PROGRAM EVALUATION UNIT

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

Second Interim Evaluation Report

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Executive summary

Background

The 2001-2002 Federal budget initiative Better Outcomes in Mental Health Care seeks to improve the mental health care available to Australians. A key component of the initiative is the Access to Allied Health Services component, which permits eligible GPs to refer consumers to allied health professionals who deliver focused psychological strategies (namely psycho-education, cognitive behavioural therapy and interpersonal therapy) in six sessions with a following six sessions available upon GP review. Since the initiative began, 69 projects have reached the point of service delivery. Fifteen pilot projects and 14 supplementary projects were funded in Round 1, and a further 40 projects were funded in Round 2. A third funding round will shortly see the commencement of 33 additional projects.

Method

The current report synthesises evaluation evidence from the Round 1 pilot and supplementary projects. Specifically, it draws on information from the local evaluation reports of these projects and data from a purpose-designed minimum dataset. It aims to answer the following questions:

- What models of service delivery are being used by the projects?
- What is the level of uptake of the projects?
- Who is accessing services through the projects?
- What services are consumers receiving through the projects?
- What are the advantages and disadvantages of the projects?

Results and discussion

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

The Round 1 pilot and supplementary projects are operating under a range of different models, ranging from simple voucher systems to more complex brokerage models. Some of the pilot projects that began with a model at one or other end of the spectrum have modified their models, and are now approaching the 'middle ground'. The modified models involve providing GPs with detailed registers which profile allied health professionals in terms of their skills and competencies, thereby enabling GPs to make informed referral decisions themselves. Learning from the experiences of the pilot projects, a number of the supplementary projects have adopted this intermediate model as their model of choice.

What is the level of uptake of the projects?

Depending on whether the minimum dataset of the local evaluation reports are used as the authoritative data source, the Round 1 pilot and supplementary projects have involved between 710 and 926 GPs and between 160 and 229 allied health professionals. Together, these providers have enabled between 3,476 and 3,656 consumers to access mental health care which would otherwise have been out of their reach.

These figures are impressive by any standard, and represent a significant increase over time. Having said this, there are some concerns about managing uptake. In particular, the number of referrals available to any given GP averages at somewhere between three and five, because the total number of services is effectively 'capped' by the particular project's budget. This is raising participation issues among GPs.

Who is accessing services through the projects?

On the basis of available data in the minimum dataset, the Round 1 pilot and supplementary projects appear to be reaching the consumers that they are supposed to be targeting. So, for example, the majority are on low incomes (58%) and have not completed secondary education to Year 12 (56%), most have been diagnosed with depression (77%) and/or anxiety (55%) by their GP, and 40% have no previous history of specialist mental health care, indicating that their access may have previously been problematic.

What services are consumers receiving through the projects?

According to the minimum dataset, the number of sessions of therapy received to date by consumers in the Round 1 pilot and supplementary projects is 8,678 (a mean of 2.5 per consumer). Most sessions tend to be close to an hour in length (71%), and involve individual treatment (99%). The most common interventions delivered through these sessions are CBT-based cognitive and behavioural interventions (55% and 41%, respectively). In 76% of all sessions, consumers are not required to contribute to the cost of care; in the remainder of cases they are asked to make a co-payment, usually of not more than $10.

These findings suggest that the Access to Allied Health Services projects are being delivered in the way in which they were intended, providing evidence-based mental health care to consumers at minimal or no cost through a series of structured sessions. Qualitative data from the local evaluation reports suggests that the quality of these services is high, as projects have ensured that their allied health professionals are qualified, skilled and well-supported.

What are the advantages and disadvantages of the projects?

GPs and allied health professionals involved in the pilot and supplementary projects are now feeling more satisfied that the initiative is viable and ongoing, and consumers are benefiting. Benefits observed by GPs include improved collaboration with allied health professionals, new skills and knowledge in the area of mental health, a structured approach to the provision of mental health care, and new referral options. Benefits observed by allied health professionals include improved relationships with GPs, an increased referral base, and clinical supervision and professional support. Consumers are benefiting from ready access to high quality care, which is leading to increased satisfaction with care and improved outcomes of care.

Despite these positives, GPs and allied health professionals have experienced some barriers to participation. For GPs, some of these barriers are attitudinal, and relate to perceptions that the benefits of participation outlined above may not outweigh potential costs (e.g., time spent on training, time spent on completing the 3 Step Mental Health Process). Some GPs are still confused about how the projects operate; others understand their operation, but have concerns about aspects such as a perceived lack of flexibility, limited referral capacity (see above), payment issues and the impact on their caseloads. For allied health professionals, there are logistical concerns such as location and payment issues, and, for some, issues with distance and travel time. Some allied health professionals also have concerns about the lack of decision-making power vested in them as clinicians. For consumers, there are some referral issues (particularly to do with inequities regarding who gets referred) and some location issues.

Conclusions

The models utilised in the Access to Allied Health Services projects have evolved over time, with earlier pilot projects modifying their approaches to best meet the needs of GPs, allied health professionals and consumers, and later supplementary projects learning from the experiences of the pilots. The projects have achieved a high level of participation by GPs and allied health professionals, and reached a significant number of consumers. In general terms, these consumers comprise the target groups that the projects have been designed to reach, in that they would previously have had limited access to specialist mental health care due to barriers such as cost, language and/or distance. Further, there is evidence that the projects are providing high quality, evidence-based mental health care for these consumers. Like any new initiative, there are some practical and professional issues that need to be addressed. For example, solutions must be sought to the limited number of referrals available to any given GP. However, the continuation and expansion of the initiative should be a high priority for ongoing funding. Likewise, rigorous evaluation efforts should be maintained.

Chapter 1: Background

The Better Outcomes in Mental Health Care initiative

The Better Outcomes in Mental Health Care initiative aims to improve the mental health care available to Australians. It is a four-year initiative, which received funding totalling $120.4 million in the 2001-2002 Federal budget The initiative has five inter-related components, each of which is described in more detail in Appendix 1:

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

The Access to Allied Health Services component

This evaluation report focuses specifically on the Access to Allied Health Services component of the Better Outcomes in Mental Health Care initiative. This component permits eligible GPs to refer consumers to allied health professionals[a] who deliver Focused Psychological Strategies, namely (a) psycho-education; (b) cognitive behavioural therapy (including behavioural interventions, cognitive interventions, relaxation strategies and skills training); and (c) interpersonal therapy. These services are deliverable in up to six time-limited sessions with an option for up to a further six sessions following a mental health review by the referring GP. Divisions of General Practice act as fundholders in this component of the Better Outcomes in Mental Health Care initiative.

Since the initiative began, 70 Access to Allied Health Services projects have been funded in two major funding Rounds (see Appendix 2 for a complete list), 69 of which have reached the point of service delivery. In Round 1, 15 pilot projects received funding between June and August 2002, and a further 14 supplementary projects received funding between January and March 2003. In Round 2, 40 additional projects received Round 2 funding after July 2003. A third funding round will shortly see the commencement of 33 new projects.

Evaluating the Access to Allied Health Services component

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

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

- **Support to local evaluations:** Under the terms of their funding agreements, each project has allocated a portion of its budget to evaluation. Varying arrangements have been pursued with this funding, including the appointment of external evaluators. The design and nature of the local evaluations differ, depending on the model of service delivery and the local context. Typically, however, the local evaluations are employing a combination of quantitative and

[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.

qualitative methods to examine the processes/structures and impacts/outcomes of the different models. The Program Evaluation Unit is providing support to Divisions with these local evaluations, recognising the different circumstances under which these evaluations are being conducted.

- **The development of a minimum dataset:** On behalf of the Evaluation Working Group, the Program Evaluation Unit developed a minimum dataset that standardises the basic information collected by Divisions running Access to Allied Health Services Projects, and therefore acts as an important evaluation tool. The minimum dataset is designed to capture de-identified consumer-level information, which is invaluable for describing who is accessing allied health care as a result of these projects, as well as for providing a broad overview of the care these people are receiving.

- **Synthesising evaluation lessons from the Access to Allied Health Services projects:** Periodically, the Program Evaluation Unit is drawing together information from the local evaluations (and related local reports) and the minimum dataset to provide ongoing lessons about how the Access to Allied Health Services components are going, who they are reaching, the type of care they are providing, and whether specific models of service delivery seem to be particularly effective in given circumstances.

The current report

This Second Interim Evaluation Report represents the second synthesis of evaluation lessons from the Access to Allied Health Services component, and follows the First Interim Evaluation Report[1] produced in December 2003.

The current report draws on two main information sources, namely the local evaluation reports from the Round 1 pilot and supplementary projects, and data from the minimum dataset. It uses these information sources to answer the following questions:

- What models of service delivery are being used by the projects?
- What is the level of uptake of the projects?
- Who is accessing services through the projects?
- What services are consumers receiving through the projects?
- What are the advantages and disadvantages of the projects?

In synthesising this information, the current report expands on the First Interim Evaluation Report[1] which relied solely on the local evaluations of the pilot projects and addressed a more restricted set of questions.

Chapter 2: Method

As noted in the previous section, this Second Interim Evaluation Report addresses the following evaluation questions:

- What models of service delivery are being used by the projects?
- What is the level of uptake of the projects?
- Who is accessing services through the projects?
- What services are consumers receiving through the projects?
- What are the advantages and disadvantages of the projects?

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

To do this, the report draws on information from two sources, namely the local evaluation reports from the Round 1 pilot and supplementary projects, and data from the minimum dataset. Each of these data sources is described in more detail below.

Data from local evaluation (and project implementation) reports

This report synthesises the most recent information from relevant documentation associated with Round 1 pilot and supplementary projects.

In the case of the pilot projects, information was available from project implementation reports and evaluation reports. As at 30 June 2004, the 15 pilot projects had been running for 21-24 months and all had submitted at least three quarterly project implementation reports to the Commonwealth Department of Health and Ageing. Thirteen had also submitted a fourth quarterly project implementation report, and 10 had made evaluation reports available.

In the case of the supplementary projects, information was available only from evaluation reports. At June 2004, the 14 supplementary projects had been running for 16-18 months, and 13 had submitted evaluation reports.

The quantitative findings (from routinely-collected registration and utilisation data) and qualitative findings (from surveys, interviews and/or focus groups with key informants) in these reports were synthesised for the purposes of the current analysis.

Data from the minimum dataset

As noted earlier, the minimum dataset was developed to gather common, basic information from all Access to Allied Health Services projects. Specifically, it collects information that provides a picture of the number of people accessing services through the projects, a description of their socio-demographic and clinical characteristics, and an overview of the services they are receiving. All data are de-identified.

Divisions vary in their method of providing data to the national database. While the majority are entering data directly, some are utilising other databases in formats such as Excel and Access and uploading data to the minimum dataset, typically doing so on a monthly basis.

Table 1 shows the number of Round 1 pilot and supplementary projects represented in the minimum dataset, as at 31 May 2004. It can be seen that 21 of the 29 Round 1

projects (72%) are represented in the minimum dataset. These are made up of 13 of the 15 pilot projects (87%), and 9 of the 14 supplementary projects (64%). Projects in Victoria, New South Wales, Queensland, Western Australia, South Australia and the Northern Territory are represented, but those in Tasmania and the Australian Capital Territory are not.

Table 1: Overview of Access to Allied Health Services projects submitting data to the minimum dataset (Round 1 pilot and supplementary projects only)

State	Pilot projects	Supplementary projects	Total projects
VIC	5	5	10
NSW	2	3	5
QLD	3		3
WA	1	1	2
SA/NT	2		2
Total	**13**	**9**	**21**

For the purposes of the current report, data were extracted from the minimum dataset and analysed using SPSS (Version 12). All data are presented as simple frequencies and percentages.

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

Relevant documentation from the Round 1 pilot and supplementary projects indicates that the projects are operating under a range of models, with many drawing on elements from several models. The models differ in terms of referral mechanisms, means of retaining allied health professionals and location of allied health professionals:

- **Referral mechanisms:** The simplest referral mechanisms involve systems whereby the Division distributes vouchers to participating GPs who, in turn, give them to 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. More complex referral mechanisms involve an agency (either the Division or a contracted third party) acting as a broker. GPs refer to this agency, which then allocates the referral to a specific allied health professional, sometimes using prioritisation or matching criteria. An intermediate model, which represents a compromise between the two, is a system whereby a register that profiles eligible allied health providers is provided to participating GPs, who can then make their own decisions about referral.

- **Means of retaining allied health professionals:** Some allied health professionals are directly employed by the Division, but the majority are retained under some sort of contract or memorandum of understanding. In most cases, contracts are with individual providers, but some Divisions have elected to enter into contracts with agencies.

- **Location of allied health professionals:** Some allied health professionals provide services to the pilots in rooms at the GPs' practices; others have provided services at their own premises, and still others have provided services at a third location.

In the main, the range of models is similar to that described in the First Interim Evaluation Report.[1] However, some pilot projects have made adjustments to their models to cater optimally for emerging local need. The supplementary projects have drawn on the lessons learned in the pilot projects, adapting the early models for use in their own contexts.

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

Table 2 shows the level of uptake of the Access to Allied Health Services projects, as reflected in participation by referring GPs, allied health professionals providing services, and referred consumers. Specifically, it presents data on the numbers of each in the Round 1 pilot and supplementary projects, drawing on data from the minimum dataset and on the local evaluation reports.

The minimum dataset suggests that, in total, 710 GPs have referred 3,476 consumers to 160 allied health professionals (primarily psychologists). When compared with the figures from the local evaluation reports, this would appear to be something of an underestimate, since the latter source suggests that the figures are 926 referring GPs, 229 allied health professionals (again, primarily psychologists) and 3,656 consumers. In other words, the minimum dataset may be underestimating the uptake of the projects by somewhere between 5% and 13%, depending on the indicator. The discrepancy may be partially explained by the fact that cut-off point for the minimum dataset data available for the current report was 31 May 2004, whereas the cut-off point for evaluation reports was 30 June 2004. A more significant contributor to the difference is probably the fact that 18% of Round 1 pilot and supplementary projects are not yet represented in the minimum dataset. Having said this, once the minimum dataset reaches a point where it comprehensively represents all projects, it is likely to provide a more accurate estimate of uptake than the local evaluation reports, since the units of counting will be common across all projects.

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

		Pilot projects		Supplementary projects		Total Round 1 projects	
		Minimum dataset[a]	Evaluation reports[6]	Minimum dataset[a]	Evaluation reports[6]	Minimum dataset[a]	Evaluation reports[6]
Referring GPs		318	493	392	433	710	926
Allied health professionals	**Psychologists**		144		35		179
	Social workers		7		1		8
	Occupational therapists		5		2		7
	Psychiatric nurses		9		2		11
	Not reported		23		1		24
	Total	99	188	61	40	160	229
Referred consumers		2,101	2,036	1,375	1,620	3,476	3,656

a. Data as at 31 May 2004
b. Data as at 30 June 2004

It is clear that since the First Interim Evaluation Report[1] there has been a clear growth in the initiative, both in terms of referral and service provision by GPs and allied health professionals, and in terms of service utilisation by consumers. At 30 September 2003 (the cut-off date for local evaluation reports from the pilot projects to be included in the First Interim Evaluation Report[1]), 136 GPs had referred 2,036 consumers to 136 allied health professionals. With the passage of nine months, and a near-doubling of the number of projects, these figures have increased considerably. Depending on whether

the minimum dataset or the evaluation reports are taken as the gold standard, the number of referring GPs has increased by 83-139%, the number of allied health professionals by 18-68%, and the number of consumers by 71-80%. These data, and qualitative information from the local evaluation reports, indicate that whereas Divisions undertaking pilot projects often took a number of months to establish the infrastructure necessary to ensure the smooth running of the projects, Divisions responsible for the supplementary projects have learnt lessons from their predecessors and have been able to 'hit the ground running'. Similar growth is expected to be observed for the Round 2 projects that are currently underway, and for the Round 3 projects that are about to start.

Chapter 5: Who is accessing services through the projects?

Socio-demographic characteristics

The minimum dataset provided a breakdown of consumers accessing the Round 1 pilot and supplementary projects by age/sex, language spoken at home, language, Aboriginal and Torres Strait Islander status, socio-economic status and residential circumstances.

Age/sex

Data on age/sex were available for 3,104 consumers. Of these, 2,261 (73%) were female and 843 (27%) were male. These consumers' ages ranged from six to 90 years, with a mean of 40 years.

Language

Language has been identified as a particular barrier to accessing psychological services given the dependence on good communication to deliver such services effectively.

Table 3: Language spoken at home by consumers receiving services through the Round 1 pilot and supplementary projects (n=2,808)

	Frequency	Percent
Afrikaans	2	0.1
Cantonese	7	0.2
Chinese	1	0.0
Croatian	5	0.2
Danish	1	0.0
Dari	1	0.0
Dutch	3	0.1
English	2,697	87.4
Filipino	2	0.1
French	3	0.1
German	3	0.1
Greek	10	0.3
Hebrew	1	0.0
Hindi	1	0.0
Indonesian	4	0.1
Italian	20	0.6
Macedonian	1	0.0
Maltese	3	0.1
Mandarin	2	0.1
Russian	3	0.1
Serbian	1	0.0
Slovak	1	0.0
Spanish	10	0.3
Tongan	1	0.0
Turkish	22	0.7
Vietnamese	1	0.0
Yugoslavian	2	0.1
Unknown	278	9.0
Total	3,086	100.0

Language spoken at home was recorded in the minimum dataset for 3,086 consumers, and a breakdown of the listed languages is provided in Table 3. Eighty seven per cent of all consumers spoke English at home, but a variety of other languages were spoken by the remainder, with Italian and Turkish being the most common. Language was recorded as 'unknown' for 9% of consumers.

Simply ascertaining whether the person speaks a language other than English does not indicate how well the consumer will be able to participate in a consultation with a GP or allied health professional. The minimum dataset also collects information on the English proficiency of consumers, as judged by the referring GP. These data were available for 249 of the consumers who spoke a language other than English at home. The majority were considered to speak English 'well' or 'very well' (88%), as judged by their GP. However, 12% spoke English 'not well' or 'not at all'.

Taken together, these figures tell an important story. The fact that a number of languages other than English were spoken at home by consumers is positive. Seven projects (located in Victoria, Queensland, Western Australia and South Australia) have specifically targeted consumers from culturally and linguistically diverse backgrounds, providing a service to those who would otherwise encounter difficulty in accessing psychological services due to language barriers. These projects have employed a range of innovative approaches, including provision of services by bilingual allied health professionals. While this is clearly an achievement, there would appear to be scope for the projects to increase their efforts in this regard, as members of different language groups would appear to be under-represented in the above figures.

Aboriginal and Torres Strait Islander origin

Aboriginal and Torres Strait Islander consumers may experience a range of hurdles when trying to access psychological services, particularly cultural barriers. The minimum dataset collects data on whether consumers identify as being from Aboriginal or Torres Strait Islander descent, and a response was available for all 3,177 consumers. Table 4 shows that, overall, 2% of all consumers were classified as being of Aboriginal or Torres Strait Islander origin.

Table 4: Aboriginal and Torres Strait Islander origin of consumers receiving services through the Round 1 pilot and supplementary projects (n=3,177)

	Frequency	Percent
Yes	54	1.7
No	2,263	72.5
Unknown	860	27.5
Total	3,123	100.0

Divisions implementing the Access to Allied Health Services projects which are located in catchment areas that have a large Aboriginal and Torres Strait Islander populations are tailoring their services to the needs of these consumers in order to reduce these barriers and facilitate access. Ten Divisions in Victoria, New South Wales, Western Australia, South Australia and the Northern Territory are providing access to psychological services for consumers who are of Aboriginal or Torres Strait Islander origin.

Socio-economic status

Financial cost has traditionally been a barrier for many of those attempting to access psychological services, and the Access to Allied Health Services projects have been specifically designed to overcome this barrier. The minimum dataset includes two fields

that permit a profile to be constructed of the socio-economic status of consumers who are receiving services through the projects.

The first is a field that asks the referring GP to make a judgement about the income level of the consumer, taking into account comparative levels of income and evidence that the person is a Health Care Card holder or pensioner. Examination of data presented in Table 5 reveals that 58% of those consumers accessing psychological services through the Round 1 pilot and supplementary projects were judged by their GP to be low-income earners.

Table 5: Income level of consumers receiving services through the Round 1 pilot and supplementary projects (n=3,238)

	Frequency	Percent
Yes	1,853	57.2
No	604	18.7
Unknown	781	24.1
Total	3,238	100.0

The second is a field that ascertains the highest level of education achieved by the consumer. Table 6 indicates that over half of the consumers (56%) who have received services through the pilot and supplementary projects have not completed secondary education to Year 12.

Table 6: Highest level of education achieved by consumers receiving services through the Round 1 pilot and supplementary projects (n=2,121)

	Frequency	Percent
Primary or below	99	4.7
Year 10	755	35.6
Year 11	343	16.2
Year 12	424	20.0
Tertiary	500	23.6
Total	2,121	100.0

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

Residential circumstances

The minimum dataset includes a field that describes the consumer's residential circumstances, in terms of whether he or she lives alone. This was intended as a proxy measure of whether the consumer has care or support at home, but it is acknowledged that the availability of support does not guarantee that such support is provided nor the quality and benefit of such support. Information on residential circumstances was available for 3,240 consumers, of whom 14% were found to live alone (see Table 7).

Table 7: Residential circumstances of consumers receiving services through the Round 1 pilot and supplementary projects (n=3,240)

	Frequency	Percent
Lives alone	440	13.6
Does not live alone	1,901	58.7
Unknown	899	27.7
Total	3,240	100.0

Clinical characteristics at the point of referral

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

Diagnosis

All components of the Better Outcomes in Mental Health Care Initiative, including the Access to Allied Health Services component, prioritise access to specialist mental health services for consumers with high prevalence disorders such as depression and anxiety. For the purposes of referring a consumer to a given project, GPs are asked to provide a one or more diagnoses within the ICD-10 primary care diagnostic categories: Chapter V Primary Care Version Brief Version (with amended categories).[2] These diagnoses are recorded in the minimum dataset, with multiple responses permitted.

Table 5 shows that the clear majority of consumers accessing psychological services through the Access to Allied Health Services projects have been diagnosed with depression (77%) and/or anxiety (55%) by their GP at the point of referral, suggesting that the projects are correctly targeting consumers to meet the objectives of the initiative and to prioritise access for consumers who will benefit most from psychological services.

Table 8: ICD-10 diagnosis of consumers receiving services through the Round 1 pilot and supplementary projects (n=2,897, multiple responses permitted)

	Frequency	Percent
F1 Alcohol and drug use disorders	135	4.7
F2 Psychotic disorders	32	1.1
F3 Depression	2,221	76.7
F4 Anxiety disorders	1,582	54.6
F5 Unexplained somatic disorders	86	3.0

Current psychotropic medication

The Access to Allied Health Services projects are aimed at providing non-pharmacological forms of treatment by non-medical mental health specialists. The minimum dataset collects information on whether consumers are taking psychotropic medication, and if so, what type (with multiple responses permitted). In total, 1,683 consumers (48%) were taking psychotropic medication at the point of referral to the Round 1 pilot and supplementary projects. This suggests that the projects are providing focused psychological strategies both as an adjunct to, and as an alternative to, pharmacological therapies.

Of the 1,683 consumers receiving psychotropic medication, 92% were receiving antidepressants, 11% benzodiazepines and/or anxiolytics, 4% phenothiazines and major

tranquillisers, and 2% mood stablilisers. This is consistent with the diagnostic information presented above, suggesting that the majority of consumers who are accessing services through the projects are experiencing depression and anxiety disorders.

Psychiatric service history

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

Table 9 shows that 40% of consumers had not previously received specialist mental health care. While some of these consumers may have no previous need to access mental health care, this finding suggests that the projects are improving access for at least some consumers who would otherwise have experienced barriers.

Table 9: Previous receipt of specialist mental health care by consumers receiving services through the Round 1 pilot and supplementary projects (n=3,002)

	Frequency	Percent
Yes	821	27.3
No	1,199	39.9
Unknown	982	32.7
Total	3,002	100.0

Focused psychological strategy for which referral was made

The minimum dataset collects information on the particular focused psychological strategy for which the consumer was referred, permitting multiple responses. Data were available for 2,632 consumers, and Table 10 shows the results. Specifically, it shows that the most common referral was for diagnostic assessment (62%), followed by cognitive interventions (59%) and other cognitive behavioural therapy (behavioural interventions (44%) and relaxation strategies (31%)).

Table 10: Focused psychological strategy for which referral was made for consumers receiving services through the Round 1 pilot and supplementary projects (n=2,632, multiple responses permitted)

	Frequency	Percent
Diagnostic assessment	1640	62.3
Psycho-education	986	37.5
CBT - Behavioural interventions	1156	43.9
CBT - Cognitive interventions	1552	59.0
CBT - Relaxation strategies	805	30.6
CBT - Skills training	512	19.5
Interpersonal therapy	405	15.8
Other	10	0.4

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

Treatment characteristics

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

Number of sessions

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

According to the minimum dataset, the total number of sessions received to date by consumers in the Round 1 pilot and supplementary projects was 8,678. The mean number per consumer was 2.5. It should be noted that these figures represent an underestimate, as many Divisions do not receive information on a given consumer's sessions until he/she completes the full six.

The number of sessions per consumer varied from one to 24. Of the 3,476 consumers accessing psychological services through the Access to Allied Health Services projects, 205 (6%) have been re-referred, following review by their GP, to receive an additional six sessions.

Duration of sessions

Data were available from the minimum dataset on the duration of 8,514 sessions. As Table 11 shows, the majority of these (71%) were 46-60 minutes in length. Shorter sessions of 0-30 minutes and 31-45 minutes were provided in 9% and 11% of instances, respectively. Longer sessions in excess of one hour were made available in 9% of cases.

Table 11: Duration of sessions provided through the Round 1 pilot and supplementary projects (n=8,514)

	Frequency	Percent
0-30 mins	749	8.8
31-45 mins	952	11.2
46-60 mins	6,053	71.1
>60 mins	760	8.9
Total	8,514	100.0

Format of sessions

Data were available on session format for 8,523 sessions. The vast majority of these sessions involved the provision of individual treatment (99%), with only 1% consisting of treatment provided in a group format. Group sessions are currently being provided by four Round 1 pilot and supplementary projects.

Content of sessions

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

The minimum dataset provided an insight into the content of 7,949 sessions. Table 12 shows that the most common interventions were CBT-based cognitive and behavioural interventions, provided at 55% and 40% of all sessions, respectively. Each of the remaining focused psychological strategies were provided in approximately one-fifth of sessions.

Table 12: Content of sessions provided through the Round 1 pilot and supplementary projects (n=7,949, multiple responses permitted)

	Frequency	Percent
Diagnostic assessment	1,610	20.3
Psycho-education	1,974	24.8
CBT - Behavioural interventions	3,247	40.8
CBT - Cognitive interventions	4,361	54.9
CBT - Relaxation strategies	1,750	22.0
CBT - Skills training	1,492	18.8
Interpersonal therapy	1,669	21.0

It is worth considering the focused psychological strategies that consumers have been receiving, in the light of those for which they were referred (as shown in Table 10). Of note is the fact that 62% of consumers were referred for diagnostic assessment, whereas only 20% of sessions were devoted to this activity. A likely explanation for this is the fact that diagnostic assessment occurred in the first session, leaving up to five other sessions for therapeutic interventions. In the main, consumers seem to have been delivered the focused psychological strategies for which they were referred, with cognitive and behavioural interventions featuring prominently in the referral data and in the session content data.

Cost to the consumer

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

Information on co-payments was available from the minimum dataset for 3,454 sessions. Table 13 shows that in the majority of these sessions (76%), a co-payment was not collected. Where a co-payment was collected, the minimum was $5 and the maximum was $65. Most commonly, co-payments were at the lower end of this scale, with 7% of all sessions costing the consumer $5 and 11% costing between $6 and $10. This clearly suggests that the Access to Allied Health Services projects are effectively removing financial barriers to specialist mental health care.

Table 13: Consumer co-payments for sessions provided through the Round 1 pilot and supplementary projects (n=3,454)

	Frequency	Percent
No co-payment	2,634	76.3
$5	225	6.5
$6-$10	365	10.6
$11-$15	70	2.0
$16-$20	61	1.8
$21-$25	65	1.9
$26-$30	7	0.2
$31-$35	8	0.2
$60-$65	19	0.6
Total	3,454	100.0

Chapter 7: What are the advantages and disadvantages of the projects?

The majority of evaluation reports from the Round 1 pilot and supplementary projects included qualitative information from focus groups, key informant interviews and surveys that explored the advantages and disadvantages of the projects for GPs, allied health professionals, consumers and Divisions. Key themes from these qualitative data are explored and elaborated here.

Advantages for GPs

Upskilling of GPs in mental health

In order to participate in the Access to Allied Health Services projects, GPs must complete Level 1 Training. Consistent with the findings reported in the First Interim Evaluation Report,[1] the current analysis found that GPs involved in the Round 1 pilot and supplementary projects report that this has increased their knowledge and understanding of psychological issues. GPs also note that the training has increased their confidence with respect to managing the care of consumers with mental health issues. The interactive component of the training in the form of case studies has been particularly appreciated by some GPs. There have been suggestions that the training should be more advanced in the future, and could potentially include more input from specialists.

New referral choices for GPs

The local evaluation reports from the Round 1 pilot and supplementary projects suggest that GPs are attracted to the projects because they have a genuine desire to provide a high level of service to consumers with mental health problems but have previously found it difficult to provide appropriate care themselves, and have struck problems with limited referral options. The Access to Allied Health Services projects are seen by many GPs as providing a range of appropriate referral choices. Specifically, they appreciate the fact that in referring a consumer to an allied health professional, they can be confident that the consumer will receive high quality, affordable care. They are also sanguine about the fact that the referral does not mean that they lose contact with the consumer, but rather that they remain involved in his or her care because the consumer comes back to them for review.

In the First Interim Evaluation Report,[1] the observation was made that GPs saw different advantages in different referral models. Those who were exposed to voucher-type systems appreciated the fact that they could refer consumers directly and quickly, and those who were involved in brokerage-type systems were positive about the quality of care facilitated by the process of carefully matching consumers and allied health professionals. The current analysis showed that several pilot and supplementary projects have modified their referral models to provide ‘the best of both worlds’, providing GPs with registers that profile eligible allied health professionals in terms of their qualifications and skills, thereby allowing the GP to select the allied health professional who can best meet the needs of the given consumer. Such registers were originally held by the Division or a third party, which acted as a broker. This has largely been in response to feedback from GPs indicating a strong preference for being able to refer directly to the allied health professional.

A structured approach

Many GPs view the referral process as part of a broader approach to providing mental health care, and appreciate its structure and holistic nature. Several of the local evaluation reports from the Round 1 pilot and supplementary projects reported, for example, that GPs were positive about the 3 Step Mental Health Process. Specifically, they noted that it provides them with a framework, and acts as a prompt in their consultations with consumers with mental health problems. Likewise, a number of the local evaluation reports observed that GPs saw the virtues of the six-session limit on care provided by allied health professionals, while at the same time appreciating the facility to refer a consumer for an additional six sessions after review, if necessary.

Improved collaboration between GPs and allied health professionals

Evaluation reports from both the pilot and supplementary projects funded in Round 1 suggest that that communication between GPs and allied health professionals has increased, creating a mutual appreciation of the role of each in mental health care, and improved collaboration between the two. This confirms similar findings in the First Interim Evaluation Report,[1] and highlights the fact that, prior to the Better Outcomes in Mental Health Care initiative, there were few formal opportunities for GPs and allied health professionals to work together.

Location of service delivery by allied health professionals

Consistent with the First Interim Evaluation Report,[1] GPs continue to express support for allied health professionals providing services at their practices, as colleagues rather than as more distant referral points. From the GP's perspective, this arrangement promotes collaboration between providers. It also simplifies the process of the consumer returning for review after the final session, thereby reducing the likelihood of non-attendance, and circumventing problems of GPs not being recompensed for their time (see below).

Increased support for GPs from Divisions

The Round 1 pilot and supplementary project evaluation reports show that, over time, GPs have become increasingly satisfied that the projects are viable and ongoing. To a large extent, this reflects a growing acknowledgement that Divisions have the capacity to manage these projects. In the main, GPs appear to be very content with the continuing support Divisions are providing with regards to setting up and maintaining referral systems, visiting practices and informing GPs of new developments. There is also a recognition that, over time, Divisions have become more tuned in to the needs of GPs (and allied health professionals and consumers), and an appreciation of the efforts of Divisions to modify projects in response to feedback. These findings represent a shift from those reported in the First Interim Evaluation Report,[1] where the initiative was newer and Divisions were 'finding their feet' in terms of managing the Access to Allied Health Services projects.

Disadvantages for GPs

Barriers to participating in education and training

The First Interim Evaluation Report[1] observed that some GPs were discouraged from participating in the Access to Allied Health Services Projects because they held negative views about the education and training component of the Better Outcomes in Mental Health Care initiative (a pre-requisite for participation in the projects). Criticisms included the fact that the training was viewed as time consuming and somewhat simplistic. These problems are ongoing, with later evaluation reports noting that GPs are negative about the discrepancy between the stringent training requirements of the Access to Allied

Health Services projects and the lack of such requirements in alternative initiatives, such as the More Allied Health Services projects.

Confusion about how the projects operates

When the First Interim Evaluation Report[1] synthesised information from the local evaluation reports of the Round 1 pilot projects, it was apparent that GPs were experiencing some confusion with the early operation of these projects. Specifically, there were difficulties associated with referral systems (e.g., the information required by Divisions and allied health professionals at the point of referral), and misunderstandings about whether they could refer consumers for a further six sessions. The later local evaluation reports of the pilot projects do not focus on the earlier set backs, and suggest that there is greater clarity with respect to how the projects operate.

The local evaluation reports of the Round 1 supplementary projects (which are at an earlier stage of development) paint a slightly different picture. Although these projects have drawn on lessons from their earlier counterparts, participating GPs are still experiencing some confusion. For example, some evaluation reports suggest that GPs are unclear about how these projects differ from other initiatives (e.g., the More Allied Health Services projects across Australia, and the Primary Mental Health Teams in Victoria), in terms of the services they provide and the requirements for GP participation.

Lack of flexibility

Balanced against the structure provided by the Access to Allied Health Services projects (noted as an advantage in the previous section), is a perceived lack of flexibility. This was noted in the First Interim Evaluation Report,[1] and manifested itself in complaints about the degree of paperwork and red tape, which were seen by GPs as barriers to referring consumers. This was viewed as particularly problematic in situations where the projects required information to be recorded and submitted in one form, where it was already recorded in another form elsewhere (e.g., in the consumer's file or in Medical Director). GP dissatisfaction in this regard is exacerbated when they make comparisons with the less rigorous administrative and structural requirements of initiatives such as the More Allied Health Services program.

Many pilot projects have changes to the referral processes in order to streamline this aspect of the projects (and many supplementary projects have adopted the later systems), which the paperwork requirements of the 3 Step Mental Health Process are still essential for referral to the program. As a result, lack of flexibility is still seen by some GPs to be a problem. GPs continue to make comments like *'My opinion of the program is that the concept is excellent, but the paperwork required is a big turn off. I think that only the most motivated of doctors and patients are prepared to work through the fairly inflexible process. Filling out the Mental Health Assessment and Mental Health Plan takes at least two long consultations before the patient can be referred to one of the… psychologists.'* However, such comments are tempered by the views of those with longer involvement in the process, who make statements like *'The paperwork is not so bad once you have done a few – I realise that I do all this anyway, just the format is new'* and *'Any GP who can't do the paperwork in the 3 Step Mental Health Process should not be practising.'*

An additional issue regarding flexibility, raised more recently in the local evaluation reports of the supplementary projects, is the requirement that an outcome tool such as the Kessler-10 (K10) be used. Some GPs have expressed the opinion that this requirement is an insult to their clinical abilities, and that such instruments miss a lot of detail that would be gleaned in discussion with the consumer. Some GPs have also commented that the recognised outcome tools are not 'user friendly', being too time consuming to administer, and not in keeping with their clinical practice style.

Limited referral capacity

Because the funding provided to a Division (or Divisions) to conduct an Access to Allied Health Services project is finite, the total number of services that can be provided to consumers is effectively 'capped' at a certain point. Depending on the number of GPs involved, a given GP will be limited in the number of referrals he or she can make to allied health professionals associated with the project. Chapter 4 showed that, according to the minimum dataset, 710 GPs had referred 3,476 consumers to the Round 1 pilot and supplementary projects (i.e., an average of 4.9 referrals per GP). When the local evaluation reports were used as the data source, 926 GPs had referred 3,656 consumers (i.e., an average of 3.9). Either way, the average number of referrals is limited.

The local evaluation reports from the Round 1 pilot and supplementary projects suggest that these referral limitations have led to disenchantment among GPs. Many have expressed disappointment that they are not going to be able to gain the level of support that had been conveyed to them during the promotion of the initiative. Some feel that they were misled about their capacity to make referrals, and that the capping of referrals should have been made clear to them at the outset. Many GPs have noted that the available number of referrals does not reflect consumer need, making statements like *'Only being able to refer a few people is an enormous stress and it would be better not having a service at all'.* Several GPs have observed that they will not benefit as much financially as they originally thought they would, and have commented that the potential rewards are not commensurate with the amount of training they are required to complete in order to be eligible to make referrals.

As noted, the implication of a capped budget on the number of referrals was not initially apparent, and some projects expended their original budget allocations before the end of the given funding period. As time has progressed, the projects have responded to the problem in different ways. For example, some have issued batches of referral forms, in order to keep track of the potential number. Under these circumstances, a given GP is issued with a certain number of forms, and once these have been used he or she must make an application for further supplies. The success of the application will depend on other GPs' needs and the waiting time for a service. GPs have commented that this rationing may have negative consequences with regard to the acceptance and appreciation of the initiative.

Some GPs do not receive the Service Incentive Payment

In drawing together the findings from the local evaluation reports of the Round 1 pilot and supplementary projects, it was apparent that the system of Service Incentive Payments continues to present problems initially identified in the First Interim Evaluation Report.[1] Service Incentive Payments are triggered by the consumer returning to the GP for a review after six sessions with the allied health professional. If the consumer fails to return for the review session, GPs potentially face loss of income. In the local evaluation reports, it was not uncommon to read comments from GPs like *'I have not had a patient come back for the review so I have not been able to claim the … [Service Incentive Payment] … yet. The downside of course is that doctors do not get Medicare payment until after the review, but I am willing to forgo that just to make referrals easier and timelier. I am sure most of the GPs would prefer to do an assessment in their own way and not to filling a lot of forms, i.e., the referral process needs to be more flexible.'*

The pilot and supplementary projects have taken some steps to try to overcome this problem. For example, in one supplementary project allied health professionals are working closely with GPs to ensure that consumers return for the review session, and this has proved successful. GPs associated with other projects have elected to bulk-bill the review session, because they believe that some consumers may be reluctant to return for

the review if they will be out-of-pocket, particularly if they feel that their problem has been resolved. Training in the 3 Step Mental Health Process has also been revised to educate GPs in the importance of explaining the importance of the review to consumers.

Impact on GPs' case loads

Evidence from the local evaluation reports of the Round 1 pilot and supplementary projects suggests that GPs are concerned about the impact of the projects on their case loads. On the one hand, some GPs who are not registered with the initiative report that they fear they will lose consumers to those who are registered and therefore able to refer them to an allied health professional. They cite instances, for example, where consumers have sought advice from the project as to which GPs are registered to refer, and have changed practices on that basis. Some hold the view that they should not have to do extra training in order to make referrals.

On the other hand, some GPs who are registered with the initiative have expressed a desire for the Division (or Divisions) responsible for the given project to withhold their names from members of the public enquiring as to which GPs are eligible to make referrals. These GPs fear that they may be inundated with consumers with mental health problems, and believe that this would increase their workloads.

Advantages for allied health professionals

Improved relationships with GPs

Consistent with the findings of the First Interim Evaluation Report,[1] one of the key benefits of the Access to Allied Health Services projects for allied health professionals would appear to be improved relationships with GPs. As the pilot projects progress, and the supplementary projects evolve, mutually beneficial relationships are continuing to develop between GPs and allied health professionals. In the local evaluation reports, psychologists in particular reported that they are able to demonstrate to GPs that they have a variety of specialist skills (especially in the area of cognitive behavioural therapy) that can assist a range of consumers. Many of the allied health professionals involved in the pilot projects stated that the initiative has *'… legitimated the relationship between social workers, psychologists and GPs. It has formalised the relationship, built bridges, enabled a more holistic approach and been very valuable.'* Allied health professionals involved in the supplementary projects also see the potential for these relationships to develop, making statements like *'[It's] a terrific opportunity for allied health professionals to engage with GPs. Allied health professionals tend to work too much in isolation and this will promote dialogue between health professionals.'*

Increased referral base

As was the case in the First Interim Evaluation Report,[1] allied health professionals continue to report that participation in the Round 1 pilot and supplementary projects has increased their referral base. Allied health professionals have found this satisfying, not only because of the security of income it affords, but also because it increases the diversity of issues that they encounter in their day-to-day practice. Many have commented that they were particularly pleased to have the opportunity to provide services to those who would not otherwise have been able to access them.

Clinical supervision and professional support

A number of Round 1 pilot and supplementary projects have included clinical supervision of allied health professionals as a key component of their models. Consistent with the findings of the First Interim Evaluation Report,[1] the current analysis found that allied health professionals have responded favourably to the provision of supervision, noting

that it addresses issues of professional isolation. As time has gone on, Divisions conducting these projects have looked for additional ways to support their allied health professionals, including professional development and support, regular meetings with project management, and debriefing groups.

Disadvantages for allied health professionals

Lack of decision-making power

The local evaluation reports of the Round 1 pilot and supplementary projects indicate that although allied health professionals are generally positive about the work opportunities afforded by the initiative, some have encountered difficulties due to a lack of decision-making power. For example, some allied health professionals have commented that the decision to offer a consumer additional sessions beyond the original six rests with the GP. Some GPs, too, are dubious about this arrangement, which they feel places them in the position of telling a trained mental health professional what course of action they should be taking with respect to the consumer's ongoing treatment. Some projects have attempted to overcome this by arranging for allied health professional to be present at the review and/or for the decision about further sessions to be made jointly by the allied health professional and the GP.

Location issues

As noted earlier, the location of services provided by the allied health professionals has varied between, and even within, projects. Some projects have elected to have the allied health professionals provide services in their own rooms, and others have chosen to bring the allied health professionals to the rooms of the GPs. Since the First Interim Evaluation Report,[1] there have been ongoing issues with co-location. Many allied health professionals view co-location positively, noting that it increases opportunities for mutual learning, optimises inter-provider communication, promotes continuity of care, and reduces stigma for consumers. However, there have been instances where appropriate provision has not always been made for the provider in question. Examples have been cited of allied health professionals having to provide counselling services in make-shift offices and even tea rooms, particularly in the early stages of the projects. There have also been situations where allied health professionals have begun their association with the project located within a general practice, but for various reasons the arrangement has not worked out. In these circumstances, the allied health professionals have had to find alternative accommodation which has been disruptive.

Lack of guaranteed work

Local evaluation reports from the Round 1 pilot and supplementary projects point to some concerns on the part of allied health professionals regarding the certainty of work through the projects. Project staff have found it difficult to access information from the HIC as to which GPs are registered to participate in the initiative, and consequently have been hampered in their attempts to estimate the potential workload that the projects might generate for participating allied health professionals. This has created difficulties in recruiting allied health professionals. Some allied health professionals who have agreed to provide services through the projects have expressed disillusionment, saying that they had expected more work and hence are disillusioned. One supplementary project has considered reviewing the number of allied health professionals registered to provide services, as the number of referrals from GPs has not warranted the number currently listed.

Payment issues

Allied health professionals report that there is often a time lag between delivery of services and payment. This is a particular issue for allied health professionals who are contracted to, rather than employed by, Divisions. The problem is exacerbated in projects using a voucher system model, where a substantial period can elapse between when the voucher is given to the consumer and when the sessions have been completed and the allied health professional is able to lodge an invoice for payment.

In addition, allied health professionals do not receive payment if a consumer fails to attend a session. Allied health professionals have observed that non-attendance is not uncommon among the consumer group for whom they are providing care. Some projects have attempted to overcome this by tailoring services to the needs of consumers, to maximise their likelihood of keeping appointments. For example, the allied health professionals involved in a project serving an area with a significant Aboriginal population attended local meetings to seek advice about how best to meet the community's needs. As a result, the allied health professionals' services are provided at three Aboriginal health clinics, where consumers feel comfortable.

Distance and travel time for rural allied health professionals

The distances and travel time required by rural allied health professionals, identified as a problem in the First Interim Evaluation Report,[1] continues to be an issue for the pilot and supplementary projects. As an example, an allied health professional participating in one project has had to travel 165 kilometres to provide focused psychological strategies. Various steps have been taken to ameliorate this problem, such as locating the allied health professional between two rural towns to save on cost and driving time.

Advantages for consumers

Ready access to psychological services

Prior to the implementation of the Access to Allied Health Services projects, there were two ways that consumers could receive specialist mental health care. The first was through private providers (e.g., private psychologists), for which they would be out-of-pocket. The second was through public sector services, which might not be optimally appropriate to their needs. Both might involve waiting times.

Consistent with the findings of the First Interim Evaluation Report,[1] stakeholders who were consulted as part of the ongoing evaluation process unanimously agreed that the Round 1 pilot and supplementary projects have improved access to psychological services for consumers who would otherwise be missing out. GPs have applauded the fact that they are now able to refer consumers who would otherwise have struck financial barriers, making comments like *'This is great as it allows some of my patients to access care that they would otherwise not be able to afford.'* Consumers, too, are grateful for the availability of services that are not prohibitive in terms of cost, making statements such as *'Financial costs would have limited my options i.e. would have had to find (and wait for) available help at reduced rates."*

Consumers accessing services through both the pilot and supplementary projects have been especially pleased that they can access these services with minimal delays. Waiting times in most projects are short, with consumers usually being seen by the allied health professional within a week or two of the referral being made.

High quality care

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

Satisfaction with care

A recurrent theme in the local evaluation reports from the Round 1 pilot and supplementary projects is that consumers are satisfied with the care they are receiving through the projects. Through interviews, focus groups and patient satisfaction questionnaires, consumers have commented on different aspects of their care. They appreciate the opportunity to receive a non-pharmacological form of treatment and discuss their problems with a mental health specialist, some contrasting the positive experience of seeing an allied health professional with previous negative experiences with psychiatrists. They are pleased to access care at no cost, or at a low cost. Generally, they have observed that waiting times are reasonably short. Those who have attended the allied health professional in the GP's rooms have noted that this is convenient and minimises the stigma associated with seeking mental health care.

One particular aspect with which consumers have viewed particularly positively is the multidisciplinary approach whereby both the GP and the allied health professional combine their unique abilities to help the recovery process. Good communication between the two has reduced the often-frustrating requirement that consumers 'retell their story' to different providers. This communication has not occurred at the expense of consumer confidentiality; in fact, the opposite is true. In most projects, consumers explicitly agree to their information being shared between the GP and the allied health professional, often signing consent forms that formalise this agreement. Some projects have taken extra steps to protect consumer confidentiality, particularly in instances where the given service delivery model requires identifiable consumer details to be handled by Divisional staff. For instance, one project allows no faxing of consumer information; all documents containing such information are posted to the program manager marked 'confidential'.

Improved outcomes of care

The early local evaluation reports from the Round 1 pilot projects generally did not systematically assess clinical outcomes for consumers in terms of improvements on standardised measures, but more commonly asked consumers directly whether they felt they had benefited from care, or asked GPs and allied health professionals to comment on whether they had observed improvements for consumers. This remains true for the later evaluation reports from the pilot projects, and for those from the supplementary projects.

In the few instances where standardised outcome tools have been used in evaluations, they have tended to demonstrate a significant reduction in psychological distress, depression and anxiety over six sessions of therapy, as evidenced by scores on instruments such as the Kessler-10 (K10), the Beck Depression Inventory (BDI), the Beck Anxiety Inventory (BAI), and the Depression Anxiety Stress Scale (DASS). Some project evaluations have sought quantitative data on outcomes from other sources, such as purpose-designed visual analogue scales. Again, these suggest that positive outcomes, such as progress in problem-solving, have been achieved.

The qualitative responses from consumers, GPs and allied health professionals corroborate these findings. Typically, they are generally positive, with informants noting that the practical skills imparted through cognitive behavioural therapy in particular has equipped consumers to deal with current and ongoing difficulties. General practitioners and allied health professionals have made comments like *'[Participating consumers were] happy, expressed gratitude, felt valued, were positive about the experience, have felt empowered, reported positive outcomes and were grateful for being able to access services for little or no money'* and *'[Name] came in today, and I just simply couldn't believe the change in her…'*

Disadvantages for consumers

Inequity of access for consumers

Since the First Interim Evaluation Report[1] compiled data from the early pilot evaluations, pilot and supplementary projects have continued to experience some difficulties with issues of equity. Specifically, these relate to the fact that consumers can only be referred to allied health professionals by GPs who are registered to participate in the Better Outcomes in Mental Health Care initiative. Anecdotal evidence from the local evaluation reports suggests that some non-registered GPs are prepared to refer consumers on to registered GPs so that they in turn can refer them to an allied health professional. However, many unregistered GPs are reluctant to do this, fearing that they may 'lose' the consumer. Consumers themselves have no way of knowing which GPs are registered, since Divisions will not divulge this information. Consequently, there is an inequity of access to services, based on consumers' affiliation with individual GPs or practices. GPs and project managers and staff have warned that this issue is exacerbated by the limitations on the number of referrals available within a given project, and that the problem is likely to escalate as the public becomes more informed about the initiative and demand increases.

Inappropriate referrals

The First Interim Evaluation Report[1] identified inappropriate referrals as a problem for some consumers. Specifically, these consumers felt that their GP selected the name of an allied health professional at random from a list, or simply gave them the option of picking their own provider from a list. In both cases, consumers felt that the choice of provider was not based on their specific problem. Consumers placed importance on the GP being familiar with the allied health professional and making a referral on the basis of his or her capacity to deal with their difficulties.

As noted earlier, a number of pilot projects have modified their referral models so participating GPs are now provided with relatively comprehensive registers of allied health professionals to whom referrals can be made, profiling them in terms of such criteria as specialties and languages spoken. GPs are positive about this change, as it gives them more autonomy over referrals, and it is likely to circumvent the problem of consumers feeling as though referral decisions are being made on an uninformed basis.

Location issues

Evidence from the local evaluation reports of the Round 1 pilot and supplementary projects suggests that some consumers have issues with the location of the allied health professional. The model of locating the allied health professional in the GP's practice is appreciated by many, but some have felt awkward waiting for the allied health professional in the GP's waiting room. Conversely, the model of locating the allied health professional in his or her own rooms is also well received by many, but some have commented on the stigma and lack of familiarity associated with visiting a mental health professional.

Chapter 8: Discussion and conclusions

Interpreting the findings

The 15 pilot projects and 14 supplementary projects funded in Round 1 are now well-established. Information from the minimum dataset and relevant local evaluation reports enables these projects to be described in terms of their models of operation, their level of uptake, who is accessing them, what services they are providing, and their advantages and disadvantages. These findings are summarised below, and lessons that can be drawn from them are discussed. These lessons should inform the future operation of these projects, as well as that of the existing Round 2 projects and the forthcoming Round 3 projects.

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

The Round 1 pilot and supplementary projects are operating under a range of different models, ranging from simple voucher systems to more complex brokerage models. The First Interim Evaluation Report[1] considered the effectiveness of these different models. It noted that GPs appreciate the simplicity and efficiency of the voucher system, but both GPs and allied health professionals feel that it does not promote good inter-professional communication and consumers argue that it means that they are not always referred to the most appropriate provider. The brokerage system, by contrast, is more likely to cause confusion among GPs, but they are willing to accept a more complex system if the advantages to consumers can be clearly demonstrated. GPs, allied health professionals and consumers believe that the brokerage system promotes high quality care (e.g., because it improves collaboration between professionals and ensures a good 'match' between the consumer and the allied health professional).

The First Interim Evaluation Report[1] concluded that, while it was possible to articulate these advantages and disadvantages, there was insufficient evidence to determine whether one model should be favoured over another. This Second Interim Evaluation Report reaches the same conclusion, and acknowledges that the specific choice of model will, to a large extent, depend on local circumstances. It is noteworthy, however, that some of the pilot projects have modified their models, and are now approaching the 'middle ground'. The modified models involve providing GPs with detailed registers which profile allied health professionals in terms of their skills and competencies, thereby enabling GPs to make informed referral decisions themselves. This has the advantage of relative simplicity (like the voucher system), but promotes high quality care (like the brokerage system). Learning from the experiences of the pilot projects, a number of the supplementary projects have adopted this intermediate model as their model of choice.

What is the level of uptake of the projects?

Depending on whether the minimum dataset or the local evaluation reports are used as the authoritative data source, the Round 1 pilot and supplementary projects have involved between 710 and 926 GPs and between 160 and 229 allied health professionals. Together, these providers have enabled between 3,476 and 3,656 consumers to access mental health care which would otherwise have been out of their reach.

These figures are impressive by any standard, and represent a significant increase from the time of the First Interim Evaluation Report.[1] There is evidence that later projects have been able to learn from their earlier counterparts, and have therefore avoided some of the 'setting up' issues that caused delays in the early stages of the initiative. This is positive, because it means that projects are 'going live' and delivering services to consumers more quickly. Having said this, the time and effort required to put the

necessary infrastructure in place is still not insignificant, and should not be underestimated in future projects.

Who is accessing services through the projects?

Consumers accessing services through the Round 1 pilot and supplementary projects are predominantly female, middle aged, English-speaking and of low socio-economic status. The majority have diagnoses of depression and anxiety disorders, about half are taking some sort of psychotropic medication, many have no previous history of using specialist mental health services, and most are being referred for diagnostic assessment and/or CBT-based cognitive and behavioural interventions.

These findings, when considered in more detail, indicate that the projects are reaching the consumers that they are supposed to be targeting. So, for example, since the initiative is designed to provide access to mental health care for people who would otherwise experience cost barriers, it is positive that 58% of all consumers are low income earners and 56% have not completed secondary education to Year 12. Similarly, there is evidence that the projects are attempting to overcome language barriers. Although 87% of consumers speak English at home, a broad range of other languages is represented. Likewise, the initiative is primarily geared to providing services for people with high prevalence disorders, so it is encouraging that the majority of all consumers have been diagnosed with depression (77%) and/or anxiety (55%) by their GP. Perhaps the most significant finding is that 40% of all consumers have no previous history of specialist mental health care, indicating that the projects are reaching people for whom access may have previously been problematic.

What services are consumers receiving through the projects?

In total, the number of sessions of therapy received to date by consumers in the Round 1 pilot and supplementary projects is 8,678. This equates to a mean number of sessions per consumer of 2.5. Most sessions tend to be close to an hour in length, and involve individual treatment. The most common interventions delivered through these sessions are CBT-based cognitive and behavioural interventions. In about three quarters of all sessions, consumers are not required to contribute to the cost of care; in the remainder of cases they are asked to make a co-payment, usually of not more than $10.

These findings suggest that the Access to Allied Health Services projects are being delivered in the way in which they were intended, providing evidence-based mental health care to consumers at minimal or no cost through a series of structured sessions. Qualitative data from the local evaluation reports suggests that the quality of these services is high, as projects have ensured that their allied health professionals are qualified, skilled and well-supported.

What are the advantages and disadvantages of the projects?

GPs and allied health professionals involved in the pilot and supplementary projects are now feeling more satisfied that the initiative is viable and ongoing, and consumers are benefiting. Benefits observed by GPs include improved collaboration with allied health professionals, new skills and knowledge in the area of mental health, a structured approach to the provision of mental health care, and new referral options. Benefits observed by allied health professionals include improved relationships with GPs, an increased referral base, and clinical supervision and professional support. Consumers are benefiting from ready access to high quality care, which is leading to increased satisfaction with care and improved outcomes of care.

Despite these positives, GPs and allied health professionals have experienced some barriers to participation. For GPs, some of these barriers are attitudinal, and relate to

perceptions that the benefits of participation outlined above may not outweigh potential costs (e.g., time spent on training, time spent on completing the 3 Step Mental Health Process). Some GPs are still confused about how the projects operate; others understand their operation, but have concerns about aspects such as a perceived lack of flexibility, limited referral capacity, payment issues and the impact on their caseloads. For allied health professionals, there are logistical concerns such as location and payment issues, and, for some, issues with distance and travel time. Some allied health professionals also have concerns about the lack of decision-making power vested in them as clinicians. For consumers, there are some referral issues (particularly to do with inequities regarding who gets referred) and some location issues.

Implications for ongoing evaluation efforts

This Second Interim Evaluation Report has drawn on information from the implementation and evaluation reports from the first 29 projects funded under Round 1 of the Access to Allied Health Services projects, as well as the most recent statistics from the minimum dataset, to describe the projects' current status and to provide some lessons for future projects. As noted earlier, 40 additional projects received funding in Round 2. Thirty three further projects will shortly be funded in Round 3.

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

The minimum dataset has assisted to some extent in this regard. All projects have access to the minimum dataset and the majority have been able to enter consistent consumer-level information, which has enabled a description of who is accessing allied health care, and what sort of care they are receiving. Ongoing national evaluation work will continue to expand on this information, particularly with the inclusion of projects that received funding in Round 2 (and later, Round 3).

The current report has focused mainly on structures, processes and uptake of the Access to Allied Health Services projects. Impacts have been considered too, insofar as the advantages and disadvantages of the projects for GPs, allied health professionals and consumers have been considered. To date, there has been little capacity to consider whether the projects are achieving improved mental health outcomes for consumers. By design, the minimum dataset does not collect consumer-level outcome data, and very few local evaluation reports are doing so. It would be desirable for ongoing national evaluation work to move towards considering the outcomes of the projects for consumers. Local evaluations should be encouraged to collect these data wherever possible, and to do so in a systematic and consistent manner. Combining outcomes data with cost data will enable the effectiveness and efficiency of different models of service provision to be examined.

Conclusion

The models utilised in the Access to Allied Health Services projects have evolved over time, with earlier pilot projects modifying their approaches to best meet the needs of GPs, allied health professionals and consumers, and later supplementary projects learning from the experiences of the pilots. The projects have achieved a high level of participation by GPs and allied health professionals, and reached a significant number of consumers. In general terms, these consumers comprise the target groups that the projects have been designed to reach, in that they would previously have had limited access to specialist mental health care due to barriers such as cost, language and/or

distance. Further, there is evidence that the projects are providing high quality, evidence-based mental health care for these consumers. Like any new initiative, there are some practical and professional issues that need to be addressed. For example, solutions must be sought to the limited number of referrals available to any given GP. However, the continuation and expansion of the initiative should be a high priority for ongoing funding. Likewise, rigorous evaluation efforts should be maintained.

References

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2. World Health Organization. Diagnostic and management guidelines for mental disorders in primary care: ICD-10 Chapter V Primary Care Version. Gottingen: Hogrefe and Huber Publications, 1996.

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

Component 1: Education and training for GPs

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

Component 2: The 3 Step Mental Health Process

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

Component 3: Focused Psychological Strategies

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

Component 4: Access to Allied Health Services

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

health review by the referring GP. Divisions of General Practice act as fundholders in this component of the Better Outcomes in Mental Health Care initiative.

Component 5: Access to Psychiatrist Support

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

Appendix 2: Access to Allied Health Services projects

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

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