



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

Seventh Interim Evaluation Report

**Rural and urban projects:
Similarities and differences**

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

March 2006

Table of contents

EXECUTIVE SUMMARY	2
CHAPTER 1: BACKGROUND	6
CHAPTER 2: METHOD	8
CHAPTER 3: DO THE MODELS OF SERVICE DELIVERY BEING USED IN RURAL AND URBAN PROJECTS DIFFER?	11
CHAPTER 4: DOES THE LEVEL OF UPTAKE OF RURAL AND URBAN PROJECTS DIFFER?	13
CHAPTER 5: DO THE PROFILES OF CONSUMERS ACCESSING CARE THROUGH RURAL AND URBAN PROJECTS DIFFER?	14
CHAPTER 6: DO THE SERVICES CONSUMERS ARE RECEIVING THROUGH RURAL AND URBAN PROJECTS DIFFER?	19
CHAPTER 7: DO CONSUMER OUTCOMES IN RURAL AND URBAN PROJECTS DIFFER?	22
CHAPTER 8: DO THE ISSUES FACED BY RURAL AND URBAN PROJECTS DIFFER, AND DO THE SOLUTIONS TO THESE ISSUES VARY?	25
CHAPTER 9: DISCUSSION AND CONCLUSIONS	37
REFERENCES	40
APPENDIX 1: COMPONENTS OF THE BETTER OUTCOMES IN MENTAL HEALTH CARE INITIATIVE	42
APPENDIX 2: ACCESS TO ALLIED PSYCHOLOGICAL SERVICES PROJECTS	43

Executive summary

Background

Access to and quality of mental health care services have long been recognised as issues in Australia. Access and quality issues may manifest themselves in different ways in rural and urban areas. In rural areas, people may face particular environmental stressors which put them at risk of mental health problems, yet they make less use of general practitioners and specialist mental health services than their urban counterparts for various reasons, including lack of services, fear of stigma in small communities, and financial and travel barriers. In urban areas, people may face different stressors (e.g., lack of a strong sense of neighbourhood), and may face problems with access to and co-ordination of care due to funding and service constraints. The diversity of urban populations may mean that particular groups (e.g., homeless people, people from culturally and linguistically diverse communities) are particularly disenfranchised.

The Better Outcomes in Mental Health Care program has explicitly addressed issues of access and quality by offering GPs training, systemic and professional support, and financial incentives. The Access to Allied Psychological Services component of the program has improved access to high quality services by enabling eligible GPs to refer consumers to allied health professionals for 6+ sessions of evidence-based mental health care, via 108 projects being conducted by Divisions of General Practice.

The current report examines whether access to and quality of services afforded by the Access to Allied Psychological Services projects have differed in rural and urban areas.

Method

Data from a survey of models of service delivery, a purpose-designed minimum dataset and a series of case studies were analysed to answer six evaluation questions:

- Do the models of service delivery being used in rural and urban projects differ?
- Does the level of uptake of rural and urban projects differ?
- Do the profiles of consumers accessing care through rural and urban projects differ?
- Do the services consumers are receiving through rural and urban projects differ?
- Do consumer outcomes in rural and urban projects differ?
- Do the issues faced by rural and urban projects differ, and do the solutions to these issues vary?

Results

Do the models of service delivery being used in rural and urban projects differ?

According to data from the survey on models of service delivery, both rural and urban projects are using a mix of models. There are some notable differences in each of the domains on which models of service delivery differ, however.

In terms of their means of retaining allied health professionals, there was a tendency for rural projects to be more likely than urban projects to directly employ allied health professionals, with 37% of the former doing so compared with only 21% of the latter. There may be a number of reasons for this, but the retention preferences of allied health professionals in areas characterised by distance and isolation would seem to be paramount. Whereas in urban projects many allied health professionals will have existing private practices and will contract with projects to provide services on a part-time

basis, in rural projects it may only be possible to attract some allied health professionals to the area if guaranteed employment is provided.

Rural and urban projects also differ in terms of the location of their allied health professionals, with the former tending to be less likely to have allied health professionals providing services from their own rooms (53% versus 72%). Again, one reason for this may relate to the fact that alternative service provision options may be less available for allied health professionals in rural areas, so allied health professionals may not have their own rooms. Perhaps more importantly, the size of the catchment of many rural projects means that for services to be provided in a manner that equitably increases access, the allied health professional must provide services from a number of locations. The latter interpretation is supported by the findings of the rural case studies, which suggested that decentralised ways of operating were often favoured.

With regard to the referral mechanisms of choice, rural projects are significantly more likely than urban projects to implement direct referral systems (64% versus 38%), and tend to be less likely to use register systems (17% versus 32%). Direct referral systems tend to operate in circumstances where the allied health professional is co-located with the GP, which, as noted above, is more common in rural projects. Conversely, register systems rely on there being sufficient numbers of allied health professionals to warrant a choice, which may not be the case in many rural projects.

Does the level of uptake of rural and urban projects differ?

According to the minimum dataset, the absolute numbers of referring GPs in the rural and urban projects are similar (1,587 and 1,639, respectively), as are the absolute numbers of consumers (14,137 and 16,649, respectively). The populations of both GPs and the general population in rural areas are much smaller in size than those in urban areas (with around 10% of both GPs and the general population being located in rural areas), so if these absolute numbers were converted to rates, the uptake in rural projects would be much higher than that in urban projects. There may be several reasons for this. One may relate to the fact that project funding has not been allocated by a population-based formula (so urban projects have approached or reached the limit of their 'capped' budgets with more consumers left to serve. Another may relate to the relatively greater service gaps in rural areas that existed prior to the introduction of the Access to Allied Psychological Services projects, which may have translated into increased demand.

The absolute number of allied health professionals in rural projects is about half that in urban projects (359 versus 770). Using the same logic as above, and assuming that the geographic distribution of allied health professionals is not dissimilar to that of GPs, this suggests that proportionally more allied health professionals are involved in rural projects than in urban projects. The data also suggest that the average project-related caseload is higher for rural allied health professionals than for urban allied health professionals, which may relate to difficulties attracting allied health professionals to rural areas, resulting in a comparatively smaller pool of providers.

Do the profiles of consumers accessing care through rural and urban projects differ?

The socio-demographic profiles of rural and urban consumers display some important differences, as well as some similarities. Although the majority of consumers in both rural and urban locations are female, there are proportionally more male consumers in rural settings (28% versus 26%). Rural consumers are also slightly older. The proportion of consumers who speak English at home is higher in rural projects (99% versus 96%). Fewer other languages are spoken by rural consumers who do not speak English at home than by their urban counterparts (27 versus 65), but the level of English language proficiency among these groups is similar. Higher proportions of rural consumers are of Aboriginal or Torres Strait Islander origin (2.6% versus 0.9%). Rural

consumers tend to be of lower socio-economic status, as measured by educational attainment, with only 22% completing some tertiary education compared with 30% of urban consumers. Presumably, these findings reflect the differing demographic profiles found in city and country areas.

Similarly, the clinical profiles of rural and urban consumers show some differences, but also certain commonalities. Although the majority of each have depression and/or anxiety disorders, a lower proportion of rural consumers have the latter (55% versus 60%). About half of each group are taking psychotropic medication, with antidepressants being the most commonly prescribed in both (but taken by proportionally more rural consumers (90%) than urban consumers (88%) on medication). About half of each have no previous psychiatric service history. More rural consumers are referred for cognitive interventions (69% and 68%, respectively) and diagnostic assessment (45% versus 37%), and fewer for behavioural interventions (52% and 55%).

Do the services consumers are receiving through rural and urban projects differ?

The services consumers are receiving through rural and urban projects are similar in many respects, but also show some differences. The majority of sessions in both settings are 46-60 minutes in length, although a smaller proportion are of this duration in rural settings (75% versus 80%). The majority in both settings involve individual treatment (98% in both). The majority in both settings involve cognitive interventions and behavioural interventions, although the proportions of each are lower in rural settings (59% versus 62% for cognitive interventions, and 42% versus 47% for behavioural interventions).

The number and cost of sessions also display similarities and differences. The mean number of sessions per consumer is lower in rural projects than in urban projects (4.4 compared with 5.7), although similar proportions of consumers in rural and urban projects have been allocated an additional six sessions beyond the initial six (13% in the former and 16% in the latter). No co-payment is charged in 82% of rural sessions, compared with only 68% of urban sessions. Where co-payments are charged, they tend to be \$25 or less in both settings, although there is greater variability in urban settings.

Do consumer outcomes in rural and urban projects differ?

Analysis of outcome data from the minimum dataset suggested that both rural and urban projects are achieving positive consumer outcomes. The different outcome measures being used across projects precluded the possibility of directly comparing the relative magnitude of change for rural consumers and urban consumers.

Do the issues faced by rural and urban projects differ, and do the solutions to these issues vary?

The case studies suggest that the rural and urban projects have faced different issues. Rural projects have struck problems to do with: distance; attracting qualified staff; lack of training and support for GPs; limited services; large Indigenous populations; high levels of unemployment; and stigma. By contrast, the issues for urban projects have related more to: uptake and demand; workforce shortages; and availability of and co-ordination with other services. Both rural and urban projects have addressed these problems in novel and innovative ways, seeking solutions that are responsive to the local context.

Conclusions

The above findings shed some light on the similarities and differences between rural and urban Access to Allied Psychological Services projects. The thrust of the models is similar in the two localities, but there are some differences that reflect the different

environmental, contextual and demographic factors in rural and urban areas. In particular, allied health professionals in rural areas are more likely to be directly employed, provide services from GPs' rooms and receive referrals directly. The level of uptake of the projects in rural areas appears to be proportionally higher, in terms of the relative numbers of providers, consumers and sessions, perhaps reflecting greater previous service gaps in these areas. Any differences in the socio-demographic and clinical profiles of consumers, and in the extent and nature of services provided, seem to reflect the make-up of the local populations and the support needs of local GPs. Importantly, consumer outcomes are positive in both settings. Rural and urban Divisions have faced different hurdles in getting the projects 'up and running', but appear to have addressed these in a manner that has been tailored to local needs. This has undoubtedly contributed to the ongoing success of the projects in the two different settings.

Chapter 1: Background

Access to and quality of services in rural and urban areas

Access to and quality of mental health care services have long been recognised as issues in Australia, with only a relatively small minority of those with mental health problems receiving care, and those receiving care predominantly doing so from GPs who acknowledge that they are not always optimally equipped to deliver such care.¹⁻³

Access and quality issues may manifest themselves in different ways in rural and urban areas. Rural issues have been well documented. Although the prevalence of mental health problems is no greater in country areas than in cities,⁴ rural people may face particular stressors, including isolation and exposure to environmental hazards such as drought, fire and flood which have been shown to precipitate anxiety, depression, family breakdown, grief and anger.⁵ Despite this, people in rural areas make less use of general practitioners and specialist mental health services than their urban counterparts.⁶ In part this may be due to a relative lack of services and individual providers in rural areas, which in turn may be influenced by difficulties recruiting and retaining health professionals.⁷ Fear of stigma in small communities and rural stoicism may also inhibit help-seeking behaviour in rural areas.⁸ The situation may be exacerbated by the fact that rural areas are often characterised by vast distances and socio-economic disadvantage,⁹ which introduces potential travel and financial barriers to service use.

In urban areas people may face a different set of stressors that can influence their mental health and wellbeing. For example, urban residents are less likely to have a strong sense of neighbourhood than their rural counterparts, and this has been shown to be associated with poorer mental health.¹⁰ Although there may be relatively more mental health services available in urban areas, people may still face problems with accessing services in a timely fashion, due to funding and service constraints.¹¹⁻¹³ The diversity of urban populations may mean that certain groups of residents – e.g., homeless people and people from culturally and linguistically diverse communities – are disenfranchised because care is not well tailored to their needs.¹⁴ In addition, co-ordination between existing services may be poor, creating discontinuity of care.¹⁵

Addressing access and quality: The Better Outcomes in Mental Health Care program

The Better Outcomes in Mental Health Care program was introduced in the 2001-02 financial year, with the overarching aim of improving access to high quality mental health care for Australians. The Better Outcomes in Mental Health Care program has explicitly addressed these access and quality issues by offering GPs training, systemic and professional support, and financial incentives via five interlocking components (described in more detail at Appendix A):

- Education and training for GPs;
- The 3-step mental health process;
- Focused psychological strategies;
- Access to allied psychological services; and
- Access to psychiatrist support.

Various evaluation efforts have considered the extent to which the Better Outcomes in Mental Health Care program has improved access to quality services. Early in the life of the program, Hickie et al examined the uptake of each of the components.¹⁶ To the extent that uptake can be regarded as a marker of access, the early signs suggested that the program was improving access across the board. Later work by Blashki et al indicates that this success has continued.¹⁷

The most comprehensive evaluation work undertaken to date has explored the uptake and impacts of the Access to Allied Psychological Services component. Through this component, GPs can refer consumers to allied health professionals^a (predominantly psychologists) for 6+ sessions of evidence-based care (i.e., focused psychological strategies), via 108 projects being conducted by Divisions of General Practice. Since just after the projects began, The University of Melbourne's Program Evaluation Unit (located within the School of Population Health) has produced six evaluation reports which, taken together, indicate that the projects have improved access to high quality psychological care for people whose access might otherwise have been restricted by barriers such as cost.¹⁸⁻²³

An element that has been missing from the evaluation of the Better Outcomes in Mental Health Care program in general, and the Access to Allied Psychological Services component in particular, is an examination of whether access to and quality of services have differed in rural and urban areas, both in terms of the issues faced and the solutions provided by the initiative.

The current report

The current report fills this gap, by exploring the similarities and differences between rural and urban Access to Allied Psychological Services projects, in terms of their models of service delivery, their levels of uptake, the profile of consumers they are serving and the services these consumers are receiving, the outcomes they are achieving, and the issues they have faced.

^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.

Chapter 2: Method

Evaluation questions

The current report addresses six evaluation questions:

- Do the models of service delivery being used in rural and urban projects differ?
- Does the level of uptake of rural and urban projects differ?
- Do the profiles of consumers accessing care through rural and urban projects differ?
- Do the services consumers are receiving through rural and urban projects differ?
- Do consumer outcomes in rural and urban projects differ?
- Do the issues faced by rural and urban projects differ, and do the solutions to these issues vary?

Scope

As noted previously, 108 projects have been funded under the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program. These projects have been funded in four funding rounds: 15 from June 2002 (Round 1 pilot projects); 14 from January 2003 (Round 1 supplementary projects); 41 from July 2003 (Round 2 projects); 32 from July 2004 (Round 3 projects); and six from July 2005 (Round 4 projects).

The current report considers the 102 projects funded in the first three funding rounds only, on the grounds that the small number of projects funded in the most recent round are only now beginning to reach the point of implementation.

The ADGP website (<http://www.adgp.com.au>) provides a listing of all Divisions in Australia, classifying each as rural or urban. By this classification, forty nine of the 102 projects under consideration here are rural (48%), and 53 (52%) are urban. Table 1 provides an overview of these 102 projects by locality and funding round.

Table 1: Overview of 'in scope' Access to Allied Psychological Services projects, by locality and funding round

	Round 1 projects	Round 2 projects	Round 3 projects	Total
Rural projects	14	17	19	49
Urban projects	15	24	13	53
Total	29	41	32	102

Note: In instances where more than one Division is responsible for the project, locality is the locality of the fundholding Division.

Data sources

To address the above evaluation questions, the current report draws on information from three sources: a survey of the models of service delivery being implemented by the projects; a purpose-designed minimum dataset; and a set of project case studies.

Data from the survey on models of service delivery

In early 2005, a structured survey was administered to the project officers responsible for the 102 Round 1, 2 and 3 projects, in order to provide a picture of the models of service delivery being implemented nationally. Data from the survey profiled the projects in

terms of their means of retaining allied health professionals, their location of allied health professionals, and their referral mechanisms. The survey methodology and findings have been reported in detail elsewhere.²²

Survey data on models of service delivery were available for 97 (95%) of the Round 1, 2 and 3 projects. For the purposes of the current report, the project's locality was added to the survey data file. Table 2 provides a breakdown of the projects for which survey data were available, by locality and funding round.

Table 2: Overview of Access to Allied Psychological Services projects responding to models of service delivery data (April-June 2005), by locality and funding round

	Round 1 projects	Round 2 projects	Round 3 projects	Total
Rural projects	13	17	17	47
Urban projects	13	24	13	50
Total	26	41	30	97

Analyses were conducted to examine whether there were differences in the models of service delivery adopted in rural projects compared with those adopted in urban projects. The findings are presented in Chapter 3.

Data from the minimum dataset

The minimum dataset is a web-based national database which standardises the basic information collected by Divisions implementing Access to Allied Psychological Services projects. The minimum dataset captures de-identified, descriptive consumer-level and session-level information.

For the purposes of the current report, data were extracted for the period between 1 July 2003 and 31 December 2005. Ninety three (91%) of the 102 Round 1, 2 and 3 projects had submitted data to the minimum dataset for this period (44, or 90%, of the rural projects, and 49, or 93% of the urban projects), although five of these had submitted consumer-level data only and not session-level data. Table 3 provides a breakdown of these projects, by locality and funding round.

Data were extracted from the minimum dataset on the numbers of consumers accessing services through the projects, their socio-demographic and clinical characteristics, the care being provided to them, and outcomes of this care (as assessed by standardised outcome measures). These data are presented in Chapters 4 to 7.

Table 3: Overview of Access to Allied Psychological Services projects submitting data to the national minimum dataset (December 2005), by locality and funding round

	Round 1 projects	Round 2 projects	Round 3 projects	Total
Rural projects	12	17	15	44
Urban projects	14	22	13	49
Total	26	39	28	93

Data from case studies

Seven case studies were conducted that explored the issues faced by rural and urban Divisions conducting projects, and the approaches taken to address these issues. The six projects selected as case studies were chosen in order to ensure a range of localities,

with three involving rural projects, and four involving urban projects (one urban/semi-rural project, one outer urban project, and two inner-city urban projects). Preference was given to projects from the earlier funding rounds, on the grounds that they had had longer to identify and address issues (see Table 4).

Data for the case studies was gleaned from telephone interviews with the project officer responsible for each of the projects. These interviews were conducted in February 2006. Each interview took between 15 minutes and an hour, and was conducted by a member of the Program Evaluation Unit team who took extensive notes during the interview. After each interview, a written case study was produced by the Program Evaluation Unit team member, which was returned to the project officer for review and approval. The case studies are presented in Chapter 8.

Table 4: Overview of Access to Allied Psychological Services projects participating in case studies (February 2005), by locality and funding round

	Round 1 projects	Round 2 projects	Round 3 projects	Total
Rural projects	2	1	0	3
Urban projects	3	1	0	4
Total	5	2	0	7

Chapter 3: Do the models of service delivery being used in rural and urban projects differ?

The Program Evaluation Unit has undertaken extensive explorations into the models of service delivery being used by the Access to Allied Psychological Services projects. As noted earlier, the projects have different means of retaining allied health professionals, vary in terms of where their allied health professionals are located, and use a range of referral mechanisms. The various models under each of these dimensions are summarised in Table 5, and have been described in more detail elsewhere.¹⁸⁻²⁴

Table 5: Dimensions on which models of service delivery differ in the Access to Allied Psychological Services projects

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

Sources: Morley et al²⁰ and Pirkis et al²⁴

Comparisons were made between rural and urban projects in terms of the models of service delivery, using data from the models of service delivery survey, and Table 6 shows the results. Chi square tests were used to test the statistical significance of any differences between rural and urban projects. It should be noted that multiple responses were permissible on the survey, and many projects were using more than one model within a given dimension, so the totals commonly exceed 100%.

Table 6: Overview of service delivery models being implemented by Round 1, 2 and 3 Access to Allied Psychological Services projects, by locality

		Rural projects	Urban projects	Total
Means of retaining allied health professionals	Contractual arrangements	37 (80%)	39 (83%)	76
	Direct employment	17 (37%)	10 (21%)	27
Location of allied health professionals	GPs' rooms	29 (62%)	32 (64%)	61
	Own rooms	25 (53%)	36 (72%)	61
	Other location	22 (47%)	20 (40%)	42
Referral mechanisms	Voucher system	11 (23%)	15 (30%)	26
	Brokerage system	11 (23%)	12 (24%)	23
	Register system	8 (17%)	16 (32%)	24
	Direct referral	30 (64%)	19 (38%)	49
Total		47	50	97

N.B. Multiple responses permitted.

The data suggest that, in the main, rural projects and urban projects have similar profiles in terms of their models of service delivery, with some exceptions:

- The majority of both rural and urban projects retain allied health professionals under contract (about 80% in both cases). There is a non-significant trend towards rural projects being more likely to adopt a direct employment model for at least some of their allied health professionals, with 37% doing so compared with only 21% of urban projects ($\chi^2(1) = 3.08, p = .08$).
- In about two thirds of both rural and urban projects, allied health professionals are co-located with GPs; and in about two fifths of both they are located in some other location. There is a tendency for allied health professionals to be less likely to be located in their own rooms in rural projects than in urban projects (53% versus 72%), although this difference is not significant ($\chi^2(1) = 3.61, p = .06$).
- Similar proportions of both rural and urban projects use voucher systems (around one quarter in each case) and brokerage systems (just over one fifth in each case). There is a non-significant tendency for rural projects to be less likely than their urban counterparts to use register systems, with 17% of the former doing so compared with 32% of the latter ($\chi^2(1) = 2.84, p = .09$). Rural projects are significantly more likely to implement direct referral systems than urban projects (64% versus 38%) ($\chi^2(1) = 6.32, p < .05$).

Chapter 4: Does the level of uptake of rural and urban projects differ?

Using data from the minimum dataset, Table 7 shows the level of uptake of the rural and urban Access to Allied Psychological Services projects, as reflected in participation by referring GPs, allied health professionals providing services, and referred consumers. Specifically, it presents data from the national minimum dataset on the numbers participating in the Round 1, 2 and 3 projects, as at 31 December 2005, by locality.

Some caution should be exercised in interpreting the results, since the minimum dataset represents something of an underestimate. At the time of extracting the data, 9% of Round 1, 2 and 3 projects had not submitted data to the minimum dataset, and there were data entry lags for some projects that had submitted data. Nonetheless, the figures suggest an impressive level of uptake in both rural and urban projects.

Table 7: Number of GPs, allied health professionals and consumers participating in Round 1, 2 and 3 Access to Allied Psychological Services projects, by locality

	Rural Projects	Urban Projects	Total
Referring GPs	1,587	1,639	3,226
Allied health professionals	359	770	1,129
Referred consumers	14,137	16,649	30,786

Bearing in mind that similar numbers of rural and urban projects were represented in the minimum dataset at the time of data extraction (44 rural and 49 urban), it is of interest to note that similar numbers of GPs have made referrals in rural and urban projects (around 1,500 in each). According to the Productivity Commission,²⁵ 91.2% of Australian GPs operate in urban areas and 8.7% are located in rural areas (where urban areas are defined as major cities and inner regional areas, and rural areas are defined as outer regional, remote and very remote areas). This suggests that, proportionally at least, individual GPs in rural projects are taking greater advantage of the referral opportunities provided.

Similarly, the number of consumers referred in rural projects is reasonably similar to the number referred in urban projects. Again, considering that 87.0% of the Australian population lives in urban areas and only 13.0% resides in rural areas,²⁵ this suggests that individuals living in areas serviced by rural projects are proportionally more likely to benefit from referral through the projects.

Also noteworthy is the fact that despite the fact that similar absolute numbers of GPs are referring similar absolute numbers of consumers in rural and urban projects, these referrals are being 'picked up' by half the number of allied health professionals in the former. Without comparable data on the geographical distribution of allied health professionals to that described above for GPs, it is difficult to interpret this. However, assuming that the distribution of allied health professionals mirrored that of GPs (which is a reasonable assumption, given that the distribution is similar for other health and medical professional groups), it is likely that proportionally more allied health professionals are involved in rural projects than in urban projects. The fact that these allied health professionals are seeing similar numbers of consumers to those in urban projects suggests that participating rural allied health professionals are dealing with relatively larger project-related caseloads.

Chapter 5: Do the profiles of consumers accessing care through rural and urban projects differ?

Socio-demographic characteristics

The minimum dataset collects a range of socio-demographic data about consumers who are accessing care through the Access to Allied Psychological Services projects. Comparisons between rural and urban consumers are provided below, concerning age/sex, language spoken at home, proficiency with English, Aboriginality, socio-economic status and residential circumstances. Chi square tests were used to test the statistical significance of any differences between rural and urban consumers on any of these dimensions. Differences are only reported where they were statistically significant; if no significance test is reported, it can be assumed that the difference was not significant.

Age/sex

Data on age/sex were available for 13,584 rural and 15,660 urban consumers. Although the majority of consumers in both locations were female, there were proportionally more male consumers in rural areas: 9,768 (72%) rural and 11,595 (74%) urban consumers were female and 3,816 (28%) rural and 4065 (26%) urban consumers were male ($\chi^2(1) = 16.82, p < .01$). The mean age of rural consumers was 40.5 (s.d.=15.4) and the mean age of urban consumers was 40.0 (s.d.=14.6) ($\chi^2(1) = 6.67, p < .01$).

Language

Language spoken at home was recorded in the minimum dataset for 12,817 rural and 14,123 urban consumers, and a breakdown of the listed languages is provided in Table 8. Ninety nine per cent of rural consumers spoke English at home, compared with 96% of urban consumers ($\chi^2(1) = 264.50, p < .01$). While 27 other languages were spoken by the remainder of rural consumers, 65 additional languages were spoken by urban consumers. For both rural and urban consumers, Italian (0.3% rural and 1.6% urban), Greek (0.1% rural and 0.7% urban) and Chinese languages (0.02% rural and 0.6% urban) were the most common. Language was recorded as 'unknown' for 0.4% rural and 1.3% urban consumers.

The minimum dataset also collects information on the English proficiency of consumers, as judged by the referring GP. These data were available for 80 of the rural consumers who spoke a language other than English at home, and 759 of the urban consumers who did so. Similar proportions of these rural and urban consumers spoke English 'not well' or 'not at all' (15% and 17%, respectively).

Table 8: Language spoken at home by consumers receiving services through Round 1, 2 and 3 rural and urban projects (rural n=12,817, urban n=14,123)

	Rural		Urban	
	Frequency	Percent	Frequency	Percent
English	12,719	99.3	13,490	95.5
Italian	44	0.3	223	1.6
Chinese languages	2	0.0	87	0.6
Greek	8	0.1	99	0.7
Turkish	2	0.0	42	0.3
Other	37	0.3	387	2.7
Unknown	48	0.4	176	1.2
Total	12,817	100.0	14,123	100.0

Aboriginality

The minimum dataset collects data on whether consumers identify as being from Aboriginal or Torres Strait Islander descent, and a response was available for 13,379 rural and 14,460 urban consumers. Table 9 shows that, overall, 2.6% of rural and 0.9% of urban consumers identified as being of Aboriginal or Torres Strait Islander origin. It should be noted that for a substantial proportion of consumers (12% rural and 9% urban), Aboriginality was recorded as 'unknown'. Nonetheless, the data suggest that proportionally more Aboriginal and Torres Strait Islander consumers are receiving care through the rural projects ($\chi^2(1) = 113.96, p < .01$).

Table 9: Aboriginal and Torres Strait Islander origin of consumers receiving services through Round 1, 2 and 3 rural and urban projects (rural n=13,379, urban n=14,460)

	Rural		Urban	
	Frequency	Percent	Frequency	Percent
Yes	347	2.6	124	0.9
No	11,472	85.7	13,051	90.3
Unknown	1,560	11.7	1,285	8.9
Total	13,379	100.0	14,460	100.0

Socio-economic status

The minimum dataset includes a field that ascertains the highest level of education achieved by the consumer. Data were available for 10,450 rural consumers and 12,510 urban consumers. Table 10 indicates that, in aggregate, rural consumers were less highly educated than urban consumers. Twenty two per cent of rural consumers had completed some tertiary education, compared with 30% of urban consumers ($\chi^2(1) = 217.87, p < .01$).

Table 10: Highest level of education achieved by consumers receiving services through Round 1, 2 and 3 rural and urban projects (rural n=10,450, urban n=12,510)

	Rural		Urban	
	Frequency	Percent	Frequency	Percent
Primary or below	703	6.7	741	5.9
Secondary	7,467	71.0	7,955	63.6
Tertiary	2,280	21.8	3,814	30.5
Total	10,450	100.0	12,510	100.0

Residential circumstances

The minimum dataset includes a field that describes whether the consumer lives alone, as a proxy measure of whether he/she has care or support at home.^b Information on residential circumstances was available for 13,309 rural and 14,605 urban consumers. Similar proportions of each (17% and 18%, respectively) were found to live alone (see Table 11).

Table 11: Residential circumstances of consumers receiving services through Round 1, 2 and 3 rural and urban projects (rural n=13,309, urban n=14,802)

	Rural		Urban	
	Frequency	Percent	Frequency	Percent
Lives alone	2,269	17.0	2,596	17.5
Does not live alone	9,903	74.4	10,772	72.8
Unknown	1,137	8.5	1,434	9.7
Total	13,309	100.0	14,802	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 Psychological 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. Comparisons on these variables are provided below for rural and urban consumers. Again, chi square tests were used to test the statistical significance of any differences between rural and urban consumers on any of the above variables. Differences are only reported where they were statistically significant; if no significance test is reported, it can be assumed that the difference was not significant.

Diagnosis

For the purposes of referring a consumer to a given project, GPs are asked to provide one or more diagnoses within the ICD-10 primary care diagnostic categories: Chapter V Primary Care Version Brief Version (with amended categories).²⁶ These diagnoses are recorded in the minimum dataset, with multiple responses permitted. In the current analysis, data were available for 11,407 rural and 13,738 urban consumers.

Table 12 shows that the diagnostic profiles of consumers for rural and urban projects are similar. A clear majority of both rural and urban consumers accessing psychological services through the Access to Allied Psychological Services projects have been diagnosed with depression (rural 76% and urban 75%) and/or anxiety (rural 55% and urban 60%) by their GP at the point of referral, although the proportion with the latter disorder in rural projects is lower ($\chi^2(1) = 106.21, p < .01$).

^b However, it is acknowledged that the availability of support does not guarantee that such support is provided nor the quality and benefit of such support.

Table 12: ICD-10 diagnosis of rural and urban consumers receiving services through the Round 1, 2 and 3 projects (rural n=11,407, urban n= 13,738; multiple responses permitted)

	Rural		Urban	
	Frequency	Percent	Frequency	Percent
F1 Alcohol and drug use disorders	800	7.0	973	7.1
F2 Psychotic disorders	188	1.6	247	1.8
F3 Depression	8,653	75.8	10,338	75.3
F4 Anxiety disorders	6,223	54.6	8,310	60.5
F5 Unexplained somatic disorders	287	2.5	477	3.5

N.B. Multiple responses permitted.

Current psychotropic medication

The minimum dataset collects information on whether consumers are taking psychotropic medication, and if so, what type (with multiple responses permitted). Analysis of these data shows that similar proportions of rural (49%) and urban (47%) consumers were taking psychotropic medication at the point of referral to allied health professionals through the Access to Allied Psychological Services projects. Antidepressants were the most common medication for both rural and urban consumers who were taking psychotropic medication, although proportionally more rural consumers were taking them than urban consumers (90% versus 88%) ($\chi^2(1) = 21.18, p < .01$).

Psychiatric service history

The minimum dataset collects data on whether consumers have previously used specialist mental health care (from public, private, medical and allied health services). Data were available on this indicator for 12,921 rural and 14,328 urban consumers. Table 13 shows that similar proportions of rural (48%) and urban (47%) consumers had not previously received specialist mental health care.

Table 13: Previous receipt of specialist mental health care by rural and urban consumers receiving services through the Round 1, 2 and 3 projects (rural n=12,921, urban n=14,328)

	Rural		Urban	
	Frequency	Percent	Frequency	Percent
Yes	4,878	37.8	5,689	39.7
No	6,141	47.5	6,664	46.5
Unknown	1,902	14.7	1,975	13.8
Total	12,921	100.0	14,328	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 11,849 rural and 12,726 urban consumers, and Table 14 shows the results. In the main, the patterns of referral were similar for rural and urban consumers, although there were some differences in the relative proportions of focused psychological strategies for which consumers were referred. The most common referral was for cognitive interventions in both cases, but proportionally more rural consumers were referred for this strategy (69%, compared with 68% urban) ($\chi^2(1) = 12.10, p < .01$). The next most common strategy in both cases was behavioural interventions, but again there was a difference in magnitude (52% rural and 55% urban) ($\chi^2(1) = 9.26, p < .01$). Rural

consumers more likely to be referred for diagnostic assessment than urban consumers (45% versus 37%) ($\chi^2(1) = 268.35, p < .01$), and urban consumers were more likely to be referred for interpersonal therapy (23% versus 30%) ($\chi^2(1) = 50.56, p < .01$).

Table 14: Focused psychological strategy for which referral was made for rural and urban consumers receiving services through the Round 1, 2 and 3 projects (rural n=11,849 and urban n=12726; multiple responses permitted)

	Rural		Urban	
	Frequency	Percent	Frequency	Percent
Diagnostic assessment	5,271	44.5	4,742	37.3
Psycho-education	4,960	41.9	5,089	40.0
CBT - Behavioural interventions	6,206	52.4	7,024	55.2
CBT - Cognitive interventions	8,208	69.3	8,627	67.8
CBT - Relaxation strategies	5,018	42.3	5,990	47.1
CBT - Skills training	3,571	30.1	4,349	34.2
Interpersonal therapy	2,754	23.2	3,798	29.8

N.B. Multiple responses permitted.

Chapter 6: Do the services consumers are receiving through rural and urban projects differ?

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 Psychological Services projects. Specifically, data are provided about the number, duration, format and content of sessions provided by the allied health professional. Comparisons on these variables are provided below for rural and urban sessions. Chi square tests were used to test the statistical significance of any observed differences. Differences are only reported where they were statistically significant; if no significance test is reported, it can be assumed that the difference was not significant.

Number of sessions

The terms of the Access to Allied Psychological 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 in the Round 1, 2 and 3 projects was 51,587 by rural and 74,811 by urban consumers. Excluding consumers for whom patient data but no session data had been entered into the minimum dataset, the mean number of sessions per consumer was lower in rural than urban projects (4.4 compared with 5.7). However, similar proportions of consumers in rural and urban projects have been allocated an additional six sessions beyond the initial six (13% in the former and 16% in the latter). 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, and it is not possible to determine whether this might differentially affect the results for rural or urban projects.

The mean number of sessions per allied health professional was 144 in rural projects and 97 in urban projects, which adds support to the suggestion in Chapter 4 that the rural allied health professionals have larger project-related caseloads.

Duration of sessions

Data were available from the minimum dataset on the duration of 49,136 rural and 72,621 urban sessions. As Table 15 shows, the breakdown of duration of sessions was similar for rural and urban projects, with the majority of both being 46-60 minutes in length. Having said this, proportionally fewer were of this length in rural areas than in urban areas (75% versus 78%) ($\chi^2(1) = 440.30, p < .01$).

Table 15: Duration of rural and urban sessions provided through the Round 1, 2 and 3 projects (rural n=49,136 and urban n=72,621)

	Rural		Urban	
	Frequency	Percent	Frequency	Percent
0-30 mins	3,007	6.1	663	0.9
31-45 mins	3,216	6.5	5,870	8.1
46-60 mins	36,762	74.8	58,035	79.9
>60 mins	6,151	12.5	8,053	11.1
Total	49,136	100.0	72,621	100.0

Format of sessions

Data were available on the format of 49,340 rural and 73,848 urban sessions. The vast majority of both rural and urban sessions involved the provision of individual treatment (98% in each case), with only 2% consisting of treatment provided in a group format.

Content of sessions

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

Data were available on the content of 45,318 rural and 60,054 urban sessions. Table 16 shows that the profile of session content was similar for rural and urban projects, with some nuances. The most common interventions in both were CBT-based cognitive interventions, although proportionally fewer were provided in rural sessions than in urban sessions (59% versus 62%) ($\chi^2(1) = 38.83, p < .01$). The next most common interventions in both were behavioural interventions, but again these were relatively less popular in rural sessions than in urban sessions (42% versus 47%) ($\chi^2(1) = 7.47, p < .01$).

Table 16: Content of sessions provided through the rural and urban Round 1, 2 and 3 projects (rural n=45,318 and urban n=60,054, multiple responses permitted)

	Rural		Urban	
	Frequency	Percent	Frequency	Percent
Diagnostic assessment	9,662	21.3	12,485	20.8
Psycho-education	14,147	31.2	19,336	32.2
CBT - Behavioural interventions	18,876	41.7	27,939	46.5
CBT - Cognitive interventions	26,713	58.9	37,405	62.3
CBT - Relaxation strategies	11,166	24.6	15,414	25.7
CBT - Skills training	9,989	22.0	14,753	24.6
Interpersonal therapy	12,396	27.4	15,549	25.9

N.B. Multiple responses permitted.

Cost to consumers

Information on co-payments was available from the minimum dataset for 35,757 rural and 61,945 urban sessions. Table 17 shows that a co-payment was less likely to be collected in rural sessions, with 82% of rural sessions incurring no cost for consumers compared with 68% of urban sessions ($\chi^2(1) = 2159.08, p < .01$). In both settings, where co-payments were charged, they tended to be \$25 or less. Having said this, urban sessions

showed more variability than rural sessions, with more very low co-payments as well as more at the higher end.

Table 17: Consumer co-payments for rural and urban sessions provided through the Round 1, 2 and 3 projects (rural n=35,757 and urban n=61,945)

	Rural		Urban	
	Frequency	Percent	Frequency	Percent
No co-payment	29,397	82.2	42,382	68.4
\$1-\$5	1,824	5.1	4,077	6.6
\$6-\$10	1,650	4.6	6,748	10.9
\$11-\$15	53	0.1	985	1.6
\$16-\$20	2,550	7.1	4,943	8.0
\$21-\$25	132	0.4	1,791	2.9
\$26-\$30	55	0.2	599	1.0
\$31-\$40	25	0.1	237	0.4
\$41-\$50	30	0.1	73	0.1
\$51-\$60	28	0.1	43	0.1
\$61+	13	0.0	67	0.1
Total	35,757	100.0	61,945	100.0

Chapter 7: Do consumer outcomes in rural and urban projects differ?

The majority of the projects administer outcome measures to consumers before and after treatment in the form of six sessions of focused psychological strategies, in an effort to monitor improvement (or lack of change or deterioration) in psychological wellbeing.²⁷ Twenty six projects are providing outcomes data to the minimum dataset – 14 rural and 12 urban – but it should be noted that the outcome measures fields were only introduced to the minimum dataset relatively recently, so the volume of data from these projects is small.

The current chapter provides an overview of the changes from pre-treatment to post-treatment (i.e., between assessment and review) for consumers in both rural and urban projects. Ideally, outcomes for consumers in rural and urban projects would have been compared directly, but because the projects are administering a variety of outcome measures, few measures are being used in both rural and urban projects. For this reason, outcomes for consumers in rural and urban projects were considered separately. A series of two-way ANOVAs with repeated measures on one factor, and Bonferroni correction for multiple comparisons, were conducted to determine changes from pre-treatment to post-treatment in each locality.

Rural projects

For the rural projects, pre- and post-treatment scores were available for more than 10 consumers on the following measures: the Kessler 10 (K-10), the Depression Anxiety Stress Scales (DASS), the Health of the Nation Outcome Scales (HoNOS), the Behaviour and Symptom Identification Scale (BASIS-32), the General Well Being Index (GWBI), and the General Health Questionnaire (GHQ-28). In total, outcomes data were available for 743 rural consumers.

Table 18 displays mean scores (and standard deviations) pre- and post-treatment for each outcome measure, as well as the total number of consumers for whom pre- and post-treatment scores were available. It shows that outcomes for consumers in rural projects improved from pre- to post-treatment, as evidenced by:

- a significant decrease in K-10 scores ($F(1,389) = 582.47, p < .01$);
- significant decreases in DASS-21 depression subscales scores ($F(1,21) = 39.67, p < .01$), anxiety subscale scores ($F(1,21) = 24.25, p < .01$), and stress subscale scores ($F(1,21) = 49.26, p < .01$) subscales from pre- to post-treatment, and significant decreases in DASS-42 depression subscale scores ($F(1,26) = 18.20, p < .01$), anxiety subscale scores ($F(1,26) = 18.58, p < .01$), and stress subscale scores ($F(1,26) = 14.31, p < .01$);
- a significant decrease in HoNOS scores ($F(1,92) = 164.39, p < .01$);
- a significant decrease in BASIS-32 scores ($F(1,37) = 37.34, p < .01$);
- a significant increase in GWBI scores ($F(1,47) = 38.50, p < .01$); and
- a significant decrease in GHQ28 scores ($F(1,26) = 18.35, p < .00$).

Table 18: Mean scores on consumer outcome measures before and after treatment provided through the rural Round 1, 2 and 3 projects

Outcome measure	Pre-treatment	Post-treatment	N
	Mean (s.d.)	Mean (s.d.)	
K-10	32.41 (7.12)	23.27 (7.70)	390
DASS-21 – Depression	13.64 (6.33)	5.14 (5.57)	22
DASS-21 – Anxiety	10.59 (7.66)	5.50 (7.59)	22
DASS-21 - Stress	13.09 (6.91)	6.45 (5.23)	22
DASS-42 – Depression	17.41 (10.70)	9.26 (11.08)	27
DASS-42 – Anxiety	12.22 (9.27)	7.41 (8.33)	27
DASS-42 - Stress	18.81 (9.11)	11.19 (9.63)	27
HoNOS	9.27 (4.17)	5.35 (4.79)	93
BASIS-32	41.32 (20.88)	25.24 (20.92)	38
GWBI	42.85 (14.13)	57.75 (16.07)	48
GHQ-28	29.56 (13.96)	15.04 (13.29)	27

Urban projects

In the case of the urban projects, pre- and post-treatment scores were available for 687 consumers. The Kessler 10 (K-10), the Depression Anxiety Stress Scales (DASS), the Beck Depression Inventory (BDI), the Beck Anxiety Inventory (BAI), and the Hospital Anxiety and Depression Scale (HADS) each provided outcomes data for 10 or more consumers.

Table 19 shows mean scores (and standard deviations) at assessment and at review for each outcome measure. It also details the total number of consumers contributing to any given mean score. The results show that outcomes for consumers in urban projects improved from during the course of treatment, as indicated by:

- a significant decrease in K-10 scores ($F(1,523) = 537.10, p < .01$);
- significant decreases in DASS-42 scores depression subscale scores ($F(1,22) = 33.39, p < .01$), anxiety subscale scores ($F(1,22) = 10.42, p < .01$), and stress subscale scores ($F(1,22) = 20.25, p < .01$);
- a significant decrease in BDI scores ($F(1,54) = 72.94, p < .01$);
- a significant decrease in BAI scores ($F(1,23) = 12.44, p < .01$); and
- a significant decrease in HADS scores ($F(1,14) = 36.65, p < .01$).

Table 19: Mean scores on consumer outcome measures before and after treatment provided through the urban Round 1, 2 and 3 projects

Outcome measure	Pre-treatment	Post-treatment	N
	Mean (s.d.)	Mean (s.d.)	
K10	31.02 (7.60)	22.03 (8.36)	524
DASS42 – Depression	25.09 (12.46)	11.35 (11.47)	23
DASS42 – Anxiety	16.00 (11.30)	10.00 (10.61)	23
DASS42 - Stress	22.39 (13.78)	11.70 (10.64)	23
BDI	27.16 (9.89)	15.15 (10.32)	55
BAI	22.87 (13.67)	13.71 (9.42)	24
HADS	13.27 (5.08)	8.00 (4.86)	15

Chapter 8: Do the issues faced by rural and urban projects differ, and do the solutions to these issues vary?

Seven case studies are presented below. They represent three rural and four urban projects, and explore the issues faced in the given locality and the ways in which these issues have been addressed. Key themes from the case studies are discussed.

Rural projects

Seven key issues are apparent from the three rural case study projects: distance; attracting qualified staff; lack of training and support for GPs; limited services; large Indigenous populations; high levels of unemployment; and stigma. These have been addressed in innovative and novel ways, with apparent success.

Distance

Rural projects face the difficulty of providing access to psychological services to a population that is widely dispersed. This represents a barrier both for clinicians and consumers. For clinicians, extensive travel requirements potentially create an occupational health and safety issue, and this impacts on the services the projects can offer. For consumers, the large distances present a barrier to accessing services, particularly in circumstances where public transport is not available.

In order to cover the large distances in the rural projects' catchments, these projects have adopted decentralised models, with allied health professionals delivering services from GPs' practices in local centres, rather than doing so from the single location of their own practice. To ensure improved access across the region, projects have worked hard to ensure that at least one GP from each local practice is participating. This model of service delivery has also provided GPs with the opportunity to refer to a pool of psychologists in the local area, thereby providing optimum access for consumers and largely avoiding waiting lists.

The rural projects have also ensured that travel time is factored in for allied health professionals and project staff, and developed policies to reduce the stress and costs of driving. Strategies include: introducing policies of two staff on any one trip; providing a travel day per month to compensate for hours spent in a vehicle; pooling funds to lease vehicles for all allied health professionals to deliver services.

Attracting qualified staff

Attracting suitably qualified staff, particularly psychologists, is a key issue for rural projects. In recruiting allied health professionals to the projects, rural Divisional staff are cognizant of the need to avoid taking psychologists from the local pool, in order to create additional service opportunities for consumers rather than depleting already limited alternate services.

In order to attract suitably qualified staff to the region, the rural projects have undertaken concerted advertising campaigns that have utilised the Divisions' networks, electronic media and local media. Importantly, once recruited to the projects, high staff maintenance rates have been observed.

Lack of training and support for GPs

GPs in rural areas have fewer opportunities for training and support than their urban counterparts. According to the case studies, lack of funding for mental health training for GPs creates problems, as does the lack of available psychiatrists to whom GPs can turn for assessment and secondary support.

The lack of training and support for GPs has been addressed by various means, including accessing training funds from the Rural Workforce Agency, and developing a Divisional Level 1 training package which is accredited with the General Practice Mental Health Standards Collaboration.

Limited services

Rural projects also face difficulties because of the lack of alternate services to which GPs can refer consumers. For example, there are often limited local counselling services. Similarly, drug and alcohol services, parent support groups, family support groups, and domestic violence services are often 'thin on the ground'. This creates issues for the projects, because consumers are often faced with residual unsolved problems at the end of their six sessions with the psychologist, and there are few options for referring on. This has contributed to the comparatively greater number of sessions required to treat consumers in rural areas.

The rural projects have attempted to address the above issue by securing scarce resources and providing patients with written resources but it remains an issue beyond the scope of the projects.

Indigenous populations

Some rural areas have comparatively large Indigenous populations, whose members may be at particularly high risk of mental health problems. Rural projects have recognised a need to tailor their services to meet the specific needs of these populations, as a one-size-fits-all approach fails to improve their access. Strategies have included working with local Aboriginal cooperatives to improve the culturally-appropriate delivery of mental health care, and providing GPs with education about Indigenous mental health and cultural issues.

High levels of unemployment

High unemployment and low levels of education create particular issues in rural areas. These factors may create situational stressors – such as difficulties in supporting families – which may increase the risk of mental health problems. In addition, low socioeconomic status may create financial barriers to accessing services for which a fee must be paid (e.g., private psychologists). Providing free or low-cost access to evidence-based mental health care, consistent with the aims of the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program, has helped to overcome barriers posed by low socioeconomic status.

Stigma

Stigma is a significant issue in rural areas where communities are often small and close-knit. People with mental health problems may be discouraged from seeking help, for fear of being discriminated against or ostracised by the community.

While the stigma of mental illness remains an issue in rural areas, housing allied health professionals in local GPs' practices (see above) has gone some way to reducing stigma and increasing access for consumers.

Case Study 1: North West Tasmania Division of General Practice (Rural Project, Tasmania)

The North West Tasmania Division's Access to Allied Psychological Services project uses a local outreach model to support GPs and allied health professionals to work together to provide optimal mental health care in a rural setting. Four key issues exist in relation to its rural locality: difficulty in accessibility due to the widely dispersed population; large Indigenous population; high levels of unemployment; and lack of services for young people.

The project is based in a region that has a relatively small and widely dispersed population, which often has difficulty with access. All areas have local centres, with local GP clinics, so the project has worked hard to ensure that at least one GP from each local clinic participates in the program. Being housed locally, GPs also have the opportunity to refer to a pool of psychologists in the local area, so that optimum access can be achieved. As a result, patient waiting lists have, to this point, been avoided. This is perceived as a major strength of the program as mental health is recognised as benefiting from early intervention, and as requiring urgent attention.

The North West region also has a large Indigenous population. Given that this is a high risk group, project staff have worked with local Aboriginal cooperatives in order to facilitate the delivery of mental health care to this population group. This action, coupled with GP education around Indigenous mental health and cultural issues, has improved services to, and recognition of, this population.

High unemployment is also a big issue facing the project. Forty seven per cent of patients referred so far have no more than a grade 10 education, and limited job prospects. This means that they can not afford to pay for private psychologists, and contributes to their anxiety because they experience huge difficulties in supporting their families (particularly if they are sole and/or unemployed parents). The project has addressed this, by providing access to psychological services at no cost to patients. The Division also endeavours to include psychologists and non-government organisations in its mental health continuing professional development events, either as participants or presenters, to encourage appropriate referrals and forge stronger shared working relations between GPs and allied health professionals. Annual reviews of the project have also assisted both GPs and psychologists to further develop relationships and to explore and address any issues which have arisen.

Young people are perceived as missing out on the program. Given that young people do not necessarily attend GP practices, and that they are often reticent in communicating with family members or school staff, ways to assist young people to access services are needed. The Division is currently exploring funding options to enable GPs and/or psychologist to go to schools, so that young people can access intervention prior to critical points, and with a higher degree of privacy.

Source: Interview with Debra Mordha, Project Manager, North West Tasmania Division of General Practice

Case Study 2: North East Victorian Division of General Practice (Rural Project, Victoria)

The North East Victorian Division's Access to Allied Psychological Services project uses an employment model to support GPs and allied health professionals to work together to provide optimal mental health care in a rural setting. The key success of the project has been the partnership development between the Division and Northeast Health Wangaratta and the Area Mental Health Service, and the subsequent integration of primary mental health funding from Commonwealth and State bodies. The inception of the 'Integrated Primary Mental Health Service' has enabled six mental health clinicians to provide focused psychological strategies to 30 GP clinics across 33,000 square kilometres. The mental health clinicians deliver shared care within a co-location model.

A key issue the rural project faces is the lack of alternative services to which GPs can refer patients. For example, there are limited counselling services in the rural townships of the Division's catchment, resulting in the integrated service being inundated with referrals by the GPs.

Another issue is the tyranny of distance in the rural setting for both workers and clinicians delivering services, and patients accessing services. For workers and clinicians, extensive travel requirements create potential occupational health and safety issues. The project has put into place several strategies to address this. For example, the employment and integrated model, has enabled the Division to use pooled funds to lease vehicles for all its workers to deliver services. Recent recognition by the Commonwealth Department of Health and Ageing that vehicle leasing was part of direct clinical service delivery and not infrastructure, has further ensured the Division reaches its target populations. To minimise the effects of extensive workloads and distance travelled on all project mental health clinicians, staff are given a travel day per month to compensate for hours spent in the vehicle. This, in effect, provides staff with a nine day fortnight, once rostered days off are taken into account.

Funding for mental health training for GPs is also an issue in rural areas. However, being a rural Division also enables GPs to access funds from Rural Workforce Agency for training. To address access to training opportunities, the Division has developed its own Level 1 training package which is accredited with the General Practice Mental Health Standards Collaboration.

The lack of available psychiatrist in rural areas for patient assessment and secondary support is a considerable issue for GPs in the North East of Victoria.

Overall, the level of funding provided for the project was not perceived to reflect the lack of alternative services and lack of available psychiatrists, the high demand for services, and the travel issues faced in rural areas.

Source: Interview with Renee Williams, Project Manager, North East Victorian Division of General Practice

Case Study 3: Riverina Division of General Practice (Rural Project, New South Wales)

The Riverina Division's Access to Allied Psychological Services project uses a local outreach model to support GPs and allied health professionals to work together to provide optimal mental health care in a rural setting. Four key issues exist related to its rural locality, namely: attracting qualified staff; distance; limited services; and stigma.

Attracting suitably qualified staff, especially psychologists, has been a key issue, particularly given the recognition that psychologists should not be taken from the local pool. Vigorously advertising for psychologists by the project via the Divisions networks, electronic media and local media has resulted in attracting psychologists to the region. Once recruited, high staff maintenance rates have resulted.

The large distance and lack of public transport for patients to obtain services led to the decision to use a local outreach model, as compared to a centralised model. Having staff housed in local GP clinics has proved successful, as it has enabled the project to be accepted within the local community and led to increased patient access as stigma has been reduced. The model demands that travel time be factored in for staff, and that travel be recognised as an occupational health and safety issue so that where possible two staff travel together on out of town trips. This has been found to lead to a reduction in the stress associated with driving.

Few other services exist locally (e.g., counselling, drug and alcohol services, parent support groups, family support groups, domestic violence services). As a consequence, there are limited referral options for the patient at the point of discharge. This has led in some cases to patients being retained in the care of the allied health professional for a greater number of sessions. The project has attempted to address this by securing scarce resources and providing patients with written resources.

Overall, the stigma of mental illness still remains a big issue. Housing the project in local GP clinics has been a strength of the program and gone some way to reducing stigma.

Source: Interview with Dr Aine McGovern, Project Manager, Riverina Division of General Practice

Urban projects

Three major issues were highlighted in the four urban case studies: uptake and demand; workforce shortages; and availability of and co-ordination with other services. In some instances, these issues have been compounded by the demographic profile of the projects' catchment, particularly in cases where there are significant pockets of poverty.

Uptake and demand

Uptake and demand issues have varied for urban projects. In some instances, high uptake by referring GPs has been an issue. Divisions have had to put in place complex administrative systems to cope with and monitor this demand and minimise waiting lists. In some instances, however, demand had grown beyond the funding allocated, thereby putting a 'cap' on access for GPs, allied health professionals and consumers.

In other instances, the projects have been characterised by low levels of uptake and demand in inner city areas. Various reasons have been postulated for this, some GP-related (e.g., the relatively high number of non-accredited practices in inner-city areas), and some consumer-related (e.g., the fact that consumers who work in the inner city but live in the suburbs may use inner-city GPs for minor problems, and suburban GPs for more complex problems).

Workforce shortages

Although urban areas are comparatively better serviced than rural areas, both by GPs and allied health professionals, urban projects have still faced workforce issues. Some areas have significant workforce shortages, which means that the GPs who provide services locally have heavy workloads. Others have faced problems where there are relatively large numbers of GPs who work part-time, as this has impacted on their ability and/or willingness to engage with allied health professionals. Divisions have looked for innovative solutions to these problems, such as offering training to practice nurses to support GPs in mental health care service delivery in an effort to alleviate their high workloads.

Availability of and co-ordination with other services

In the inner city, a range of complementary services (e.g., counselling services, drug and alcohol services) are generally available, but issues may still arise. These services tend to be centrally located, creating problems for consumers living in outer urban areas that fall within an urban project's catchment. In addition, co-ordination between these services is not always optimal, leading to service gaps and issues with referral. The urban projects have adopted a range of innovative means to address these issues, including giving careful consideration to where and how their allied health professionals are located, and developing partnerships and formal collaborations with other services (e.g., Area Health Services) to maximise co-ordination.

Case Study 4: NSW Central Coast Division of General Practice (Outer Urban Project, New South Wales)

Program profile:

* Number of GPs registered in program: 79

* Number of allied health professionals providing services: 30

The NSW Central Coast Division's Access to Allied Psychological Services program is an outer urban program that uses a contractual model to support GPs and allied health professionals to work together to provide optimal mental health care in a metropolitan setting. Being an urban program it experiences both positive and challenging outcomes, including: high uptake and demand; collaboration opportunities; a multidisciplinary approach; GP training opportunities; and workforce issues.

Positives:

Being in an outer metropolitan location, the program has experienced a high uptake by GPs and allied health professionals since the program began in July 2003. This has meant that activity levels have grown exponentially beyond what was expected. With such an increase in service providers, extra monitoring that has been required to ensure that processes are followed – minimum dataset data entry, completion of patient care forms, payments and enactment of contracts. The patient volume has also resulted in additional monitoring on a monthly basis. This is achieved by implementing a rigorous process involving the requirement that allied health professionals send in patient details and an invoice on a monthly basis, to ensure that the status of all new, existing and completed patients are recorded. This has enabled the Division to monitor cash flow, has permitted improved activity and funding analysis, and has facilitated the Division's access to expansion funding through the Commonwealth Department of Health and Ageing. The increased number of allied health professionals has also resulted in better access for patients and shorter patients waiting times.

The local Division also aligns well with the Area Health Service which has enabled increased collaboration around the delivery of the program. A Collaboration Unit that was set up between the Division and Area Health Service four years ago has enabled additional dialogue in service planning, provision of training to GPs (one-to-one familiarisation with the program) and general support for GPs. A major benefit of the program has been the co-location of the mental health GP shared care officer within the Division who, along with the GP from the Collaboration Unit, has provided a sound clinical foundation to support GPs in the program. A Mental Health Working Party also exists for discussion, access, uptake and assessment. Overall, the existing strong links with the Area Mental Health Service have strengthened the program and have enabled it to be a responsive program for patients requiring focused psychological strategies.

Being an outer metropolitan program in a well defined coastal area, access and transport are not major issues for patients. Ease of access has also enabled face to face forums to occur between GPs, allied health professionals, patients and carers, creating multidisciplinary work.

Challenges:

The outer metropolitan location has meant that many of the Division's GPs cannot access GP training in Sydney. To overcome this, the Division linked with a pharmaceutical company which provided the opportunity for Level 1 training for GPs locally.

A broader issue/challenge for the Division is that the northern part of the region is considered an area of high GP workforce shortage (compared to the national average). The flow-on effect of being in an under-resourced area is that GP workloads are high. While practice nurses have been introduced to assist GPs in managing their workloads, the specialisation of practice nurses in mental health is not common. Teamwork is recognised as a vital ingredient for successful mental health care, within a primary care setting and there will always be opportunities to optimise patient feedback between GPs and AHPs

To date, the program has applied a model that has not restricted the number of patients a given GP can refer to the program. In January 2006, program funds for funding allied health professionals were exhausted, ceasing GP patient referrals, until further funding is secured. To optimise access for patients, the issue of increased recurrent funding is now a significant issue for this region.

Source: Interview with Paul Hussein, Operations Manager, and Donna Day, Better Outcomes in Mental Health Care Officer, NSW Central Coast Division of General Practice

Case Study 5: Mornington Peninsula Division of General Practice (Urban/Semi-rural Project, Victoria)

The Mornington Peninsula Division of General Practice's Access to Allied Psychological Services project is located in an outer urban and semi-rural location on the southern most tip of Port Phillip Bay in Melbourne, Victoria. The project uses both a centralised and decentralised model to support GPs and allied health professionals to work together to provide optimal mental health care. Its geographical location has posed several issues including: limited local service options for GP referral; long patient waiting lists; limited affordable transport options for patients; a significant low socio-economic status population; and an area designated as having a 'GP workforce shortage'.

In the area, the majority of social welfare services (e.g., counselling, drug and alcohol services etc) are centrally located in the main business centre of Frankston – the entry point to the rest of the Peninsula. Many of these services provide co-located or stand alone 'outposts' throughout the rest of the peninsula area. Most of these services have long waiting lists. This creates a dilemma for referrals requiring immediate assistance. This issue was reflected in the chronic, long-standing nature of the presenting issues of many referrals during the first 12 months the project was operating in the area.

Areas south of the central business area are almost solely accessed by private bus transport services that are costly in terms of both finances and time. This has significant implications for a community that has a high proportion of people of low socioeconomic status. The local community also has a high unemployment rate, and high levels of drug and alcohol misuse, homelessness, youth related problems and intergenerational issues. The area is also characterised by a significantly large aged population, which is increasing. These issues are further compounded by the Peninsula being designated a 'GP workforce shortage' area' with at least 25% of the GP population being 55 or older.

To address these significant issues the project uses both a centralised and decentralised model. A psychologist is employed by the Division and is based at the Division's office, centrally in Frankston (main local city) to undertake several roles: to provide psychological services to patients; to provide secondary consultations and clinical support to GPs; and to strengthen the links between the local Primary Mental Health Care Team, GP and local psychologists. A pool of 50 private allied health professionals (e.g., psychologists, psychiatric nurses etc) are also contracted by the project and are located throughout the region. This enables GPs to refer patients locally to allied health professional with a range of skills and specialties and at low cost, thereby addressing the transport and financial issues that patients would otherwise experience. Furthermore, the Division acts as broker between the GP, patient and allied health professionals, ensuring appropriated GP referral, timely pick up of referrals (approximately one week) and, to date, no waiting lists.

Overall, the Mornington Peninsula Division of General Practice has developed a project model that best suits the geographical setting and context within which it is located.

Source: Interview with Nici Lhuede, Project Manager, Mornington Peninsula Division of General Practice

Case Study 6: Canning Division of General Practice (Inner-city Urban Project, Western Australia)

The Canning Division's Access to Allied Psychological Services project straddles an inner city setting (northern end) and an outer urban setting (southern end). This case study reflects issues the program experiences in its inner city (northern end) location. The program experiences issues related to three factors: the profile of general practice clinics; the demographic profile of patients; and available referral options.

The inner city (northern) area is serviced by GPs who tend to be older (50 years and over), and work on a full-time basis in privately-owned small clinics. The program has found these GPs and clinics to be easy to work with, receptive to the program, and keen to build relationships with allied psychological services. By contrast, the outer metropolitan (southern end) area has more corporate clinics, with GPs who are part-time and work on a contractual basis. The program has found these GPs and corporate clinics difficult to engage in the program, mainly due to workforce shortages. Furthermore, these GPs in corporate clinics tend to not know or have relationships with relevant allied health services (of which there are fewer in the southern end of the corridor), and thus the appropriateness of referral may be variable. To address this low and variable interest by GP corporate clinics, the program has psychologists visit the clinics to inform them about the program.

The program has found that many patients work in the inner city (northern) area, but live in the outer metropolitan (southern) area, and prefer to utilise allied psychological/counselling services in the northern end. Furthermore, the corridor has very few mental health services, especially at the southern end (designated as an area of unmet need). To manage the demand on GPs and services in the northern end, and to supplement the appropriate referral options within the corridor, the program has now set up three counselling sites, with the most recent in the middle area to cater for the needs of patients.

The above case study has raised several key research and evaluation questions that are worthy of further exploration in the Access to Allied Psychological Services program including:

- * How different are the profiles of GPs and their clinics in inner city versus outer urban locations, and what impact does this have on the uptake and utilisation of the program?
- * Are there significant differences between corporate and privately-owned GP clinics in terms of their involvement in the Access to Allied Psychological Services Projects?

Source: Interview with Wendy Rose, Manager - Population Health, Canning Division of General Practice

Case Study 7: Perth and Hills Division of General Practice (Inner-city urban project, Western Australia)

The Perth and Hills Division's Access to Allied Psychological Services project is situated in both an inner city and a suburban setting. This case study reflects issues the program experiences in its inner city location. The program experiences issues related to three factors: the profile of general practice clinics; the demographic profile of patients; and profile of referral options. Collectively, these three factors partially explain GP involvement in the project and patient utilisation of services provided through the project.

Within the inner city area, only eight GPs (of a total of 75 spread throughout the Division) are registered with the program. These eight GPs account for 10% of patient referrals. Two clinics account for 8% of patient referrals, indicating the large variation in GP and clinic involvement in the program.

The low levels of inner city GP involvement in the Better Outcomes in Mental Health Care Program in general, and the Access to Allied Psychological Services project in particular, may be explained by several factors. Firstly, within the inner city area, there are 17 GP clinics and these comprise of a mix of privately-owned, corporate-owned, accredited and non-accredited clinics, and travel medicine/vaccination centres. The corporate-owned GP clinics have tended to be less receptive to and interested in the program. Furthermore, as only accredited/PIP practices can participate in the Better Outcomes in Mental Health Care program, 8 of the 17 inner city GP clinics are immediately ineligible. Secondly, of the GPs that do refer, the female GPs tend to be more part-time and have time constraints in their involvement in the program and subsequent building of relationships with other allied health professionals. Thirdly, it has been hypothesised that the location of the Division's premises in a suburban location, may also partly explain the low GP program uptake within the inner city area.

Prior to amalgamation with the former Swan Hills Division of General Practitioners, the former Perth Division of General Practice was situated closer to the city, and ran the precursor to the Better Outcomes in Mental Health Care Initiative. 'Mental health' GPs were not required to undergo specific training to refer to the Division's psychology service and embraced that program. However, with the rolling out of the Better Outcomes in Mental Health Care program and its associated training requirements, together with the amalgamation and relocation of the Division in the previous year to an outer suburban area, many GPs, particularly those in the inner city, failed to 'come on board'.

Another reason for the lower uptake of the ATAPs program in the inner city, could be attributed to differing patient demographics. The profile of Inner city patients includes overseas and interstate visitors and those employed in the city but living in the suburbs, who may use a city GP on an occasional basis. Indeed it is not uncommon for some patients to have more than one GP; their 'regular' GP in the suburbs for more complex and/or chronic issues, only using a city clinic on a casual basis. Furthermore, if majority of patients seen in inner city practices are employed and have private health insurance, then they are not entitled to use the program, given that the program is targeted at low income earners, health care card holders and the unemployed. The population actually residing in the inner city (6000 and 6004) is still relatively small, with new building developments affordable only to higher income earners (and therefore excluded from the ATAPs program).

In terms of GP patient referral options, only one psychologist is registered within the inner city area, and is also co-located in the clinic that has the highest referral rate. It is important to note that despite only one psychological referral option, the inner city area has many other counselling referral services.

The above case study has raised several key research and evaluation questions that are worthy of further exploration in the Access to Allied Psychological Services program including:

- * How different are the profiles of GPs and their clinics (and lengths of consultations) in inner city versus suburban locations, and what impact does this have on the uptake and utilisation of the program?
- * To what extent does the location of the Division influence the uptake of GPs in the program?
- * Do program utilisation rates differ between Australian inner city locations?
- * Are there significant differences between corporate and private GP clinic involvement in the Access to Allied Psychological Services program?

Source: Interview with Judith Bancroft, Joint Coordinator, Care & Counselling Program, Perth & Hills Division of General Practice

Chapter 9: Discussion and conclusions

Summary and interpretation of findings

Using three data sources, the current report has highlighted some similarities and differences between rural and urban Access to Allied Psychological Services projects. These similarities and differences are summarised below in answer to the six evaluation questions posed at the beginning of this report:

Do the models of service delivery being used in rural and urban projects differ?

According to data from the survey on models of service delivery, both rural and urban projects are using a mix of models. There are some notable differences in each of the domains on which models of service delivery differ, however.

In terms of their means of retaining allied health professionals, there was a tendency for rural projects to be more likely than urban projects to directly employ allied health professionals, with 37% of the former doing so compared with only 21% of the latter. There may be a number of reasons for this, but the retention preferences of allied health professionals in areas characterised by distance and isolation would seem to be paramount. Whereas in urban projects many allied health professionals will have existing private practices and will contract with projects to provide services on a part-time basis, in rural projects it may only be possible to attract some allied health professionals to the area if guaranteed employment is provided.

Rural and urban projects also differ in terms of the location of their allied health professionals, with the former tending to be less likely to have allied health professionals providing services from their own rooms (53% versus 72%). Again, one reason for this may relate to the fact that alternative service provision options may be less available for allied health professionals in rural areas, so allied health professionals may not have their own rooms. Perhaps more importantly, the size of the catchment of many rural projects means that for services to be provided in a manner that equitably increases access, the allied health professional must provide services from a number of locations. The latter interpretation is supported by the findings of the rural case studies, which suggested that decentralised ways of operating were often favoured.

With regard to the referral mechanisms of choice, rural projects are significantly more likely than urban projects to implement direct referral systems (64% versus 38%), and tend to be less likely to use register systems (17% versus 32%). Direct referral systems tend to operate in circumstances where the allied health professional is co-located with the GP, which, as noted above, is more common in rural projects. Conversely, register systems rely on there being sufficient numbers of allied health professionals to warrant a choice, which may not be the case in many rural projects.

Does the level of uptake of rural and urban projects differ?

According to the minimum dataset, the absolute numbers of referring GPs in the rural and urban projects are similar (1,587 and 1,639, respectively), as are the absolute numbers of consumers (14,137 and 16,649, respectively). The populations of both GPs and the general population in rural areas are much smaller in size than those in urban areas (with around 10% of both GPs and the general population being located in rural areas), so if these absolute numbers were converted to rates, the uptake in rural projects would be much higher than that in urban projects. There may be several reasons for this. One may relate to the fact that project funding has not been allocated by a population-based formula (so urban projects have approached or reached the limit of their 'capped' budgets with more consumers left to serve. Another may relate to the relatively greater

service gaps in rural areas that existed prior to the introduction of the Access to Allied Psychological Services projects, which may have translated into increased demand.

The absolute number of allied health professionals in rural projects is about half that in urban projects (359 versus 770). Using the same logic as above, and assuming that the geographic distribution of allied health professionals is not dissimilar to that of GPs, this suggests that proportionally more allied health professionals are involved in rural projects than in urban projects. The data also suggest that the average project-related caseload is higher for rural allied health professionals than for urban allied health professionals, which may relate to difficulties attracting allied health professionals to rural areas, resulting in a comparatively smaller pool of providers.

Do the profiles of consumers accessing care through rural and urban projects differ?

The socio-demographic profiles of rural and urban consumers display some important differences, as well as some similarities. Although the majority of consumers in both rural and urban locations are female, there are proportionally more male consumers in rural settings (28% versus 26%). Rural consumers are also slightly older. The proportion of consumers who speak English at home is higher in rural projects (99% versus 96%). Fewer other languages are spoken by rural consumers who do not speak English at home than by their urban counterparts (27 versus 65), but the level of English language proficiency among these groups is similar. Higher proportions of rural consumers are of Aboriginal or Torres Strait Islander origin (2.6% versus 0.9%). Rural consumers tend to be of lower socio-economic status, as measured by educational attainment, with only 22% completing some tertiary education compared with 30% of urban consumers. Presumably, these findings reflect the differing demographic profiles found in city and country areas.

Similarly, the clinical profiles of rural and urban consumers show some differences, but also certain commonalities. Although the majority of each have depression and/or anxiety disorders, a lower proportion of rural consumers have the latter (55% versus 60%). About half of each group are taking psychotropic medication, with antidepressants being the most commonly prescribed in both (but taken by proportionally more rural consumers (90%) than urban consumers (88%) on medication). About half of each have no previous psychiatric service history. More rural consumers are referred for cognitive interventions (69% and 68%, respectively) and diagnostic assessment (45% versus 37%), and fewer for behavioural interventions (52% and 55%).

Do the services consumers are receiving through rural and urban projects differ?

The services consumers are receiving through rural and urban projects are similar in many respects, but also show some differences. The majority of sessions in both settings are 46-60 minutes in length, although a smaller proportion are of this duration in rural settings (75% versus 80%). The majority in both settings involve individual treatment (98% in both). The majority in both settings involve cognitive interventions and behavioural interventions, although the proportions of each are lower in rural settings (59% versus 62% for cognitive interventions, and 42% versus 47% for behavioural interventions).

The number and cost of sessions also display similarities and differences. The mean number of sessions per consumer is lower in rural projects than in urban projects (4.4 compared with 5.7), although similar proportions of consumers in rural and urban projects have been allocated an additional six sessions beyond the initial six (13% in the former and 16% in the latter). No co-payment is charged in 82% of rural sessions, compared with only 68% of urban sessions. Where co-payments are charged, they tend to be \$25 or less in both settings, although there is greater variability in urban settings.

Do consumer outcomes in rural and urban projects differ?

Analysis of outcome data from the minimum dataset suggested that both rural and urban projects are achieving positive consumer outcomes. The different outcome measures being used across projects precluded the possibility of directly comparing the relative magnitude of change for rural consumers and urban consumers.

Do the issues faced by rural and urban projects differ, and do the solutions to these issues vary?

The case studies suggest that the rural and urban projects have faced different issues. Rural projects have struck problems to do with: distance; attracting qualified staff; lack of training and support for GPs; limited services; large Indigenous populations; high levels of unemployment; and stigma. By contrast, the issues for urban projects have related more to: uptake and demand; workforce shortages; and availability of and co-ordination with other services. Both rural and urban projects have addressed these problems in novel and innovative ways, seeking solutions that are responsive to the local context.

Some caveats

Some caution should be exercised in interpreting the above findings, as the data sources from which they were drawn had certain limitations.

Firstly, it should be noted that the survey on models of service delivery was conducted six months ago, so some of the models in given projects may have changed. Having said this, the majority of projects were relatively 'settled' by the time of the survey, so this is unlikely to have had a major impact.

Secondly, it must be acknowledged that the minimum dataset has some issues in terms of compliance and completion. In total, 91% of all projects had entered data into the minimum dataset at the time of analysis, resulting in data that represent underestimates. It should be noted, however, that this would not be expected to have a differential effect on the estimates for rural and urban projects, since similar proportions of each had submitted data.

Finally, the case studies were few in number and, by necessity, selected on the basis of the availability and willingness of the relevant project officer to participate in an interview. This limits the extent to which generalisations should be made from their experiences.

Conclusions

Despite the above caveats, the findings of the current evaluation exercise shed some light on the similarities and differences between rural and urban Access to Allied Psychological Services projects. The thrust of the models is similar in the two localities, but there are some differences that reflect the different environmental, contextual and demographic factors in rural and urban areas. In particular, allied health professionals in rural areas are more likely to be directly employed, provide services from GPs' rooms and receive referrals directly. The level of uptake of the projects in rural areas appears to be proportionally higher, in terms of the relative numbers of providers, consumers and sessions, perhaps reflecting greater previous service gaps in these areas. Any differences in the socio-demographic and clinical profiles of consumers, and in the extent and nature of services provided, seem to reflect the make-up of the local populations and the support needs of local GPs. Importantly, consumer outcomes are positive in both settings. Rural and urban Divisions have faced different hurdles in getting the projects 'up and running', but appear to have addressed these in a manner that has been tailored to local needs. This has undoubtedly contributed to the ongoing success of the projects in the two different settings.

References

1. Australian Bureau of Statistics. *Mental Health and Wellbeing: Profile of Adults, Australia, 1997*. Canberra: Australian Bureau of Statistics; 1998.
2. Henderson S, Andrews G, Hall W. Australia's mental health: An overview of the general population survey. *Australian and New Zealand Journal of Psychiatry*. 2000;34:197-205.
3. Joint Consultative Committee on Psychiatry. *Primary Care Psychiatry: The Last Frontier*. Canberra: Australian Government Publishing Service; 1997.
4. Eckert KA, Taylor AW, Wilkinson D, Tucker GR. How does mental health status relate to accessibility and remoteness? *Medical Journal of Australia*. 2004;181(10):540-543.
5. Commonwealth Department of Health and Aged Care. *Promotion, Prevention and Early Intervention for Mental Health: A Monograph*. Canberra: Commonwealth Department of Health and Aged Care; 2000.
6. Caldwell TM, Jorm AF, Knox S, Braddock D, Dear KBG, Britt H. General practice encounters for psychological problems in rural, remote and metropolitan areas in Australia. *Australian and New Zealand Journal of Psychiatry*. 2004;38(10):774-780.
7. Rajkumar S, Hoolahan B. Remoteness and issues in mental health care: experience from rural Australia. *Epidemiologia e Psichiatria Sociale*. 2004;13(2):78-82.
8. Regional Communities Consultative Council. *Beyond Desolation: Understanding Suicide in Rural New South Wales*. Sydney: Regional Communities Consultative Council; 2000.
9. Australian Bureau of Statistics. *Household Income, Living Standards and Financial Stress*. Canberra: Australian Bureau of Statistics; 2002.
10. Young AF, Russell A, Powers JR. The sense of belonging to a neighbourhood: Can it be measured and is it related to health and well being in older women? *Social Science and Medicine*. 2004;59(12):2627-2637.
11. SANE Australia. *SANE Mental Health Report, 2002-03*. Melbourne: SANE Australia; 2003.
12. Mental Health Council of Australia. *Out of Hospital: Out of Mind*. Canberra: Mental Health Council of Australia; 2003.
13. Mental Health Council of Australia. *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia*. Canberra: Mental Health Council of Australia; 2005.
14. Tobin M, Chen L, Edwards JL, Chan S. Culturally sensitive mental health services through quality improvement. *International Journal of Health Care Quality Assurance*. 2000;13(1):15-20.
15. Eagar K, Pirkis J, Owen A, Burgess P, Posner N, Perkins D. Lessons from the National Mental Health Integration Program. *Australian Health Review*. 2005;29(2):189-200.
16. Hickie I, Pirkis J, Blashki G, Groom G, Davenport T. General practitioners' response to depression and anxiety in the Australian community: A preliminary analysis. *Medical Journal of Australia*. 2004;181(7):S15-S20.
17. Blashki G, Pirkis J, Kohn F, Morley B, Naccarella L, Burgess P. Better Outcomes in Mental Health Care initiative update. Paper presented at: Re-order Forum, 2006; Melbourne.
18. Pirkis J, Blashki G, Headey A, Morley B, Kohn F. *Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: First Interim Evaluation Report*. Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne; 2003.
19. Morley B, Kohn F, Pirkis J, Blashki G, Burgess P. *Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care*

- Initiative: Second Interim Evaluation Report.* Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne; 2004.
20. Morley B, Kohn F, Pirkis J, Blashki G, Burgess P. *Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: Third Interim Evaluation Report: Benefits and Barriers Associated with Different Models of Service Delivery.* Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne; 2005.
 21. Kohn F, Morley B, Pirkis J, Blashki G, Burgess P. *Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: Fourth Interim Evaluation Report.* Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne; 2005.
 22. Pirkis J, Morley B, Kohn F, Blashki G, Burgess P. *Evaluating the Access to Allied Health Services Component of the Better Outcomes in Mental Health Care Initiative: Fifth Interim Evaluation Report - Models of Service Delivery: Profile and Association with Access.* Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne; 2005.
 23. Kohn F, Morley B, Pirkis J, et al. *Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Sixth Interim Evaluation Report: Progressive Achievements over Time.* Melbourne: Program Evaluation Unit, School of Population Health, The University of Melbourne; 2005.
 24. Pirkis J, Stokes D, Morley B, et al. Impacts of Australia's Better Outcomes in Mental Health Care program for psychologists. *Australian Psychologist.* In press.
 25. Australian Government Productivity Commission. *The Health Workforce.* Canberra: Australian Government Productivity Commission; 2005.
 26. 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.
 27. Pirkis J, Kohn F, Morley B, Burgess P, Blashki G. Better Outcomes in Mental Healthcare? *Primary Care Mental Health.* 2004;2:141-149.

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

Component 1: Education and training for GPs

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

Component 2: The 3 Step Mental Health Process

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

Component 3: Focused Psychological Strategies

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

Component 4: Access to Allied Psychological Services

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

Component 5: Access to Psychiatrist Support

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

Appendix 2: Access to Allied Psychological Services projects

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

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