service from consumers. Despite favourable views of GPs, they were reported to be *“passive in terms of making referrals”* and this was anecdotally attributable to both GP and consumer preference for face-to-face services, if available. Allied health professional responses were reported to be favourable, particularly when *“clients want to engage”*. T-CBT was combined with face-to-face sessions in some instances. Despite an overall positive response by allied health professionals, it was noted that they experienced: difficulty associated with the loss of behavioural cues of patients and disappointment with the low uptake, the webinar training, and the amount of paperwork. The latter may explain why some *“allied health professionals sometimes conduct sessions over the phone with their clients, but not within the T-CBT project”*.

Factors that facilitate and potentially enhance the T-CBT pilot

A substantial number of project officers commented that positive provider responses acted as facilitators of the T-CBT pilot. In addition, the flexibility of the guidelines around the referral mechanism and multimodal (i.e., the ability to combine telephone and face-to-face) service delivery was considered to be a facilitator of the T-CBT pilot. In particular, allowing allied health professionals and Divisions to make decisions about the (T-CBT) mode of service delivery, rather than relying on GPs to suggest T-

CBT to consumers was regarded as beneficial. Furthermore, the need for counselling services to be provided remotely and the fact that the pilot operates in conjunction with the Access to Allied Psychological Service projects were reported to facilitate the pilot.

Flexibility, education of stakeholders, and less paperwork emerged as key factors that would improve the T-CBT pilot. Examples of other factors that would improve the T-CBT service included increasing funding to “*improve capacity with more clinicians and therefore shorten wait list*”; “*targeting a GP practice where distance issues (barriers to access) are more relevant*”; and T-CBT services “*not being a temporary pilot*”. The majority of project officers indicated that support from the evaluators of the T-CBT pilot was not required to enhance the operation of the pilot.

Barriers to the effective operation of the T-CBT pilot

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

Impact of T-CBT pilot on Divisions

A substantial number of project officers indicated that the T-CBT pilot has had positive impacts for the Division. The flexibility and option of the mode of service delivery, and in turn, its effect of increasing accessibility for consumers that may otherwise experience difficulties accessing psychological services, was the most frequently mentioned positive impact of the T-CBT pilot for Divisions. A minority of project officers expressed that the T-CBT pilot has had negative impacts for the Division in terms of additional workload demand. Nonetheless, the value of the T-CBT pilot was acknowledged as the majority of project officers hoped that the service would continue.

Caveats

Some caution should be exercised in interpreting the above (uptake, and consumer and session characteristics) data because the minimum dataset has two limitations. Firstly, and as mentioned above, there are lags in data entry (of up to six months) because some Divisions do not enter session data into the minimum dataset until all six (or 12-18) sessions have been completed for a given consumer. Secondly, it has taken considerable time for some projects to update their data capture systems to incorporate the new pilot. Together, these caveats are likely to have led to an underestimation of the uptake data.

More importantly, the uptake of the pilot is underestimated because T-CBT data is possibly being incorrectly entered on to the minimum dataset. There have been 123 sessions delivered by telephone by T-CBT Divisions, which are not accounted for in the T-CBT dataset. This renders the consumer and session profiles described as incomplete representations of the consumers receiving and the sessions delivering T-CBT, respectively.

Conclusions

The current report indicates that the uptake of the T-CBT pilot has been underestimated because telephone sessions are being delivered more generally via the Access to Allied Psychological Services projects and not just within T-CBT pilot. As teething issues related to the delivery of T-CBT services and the collection and entry of its data are resolved, a more accurate representation will be facilitated. While some of the teething issues are probably associated with the start-up of any new program, others are specifically related to the telephone modality of treatment. There are a number of issues that need to be addressed in order to improve the quality of T-CBT service. These include: streamlining administrative and procedural issues; resolving technical difficulties related to the availability and quality of telephone network coverage; and capacity building through the development of appropriate skills among more allied health professionals to meet demand.

Data entered on to the minimum dataset as strictly being part of the T-CBT pilot indicated that the T-CBT program is reaching consumers and delivering sessions with similar profiles to the rural Access to Allied Psychological Services projects. T-CBT consumers are mainly females aged 40 years and on low incomes, but are somewhat more likely to be diagnosed with depressive disorders than those of the overall rural Access to Allied Psychological Services projects. A combination of telephone and face-to-face sessions of one-hour duration were delivered to individuals usually with no cost to the consumer. T-CBT session interventions were more likely to involve diagnostic assessment and psycho-education, but less likely to deliver CBT-cognitive interventions and never involved CBT-skills training compared with the overall rural Access to Allied Psychological Services projects. These differences may be attributable to the nuances associated with telephone modality.

Even though there was a reported general consensus among consumers, allied health professionals, GPs, and Divisions that face-to-face treatment is preferred, it is acknowledged that the T-CBT modality is valuable particularly for consumers for whom no other option exists. Despite the challenges associated with implementation of the pilot and the management of data collection, the T-CBT pilot was generally well received by Divisions, GPs and allied health professionals. Consequently, Divisions are definite that they would like the T-CBT service and its flexibility to be sustained, particularly in terms of the means of suggesting the option to consumers (i.e., not exclusively relying on GPs) and the ability to deliver a multimodal service (i.e., combine telephone and face-to-face according to consumer needs). Consumer experiences and outcomes will be described in the final report.

Promotion of the T-CBT pilot more widely to other community and health organisations and the community in general may attract more consumers who would benefit from T-CBT, particularly if inability to travel (associated with cost or disability) or unwillingness prevents some consumers even from seeing a GP. An alternative model of T-CBT would have been a centralised one. Telephone sessions are being delivered more widely across the various programs comprising the Access to Allied Psychological Services projects rather than solely via the T-CBT pilot. Consequently, there may also be some merit in considering the permanent integration of the telephone modality option more generally (nationally) under the Access to Allied Psychological Services projects, rather than offering it as a segregated program.

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

Education and training for GPs (Component 1)

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

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

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

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

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

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

The GP Mental Health Care Plan was included in the Better Outcomes in Mental Health Care program to provide a framework for the management of mental health problems and mental illness in a primary care setting, by encouraging effective and longitudinal care of consumers. Originally known as the 3 Step Mental Health Process, it included: (a) an assessment (Step 1); (b) preparation of a mental health plan (Step 2); and (c) a review of the mental health plan (Step 3). GPs were reimbursed for providing the 3 Step Mental Health Plan via a blended mechanism of payment. When they registered with Medicare Australia, they were paid a sign-on Service Incentive Payment of \$150. The GP then billed Medicare Australia under normal attendance items (Level C or D) for the assessment and the mental health plan. He or she used a specific item number to bill Medicare Australia for the review (Items 2574, 2575, 2577, 2578, 2704, 2707, 2705 or 2708), and this triggered the payment of a Service

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

Incentive Payment (\$150 per 3 Step Mental Health Process per consumer per year) in addition to attracting a Medicare rebate for the consumer.

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

Focussed Psychological Strategies (Component 3)

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

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

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

Access to Allied Psychological Services (Component 4)

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

Access to Psychiatrist Support (Component 5)

The Access to Psychiatrist Support component of the Better Outcomes in Mental Health Care program has two sub-components, both of which broaden the role of psychiatrists in providing mental health care. The first involves a series of Medicare Benefits Schedule rebates which enable psychiatrists to organise or take part in case conferences on a consumer's behalf (Items 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838, 855, 857, 858, 861, 864 and 866). The second involves the provision of consultancy assistance to GPs by psychiatrists via GP Psych Support, a service that was originally provided by McKesson and Educational Health Solutions and is now being provided by the Royal Australian College of General Practitioners. GP Psych Support provides GPs with telephone, fax and email access to quality management advice from a psychiatrist within 24 hours, seven days a week.

Appendix 2: Divisions of General Practice involved in Access to Allied Psychological Services projects

Round	Division(s)	State	Urban/Rural
1 (pilot)	Central Coast	NSW	Urban
1 (pilot)	NSW Central West	NSW	Rural
1 (pilot)	NSW Outback	NSW	Rural
1 (pilot)	General Practice Network Northern Territory (formerly Top End DGP, now amalgamated with Central Australia DGP)	NT	Rural
1 (pilot)	Logan Area	QLD	Urban
1 (pilot)	SE Alliance of GP Brisbane (Ass of Bayside)	QLD	Urban
1 (pilot)	Sunshine Coast	QLD	Rural
1 (pilot)	GP Connections (formerly Toowoomba & District)	QLD	Rural
1 (pilot)	Adelaide Nth Div of GP	SA	Urban
1 (pilot)	Central Victorian General Practice Network (formerly Bendigo & District)	Vic	Rural
1 (pilot)	Dandenong Casey DGP (formerly Dandenong DGP & is a fund holder for Greater Monash DGP))	Vic	Urban
1 (pilot)	East Gippsland Div of GP (fund holder for Sth Gipp & Central West Div)	Vic	Urban
1 (pilot)	General Practice Alliance - South Gippsland Limited	Vic	Rural
1 (pilot)	Greater Monash (formerly known as Greater South Eastern DGP, Funds now held by Dandenong Casey DGP)	Vic	Urban
1 (pilot)	Knox	Vic	Urban
1 (pilot)	Impetus (formerly North West Melbourne)	Vic	Urban
1 (pilot)	Central West Gippsland	Vic	Rural
1 (pilot)	Fremantle	WA	Urban
1 (pilot)	Perth & Hills (now amalgamated with Perth Central Coast and known as Perth Primary Care Network)	WA	Urban
1 (supplementary)	ACT Division of GP	ACT	Urban
1 (supplementary)	Hastings Macleay	NSW	Rural
1 (supplementary)	Mid North Coast	NSW	Rural
1 (supplementary)	Riverina (now a fund holder for Barrier)	NSW	Rural
1 (supplementary)	Nth & West QLD Primary Health Care	QLD	Rural
1 (supplementary)	General Practice Network South (formerly Southern Division of GP SA or Adelaide Southern)	SA	Urban
1 (supplementary)	Ballarat & District	Vic	Rural
1 (supplementary)	Central Highlands	Vic	Urban
1 (supplementary)	General Practice Association of Geelong	Vic	Urban
1 (supplementary)	Mornington Peninsula	Vic	Urban
1 (supplementary)	North East Victoria	Vic	Rural
1 (supplementary)	Otway	Vic	Rural
1 (supplementary)	GP Down South (Peel SW)	WA	Rural
1 (supplementary)	Greater Bunbury (split from Peel SW 01.07.04)	WA	Rural
2	Blue Mountains	NSW	Urban

Round	Division(s)	State	Urban/Rural
2	Canterbury (no longer providing ATAPS)	NSW	Urban
2	Dubbo / Plains	NSW	Rural
2	Illawara	NSW	Urban
2	Murrumbidgee	NSW	Rural
2	Nepean Div of GP	NSW	Urban
2	New England	NSW	Rural
2	North West NSW Slopes	NSW	Rural
2	Southern Highlands	NSW	Rural
2	Sutherland	NSW	Urban
2	Sydney South West GP Network Ltd (formerly Fairfield and no longer operating)	NSW	Urban
2	Brisbane South	QLD	Urban
2	Capricornia	QLD	Rural
2	Central QLD Rural	QLD	Rural
2	Far Nth QLD Rural	Qld	Rural
2	General Practice Gold Coast/Tweed Valley Div of GP	QLD	Urban
2	Ipswich/West Moreton	QLD	Urban
2	Mackay	QLD	Rural
2	Townsville	QLD	Rural
2	GP Partners Adelaide (formerly Adelaide Central and Eastern Div of GP)	SA	Urban
2	Adelaide Hills Div of GP	SA	Rural
2	Adelaide NE Div of GP	SA	Urban
2	Adelaide Western General Practice Network (formerly Adelaide Western Div of GP)	SA	Urban
2	Limestone Coast Div of GP	SA	Rural
2	Murray Mallee Div of GP	SA	Rural
2	General Practice Northern Tasmania (formerly North Tasmania)	Tas	Rural
2	NW Tasmania	Tas	Rural
2	General Practice South (formerly Southern Tasmania)	Tas	Urban
2	Central Bayside	Vic	Urban
2	Monash DGP Moorabbin	Vic	Urban
2	Melbourne Eastern (formerly Inner Eastern Melbourne DGP)	Vic	Urban
2	Melbourne DGP	Vic	Urban
2	Murray Plains	Vic	Rural
2	NE Valley	Vic	Urban
2	Southcity GP Services (Inner SE Melb)	Vic	Urban
2	Pivot West (formerly Western Melbourne)	Vic	Urban
2	Westgate	Vic	Urban
2	Whitehorse Div of GP (formerly Inner East Melbourne, now amalgamated with Inner East Melbourne and known as Melbourne Eastern GPN)	Vic	Urban
2	Canning	WA	Urban
2	GP Coastal (formerly Perth Central Coast, now amalgamated with Perth Hills, now known as Perth Primary Care Network)	WA	Urban
2	Great Southern	WA	Rural
2	Osborne	WA	Urban

Round	Division(s)	State	Urban/Rural
3	Adelaide Southern DGP	SA	Urban
3	Barrier (funds held by Riverina)	NSW	Rural
3	Barwon	NSW	Rural
3	Central Sydney	NSW	Urban
3	East Sydney Div of GP (Includes SE Sydney Div)	NSW	Urban
3	GP Network Northside (Hornsby Ku-ring-gai Ryde) (fund holder for Northern Sydney)	NSW	Urban
3	Hunter Rural	NSW	Rural
3	Hunter Urban	NSW	Urban
3	Macarthur	NSW	Urban
3	Northern Rivers	NSW	Rural
3	Northern Sydney (funds held by GP Network Northside)	NSW	Urban
3	SE NSW	NSW	Rural
3	Shoalhaven	NSW	Rural
3	St George	NSW	Urban
3	Went West	NSW	Urban
3	GP Partners (Brisbane North)	QLD	Urban
3	Southern QLD Rural	QLD	Rural
3	Wide Bay	QLD	Rural
3	Barossa DGP	SA	Rural
3	Eyre Peninsula DGP	SA	Rural
3	Flinders and Far Nth	SA	Rural
3	Mid Nth Rural Div of GP	SA	Rural
3	Riverland Div of GP	SA	Rural
3	Yorke Peninsula Div of GP	SA	Rural
3	Albury-Wodonga Regional GP network (formerly known as Border DGP)	Vic	Rural
3	Central West Victoria	Vic	Rural
3	Eastern Ranges GP Association	Vic	Urban
3	Goulburn Valley	Vic	Urban
3	Mallee	Vic	Rural
3	Northern	Vic	Urban
3	Central Wheatbelt (formerly Wheatbelt GP Network)	WA	Rural
3	Eastern Goldfields Medical DGP	WA	Rural
3	Mid West	WA	Rural
3	Rockingham Kwinana	WA	Urban
4	Bankstown	NSW	Urban
4	Hawkesbury Hills	NSW	Urban
4	Liverpool (no longer operational)	NSW	Urban
4	Central Aust Div of Primary Health (amalgamated with Top End DGP, Now known as General Practice Network Northern Territory)	NT	Rural
4	General Practice Cairns	QLD	Rural
4	Redcliffe Bribie Caboolture	QLD	Urban
	Pilbara	WA	Rural
	Kimberley DGP	WA	Rural

Appendix 3: Divisions of General Practice participating in T-CBT pilot

Western Australia

- Midwest GP Network
- GP Down South
- Great Southern GP Network

South Australia

- Eyre Peninsula Division of General Practice
- Barossa Division of General Practice
- Murray Mallee General Practice Network
- Flinders and Far North Division of General Practice

Queensland

- GP Connections
- North & West Queensland Primary Health Care
- RHealth
- Central Queensland Rural Division of General Practice
- Mackay Division of General Practice

New South Wales

- Southern General Practice Network
- Dubbo/Plains Division of General Practice
- Northern Rivers General Practice Network
- Riverina Division of General Practice and Primary Health

Victoria

- East Gippsland Division of General Practice
- North East Victorian Division of General Practice
- West Vic Division of General Practice

Tasmania

- General Practice North
- General Practice South
- General Practice North West

Appendix 4: Session information form for T-CBT evaluation

PLEASE REFER TO SEPARATE PDF ATTACHMENT

9. Had any of the following barriers prevented you from seeking psychological care in the past? (Tick as many as applicable)
- Mobility (difficulty moving)
 - Distance
 - Transport
 - Cost
 - Other, please specify: _____
10. In thinking about your experience with the overall service you received, please rate how you felt about the following aspects by circling the relevant number:

	Very Positive	Positive	Neutral	Negative	Very Negative	N/A
a. the number of sessions	5	4	3	2	1	0
b. the length of sessions	5	4	3	2	1	0
c. the use of the telephone as a mode of service delivery	5	4	3	2	1	0
d. the setting of an agenda for each session (with your input)	5	4	3	2	1	0
e. establishing priorities for each session (with your input)	5	4	3	2	1	0
f. the homework assigned	5	4	3	2	1	0
g. the change in your symptoms	5	4	3	2	1	0
h. the coping strategies and skills you learnt	5	4	3	2	1	0
i. the professional relationship with your therapist	5	4	3	2	1	0
j. the therapist showing genuine care and concern for you	5	4	3	2	1	0
k. a feeling of being supported by the therapist	5	4	3	2	1	0
l. your level of comfort to be open and honest about your feelings	5	4	3	2	1	0
m. the overall experience of the telephone sessions	5	4	3	2	1	0
n. the possibility of receiving the same type of service, by telephone, in the future	5	4	3	2	1	0

11. Rate the level of change that the overall service has made in the following areas by circling the relevant number:

	Decreased a Lot	Decreased a Little	No Change	Increased a Little	Increased a Lot	N/A
a. your ability to understand your feelings, thoughts and behaviour	1	2	3	4	5	0
b. your awareness of your unhelpful beliefs and thoughts	1	2	3	4	5	0
c. your knowledge about the relationship between thoughts, feelings and behaviour	1	2	3	4	5	0
d. your ability to control and manage your thoughts, feelings and behaviour	1	2	3	4	5	0
e. your ability to handle difficult situations	1	2	3	4	5	0

12. What has been the most useful aspect about the Telephone CBT service for you?

13. What has been the least useful aspect about the Telephone CBT service for you?

14. If you have any further comments about your experience, please note these below:

Thank you for completing this survey. Please seal the form in the envelope provided and post.

Appendix 6: Instructions for project officers

The team at The Centre for Health Policy, Programs and Economics from the University of Melbourne are conducting the evaluation of telephone-CBT. The patient data that are collected as part of the general ATAPS projects will stay the same. 'Telephone-CBT' will be added as referral type on the MDS and must be selected for T-CBT referral. A new field, 'session modality' will also be added to MDS so you can indicate how the session was delivered – by telephone, face-to-face, or videoconference.

The main change for T-CBT is the collection of session-based data; this will now be collected and entered by the allied health professional. In the first instance this will be paper-based and sent to Strategic Data for data entry. The rationale for this is that more substantial session data is being collected and in the future the allied health professional will be able to login to the MDS to input this data directly online, in a separate area to the mainstream MDS. The data that coincides with the general MDS fields will be populated automatically, so that the data and reports that you have access to via the MDS will remain the same.

Either the 21- or 42-item version of the Depression, Anxiety, Stress Scale (DASS) is the outcome measure to be used for T-CBT and it will be collected and entered by the allied health professional. This does not prevent Divisions from using other outcome measures as well if they choose. Importantly, if your Division has not previously used the DASS, you will need to select the relevant DASS subscales on the measures list.

How to select outcome measures

1. Login to the MDS
2. Click on the 'Admin' tab
3. Select 'Measures List'
4. Tick the relevant outcome measures from the list (e.g., DASS-21 Depression, DASS-21 Anxiety, and DASS-21 Stress or the equivalent if your Division is using the DASS-42)

The training that allied health professionals received for T-CBT included a section on the Evaluation and took them through step-by-step what they need to do. A checklist for allied health professionals has also been developed and provided to them.

To facilitate the evaluation data collection from allied health professionals, there are a number of things that they will need from their Divisions;

1. The allied health professional's unique code that is used by the Division for the MDS
2. When referrals are made, the allied health professional will need to be informed, prior to their first contact with the client, of the following;
 - a. The GP referral date
 - b. The Patient Key/ID generated by the Division

All of this information will be used to match client data in the MDS whilst maintaining client confidentiality from the evaluation team.

Allied health professionals will be provided with a user name and password for the MDS, they will only have access to their own clients, they will not 'see' all the Division's data. As the allied health professional will be entering data after each session, it is important for the Division to enter the 'patient' and 'referral' information regarding each client when the referral is made, so that allied health professionals enter data in the appropriate position on the MDS. They will look up the clients based on the 'patient Key/ID' that is provided by the Division.

Summary checklist for Divisions providing T-CBT services

1. Ensure the DASS subscales (either 21 or 42 item versions) are selected from the outcome measures list on the MDS.
2. Tell your T-CBT trained AHPs what their AHP code is.
3. When referrals come in for T-CBT
 - a. Promptly enter patient and referral data on to MDS
 - b. Provide 'patient key/ID' to AHP.

Appendix 7: Instructions for allied health professionals

Before Providing T-CBT sessions obtain the following information from your Division:

1. Your AHP code on the MDS
2. For each referral for T-CBT sessions
 - a. The GP referral date
 - b. The Patient Key/ID, allocated by your Division

Contacting the client before providing sessions

1. Call client to make the first appointment
2. During or after this phone call, complete the **Initial Phone Contact Form***
3. Once form is completed send immediately to Strategic Data by
 - a. Fax – 03 8677 2950 or
 - b. Post – Strategic Data, Reply Paid 1166, Carlton, Victoria 3053 (reply paid envelopes**)
4. Send the client the DASS* and ask them to return it to you before the first session

Providing Sessions and completing the evaluation

Session 1

1. Complete **Session Information Form*** and **Section A** on page 5
2. Include the DASS scores in Section A
3. Once form is completed send immediately to Strategic Data
 - a. Fax – 03 8677 2950 or
 - b. Post – Strategic Data, Reply Paid 1166, Carlton, Victoria 3053 (reply paid envelopes)

Middle Sessions

1. Complete **Session Information Form** pages 1 -4
2. Once form is completed send immediately to Strategic Data
 - a. Fax – 03 8677 2950 or
 - b. Post – Strategic Data, Reply Paid 1166, Carlton, Victoria 3053 (reply paid envelopes)

Second Last Session; either Session 5 or 11, or session prior to the final session by agreement

1. Send the DASS & T-CBT Experience Survey (and Strategic Data postage paid envelope) to the client so that they can complete it at or just after the last session.

Last Session

1. Complete **Session Information Form** and **Section B** on page 5
2. Request that client completes
 - a. DASS during or immediately after the last session and returns it to you
 - b. Completes T-CBT Experience Survey and returns it to Strategic Data in the reply paid envelope
3. When you have received the post-intervention DASS scores from the client, record the scores in Section B
4. Once Session Information Form is completed, send immediately to Strategic Data
 - a. Fax – 03 8677 2950 or
 - b. Post – Strategic Data, Reply Paid 1166, Carlton, Victoria 3053 (reply paid envelopes)

*All evaluation forms and DASS survey can be obtained from the T-CBT component of our website
<http://boimhc.org/bin/view/Main/TeleCBT>
**Strategic Data Reply Paid envelopes can be obtained from your Division
For technical support, email support@boimhc.org

Appendix 8: Questions for Access to Allied Psychological Services project officers participating in the T-CBT pilot

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

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

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

2. Is your Division a fund holder for another Division which is also conducting the T-CBT project?

- Yes
 No

If yes, please specify,

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

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

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

4a. If there was a delay starting, what was the reason for the delay?

5. Who has been suggesting T-CBT as a mode of service delivery?

- GPs
 Allied health professionals
 Both GPs and allied health professionals
 Division project officer

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

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

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

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

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

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

-

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

- Yes
- No

9a. If yes, how do they differ?

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

11 How did GPs respond to the introduction of the T-CBT project?

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

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

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

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

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

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

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

18. Are there any other comments you would like to make about the T-CBT project?
