
PROGRAM EVALUATION UNIT



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

Ninth Interim Evaluation Report

Demand Management Strategies

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Executive summary

Background

One hundred and eight Access to Allied Psychological Services projects have been funded under the Better Outcomes in Mental Health Care program since July 2001. These projects, run by Divisions of General Practice, enable GPs to refer consumers to allied health professionals for 6+sessions of evidence-based care. The projects have improved access to high quality psychological care for people whose access might otherwise have been restricted by barriers such as cost. Divisions have struggled to meet demand, with GP referrals outstripping the capacity of the projects to provide psychological services. The current report examines the extent to which demand management strategies are being used in the projects, and how well these strategies are working.

Method

A brief survey was emailed to the project officer responsible for each of the projects, with the request that it be completed and returned by email or fax. The survey explored the following evaluation questions:

- How many projects are using demand management strategies?
- What demand management strategies are being used within projects?
- Which demand management strategies have been found to be most useful?
- What features of any demand management strategy have worked well and not worked well?

Key findings

Surveys were returned by project officers from 89 Access to Allied Psychological Services projects (81%). Of these, 76 (85%) were using at least one demand management strategy.

The survey data suggest that there is considerable activity across the Access to Allied Psychological Services projects with respect to demand management. The most commonly-used demand management strategies are: informing/training GPs (used in 82% of projects), putting in place systems and/or administrative procedures (used in 76%), and monitoring and limiting referrals (used in 61%).

The majority of projects are using a combination of broad demand management strategies (5.6 per project, on average). They are also employing a range of approaches within each demand management strategy. So, for example, within the general strategy of monitoring and limiting referrals, a given project might adopt pre-numbered vouchers, track referral numbers, recall and re-allocate unused or partially-used vouchers, and cap the number of referrals available to each GP.

Monitoring and limiting referrals and putting in place systems and/or administrative procedures are ranked as the most useful demand management strategies, with 29% of project officers endorsing the former and 24% the latter. Different features of these demand strategies appear to work well for different projects, but a common theme is that they need to be underpinned by strong partnerships and solid infrastructure. There is concern that the need for demand management reflects the fact that projects are insufficiently resourced, and that as a consequence demand management strategies such as limiting referrals can have a negative effect on stakeholder perceptions.

Conclusions

To conclude, it is apparent that the Access to Allied Psychological Services projects are using a broad range of demand management strategies, and that the majority are using multiple strategies in combination. These strategies tend to be supply-side strategies instituted at the point where the consumer makes contact with the GP and/or approaches the GP-allied health professional interface, rather than demand-side strategies aimed at the patient-practice interface. The primary mental health care landscape will change with the introduction of the range of new mental health initiatives proposed by the Council of Australian Governments, and this is likely to have an impact on the extent and nature of demand management strategies. At present, however, the current strategies appear to be working reasonably well as long as they are supported by good collaborations and appropriate infrastructure, although there are concerns that the need for demand management strategies reflects broader resourcing issues that can impact on providers' morale and consumers' satisfaction.

Chapter 1: Background

Setting the context

The Better Outcomes in Mental Health Care program began in July 2001, in response to the high burden of mental illness in Australia. As its name suggests, the Better Outcomes in Mental Health Care program strives to achieve better outcomes for Australians with mental health problems (particularly depression and anxiety), by improving access to high quality mental health care. The program has sought to achieve this by offering GPs training, systemic and professional support, and financial incentives via a number of interlocking components (described in more detail in Appendix 1).

One of these is the Access to Allied Psychological Services component. Through this component, GPs can refer consumers to allied health professionals^a (predominantly psychologists) for six sessions of evidence-based care (i.e., focused psychological strategies), with the option of a further six sessions after review by the GP. These services are being delivered via 108 projects being conducted by Divisions of General Practice. These projects have been funded in four funding rounds: 15 from June 2002 (Round 1 pilot projects); 14 from January 2003 (Round 1 supplementary projects); 41 from July 2003 (Round 2 projects); 32 from July 2004 (Round 3 projects); and six from July 2005 (Round 4 projects). A full list of projects is provided in Appendix 2.

Since just after the projects began, the University of Melbourne's Program Evaluation Unit (located within the University's School of Population Health) has produced eight interim evaluation reports, drawing on data from the projects' local evaluation reports, a purpose-designed minimum dataset, a forum and several surveys. Taken together, these reports indicate that the projects have improved access to high quality psychological care for people whose access might otherwise have been restricted by barriers such as cost.¹⁻⁸

Despite – or perhaps because of – this success, there are anecdotal reports that Divisions have struggled to meet demand, due to the capped budgets provided for the Access to Allied Psychological Services projects. Specifically, project staff have reported that GP referrals outstrip the capacity of the projects to provide psychological services.

The current report explores the demand management strategies that Divisions have put in place to deal with this issue. It is timely to consider this in the light of recent developments in mental health, which saw the Australian Government commit \$1.9 billion over five years to the *National Action Plan on Mental Health 2006-2011*,⁹ agreed to by the Council of Australian Governments on 14 July 2006. This funding will support a range of new initiatives, some of which will have direct relevance to the Access to Allied Health Services projects. These include, but are not limited to, new Medicare Benefits Schedule item numbers for the provision of services by psychologists, funding for services in rural and remote areas, funding for mental health nurses, and funding for mental health workers in Indigenous communities.

Demand management: Theory and practice

Issues of managing demand are by no means unique to the Access to Allied Psychological Services projects, and there is a body of theoretical and practical literature which conceptualises and operationalises demand management in the primary care sector and in the mental health sector. Within this literature, 'demand management' is

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

generally defined in a way that reflects that it is not designed to reduce the scope or standard of services to offset service deficiencies, but rather to align demand for services with available resources to ensure that genuine needs are met and benefit is maximised. A standard definition is that of Brown, Parker and Godding:¹⁰

'[Demand management is] the process of identifying where, how, why and by whom demand for health care is made and then deciding on the best methods for of managing this demand (which might mean curtailing, coping or creating demand) such that the most cost-effective, appropriate and equitable health care system can be developed. It critically depends on understanding how the behaviour of those who express the demand – citizens and professional – is changing. It is concerned with making more appropriate use of health services (not necessarily reducing it or making it cheaper).''

The primary care literature suggests that when demand exceeds supply, efforts are made to reduce demand (e.g., by educating consumers) or to streamline supply (e.g., by instituting triage systems or waiting lists). Gillam and Pencheon¹¹ have considered demand management strategies with respect to the general practice setting, and provide a further breakdown in relation to how consumers travel through the health care system. Specifically, they suggest that attempts to manage demand can be directed at three interfaces: (a) the patient-practice interface; (b) the primary care or first point of contact phase, and referral; and (c) the primary and secondary care interface. At the first interface, demand-side strategies (e.g., encouragement of self-management, co-payments) dominate. At the latter two interfaces, supply-side strategies (e.g., referral criteria or guidelines) come to the fore.

The mental health literature on demand management has a heavy emphasis on triage systems and waiting lists. Triage (or duty) systems constitute the entry point to specialist mental health services,¹² and have three functions as an entry system: prioritising referrals based on urgency; directing resources to managing emergencies quickly; and reducing unnecessary use of resources by limiting the inappropriate use services. Waiting lists, as their name suggests, are lists that effectively 'stagger' the delivery of services, based on chronological presentation or some kind of ranking criteria. Both triage systems and waiting lists may have costs and benefits for consumers and providers. For example, Brown, Parker and Godding¹⁰ suggest that waiting lists may benefit consumers by facilitating independence in their treatment, and providers by offering providing tangible evidence to support continuing need for the given service. Equally, however, they may have costs for both parties (e.g., prolonging emotional suffering for consumers, and introducing time commitments associated with maintaining the list for providers). To maximise the benefits and to minimise the costs, both triage systems and waiting lists must be designed and implemented in a planned, thoughtful and ethical manner.

Demand management in the Access to Allied Psychological Services projects

As noted above, anecdotal reports indicate that project staff are finding that GP requests for psychological services are exceeding the capacity of the Access to Allied Psychological Services projects. Consideration of the problem and of potential solutions has been the focus of discussion on the projects' listserver and at various state/territory and national meetings.

In addition, an open-ended question on the mid-2006 Australian Government Department of Health and Ageing reporting template sought information on the demand strategies which projects had put in place at that stage to reconcile supply and demand. The Program Evaluation Unit conducted a thematic analysis of the responses to this question,

and summarised them the taxonomy shown in Table 1. It can be seen that a range of innovative demand strategies were reported at that time.

Table 1: Summary of demand management strategies being used by projects, according to 2006 Australian Government Department of Health and Ageing reporting template

STRATEGY	WAYS IN WHICH STRATEGY MIGHT BE OPERATIONALISED
Restrict intake criteria	<ul style="list-style-type: none"> • Develop specific inclusion/exclusion guidelines (e.g., target patients who have particular diagnoses, are on low incomes, and/or have not accessed or are unable to access other mental health services)
Monitor and limit referrals	<ul style="list-style-type: none"> • Track and cap number of referrals per GP per period (e.g., allocate set number of vouchers per GP per month/quarter) • Track and redistribute unused referrals (e.g., recall and reallocate unused or partially used vouchers)
Prioritise referrals	<ul style="list-style-type: none"> • Establish and maintain a waiting list • Establish and maintain a triage system
Optimise session delivery	<ul style="list-style-type: none"> • Encourage group sessions (e.g., offer group session referral options to GPs, provide incentives for allied health professionals to provide group sessions, and/or encourage patients to attend groups sessions) • Limit number of sessions available to patients • Monitor session attendance and reallocate unused sessions
Seek co-payments	<ul style="list-style-type: none"> • Establish and maintain a co-payment system
Inform/train GPs	<ul style="list-style-type: none"> • Provide Level 2 training to equip GPs with skills to manage some patients themselves • Identify and promote other referral pathways to GPs • Inform GPs of the need to cap services • Promote GP provision of psychological support
Match allied health professional workforce to demand	<ul style="list-style-type: none"> • Ensure appropriate numbers and time fractions of allied health professionals to whom referrals can be made
Put in place systems and/or administrative procedures	<ul style="list-style-type: none"> • Centralise administration to implement and monitor and enforce demand management strategies
Encourage partnerships/collaboration	<ul style="list-style-type: none"> • Encourage GPs and allied health professionals to monitor referral levels together • Encourage Divisional and Area Mental Health Service collaboration
Develop strategic funding arrangements	<ul style="list-style-type: none"> • Review/monitor overall expenditure (e.g., introduce quarterly billing system) • Allocate services by geographical region • Develop demand management-specific formulae • Buy 'bulk time' from allied health professionals

The current report

The current report quantifies the extent and nature of the demand strategies being used in the Access to Allied Psychological Services projects. Using the above taxonomy as the basis for a purpose-designed survey, it explores the following evaluation questions:

- How many projects are using demand management strategies?
- What demand management strategies are being used within projects?
- Which demand management strategies have been found to be most useful?
- What features of any demand management strategy have worked well and not worked well?

Chapter 2: Method

At the beginning of August 2006, a brief survey was emailed to the project officers of the 108 Access to Allied Psychological Services projects. Respondents were asked to complete the survey and return it by email or fax. Reminder phone calls were made as necessary, and the cut-off for returned surveys was late August 2006.

The survey sought information on the demand management strategies being used by the given project, in line with the taxonomy presented in Table 1. Respondents were asked whether any demand management strategies were being used in their project. If they responded affirmatively to this, they were then asked which particular strategies were being used, and how they were being implemented. Respondents were then asked to indicate the demand management strategy they found the most useful. Next, they were asked what features of any demand strategies they had used had worked well and what features had not worked so well. Finally, they were given the opportunity to provide any additional comments regarding demand management strategies. A copy of the survey instrument can be found at Appendix 3.

Quantitative data from the survey were analysed using SPSS (Version 12.0.2) and are presented as simple frequencies and percentages. Qualitative data were analysed manually and organised into thematic areas.

Chapter 3: Results

Response rate

Surveys were returned by project officers from 89 Access to Allied Psychological Services projects (81%).

Overall use of demand management strategies

Of the 89 projects on which data were available, 76 (85%) were using at least one demand management strategy. The remainder of this chapter deals with these 76 projects.

Specific demand management strategies being used

For all of the 76 projects using demand management strategies, data were available on the specific strategies being employed. Table 1 provides a breakdown of these strategies, listing them from most common to least common.

Of note is the fact that the total well exceeds 100%, reflecting the fact that the majority of projects were using more than one strategy. To be specific, each project used an average of 5.6 different overarching strategies. These are operationalised in different ways in different projects, and further detail is provided below on the way each of these strategies was implemented.

Table 2: Demand management strategies being used (multiple responses permitted)

Demand management strategies	Freq.	%
Inform/train GPs	62	82
Put in place systems and/or administrative procedures	58	76
Monitor and limit referrals	46	61
Encourage partnerships/collaboration	42	55
Optimise session delivery	40	53
Restrict intake criteria	38	50
Match allied health professional workforce to demand	38	50
Develop strategic funding arrangements	33	43
Prioritise referrals	31	41
Seek co-payments	28	37
Other	12	16
Total	76	100

Inform/train GPs

Informing/training GPs was the most popular demand management strategy, used in 81% of projects. The most commonly-reported ways in which this strategy was implemented included promoting alternative referral pathways and promoting Level 2 Training to GPs. Both of these strategies have the potential to relieve the demand on allied health professionals employed by or contracted to the projects, by highlighting other relevant providers (in the case of the former) and suggesting a means by which GPs can better equip themselves to provide mental health care (in the case of the latter). The quotations below typify survey responses of this nature:

'GPs have been advised to consider other referral pathways that may be more appropriate – e.g., employment counselling services, victims of crime, workers compensation etc., as well as community mental health. GPs are advised by the psychologists when waiting lists are long [and/or] their referrals are inappropriate. GPs have been informed of other psychological support services – e.g., GP Psych Support, State Government Support Lines...'

Rural Division of General Practice

'GPs are encouraged to undertake Level 2 Training when it is available. The Division trains GPs in the limits of the service and in how to make appropriate referrals, directly in the form of written information, and indirectly through visits by the Mental Health Project Officer and the psychologists themselves. Psychologists are encouraged to work directly within their practices to educate GPs and staff. Work is being put into developing an effective set of information about referral pathways outside Division psychological services. This will take the form of a laminated quick reference decision tree for making appropriate referrals, and also an on-line communication board that will provide more qualitative information about service providers and what they offer.'

Urban Division of General Practice

Other common ways in which training/informing GPs was operationalised included advising GPs about limits to or caps on referrals, budget constraints and the use of co-payments. Other implementation mechanisms were also mentioned, including providing GPs with regular updates on numbers referrals within and across Divisions, and informing them about referral criteria, appropriateness of referrals and the use of waiting lists.

Put in place systems and/or administrative procedures

Putting in place systems and/or administrative procedures was the second most popular demand management strategy, used in 76% of projects. Often this occurred as a process underpinning other strategies. For example, a central administration or management point was often created to facilitate informing GPs about referrals (see above) or monitoring referral patterns and voucher use (see below), or, more generically, to govern demand management strategies. Likewise, the minimum data set and other information systems were used to monitor new referrals and upcoming sessions (again, see below). These activities are reflected in the quotations below:

'Centralise administration to implement and monitor and enforce demand management strategies.'

Rural Division of General Practice

'The referral process is managed centrally by the Division. GPs are provided with information, referral documentation etc. when they register. GPs generally fax or send the referrals to the psychologists via the Division's mental health project officer. Minimum data set and referral patterns are monitored.'

Rural Division of General Practice

Monitor and limit referrals

Monitoring and limiting referrals was also commonly used to manage demand, adopted in 61% of projects. Typically, this was operationalised by the use of pre-numbered vouchers, tracking referral numbers, recalling and re-allocating unused vouchers, and

limiting or capping the number of referrals made by each GP and/or received by each allied health professional in a given period. Many of these strategies were used in combination, and some were supported by systems and/or administrative procedures (see above), such as electronic referral systems and/or routine contact with GPs if referral rates reached a certain threshold. The responses below were fairly standard:

'Sending out a predetermined number of vouchers per GP when GP requests additional vouchers, based on previous usage; Recalling and reallocating unused or partially used vouchers.'

Urban Division of General Practice

'Track and redistribute unused referrals or partially used vouchers.'

Urban Division of General Practice

Encourage partnerships/collaborations

Fifty five per cent of projects managed demand by encouraging partnerships or collaborations. Within-project collaborations between GPs and allied health professionals were supported through, for example, regular meetings. Beyond-project collaborations were also encouraged. Usually these occurred at an agency level, with partnerships being fostered between Divisions and various other parties, including area mental health services (or their equivalent), tertiary mental health services and consumer/carer advisory groups. The response below is typical:

'Encouraging partnerships/liaison between Division (GPs) and Area Mental Health Service via Teams-of-Two Program.'

Urban Division of General Practice

These partnerships were facilitated by various means, including formal memoranda of understanding and mental health sub-committees. However, some projects, like the one below, struggled to establish or maintain them:

'We have and still are trying to work with local Primary Mental Health Team to share burden of patient numbers however, the structure of the Access to Allied Psychological Services program discourages advertising to wider patient population and/or sharing of participating GP information therefore partnerships with other agencies is extremely difficult.'

Rural Division of General Practice

Optimise session delivery

Optimising session delivery was one of the demand management strategies of choice in 55% of projects. To implement this, projects monitored sessions carefully and re-allocated unused sessions, with some setting strict criteria as to how soon after referral consumers must present for treatment. Session limits (six sessions, with the option of a further six after review by the GP) were closely monitored. A number of projects were also moving to a group session format, in order to maximise the number of consumers who could be seen. These methods, often used in combination, are illustrated in the quotations below:

'Group sessions used where efficient and appropriate. Unused sessions reallocated.'

Rural Division of General Practice

'[Running group sessions] is our main strategy which we are only now implementing. Previously, groups have been an option for clients but most have chosen individual treatment. From now on, groups will be the norm for patients with depression or anxiety disorders with avoidance and only patients who are unsuitable for groups will be seen on an individual basis. GPs have previously been surveyed on demand management strategies and groups were their preferred first line strategy.'

Urban Division of General Practice

Restrict intake criteria

Fifty per cent of projects restricted intake criteria as one means of managing demand. Operationally, this involved clearly articulating the target group, and communicating eligibility criteria to GPs. Projects did this in different ways, with target groups including people of low socio-economic status (e.g., health care card holders), people meeting specific clinical criteria (e.g., having symptoms of anxiety and/or depression, with or without co-morbidities), people assessed as meeting a particular severity threshold (e.g., having a K10 score of 25 or above), and people from culturally and linguistically diverse backgrounds. Other criteria related to individuals not being able to access other mental health services and/or demonstrating that they were likely to benefit from treatment. One project required consumers to have been known to the referring GP for at least six months. The quotation below is typical of the responses in this regard:

'We have developed specific inclusion/exclusion guidelines which have recently been updated /revamped and are currently being disseminated to GPs. These criteria allow for the inclusion of patients who have particular diagnoses, target low incomes, and those who are unable to access other mental health services.'

Rural Division of General Practice

Several projects reported that their intake criteria may change once new Medicare Benefits Schedule psychologist item numbers are introduced on 1 November. This sentiment is exemplified by the quotation below:

'May start restricting intake criteria after impact of Medicare commencement for psychology services is better known and because we have elected to use most of our year's funding in the first half of year, as it is proposed Medicare rebates will take over large amounts of work that were previously funded by the Better Outcomes in Mental Health Care program. We want to look at where the gaps are after that and position [our] Access to Allied Psychological Services project accordingly.'

Rural Division of General Practice

Match allied health professional workforce to demand

Half of the projects had made efforts to match their allied health professional workforce to demand. In some instances, this meant increasing the absolute number of full time equivalent allied health professionals, either by recruiting additional providers or increasing the capacity of existing providers. Where the budget permitted, this involved contracting additional allied health professional services if waiting lists got too long. Where the budget was already stretched, innovative means were sometimes employed, such as engaging the services of trainee psychologists under appropriate supervision arrangements, as illustrated in the quotation below:

'The Division prides itself on our program structure. We have developed relationships with all of the major (accredited) universities and provide a number of placements for postgraduate psychology registrars within the Better Outcomes in Mental Health Care program. We currently provide 30-40 sessions per week as a

result of this initiative. These sessions occur 'above and beyond' those provided by our employed psychologists (approx 55-66 per week).'

Rural Division of General Practice

In other instances, matching was interpreted as re-distributing available services, rather than increasing them. In practice, this meant reallocating 'overflow' referrals from one allied health professional to another, and/or ensuring that existing services were made available to those most in need. Projects offered psychological services to different groups, including people in areas under-serviced by Medicare, people in rural and remote locations, people from culturally and linguistically diverse backgrounds.

Develop strategic funding arrangements

Forty three per cent of projects had developed strategic funding arrangements as a means of managing demand. At a macro level, this involved developing resource allocation formulae based on factors like geographical area, and establishing efficiencies in retaining allied health professionals (e.g., balancing the benefits and costs of employing and contracting allied health professionals; retaining the services of supervised postgraduate psychology students to minimise costs, as described above). It also involved limiting the distribution of the names of GPs registered with the Better Outcomes in Mental Health Care program.

At a more micro level, it involved monitoring and reviewing overall expenditure on monthly or quarterly basis, as described in the following quotation:

'Overall expenditure is monitored and reviewed each quarter, and the number of vouchers allocated to GPs each quarter is dependent on the remaining funds.'

Urban Division of General Practice

Again, survey respondents commented that for their funding arrangements to continue to work optimally as demand management strategies, they would need to be reviewed in the light of the new mental health initiatives, including the forthcoming Medicare Benefits Schedule psychologist item numbers. This is exemplified by the quotation below:

'Waiting for final implementation strategies of the roll-out of the Federal mental health initiatives, with a particular focus on youth, mental health practice nurses, new Medicare Benefits Schedule items for psychologists, new Medicare Benefits Schedule items for GPs, and Indigenous funding.'

Rural General Practice

Prioritise referrals

Forty one per cent of projects were managing demand by prioritising referrals in some way. Most commonly, this involved using waiting lists and triage systems, with the latter based on level of urgency or degree of symptomatology as assessed by, for example, the K10. The following quotations are indicative of these approaches:

'Waiting lists have been established. Psychologists, in consultation with the GP, assesses and prioritises their referrals. Psychologists provide services across a number of locations, and will increase or decrease service provision depending on the demand for services in that location.'

Rural Division of General Practice

'We use the patients K10 score as to the urgency, and go off GPs' and psychologists' judgements on when to prioritise. Otherwise referrals are placed in order of receiving them.

Rural Division of General Practice

Seek co-payments

Seeking co-payments from patients was the least commonly used demand management strategy, reported by 37% of projects. Co-payments varied across projects, and sometimes within projects with different providers charging different amounts. Some projects charged co-payments to non-health care card holders, but provided services free to health care card holders. Some projects charged consumers for non-attendance.

Usefulness of specific demand management strategies

Data were available on the most useful demand management strategy for 68 of the 76 projects (see Table 3). Monitoring and limiting referrals was most commonly reported as the most useful strategy (29%), followed by putting in place systems and/or administrative procedures (23%). None of the project officers responsible for these projects listed seeking co-payments as the most useful demand management strategy.

Table 3: Most useful demand management strategy

Demand management strategies	Freq.	%
Monitor and limit referrals	20	29
Put in place systems and/or administrative procedures	16	24
Restrict intake criteria	9	13
Optimise session delivery	5	7
Prioritise referrals	4	6
Inform/train GPs	4	6
Encourage partnerships/collaboration	4	6
Develop strategic funding arrangements	4	6
Match allied health professional workforce to demand	2	3
Seek co-payments	0	0
Total	68	100

Features of demand management strategies that worked well

When asked which features of any demand strategies worked well, most survey respondents provided examples of the approaches described above that they felt had helped to balance supply and demand. Some of these could be regarded as directly impacting on supply or demand, with commonly-cited examples including recalling and re-allocating unused or partially used vouchers, educating both GPs and psychologists on the operation of the program, and involving supervised postgraduate psychology students in service provision. These commonly-mentioned features are exemplified in the quotations below. Other features mentioned by respondents included the delivery of group sessions, promoting alternative referral pathways and tracking referral numbers.

'Recalling and reallocating unused or partially used vouchers, and reallocating unused sessions, has been effective at enabling GPs to continue referrals until new funding was received, but was very time-consuming.'

Urban Division of General Practice

'Educating GPs and psychologists about making appropriate referrals has been effective in focussing services and limiting the involvement of psychologists in situations beyond the range of their funding and support. Focussed psychologists with firm boundaries look for better referral pathways, and this leads on to collaboration between service providers, so that could be seen as another positive outcome. It is possible that placing psychologists in specific practices leads to better use of Access to Allied Psychological Services projects, not only because referrals are more appropriate but also because of the better practice-psychologist relationship. This has spin-offs in greater mutual understanding and more collaborative working relationships between psychologists and GPs.'

Rural Division of General Practice

'The model of employing university interns works really well. It's very well received by the clients, demonstrates good clinical outcomes and offers a professionally developing environment for treatment providers. Liaising with GPs and having two referring GPs on the clinic's management committee allows us to maximise the efficiency of the service.'

Rural Division of General Practice

Other features related to the conditions necessary to underpin some of the above demand management strategies, notably strong partnerships between providers, and solid infrastructure. With regard to the latter, respondents like the one quoted below highlighted the need for a central administration system to implement, monitor and enforce demand management strategies:

'Monitoring of demand through our referral tracking system is the most effective management tool. If you do not have an effective monitoring system then it is impossible to know if demand has outstripped supply (funding \$). Demand MUST be managed at the point of referral – the central information point MUST know at any given time how many referrals are in the system in real time. An allocation (or registration) number should be supplied at the time of referral by the FUND HOLDER. This then allows an immediate allocation of funds to be given to that referral. If this is efficiently recorded then the maximum funds payable by the Division for service provision will always be known at any point in time. A follow-up administration procedure is also necessary to determine whether the funds allocated have been used by the client within the stipulated time period of six months. If not, these funds are released for new referrals.'

Rural Division of General Practice

It should be noted that some respondents were unable to specify features of demand management strategies that had worked well, as it was 'early days'.

Features of demand management strategies that did not work so well

When survey respondents were asked to highlight features of demand management strategies that had not worked so well, many respondents prefaced their statements with the comment that demand management would not be an issue if the projects were appropriately resourced. Respondents typically made statements like:

'Demand management is a cop out. [Our] Division has higher than average GPs trained in Better Outcomes in Mental Health Care, and large proportion of low income patients. Better Outcomes in Mental Health Care needs a longer time. [The]

[G]overnment does not understand what GPs face in primary mental health care. Demand management is one thing but mental health is another problem.'

Rural Division of General Practice

Within this context, respondents felt that restricting demand by any means had potential for problems. In particular, they highlighted the fact that monitoring and limiting referrals had created administrative and decision-making problems for GPs, and engendered resentment among stakeholders. The following quotations illustrate this point:

'Limiting the number of referral forms provided to GPs was not well received. Some GPs see more disadvantaged people than others, prefer to utilise the 3 Step Mental Health Process more, see more clients with mental health problems than other etc. Restricting the numbers of referrals provides a potent dilemma for GPs – i.e., to decide which 10 of their patients should be referred to the psychologists over others and also then is provided on first in first served rather than most needed. Through patient survey and verbal feedback, asked to promote the availability of the service in the region. However have been reluctant as the service is not meeting current demands. GPs can not always refer to contracted psychologists when they need to, due to insufficient funds.'

Rural Division of General Practice

'Issuing GPs with a number of sessions they could use in a six month period. Allocations were made on a pro rata basis on how many sessions a GP worked in general practice. This worked VERY BADLY because: GPs used up all their sessions in the first month. Many took no notice of the allocation and referred above their quota. GPs who did a lot of mental health work felt disadvantaged. We were planning to track usage each month and reallocate unused sessions to those who needed extra. We had calculated session numbers to be spread over four months, given we were expecting Medicare rebates to largely take over funding of psychology sessions. Rationing didn't work and what actually happened was that all our available service delivery funding was committed in the month of July and we have had to stop GPs referrals except to our three employed staff (for whom we now have a long waiting list). Our service has been incredibly successful and well received and utilised by GPs. We have worked hard (as requested) to help nearly 40% (n=150) of our GP members become registered for mental health. The expectation that we can somehow reduce demand from 300 patients per month to 30 (because of reduced funding this financial year) has been very devaluing for all concerned, most of all patients in need.'

Urban Division of General Practice

Respondents also commented on an array of other features that had not worked well in terms of managing demand. Several reported that as their project was in an area of low socio-economic status, restricting access to those with low incomes did little to reduce numbers. Some commented that strategies to offer GPs alternative referral pathways had not worked because they had developed relationships with the given project's allied health professionals, and trusted them to achieve positive consumer outcomes. Others noted that equipping GPs to manage presenting mental health problems themselves had not worked because there had been a poor response to Level 2 Training. One reported that a new voucher system that capped referrals had reduced confidence in and relevance of the program. One respondent went so far as to say that no demand management strategies had been effective.

Once again, it should be noted that some respondents were reluctant to suggest features of demand management strategies that had not worked well, as they felt these strategies needed time to mature.

Chapter 4: Discussion and conclusions

Summary of findings

The survey data collected for the current report suggest that there is considerable activity across the Access to Allied Psychological Services projects with respect to demand management. The most commonly-used demand management strategies are: informing/training GPs (used in 82% of projects), putting in place systems and/or administrative procedures (used in 76%), and monitoring and limiting referrals (used in 61%).

The majority of projects are using a combination of broad demand management strategies. They are also employing a range of approaches within each demand management strategy. So, for example, within the general strategy of monitoring and limiting referrals, a given project might adopt pre-numbered vouchers, track referral numbers, recall and re-allocate unused or partially-used vouchers, and cap the number of referrals available to each GP.

Monitoring and limiting referrals and putting in place systems and/or administrative procedures are ranked as the most useful demand management strategies, with 29% of project officers endorsing the former and 24% the latter. Different features of these demand strategies appear to work well for different projects, but a common theme is that they need to be underpinned by strong partnerships and solid infrastructure. There is concern that the need for demand management reflects the fact that projects are insufficiently resourced, and that as a consequence demand management strategies such as limiting referrals can have a negative effect on stakeholder perceptions.

Some caveats

Several caveats should be taken into account in interpreting the above findings. Firstly, the survey provides a snapshot of demand management strategies at a single point in time, and thus is not sensitive to whether strategies may have evolved over time. Secondly, the findings are not set in the context of factors which may be related to levels of supply and demand, such as population profile, geographic location, number of participating GPs and allied health professionals, and availability of alternative mental health services. Thirdly, no information was available on how projects are evaluating their demand management strategies, so comments about what worked well and not so well should be interpreted with care. Finally, no data were collected on the investment by projects in their demand management strategies of choice, nor on the extent to which they are sustainable.

Interpreting the findings

Notwithstanding these caveats, it is worthwhile considering the findings in the context of existing literature on demand management in the primary care and mental health arenas.^{11, 12}

The findings suggest that few demand management strategies are directed at the patient-practice interface. Seeking a co-payment, for example, was the least commonly-used strategy for demand management, and was not regarded by any project officers as the most useful strategy. Similarly, no project officers reported encouraging consumer self-management, despite being given the opportunity to list any additional strategies.¹¹

By contrast, many demand management strategies are directed at the GP as the first point of contact and the referring agent. Informing GPs about budgetary constraints, the

need to cap referrals and alternative referral pathways are prime examples, as is encouraging them to undertake Level 2 Training. Restricting intake criteria on the basis of diagnosis, level of symptomatology, income level, access to other service options and likely responsiveness to care can also be regarded as approaches targeting this point in the consumers' path through the mental health care system.¹¹

Many demand management strategies also occur at the GP-allied health professional interface. In particular, monitoring and limiting referrals (e.g., reviewing referrals over a specific period, tracking referrals, recalling and re-allocating unused referrals) can be regarded as occurring at this point in the consumer's care trajectory. Having said this, there are some demand management strategies that might have been expected to be more popular at this point, on the basis of the literature. For example, systems to prioritise referrals (e.g., waiting lists and triage systems) are used, but are by no means the most common strategy put in place to manage demand.^{11, 12}

Conclusion

To conclude, it is apparent that the Access to Allied Psychological Services projects are using a broad range of demand management strategies, and that the majority are using multiple strategies in combination. These strategies tend to be supply-side strategies instituted at the point where the consumer makes contact with the GP and/or approaches the GP-allied health professional interface, rather than demand-side strategies aimed at the patient-practice interface. The primary mental health care landscape will change with the introduction of the range of new mental health initiatives proposed by the Council of Australian Governments, and this is likely to have an impact on the extent and nature of demand management strategies. At present, however, the current strategies appear to be working reasonably well as long as they are supported by good collaborations and appropriate infrastructure, although there are concerns that the need for demand management strategies reflects broader resourcing issues that can impact on providers' morale and consumers' satisfaction.

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

Component 1: Education and training for GPs

Through this component, GPs can participate in Familiarisation Training which introduces them to the Better Outcomes in Mental Health Care program (2 hours), then Level 1 Training which equips them to perform the 3-step mental health process (6 hours), described below and then Level 2 Training which provides them with the skills necessary to undertake focused psychological strategies (20 hours), also described below.

Component 2: The 3 Step Mental Health Process

This component provides a framework for GPs to manage mental health problems, and includes an assessment (Step 1), preparation of a mental health plan (Step 2) and a review (Step 3). GPs who have completed Level 1 Training can access a Service Incentive Payment from Medicare Australia (the body responsible for administering Medicare) for providing the 3-step process.

Component 3: Focused Psychological Strategies

This component promotes evidence-based focused psychological strategies, namely psycho-education, cognitive behavioural therapy and interpersonal therapy. These strategies are normally delivered by GPs in planned sessions, each lasting a minimum of 30 minutes. GPs who have completed Level 2 Training can bill Medicare Australia against specific Medicare item numbers which have been created to recompense them for their time in delivering focused psychological strategies.

Component 4: Access to Allied Psychological Services

Through this component, GPs who have completed Level 1 Training are able to refer consumers to allied health professionals for the same focused psychological strategies described above. The allied health professionals are contracted to or employed by Divisions of General Practice through Access to Allied Psychological Services projects.

Component 5: Access to Psychiatrist Support

This component enables psychiatrists to be reimbursed for participating in case conferences with GPs and others, and provides access to patient management advice to GPs from psychiatrists through the GP Psych Support service.

Appendix 2: Access to Allied Psychological Services projects

ROUND	DIVISION(S)	STATE	RURAL/URBAN
1 (Pilot)	NSW Central West	NSW	Rural
1 (Pilot)	NSW Outback	NSW	Rural
1 (Pilot)	Top End	NT	Rural
1 (Pilot)	Logan Area - QLD	QLD	Urban
1 (Pilot)	South East Alliance (formerly Bayside Brisbane)	QLD	Urban
1 (Pilot)	Sunshine Coast	QLD	Rural
1 (Pilot)	Toowoomba and District	QLD	Rural
1 (Pilot)	Adelaide Northern	SA	Urban
1 (Pilot)	Bendigo & District Div	VIC	Rural
1 (Pilot)	Dandenong Div	VIC	Urban
1 (Pilot)	East Gippsland Div	VIC	Rural
1 (Pilot)	Knox - VIC	VIC	Urban
1 (Pilot)	North West Melbourne	VIC	Urban
1 (Pilot)	Fremantle Regional Div	WA	Urban
1 (Pilot)	Perth & Hills WA	WA	Urban
1 (Supplementary)	ACT	ACT	Urban
1 (Supplementary)	Central Coast NSW	NSW	Urban
1 (Supplementary)	Hastings Macleay NSW	NSW	Rural
1 (Supplementary)	Mid North Coast NSW	NSW	Rural
1 (Supplementary)	Riverina	NSW	Rural
1 (Supplementary)	North & West Queensland	QLD	Rural
1 (Supplementary)	Southern Division of Adelaide	SA	Urban
1 (Supplementary)	Ballarat & District	VIC	Urban
1 (Supplementary)	Central Highlands - VIC	VIC	Urban
1 (Supplementary)	Geelong Division & Otway Division	VIC	Urban
1 (Supplementary)	Mornington Peninsula	VIC	Urban
1 (Supplementary)	North East Victoria	VIC	Rural
1 (Supplementary)	GP Down South (formerly known as Peel South West)	WA	Rural
1 (Supplementary)	Greater Bunbury WA	WA	Rural
2	Blue Mountains	NSW	Urban
2	Canterbury	NSW	Urban
2	Dubbo / Plains	NSW	Rural
2	Fairfield	NSW	Urban
2	Illawarra	NSW	Urban
2	Murrumbidgee	NSW	Rural
2	Nepean Division & Hawkesbury Division	NSW	Urban
2	New England	NSW	Rural
2	North West Slopes	NSW	Rural
2	Southern Highlands	NSW	Rural
2	Sutherland	NSW	Urban
2	Brisbane South	QLD	Urban
2	Capricornia	QLD	Rural
2	Central Queensland Rural	QLD	Rural
2	Far North Queensland	QLD	Rural
2	Gold Coast & Tweed Valley	QLD	Urban
2	Ipswich and West Moreton	QLD	Urban
2	Mackay	QLD	Rural
2	Townsville	QLD	Rural
2	Adelaide Central and Eastern	SA	Urban
2	Adelaide Hills	SA	Rural
2	Adelaide North East	SA	Urban
2	Adelaide Western	SA	Urban
2	Limestone Coast	SA	Rural

ROUND	DIVISION(S)	STATE	RURAL/URBAN
2	Murray Mallee	SA	Rural
2	North West Tasmania	TAS	Rural
2	Northern Tasmania - GP North	TAS	Rural
2	Southern Tasmania	TAS	Urban
2	Central Bayside - VIC	VIC	Urban
2	Melbourne	VIC	Urban
2	Monash (Moorabbin)	VIC	Urban
2	Murray Plains	VIC	Rural
2	North East Valley - VIC	VIC	Urban
2	Southcity GP Services (Inner SE Melbourne)	VIC	Urban
2	Western Melbourne	VIC	Urban
2	Westgate	VIC	Urban
2	Whitehorse - VIC	VIC	Urban
2	Canning - WA	WA	Urban
2	Great Southern	WA	Rural
2	Osborne	WA	Urban
2	Perth Central Coast (trading as GP Coastal)	WA	Urban
3	Barrier	NSW	Rural
3	Barwon	NSW	Rural
3	Central Sydney	NSW	Urban
3	Eastern Sydney	NSW	Urban
3	Hornsby Ku-ring-gai Ryde	NSW	Urban
3	Hunter Rural	NSW	Rural
3	Hunter Urban	NSW	Urban
3	Macarthur	NSW	Urban
3	Northern Rivers	NSW	Rural
3	Northern Sydney	NSW	Urban
3	Shoalhaven	NSW	Rural
3	South East NSW	NSW	Rural
3	St George	NSW	Urban
3	Brisbane North	QLD	Urban
3	Southern Queensland Rural	QLD	Rural
3	Wide Bay	QLD	Urban
3	Barossa	SA	Rural
3	Eyre Peninsula	SA	Rural
3	Flinders and Far North	SA	Rural
3	Mid North Rural SA	SA	Rural
3	Riverland	SA	Rural
3	Yorke Peninsula	SA	Rural
3	Border	VIC	Rural
3	Central West Victoria	VIC	Rural
3	Eastern Ranges GP Association	VIC	Urban
3	Goulburn Valley	VIC	Urban
3	Mallee	VIC	Rural
3	Northern (VIC)	VIC	Urban
3	Central Wheatbelt	WA	Rural
3	Eastern Goldfields	WA	Rural
3	Mid West	WA	Rural
3	Rockingham Kwinana	WA	Urban
4	Bankstown Division of General Practice	NSW	Urban
4	Hawkesbury Division of General Practice (fundholder for former Western Sydney Division of General Practice)	NSW	Urban
4	Liverpool Division of General Practice	NSW	Urban
4	Central Australia	NT	Rural
4	Cairns Division of General Practice	QLD	Rural
4	Redcliffe Bribie Caboolture	QLD	Urban

Appendix 3: Demand management strategies survey instrument

PROGRAM EVALUATION UNIT



Demand management strategies used in the Access to Allied Psychological Services projects

Anecdotal reports indicate that many Divisions are finding that GP requests for psychological services are exceeding the capacity of the Access to Allied Psychological Services (ATAPS) projects. As part of our role in synthesising information from the ATAPS projects, we have developed a list of the kinds of strategies that Divisions are using to manage demand (see below).

STRATEGY	WAYS IN WHICH STRATEGY MIGHT BE OPERATIONALISED
1. Restrict intake criteria	<ul style="list-style-type: none"> Develop specific inclusion/exclusion guidelines (e.g., target patients who have particular diagnoses, are on low incomes, and/or have not accessed or are unable to access other mental health services)
2. Monitor and limit referrals	<ul style="list-style-type: none"> Track and cap number of referrals per GP per period (e.g., allocate set number of vouchers per GP per month/quarter) Track and redistribute unused referrals (e.g., recall and reallocate unused or partially used vouchers)
3. Prioritise referrals	<ul style="list-style-type: none"> Establish and maintain a waiting list Establish and maintain a triage system
4. Optimise session delivery	<ul style="list-style-type: none"> Encourage group sessions (e.g., offer group session referral options to GPs, provide incentives for allied health professionals to provide group sessions, and/or encourage patients to attend groups sessions) Limit number of sessions available to patients Monitor session attendance and reallocate unused sessions
5. Seek co-payments	<ul style="list-style-type: none"> Establish and maintain a co-payment system
6. Inform/train GPs	<ul style="list-style-type: none"> Provide Level 2 training to equip GPs with skills to manage some patients themselves Identify and promote other referral pathways to GPs Inform GPs of the need to cap services Promote GP psychological support
7. Match allied health professional workforce to demand	<ul style="list-style-type: none"> Ensure appropriate numbers and time fractions of allied health professionals to whom referrals can be made
8. Put in place systems and/or administrative procedures	<ul style="list-style-type: none"> Centralise administration to implement and monitor and enforce demand management strategies
9. Encourage partnerships/collaboration	<ul style="list-style-type: none"> Encourage GPs and allied health professionals to monitor referral levels together Encourage Divisional and area mental health service collaboration
10. Develop strategic funding arrangements	<ul style="list-style-type: none"> Review/monitor overall expenditure (e.g., introduce quarterly billing system) Allocate services by geographical region Develop demand management-specific formulae Buy 'bulk time' from allied health professionals

We believe that it is important to clarify the extent to which these demand management strategies are being used, and how well they are working, in order that successful strategies can be shared. For this reason, we would appreciate it if you would spend a few minutes completing the attached survey and return it by email or fax to:

Belinda Morley (if you're in Vic, SA, Tas or NT)
 Email: bcmorley@unimelb.edu.au
 Fax: 03 9348 1174

Fay Kohn (if you're in Qld, NSW, WA or ACT)
 Email: fkohn@unimelb.edu.au
 Fax: 03 9348 1174

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

2. Are any demand management strategies being used in your ATAPS project?

Yes No If no, go to end of survey

3. Which of the following demand management strategies being used in your ATAPS project?

Restrict intake criteria	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this being implemented? _____ _____
Monitor and limit referrals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this being implemented? _____ _____
Prioritise referrals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this being implemented? _____ _____
Optimise session delivery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this being implemented? _____ _____
Seek co-payments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this being implemented? _____ _____
Inform/train GPs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this being implemented? _____ _____
Match allied health professional workforce to demand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this being implemented? _____ _____
Put in place systems and/or administrative procedures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this being implemented? _____ _____
Encourage partnerships/collaboration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this being implemented? _____ _____
Develop strategic funding arrangements	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this being implemented? _____ _____
Other (please specify)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this being implemented? _____ _____

4. Which of the demand management strategies specified at Question 3 have you found most useful? [Tick one only]

- | | |
|--|--|
| <input type="checkbox"/> Restrict intake criteria | <input type="checkbox"/> Match allied health professional workforce to demand |
| <input type="checkbox"/> Monitor and limit referrals | <input type="checkbox"/> Put in place systems and/or administrative procedures |
| <input type="checkbox"/> Prioritise referrals | <input type="checkbox"/> Encourage partnerships/collaboration |
| <input type="checkbox"/> Optimise session delivery | <input type="checkbox"/> Develop strategic funding arrangements |
| <input type="checkbox"/> Seek co-payments | <input type="checkbox"/> Other (as specified at Question 3) |
| <input type="checkbox"/> Inform/train GPs | |

5. What features of any demand management strategies you have used have worked well?

6. What features of any demand management strategies you have used have not worked so well?

7. Additional comments regarding demand management strategies

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY