
PROGRAM **E**VALUATION **U**NIT



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

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Table of contents

Executive summary	2
Chapter 1: Background	5
Chapter 2: Method	9
Chapter 4: Has participation in the projects by GPs and allied health changed over time?	11
Chapter 5: Has access to and the nature of mental health care for consumers changed over time?	14
Chapter 6: Have the experiences of GPs, allied health professionals and consumers changed over time?	19
Chapter 7: Are the projects achieving positive outcomes for consumers?	24
Chapter 8: Summary and conclusions	26
References	29
Appendix 1: Components of the Better Outcomes in Mental Health Care program	30
Appendix 2: Access to Allied Psychological Services projects	32

Executive summary

Background

The Better Outcomes in Mental Health Care program seeks to improve consumers' access to high quality primary mental health care. The Australian Government initially provided \$120m for the program for four years from July 2001, and in July 2005 committed a further \$145m funds for a new phase of continuation and expansion over the next 4 to 5 years.

A key component of the program is the Access to Allied Psychological Services (ATAPS) component, which supports GPs and psychologists to work together to provide optimal mental health care. This is occurring through 104 projects being conducted by Divisions of General Practice and funded in four funding rounds: 15 from June 2002 (Round 1 pilot projects); 14 from January 2003 (Round 1 supplementary projects); 40 from July 2003 (Round 2 projects); 33 from July 2004, one of which is no longer running (Round 3 projects); and three from July 2005 (Round 4 projects).

The projects enable trained and registered GPs to refer consumers to allied health professionals for six free or low-cost sessions of evidence-based mental health care, with the option of a further six sessions after review by the GP. GPs can refer to specified allied health professionals, around 90% of whom are psychologists.¹ The projects are operating under a range of service delivery models which differ in how psychologists are retained and located, and how they received referrals.

Method

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

- Has participation in the projects by GPs and allied health professionals changed over time?
- Have access to and the nature of mental health care for consumers changed over time?
- Have the experiences of GPs, allied health professionals and consumers changed over time?
- Are the projects achieving positive outcomes for consumers?

Key findings

Has participation in the projects by GPs and allied health professionals changed over time?

In total, 2,980 GPs have made referrals to 1,040 allied health professionals since the projects began. There has been a dramatic increase in participation rates by both GPs and allied health professionals over the life of the projects. In the first quarter for which data were available (July-September 2003), 417 GPs made referrals to 118 allied health professionals; in the most recent quarter for which complete data were available (April-June 2005), the equivalent figures were 1,266 and 627.

Have access to and the nature of mental health care for consumers changed over time?

The total number of consumers receiving care through the projects is 26,444. The number of consumers receiving care through the projects has increased on a quarter-by-quarter basis, beginning at 1,056 in July-September 2003 and peaking at 4,196 in April-June 2005. This translates to an increase from an average of 11.5 consumers receiving treatment per day to an average of 46.1 doing so. The profile of these consumers has remained fairly consistent over time, and is well aligned with the target group that the projects are designed to reach: they are typically female, are aged around 40, are on low incomes, have no previous history of mental health care, and have been diagnosed with depression or anxiety disorders.

The total number of sessions provided to these consumers is 102,120. Once again, there is a clear increase in the number of sessions provided over time, rising from 3,928 provided in the July-September 2003 quarter (i.e., 42.7 sessions per day) to peak at 16,481 in the April-June 2005 quarter (i.e., 181.1 sessions per day). The average number of sessions per consumer has remained relatively constant over time, at around four. In the main, the profile of these sessions has not changed over time, with the majority being individually-based, an hour in length, and consisting of CBT-based cognitive and behavioural therapies. The only notable fluctuation over time relates to the charging of a co-payment. Early sessions rarely incurred a co-payment, and where they did it was usually \$10 or less; subsequent sessions more commonly involved a co-payment, sometimes of as much as \$20 or more; and more recent sessions have been less commonly associated with a co-payment although the situation has not returned to the original low.

Have the experiences of GPs, allied health professionals and consumers changed over time?

Qualitative data from the local evaluation reports indicates that some experiences for stakeholders have remained constant over time, while others have changed. Round 1 and 2 GPs have cited a number of benefits of involvement in the projects – namely upskilling opportunities, mutual advantages of collaboration with allied health professionals, increased referral options and the structured approach to providing mental health care – and Round 3 GPs concur. Round 1 and 2 GPs have also articulated various barriers to their participation that are underscored by Round 3 GPs, including the hurdles of training and paperwork requirements. However, some other barriers cited by Round 1 and 2 GPs – such as remuneration issues, inadequate feedback from allied health professionals and confusion over the operation of the projects – have proved less problematic for Round 3 GPs, largely because of the efforts of Divisions to ‘iron them out’.

Round 1 and 2 allied health professionals have consistently cited their improved relationships with GPs and increased referral base as benefits of involvement in the projects, and have expressed appreciation for the high level of Divisional support. Their Round 3 counterparts reiterate these benefits. Round 1 and 2 allied health professionals have identified inadequate remuneration as the major barrier to their involvement, along with operational issues like travel time. Round 3 allied health professionals have also cited these as issues, but have not expressed the same degree of difficulty with lack of security of work and inappropriate referrals as their Round 1 and 2 colleagues.

Consumers who have received services through the Round 1 and 2 projects appreciate their improved access to high quality care and believe that this has translated into positive mental health outcomes. Round 3 consumers agree. The major issue for Round 1 and 2 consumers has always been equity, and this remains the case for Round 3

consumers. The restricted nature of sessions has also been flagged as a concern by all three groups.

Are the projects achieving positive outcomes for consumers?

In recent times, specific fields have been added to the minimum dataset that enable Divisions to enter data from standardised outcome measures. To date, data have been entered for only a small proportion of consumers (less than 5%), but the findings are encouraging. In 88% of cases, consumers who have contact with allied health professionals through the Access to Allied Psychological Services projects get better.

Conclusions

The current report indicates that the Access to Allied Psychological Services projects have gained considerable momentum over time. Collectively, they are attracting far more GPs and allied health professionals and are providing access to high quality mental health care than was the case originally. The projects are now well-established, and have passed their initial 'settling in' period, as is evidenced by the fact that the profile of consumers they are treating and the nature of sessions they are providing have both reached a point of consistency (with the only notable variation in either relating to the issue of a co-payment). Further evidence that the projects are well-established comes from focus group, interview and survey data provided in local evaluation reports. To use a qualitative research term, these data have reached 'saturation', in the sense that relatively few new issues are being identified. There is good evidence that the projects are achieving positive results for consumers, in terms of alleviating symptoms, improving levels of functioning, and impacting on general wellbeing.

The Access to Allied Health Services projects appear to have become a crucial part of the mental health care landscape in Australia. They are reaching more and more people who may previously have had difficulty accessing services, they are providing high quality care in a consistent fashion. Most significantly, they are achieving their desired results. It will be important from now on to ensure that the appropriate funding and support systems are in place to ensure that the projects continue to be sustainable.

Chapter 1: Background

The Better Outcomes in Mental Health Care program

The Better Outcomes in Mental Health Care program^a seeks to improve consumers' access to high quality primary mental health care. The Australian Government initially provided \$120m for the program for four years from July 2001, and in July 2005 committed a further \$145m funds for a new phase of continuation and expansion over the next 4 to 5 years. The program involves five components, each of which is described in more detail in Appendix 1:

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

The Access to Allied Psychological Services component

This report concentrates on the Access to Allied Psychological Services component, which supports GPs and psychologists to work together to provide optimal mental health care. This is occurring through 104 projects being conducted by Divisions of General Practice and funded in four funding rounds: 15 from June 2002 (Round 1 pilot projects); 14 from January 2003 (Round 1 supplementary projects); 40 from July 2003 (Round 2 projects); 33 from July 2004, one of which is no longer running (Round 3 projects); and three from July 2005 (Round 4 projects). Appendix 2 provides a full list of these projects.

The projects are similar, in that they permit eligible GPs^c to refer consumers to allied health professionals^d who deliver focused psychological strategies, namely (a) psycho-education; (b) cognitive behavioural therapy (including behavioural interventions, cognitive interventions, relaxation strategies and skills training); and (c) interpersonal therapy. These services are deliverable in up to six time-limited sessions with an option for up to a further six sessions following a mental health review by the referring GP.

However, they differ in terms of their models of service delivery. Specifically, they differ in: (a) their means of retaining allied health professionals (with some retained under contractual arrangements and others being directly employed); (b) where allied health professionals are located (with some providing services from GPs' rooms, others from their own rooms, and still others from a third location); and (c) the way in which allied health professionals receive referrals (with voucher systems, brokerage systems, register systems and direct referral being used).

Evaluating the Access to Allied Psychological Services component

For the past two years, the Program Evaluation Unit from The University of Melbourne's School of Population Health has been synthesising evaluation evidence from these projects, drawing on information from projects' local evaluation and project

^a Formerly the Better Outcomes in Mental Health Care initiative.

^b Formerly the Access to Allied Psychological Services component.

^c GPs who have undergone Level 1 training, as described in Appendix 1.

^d Allied health professionals have been defined to include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers.

implementation reports,^e a purpose-designed minimum dataset, a Divisional forum, and one-off surveys. Progressively, five interim evaluation reports have been produced, all of which are available on the Primary Mental Health Care Australian Resource Centre (PARC) website (<http://som.flinders.edu.au/FUSA/PARC/alliedhealthmain.html>).¹⁻⁵

These reports have varied in focus, depending on the information that has been available at the time. Table 1 summarises the content of each, describing the projects that were included in the relevant data collection and analysis exercises, the specific data sources that were utilised, and the evaluation questions that were considered. Together, the reports have monitored the progress of the projects over time.

The current report

The current report is the sixth in the series. As Table 1 shows, it is the most comprehensive to date, in that it provides an Australia-wide picture of the achievements of the projects in the first three funding rounds. It draws on data from the projects' local evaluation reports and the minimum dataset, and focuses specifically on the progressive achievements of the projects, considering changes over time and outcomes to date.

^e For simplicity, local evaluation and project implementation reports are all referred to as 'local evaluation reports' in the remainder of this report.

Table 1: Summary of focus of interim evaluation reports

Report	Projects included	Data sources	Evaluation questions
First Interim Evaluation Report ²	Round 1 pilot projects – Australia	<ul style="list-style-type: none"> Local evaluation reports 	<ul style="list-style-type: none"> What models of service delivery are being used by the pilots? What is the uptake of the pilots? What are the advantages and disadvantages of the pilots?
Second Interim Evaluation Report ¹	Round 1 pilot and supplementary projects – Australia	<ul style="list-style-type: none"> Local evaluation reports Minimum data 	<ul style="list-style-type: none"> What models of service delivery are being used by the projects? What is the level of uptake of the projects? Who is accessing services through the projects? What services are consumers receiving through the projects? What are the advantages and disadvantages of the projects?
Third Interim Evaluation Report ³	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects – Victoria and Tasmania	<ul style="list-style-type: none"> Evaluation forum 	<ul style="list-style-type: none"> Do models of service delivery differ from the conceptualisation outlined in the First and Second Interim Evaluation Reports? What are the benefits and barriers associated with the means of retaining allied health professionals? What are the benefits and barriers associated with the various locations from which allied health professionals deliver services? What are the benefits and barriers associated with the different referral mechanisms?
Fourth Interim Evaluation Report ⁴	Round 1 pilot and supplementary projects, Round 2 projects – Australia	<ul style="list-style-type: none"> Local evaluation reports Minimum data 	<ul style="list-style-type: none"> What models of service delivery are being used by the projects? What is the level of uptake of the projects? Who is accessing services through the projects? What services are consumers receiving through the projects? What are the benefits and barriers associated with the projects? What lessons have been learned from the early experiences of the projects?

Report	Projects included	Data sources	Evaluation questions
Fifth Interim Evaluation Report ⁵	Round 1 pilot and supplementary projects, Round 2 projects – Australia	<ul style="list-style-type: none"> • Survey 	<ul style="list-style-type: none"> • What is the profile of models of service delivery across the Access to Allied Psychological Services projects? • Are particular models associated with differential levels of consumer access to services?
Sixth Interim Evaluation Report (current)	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects – Australia	<ul style="list-style-type: none"> • Local evaluation reports • Minimum data 	<ul style="list-style-type: none"> • Has participation in the projects by GPs and allied health professionals changed over time? • Has access to and the nature of mental health care for consumers changed over time? • Have the experiences of GPs, allied health professionals and consumers changed over time? • Are the projects achieving positive outcomes for consumers?

Chapter 2: Method

Evaluation questions

As noted in the previous section, this Sixth Interim Evaluation Report considers the progressive achievements of the Access to Allied Psychological Services projects, via the following evaluation questions:

- Has participation in the projects by GPs and allied health professionals changed over time?
- Has access to and the nature of mental health care for consumers changed over time?
- Have the experiences of GPs, allied health professionals and consumers changed over time?
- Are the projects achieving positive outcomes for consumers?

Data sources

To do this, the report draws on information from two sources, namely the local evaluation reports and data from the minimum dataset for the Round 1, 2 and 3 projects. Each of these data sources is described in more detail below. For each, the cut-off point for inclusion in the current report was 30 September 2005.

Data from local evaluation reports

As at 30 September 2005, 84 (83%) of the Round 1, 2 and 3 projects had submitted local evaluation reports (152 reports in total). Table 2 provides a breakdown of these projects by funding round, and shows that, proportionally, the Round 3 projects had the most impressive record of submitting local evaluation reports (with 94% doing so).

The local evaluation reports varied in terms of content – some drew on quantitative data sources, most commonly routinely-collected registration and utilisation data; others cited qualitative data, reporting on the opinions of GPs, allied health professionals and consumers elicited from surveys, focus groups and key informant interviews. The local evaluation reports also varied in terms of quality and comprehensiveness, with some providing extensive information from rigorously-designed evaluations, and others providing only brief details of the operation of the given project. Together, these differences had some impact on the comparability of the information contained in these reports, but every effort was made to synthesise this information in a meaningful manner. It should be noted that the Round 3 projects adopted a template for their initial reporting which made the synthesis task easier for this group of projects.

Data from the minimum dataset

Data from the minimum dataset was available for the nine quarters from 1 July 2003 (when the minimum dataset had been 'rolled out') to 30 September 2005.^f Ninety six per cent of all projects submitted data to the minimum dataset during this period – 100% of the Round 1 projects, 100% of the Round 2 projects, and 88% of the Round 3 projects (see Table 2).

^f The minimum dataset was not 'rolled out' until approximately one year after the Round 1 pilot projects had been funded and six months after the Round 1 supplementary projects had been funded. Having said this, most of these projects did not reach full operation until some months after they were funded, and the majority entered any data they had collected prior to the introduction of the minimum dataset, once the dataset became available.

Data were extracted from the minimum dataset on the numbers of GPs and allied health professionals providing services through the projects, the number and profile of consumers accessing these services, the number and nature of these services, and the consumer outcomes associated with these services. All data were analysed using SPSS (Version 11.5), and are presented as simple frequencies, percentages and means.

Table 2: Overview of Round 1, 2 and 3 projects submitting local evaluation reports and minimum dataset data as at 30 September 2005

	Projects submitting local evaluation reports	Projects submitting data to the minimum dataset
Round 1 projects (n=29)	22 (76%)	29 (100%)
Round 2 projects (n=40)	32 (80%)	40 (100%)
Round 3 projects (n=32)	30 (94%)	28 (88%)
TOTAL (n=101)	84 (83%)	97 (96%)

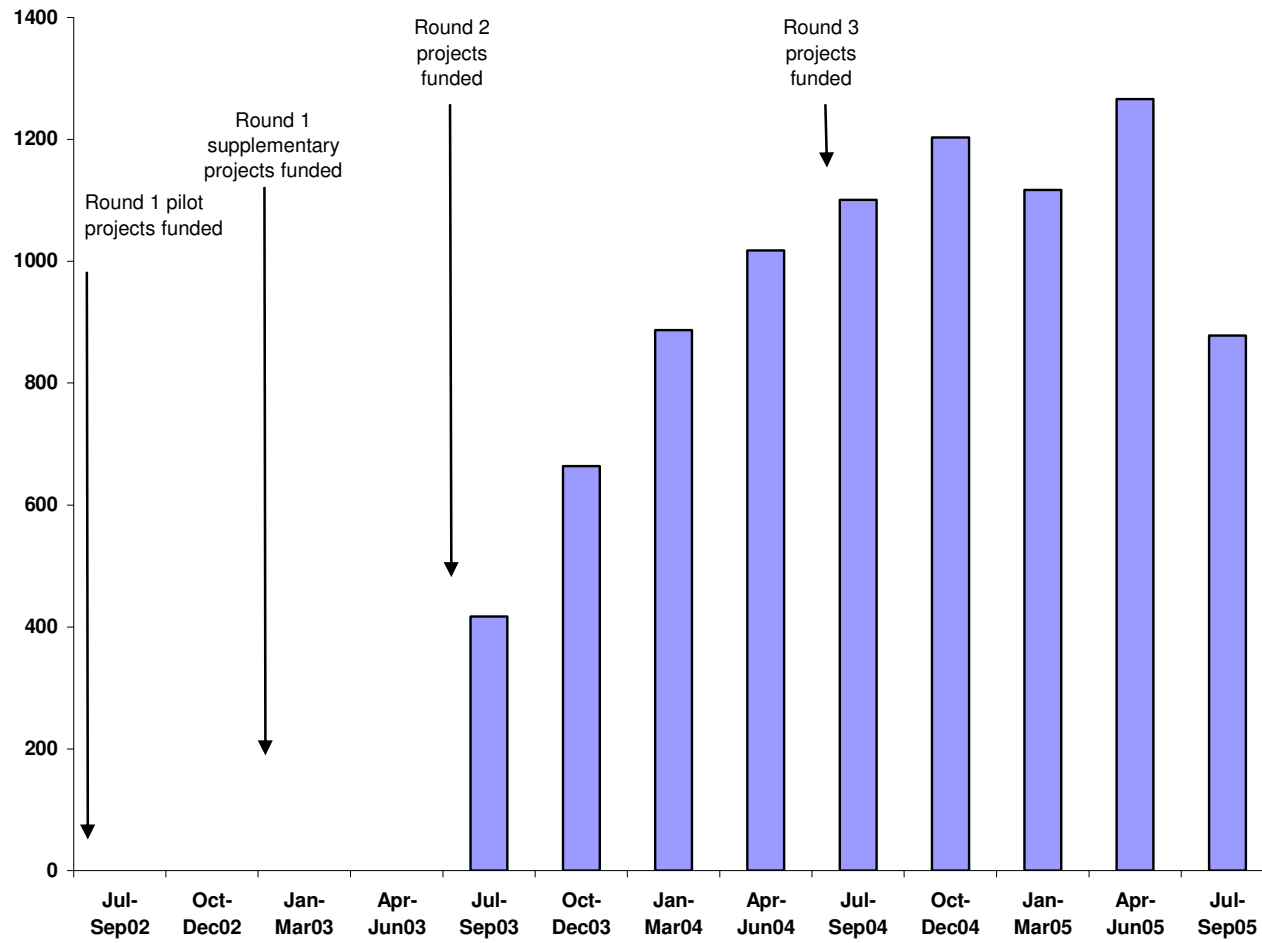
- a. Total number of reports: 15
- b. Total number of reports: 17
- c. Total number of reports: 54
- d. Total number of reports: 66
- e. Total number of reports: 152

Chapter 4: Has participation in the projects by GPs and allied health changed over time?

Increases in GP and allied health professional participation over time

Between when the Access to Allied Psychological Services projects began and 30 September 2005, 2,980 GPs have referred consumers to 1,040 allied health professionals. Figures 1 and 2 show that, on a quarter-by-quarter basis, there has been an increase over time that corresponds with additional projects coming 'on line', and existing projects becoming more established. The number of GPs making referrals rose from 417 in the July-September 2003 quarter to 1,266 in the April-June quarter 2005. The equivalent figures for allied health professionals were 118 and 627. It should be noted that the slight drop in the July-September 2005 quarter for both GPs and allied health professionals is likely to be due to a data entry lag, rather than a real drop in service provision.

Figure 1: GP participation in the Access to Allied Psychological Services projects over time



Chapter 5: Has access to and the nature of mental health care for consumers changed over time?

Improved access for consumers

The Access to Allied Psychological Services projects have provided psychological treatment for 26,444 consumers. Figure 3 shows that the numbers of consumers accessing care have increased over time, with 1,056 doing so in the first quarter for which data were available (July-September 2003) and 4,196 doing so in the last quarter for which complete data were available (April-June 2005). This translates into an increase from an average of 11.5 consumers receiving treatment per day to an average of 46.1 doing so.

Table 3 summarises some of the key characteristics of the consumers receiving care through the projects, and provides a breakdown over time. It shows that the demographic profile of consumers has been consistent over time, with around three quarters of all consumers being female, and the mean age being static at just under 40.

Table 3 also shows that, the projects have been and are continuing to reach the consumers that they are designed to reach. The majority (around two thirds) are on low incomes. About half have no previous history of mental health care, indicating that access may previously have been problematic for them. Most have been diagnosed with depression (around three quarters) or anxiety disorders (over half).

Improved quality of care for consumers

Between their inception and 30 September 2005, the Access to Allied Psychological Services projects have provided 102,120 sessions of psychological care to the above consumers. Figure 3 shows the number of sessions provided to consumers on a quarter-by-quarter basis. Once again, there is a clear increase in the number of sessions provided over time, rising from 3,928 provided in the July-September 2003 quarter to peak at 16,481 in the April-June 2005 quarter. This translates to an increase from an average of 42.7 sessions per day to an average of 181.1 per day. The average number of sessions per consumer has remained relatively constant over time, at around four. As noted in previous reports, this is lower than the six prescribed sessions because some Divisions do not receive information about any sessions until all six are completed (and therefore cannot enter the relevant sessional data into the minimum dataset).

Table 4 summarises some of the key features of the sessions of care provided to consumers, profiling changes over time. It shows that the projects are being delivered in the way in which was originally intended, in that they are providing free or low-cost, evidence-based mental health care through structured sessions. In the main, the profile of these sessions has not changed over time. One-hour sessions have consistently been the most popular format over time, accounting for around four fifths of all sessions, and reflecting the complexity of care provided in these sessions.

Almost all of these sessions have been delivered to individuals, rather than groups, presumably because of the difficulty of organising the latter. Having said this, the local evaluation reports indicate that a number of projects have run or are planning to run group programs, in some cases to manage waiting lists or to extend funding.

The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 60% of sessions and

45% of session, respectively. These interventions are evidence-based, and widely regarded as appropriate for treating the types of high prevalence disorders with which consumers are presenting (see above).

The only notable change over time has been in the charging of a co-payment. In the first quarter for which data were available (July-September 2003), only 9% of sessions incurred a co-payment, and the out-of-pocket cost to the consumer was \$10 or less. Over time, a greater proportion of sessions involved a co-payment, and the magnitude of the co-payment became more substantial. So, for example, one year later (July-September 2004), a co-payment was made at 41% of sessions, and in 5% of sessions this was over \$20. As still more time elapsed, the pendulum swung back the other way, and the proportion of sessions associated with a co-payment reduced, though not to its previous low. In the July-September 2005 quarter, 22% of sessions involved a co-payment, with only 1% being greater than \$20. Anecdotal evidence suggests that these fluctuations over time represent an attempt to strike a balance between providing a free service to a limited number of people, and a low-cost service to a larger number of people. They may also reflect the view that a small co-payment may encourage greater commitment to treatment on the part of the consumer.

Figure 3: Consumers accessing sessions of care through the Access to Allied Psychological Services projects over time

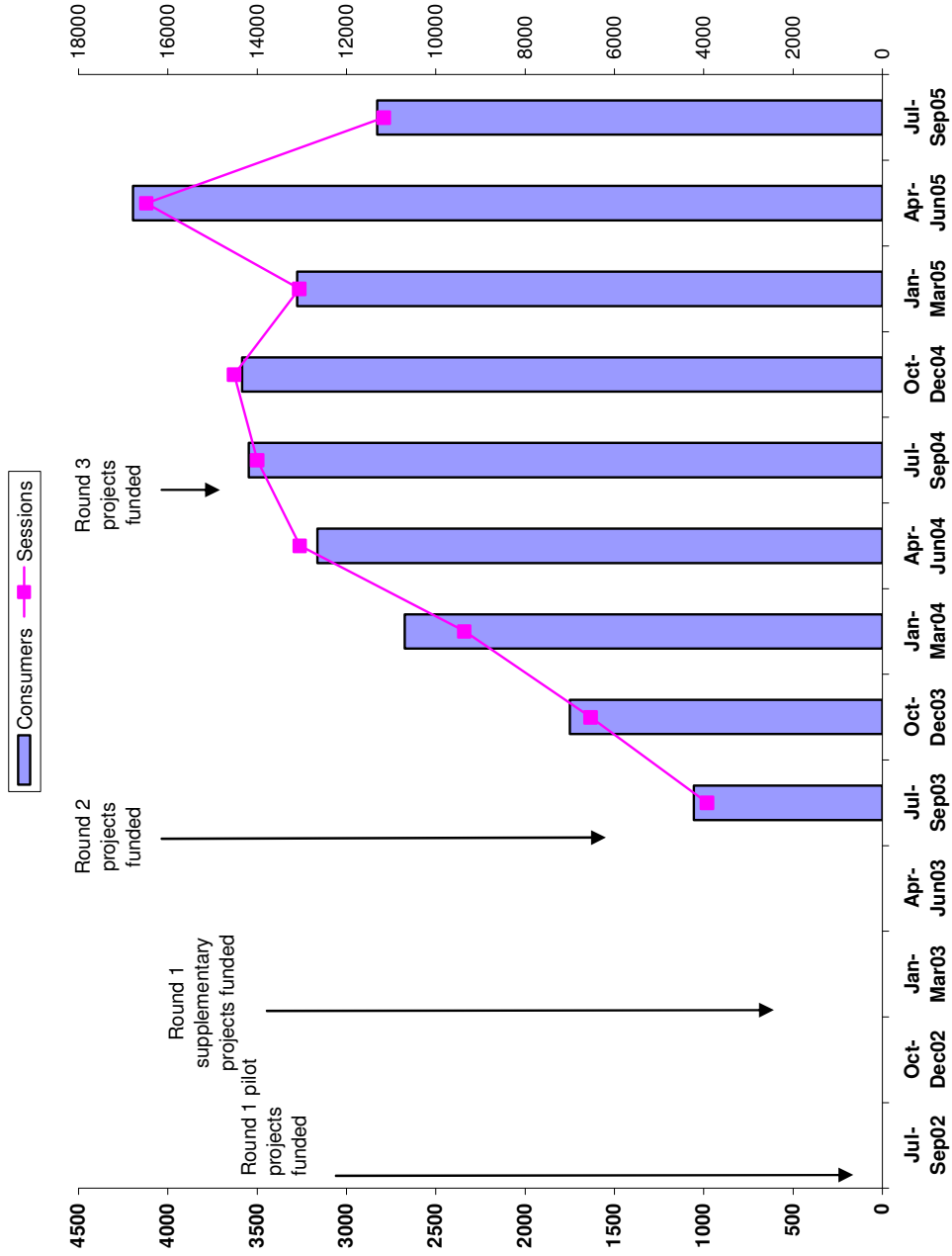


Table 3: Summary characteristics of consumers receiving care through the Access to Allied Psychological Services projects over time

	Jul-Sep03	Oct-Dec03	Jan-Mar04	Apr-Jun04	Jul-Sep04	Oct-Dec04	Jan-Mar05	Apr-Jun05	Jul-Sep05
Gender									
• Female	72%	77%	73%	73%	74%	72%	73%	73%	71%
• Male	28%	23%	27%	27%	26%	28%	27%	27%	28%
Mean age									
	39	39	39	39	38	39	39	39	38
Low income									
• Yes	55%	59%	62%	64%	63%	63%	62%	64%	65%
• No	23%	24%	24%	23%	22%	23%	25%	25%	22%
• Unknown	22%	16%	15%	14%	15%	14%	13%	11%	12%
Previous psychiatric service use									
• Yes	31%	33%	36%	39%	36%	40%	40%	41%	40%
• No	42%	47%	49%	48%	48%	45%	47%	47%	49%
• Unknown	27%	21%	15%	12%	15%	16%	13%	12%	12%
Diagnosis									
• Alcohol and drug use disorders	7%	6%	6%	6%	7%	8%	7%	7%	7%
• Psychotic disorders	1%	2%	2%	2%	2%	2%	2%	2%	2%
• Depression	76%	77%	74%	74%	76%	74%	73%	76%	74%
• Anxiety disorders	50%	57%	55%	56%	57%	58%	56%	58%	57%
• Unexplained somatic disorders	3	3	3	3	3	3	4	3	3
• Unknown	5	0	3	0	0	3	2	0	0

a. Multiple responses permitted

Table 4: Summary characteristics of sessions provided to consumers through the Access to Allied Psychological Services projects over time

	Jul-Sep03	Oct-Dec03	Jan-Mar04	Apr-Jun04	Jul-Sep04	Oct-Dec04	Jan-Mar05	Apr-Jun05	Jul-Sep05
Duration									
• 0-30 mins	7%	5%	4%	3%	3%	3%	3%	2%	2%
• 31-45 mins	7%	7%	10%	10%	10%	10%	6%	4%	7%
• 46-60 mins	81%	79%	77%	75%	75%	74%	75%	80%	82%
• over 60 mins	5%	9%	10%	12%	11%	14%	16%	14%	9%
Type									
• Group	0%	2%	3%	2%	2%	3%	3%	2%	1%
• Individual	100%	98%	97%	98%	98%	97%	97%	98%	99%
Interventions^a									
• Diagnostic assessment	24%	23%	23%	21%	20%	20%	21%	19%	19%
• Psycho-education	36%	32%	30%	31%	31%	31%	32%	32%	32%
• CBT- Behavioural interventions	49%	44%	40%	42%	45%	46%	46%	46%	43%
• CBT - Cognitive interventions	59%	58%	58%	59%	62%	62%	62%	63%	62%
• CBT - Relaxation strategies	29%	30%	27%	23%	26%	26%	25%	25%	25%
• CBT- Skills training	29%	26%	22%	22%	23%	24%	25%	23%	24%
• Interpersonal therapy	20%	24%	26%	25%	25%	27%	27%	28%	28%
Co-payment									
• \$0	91%	81%	64%	59%	59%	62%	71%	76%	78%
• \$1-6	5%	5%	8%	7%	6%	6%	6%	7%	4%
• \$6-10	4%	8%	13%	17%	20%	13%	7%	5%	5%
• \$11-15	0%	1%	3%	2%	2%	1%	1%	1%	1%
• \$16-20	0%	4%	5%	6%	7%	13%	11%	9%	11%
• \$21-25	0%	0%	4%	5%	4%	3%	2%	1%	1%
• \$26-30	0%	0%	2%	2%	1%	1%	0%	0%	0%
• >\$30	0%	0%	0%	0%	0%	0%	0%	0%	0%

a. Multiple responses permitted.

Chapter 6: Have the experiences of GPs, allied health professionals and consumers changed over time?

The local evaluation reports have provided a valuable source of information on the way in which GPs, allied health professionals and consumers have viewed their involvement in the projects, because they have drawn on focus groups, interviews and surveys of these stakeholder groups. The First, Second and Fourth Interim Evaluation Reports^{1, 2, 4} have progressively synthesised the findings reported in these local evaluation reports to highlight the benefits and barriers for those involved in the Round 1 and 2 projects. The current report adds the voice of stakeholders involved in the Round 3 projects to the mix.

Benefits for GPs

GPs involved in the Round 1 and 2 projects have noted several key benefits of involvement. They have appreciated the upskilling opportunities offered to them, commenting that their confidence and knowledge have improved as a direct result of their participation, that the program has provided them with opportunities to learn new techniques and strategies that have helped them practice better 'psychological medicine', and, in some cases, that the program has ignited their interest in mental health and encouraged them to obtain further training and education in the area. Round 3 GPs concur with this, noting that their clinical skills and willingness to provide services to people with mental health problems have improved.

GPs involved in the Round 1 and 2 projects have commented on the mutual benefits of collaborating with allied health professionals. In particular, GPs have gained a deeper understanding of allied health professionals' skills and knowledge, have expressed high levels of satisfaction with their work, and have observed improvements in consumers' symptomatology and general wellbeing. For the most part, they have felt that communication between themselves and the allied health professionals has improved, and have indicated that the feedback they have received has aided them in managing the care of given consumers. This has had the added benefit of reducing their own professional isolation. Round 3 GPs have reiterated these sentiments, variously describing the collaborative opportunities as '*God sent*' and '*the best project the Division has ever run*'.

More generally, Round 1 and 2 GPs have expressed satisfaction with the range of referral options available to them via the projects, and their increased capacity to offer high quality care to consumers who could otherwise not access such care. They have been particularly pleased to be able to provide consumers with psychological alternatives or adjuncts to pharmacotherapy, recognising that allied health professionals may be better placed to provide this care and that this frees up their own time to '*deal medically with other problems*' in the context of '*time pressures in the clinic*'. Round 3 GPs have also commented on the breadth of referral options, with some making particular reference to opportunities to refer consumers to group programs.

Finally, Round 1 and 2 GPs have been generally satisfied with the structured approach afforded by the projects. Despite some initial reservations, many are now confident with the respective referral processes, are familiar with the 3-Step Mental Health Process, and consider the number of sessions of allied health professional care to be adequate (particularly since there is the option for further sessions on review). They also appreciate the efforts of Divisions to support them in participating in the projects – for example, minimising the paperwork requirements associated with the program. Some have also commented that the outcome measurement associated with the program is beneficial to planning and monitoring progress, both from their own perspective and that

of the consumer. Again, Round 3 GPs have expressed similar views – for example commenting that the training requirements act to reinforce aspects of mental health care.

Barriers/difficulties for GPs

GPs involved in the Round 1 and 2 projects have highlighted several barriers to their participation, mostly to do with the conditions associated with the initiative. Key among these is the issue of remuneration. Specifically, Round 1 and 2 GPs have expressed concern about the Service Incentive Payment, which they can claim once the consumer returns to them for review after six sessions with the allied health professional. Many have noted that if the consumer does not return for the review session, they face loss of income. This can occur because the consumer ceases treatment before the six sessions have been completed (either because he/she feels that there is no benefit that he/she has benefited fully), completes the six sessions but does not feel the need to return to the GP for review, sees another GP (in the same practice or elsewhere), or returns for review outside the necessary time frame. Alternatively, it can occur because the GP forgets that the review is due. A number of successful strategies have been implemented that have led to increases in consumers returning for review, including GPs making review appointments at time of assessment, allied health professionals making review appointments at the time of the sixth session, and reminder phone calls. Perhaps as a consequence, issues with the Service Incentive Payment feature less prominently among the comments of GPs in the Round 3 local evaluation reports.

Having reported above that many GPs appreciate the upskilling opportunities offered through the Better Outcomes in Mental Health Care program, it should also be noted that some Round 1 and 2 GPs have objected to undertaking further training to satisfy the Level 1 eligibility requirement, believing that they have sufficient expertise in mental health, and/or wanting to be able to refer consumers without facing this ‘hurdle’. Others, particularly those in rural areas, have been prepared to undertake training but have been offered limited training options. On a related note, some Round 1 and 2 GPs have expressed concern about the requirement that referrals be made from an accredited practice, particularly those who work in multiple practices (some accredited, some not accredited). Together, these issues have created a disincentive for some Round 1 and 2 GPs to be involved, and continue to raise concern among Round 3 GPs.

Likewise, although many Round 1 and 2 GPs have appreciated the structured approach offered by the projects, a number have complained about the paperwork and ‘red tape’. Divisions have made concerted efforts to streamline relevant processes, and some Round 1 and 2 GPs have noted that *‘the paperwork is tedious, but less so’*. However, some still find that the time consuming requirements hinder their involvement. Their views are echoed by the Round 3 GPs, who reiterate that the projects are too bureaucratic, too prescriptive, and associated with onerous paperwork requirements.

Although Round 1 and 2 GPs have generally been positive about their improved professional relationships with allied health professionals (see above), some have commented that feedback from their new colleagues is sometimes slow, and not always sufficiently informative (particularly regarding consumers’ progress and outcomes). Round 3 GPs, by contrast, have generally rated the processes for two-way information sharing highly, and have praised the thoroughness of the allied health professionals’ reports.

Round 1 and 2 GPs have experienced confusion regarding the operation of the Access to Allied Psychological Services projects. Some misunderstandings have been addressed by Divisions offering one-to-one consultations, forums and written information, and this has smoothed the way for Round 3 GPs. Despite this, some GPs still find it difficult to ‘keep track’, particularly in situations where Divisions are offering them the option of referring consumers through multiple programs with different eligibility criteria.

Benefits for allied health professionals

Allied health professionals involved in the Round 1 and 2 projects have consistently cited improved relationships with GPs as one of the major benefits of their involvement in the Access to Allied Psychological Services projects. They have described these strengthened relationships as mutually beneficial, leading to improved understanding on the part of both parties regarding the others' roles in mental health care. They have also noted that collaboration combats professional isolation. Round 3 allied health professionals have expressed similar views, with comments like *'it's wonderful to work more closely with GPs and be an integral part of the treatment plan ... also great for GPs to have support and feedback'*.

On the whole, Round 1 and 2 allied health professionals have been appreciative of the increased referral base that is a consequence of the Access to Allied Psychological Services projects. Many have indicated that they experience no difficulties in fitting the referrals into their normal workload, and feel strongly that the consumers are benefiting from the referral. Early on, Round 1 and 2 allied health professionals reported that some consumers were referred inappropriately and/or with too little information, but as GPs have become more familiar with the referral process these issues have been largely 'ironed out'. Testament to this is the fact that the Round 3 allied health professionals are reporting high levels of satisfaction with the number of referrals, the accuracy of the diagnoses made by GPs prior to referral, and the information provided at referral.

Like Round 1 and 2 GPs, Round 1 and 2 allied health professionals have been positive about the level of Divisional support provided through the projects. In particular, they have expressed satisfaction with the role Divisions have played in facilitating communication between themselves and GPs, co-ordinating the projects, developing resources (e.g., kits containing the relevant information and forms to assist them in delivering services), running professional development sessions, organising clinical supervision and setting up meetings with project management. Round 3 allied health professionals continue to comment that Divisions have been crucial to encouraging collaborative arrangements between themselves and GPs.

Barriers/difficulties for allied health professionals

Allied health professionals in the Round 1 and 2 projects have identified remuneration as a major issue. Specifically, many have raised concerns that the typical salaries and sessional rates paid to employed and contracted allied health professionals, respectively, put them at a level of remuneration which is lower than that recommended by the Australian Psychological Society. In some cases, this has been addressed by allied health professionals agreeing to an average rate; in other cases, allied health professionals have been given permission to request co-payments from consumers (see above). In areas where supply outweighs demand, however, some allied health professionals have found that they either accept the offered rate or decline to participate. The problem has been exacerbated by the fact that payment is often (though not always) dependent on consumer attendance, according to many Round 1 and 2 allied health professionals. Some Divisions have addressed this by instituting systems of consumer reminder calls, attempting to fill sessions left vacant by cancellations, implementing fee structures that encourage consumers to attend, sanctioning co-payments (with the view that consumers who invest financially in their treatment may be more likely to attend), and encouraging GPs to motivate consumers. There is some evidence that Round 3 allied health professionals are experiencing fewer issues with remuneration.

At various times, Round 1 and 2 allied health professionals have expressed concerns about the uncertainty of their involvement with the Access to Allied Psychological Services projects. Early on, this reflected the fact that the projects were new, and that if

they did not 'take off' then allied health professionals might have invested time and effort, and/or given up other work opportunities, for no professional gain. As time passed, and the projects became part of the mental health care provision landscape in Australia, Round 1 and 2 allied health professionals found that they were in high demand and their initial fears were allayed, and Round 3 allied health professionals joined the projects in a climate of greater certainty. However, towards the end of the initial five-year funding period of the Better Outcomes in Mental Health Care program, concerns were again voiced by allied health professionals from all three funding rounds about the continuation of their work, and some experienced allied health professionals began seeking more assured employment elsewhere. With the announcement of additional funding for the continuation and expansion of the program from July 2005, these concerns have again receded.

As noted above, Round 1 and 2 allied health professionals initially expressed concerns that they were receiving some inappropriate referrals – e.g., being asked to treat people with chronic mental health issues that were not likely to experience significant improvement in six (or even 12) sessions. Divisions have rectified this situation by providing education to GPs regarding eligibility guidelines for referral. Some have also developed relationships with other mental health care services (e.g., local community mental health teams), in order to provide alternative referral routes. Although some inappropriate referrals do still occur, Round 3 allied health professionals do not report this as a major issue.

Round 1 and 2 allied health professionals – particularly those in rural and remote areas – have reported that travel time presents a problem for them. This continues to be a problem for Round 3 allied health professionals in non-metropolitan areas.

Benefits for consumers

Reports from consumers who have received care through the Round 1 and 2 projects have consistently indicated that they appreciate the improved access to psychological services afforded by the projects. In the time that Round 3 projects have been operational, responses from consumers have been extremely positive in this regard. They have generally not had to wait long to receive care, and have found the services affordable, making comments like, *'If my GP had not facilitated this for me I doubt that I would be on this path due to my previous hesitancy to consult medical/allied health services because of a) anxiety and b) cost'*.

Not only has access improved, according to the Round 1 and 2 consumers, but so too has the quality of care available. Round 3 consumers have endorsed this, commenting on their satisfaction with the quality (and amount) of help they have received. Many consumers have stated that they would refer others to the service or use the service again themselves, making statements like, *'I would not hesitate [to recommend this service], as the project meets specific individual needs and cognitive behavioural therapy seems to be very effective.'* They have appreciated the communication between GPs and allied health professionals, and have indicated that they have been treated well and shown respect, and that their privacy and confidentiality has been assured. Some have also expressed satisfaction with the level of information provided to them (e.g., regarding the purpose of their referral, the nature of their treatment, and their progress), as well as with the *'sense of ownership'* of their treatment and the level of decision-making vested in them during care.

There has also been evidence that consumers have benefited in terms of tangible outcomes, such as reductions in psychological distress, depression and anxiety. Round 1 and 2 consumers have reported that they have found the treatment they have been offered effective, in terms of learning various problem-solving skills and meeting personal goals. Round 3 consumers makes similar claims, via statements like, *'The project has*

helped me cope with every day situations. I can't thank everybody involved enough. My life is easier, less stressful and enjoyable for me. I actually enjoy living now'. Where standardised outcome measures have been used in Round 1, 2 and 3 projects to assess improvements in symptomatology and level of functioning, they have consistently demonstrated significant gains.

Barriers/difficulties for consumers

For Round 1 and 2 consumers, the major issue has always been one of equity. The problem has arisen because consumers of non-trained and non-registered GPs may miss out on services. Equity of access continues to be problematic from Round 3 consumers' perspectives. Access is still determined by consumers' associations with individual GPs or practices. Often consumers have no way of knowing whether a given GP is eligible to refer them on to an allied health professional, and, as awareness of the projects grows, Divisions are being pressured to release details of registered GPs to community members, professionals and organisations. In some cases, consumers have been referred to a registered GP (either by a non-registered GP or by an allied health professional), in order that they can then be referred for psychological care through a given project. This creates other issues, however, because of the requirement that these consumers to transfer their psychological care to the new GP.

Round 1 and 2 consumers have also commented on the restricted nature of sessions. As noted above, many have indicated that six (or 12) sessions seems appropriate to meet their needs, but some have expressed dissatisfaction with the projects have again raised the concern that some consumers are dissatisfied with the allocated number of sessions. Round 3 consumers have also noted this as an issue.

Chapter 7: Are the projects achieving positive outcomes for consumers?

As noted in the previous chapter, there are various indications that consumers receiving treatment through the Round 1, 2 and 3 projects have experienced improvements in their psychological well-being. Until now, most of the data relating to consumer outcomes has been gleaned from the projects' local evaluation reports, and based on qualitative data from focus groups, interviews and surveys and/or a small amount of quantitative data from standardised outcome measures. In recent times, however, relevant outcome measurement fields have been added to the minimum dataset and Divisions have begun to enter routinely-collected outcome data in a manner which allows these data to be systematically analysed.

The outcome scores are calculated by taking the score on a given outcome measure at assessment and the score on the same outcome measure at review, and calculating a 'change' score. To date, 1,047 before-and-after pairs of scores have been made available and recalculated as change scores. These scores have been derived from 10 different outcome measures: the Kessler-10 (K-10); the Depression Anxiety Stress Scale (DASS); the Health of the Nation Outcome Scales (HoNOS); the Behaviour and Symptom Identification Scale (BASIS-32); the Beck Anxiety Inventory (BAI); the Beck Depression Inventory (BDI); the Hospital Anxiety and Depression Scale (HADS); the Zung Self-Rating Depression Scale (SDS); the Depression Recovery Scale (DRS) and the State-Trait Anxiety Inventory (STAI). For the comparability purposes in the current analysis, the change scores have been converted into discrete global judgements as to whether the consumer 'got better', 'remained the same', or 'got worse' during the course of treatment.

Figure 4: Outcomes for consumers

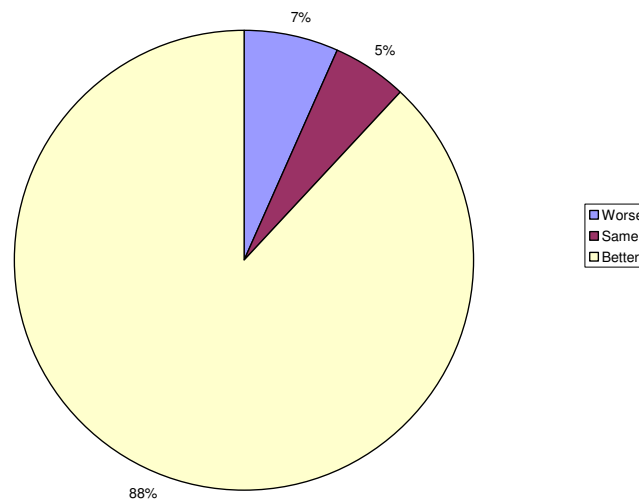


Figure 4 shows the distribution of the change scores, and indicates that in 88% of cases consumers got better, in 5% they remained the same, and in 7% they got worse. Some caution should be exercised in interpreting these findings, since the data are provided for fewer than 5% of all consumers, and, a small proportion of these (around 3%) had data from more than one outcome measure and are therefore counted twice in the

denominator, and the method of comparing change scores across outcome measures is somewhat rudimentary. Nonetheless, it is safe to say that the majority of consumers experience a reduction in symptomatology and/or an increase in level of functioning after contact with allied health professionals via the projects.

Chapter 8: Summary and conclusions

Summary of the progressive achievements of the Access to Allied Psychological Services projects

The current report focused on how the Access to Allied Psychological Services projects have changed over time. Specifically, it set out to investigate four evaluation questions, the answers to which are summarised below.

Has participation in the projects by GPs and allied health professionals changed over time?

In total, 2,980 GPs have made referrals to 1,040 allied health professionals since the projects began. There has been a dramatic increase in participation rates by both GPs and allied health professionals over the life of the projects. In the first quarter for which data were available (July-September 2003), 417 GPs made referrals to 118 allied health professionals; in the most recent quarter for which complete data were available (April-June 2005), the equivalent figures were 1,266 and 627.

Have access to and the nature of mental health care for consumers changed over time?

The total number of consumers receiving care through the projects is 26,444. The number of consumers receiving care through the projects has increased on a quarter-by-quarter basis, beginning at 1,056 in July-September 2003 and peaking at 4,196 in April-June 2005. This translates to an increase from an average of 11.5 consumers receiving treatment per day to an average of 46.1 doing so. The profile of these consumers has remained fairly consistent over time, and is well aligned with the target group that the projects are designed to reach: they are typically female, are aged around 40, are on low incomes, have no previous history of mental health care, and have been diagnosed with depression or anxiety disorders.

The total number of sessions provided to these consumers is 102,120. Once again, there is a clear increase in the number of sessions provided over time, rising from 3,928 provided in the July-September 2003 quarter (i.e., 42.7 sessions per day) to peak at 16,481 in the April-June 2005 quarter (i.e., 181.1 sessions per day). The average number of sessions per consumer has remained relatively constant over time, at around four. In the main, the profile of these sessions has not changed over time, with the majority being individually-based, an hour in length, and consisting of CBT-based cognitive and behavioural therapies. The only notable fluctuation over time relates to the charging of a co-payment. Early sessions rarely incurred a co-payment, and where they did it was usually \$10 or less; subsequent sessions more commonly involved a co-payment, sometimes of as much as \$20 or more; and more recent sessions have been less commonly associated with a co-payment although the situation has not returned to the original low.

Have the experiences of GPs, allied health professionals and consumers changed over time?

Qualitative data from the local evaluation reports indicates that some experiences for stakeholders have remained constant over time, while others have changed. Round 1 and 2 GPs have cited a number of benefits of involvement in the projects – namely upskilling opportunities, mutual advantages of collaboration with allied health professionals, increased referral options and the structured approach to providing mental health care – and Round 3 GPs concur. Round 1 and 2 GPs have also articulated various barriers to their participation that are underscored by Round 3 GPs, including the

hurdles of training and paperwork requirements. However, some other barriers cited by Round 1 and 2 GPs – such as remuneration issues, inadequate feedback from allied health professionals and confusion over the operation of the projects – have proved less problematic for Round 3 GPs, largely because of the efforts of Divisions to ‘iron them out’.

Round 1 and 2 allied health professionals have consistently cited their improved relationships with GPs and increased referral base as benefits of involvement in the projects, and have expressed appreciation for the high level of Divisional support. Their Round 3 counterparts reiterate these benefits. Round 1 and 2 allied health professionals have identified inadequate remuneration as the major barrier to their involvement, along with operational issues like travel time. Round 3 allied health professionals have also cited these as issues, but have not expressed the same degree of difficulty with lack of security of work and inappropriate referrals as their Round 1 and 2 colleagues.

Consumers who have received services through the Round 1 and 2 projects appreciate their improved access to high quality care and believe that this has translated into positive mental health outcomes. Round 3 consumers agree. The major issue for Round 1 and 2 consumers has always been equity, and this remains the case for Round 3 consumers. The restricted nature of sessions has also been flagged as a concern by all three groups.

Are the projects achieving positive outcomes for consumers?

In recent times, specific fields have been added to the minimum dataset that enable Divisions to enter data from standardised outcome measures. To date, data have been entered for only a small proportion of consumers (less than 5%), but the findings are encouraging. In 88% of cases, consumers who have contact with allied health professionals through the Access to Allied Psychological Services projects get better.

Some caveats

Some caution should be exercised in interpreting the above findings, because the two data sources which informed the current report had certain limitations. The local evaluation reports varied in structure, content and quality – some were extensive and comprehensive; others were brief. This required some caution to be exercised, because absence of evidence regarding a particular benefit or barrier for GPs, allied health professionals could not necessarily be regarded as evidence of absence of that benefit or barrier.

The minimum dataset contained more standardised information, and the proportion of projects submitting data to it was high (at 96%). However, the minimum dataset probably presented an underestimate of the true magnitude of achievements by the projects, because of time lags in data entry. In particular, this may have had an effect for session data, since, Divisions often do not enter data regarding sessions until all six (or 12) sessions have been completed.

Conclusions

The current report indicates that the Access to Allied Psychological Services projects have gained considerable momentum over time. Collectively, they are attracting far more GPs and allied health professionals and are providing access to high quality mental health care than was the case originally. This is probably due both to an increase in the number of projects that are now in operation and to the streamlining of existing projects.

The projects are now well-established, and have passed their initial ‘settling in’ period, as is evidenced by the fact that the profile of consumers they are treating and the nature of

sessions they are providing have both reached a point of consistency. The only notable variations in either relates to the issue of a co-payment, and the extent to which this has been charged has varied over time in line with projects' relative fluctuations in levels of funding.

Further evidence that the projects are well-established comes from focus group, interview and survey data provided in local evaluation reports. To use a qualitative research term, these data have reached 'saturation', in the sense that relatively few new issues are being identified. Round 1, 2 and 3 GPs, allied health professionals and consumers consistently report the same kinds of benefits when they describe their experiences with the projects. Some of the barriers reported by the stakeholders involved in the earlier projects have been resolved (largely due to the efforts of Divisions); others remain an issue for the stakeholders involved in the later projects. There is little evidence of previously-unidentified issues arising for the Round 3 stakeholders.

For the first time, the current report was able to describe outcomes for consumers in a standardised fashion, albeit for a relatively small proportion of consumers. There is good evidence that the projects are achieving positive results for consumers, in terms of alleviating symptoms, improving levels of functioning, and impacting on general wellbeing.

The Access to Allied Health Services projects appear to have become a crucial part of the mental health care landscape in Australia. They are reaching more and more people who may previously have had difficulty accessing services, they are providing high quality care in a consistent fashion. Most significantly, they are achieving their desired results. It will be important from now on to ensure that the appropriate funding and support systems are in place to ensure that the projects continue to be sustainable.

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

Component 1: Education and training for GPs

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

Component 2: The 3 Step Mental Health Process

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

Component 3: Focused Psychological Strategies

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

Component 4: Access to Allied Psychological Services

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

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

Component 5: Access to Psychiatrist Support

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

Appendix 2: Access to Allied Psychological Services projects

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

Round	State	Division(s)
2	QLD	Brisbane Southside Central Division of General Practice Association Inc
2	QLD	Capricornia Division of General Practice Ltd
2	QLD	Central Queensland Rural Division of General Practice Association Inc
2	QLD	Far North Queensland Rural Division of General Practice Association Inc
2	QLD	Gold Coast Division of General Practice Ltd
2	QLD	Ipswich and West Moreton Division of General Practice
2	QLD	Townsville Division of General Practice
2	QLD	Mackay Division of General Practice
2	SA	Adelaide Central and Eastern Division of General Practice
2	SA	Adelaide Hills Division of General Practice Inc
2	SA	Adelaide North East Division of General Practice Inc
2	SA	Adelaide Western Division of General Practice Inc
2	SA	Limestone Coast Division of General Practice
2	SA	Murray Mallee Division of General Practice Inc
2	TAS	Division of General Practice Northern Tasmania Inc
2	TAS	North West Tasmania Division of General Practice
2	TAS	The Division of General Practice (Tasmania -Southern Region) Inc
2	VIC	Central Bayside Division of General Practice Ltd
2	VIC	Melbourne Division of General Practice Inc
2	VIC	Monash Division of General Practice Moorabbin Inc
2	VIC	Murray-Plains Division of General Practice Inc
2	VIC	North East Valley Division of General Practice Pty Ltd
2	VIC	Western Melbourne Division of General Practice Ltd
2	VIC	Westgate Division of General Practice Ltd
2	VIC	South City GP Services Inner South East Melbourne
2	VIC	Whitehorse and Inner Eastern Melbourne Divisions of General Practice
2	WA	Canning Division of General Practice Ltd
2	WA	Great Southern Division of General Practice Ltd
2	WA	Osborne Division of General Practice Ltd
2	WA	Perth Central Coastal Division of General Practice Ltd
3	NSW	Barrier Division of General Practice Ltd.
3	NSW	Barwon Division of General Practice Inc.
3	NSW	Central Sydney Division of General Practice
3	NSW	Eastern Sydney Division of General Practice Ltd (includes South Eastern Sydney Division)
3	NSW	Hornsby Ku-Ring-Gai Division of General Practice Ltd.
3	NSW	Hunter Rural Division of General Practice Ltd.
3	NSW	Hunter Urban Division of General Practice Ltd.
3	NSW	Macarthur Division of General Practice Ltd.
3	NSW	Northern Rivers Division of General Practice (NSW) Ltd.
3	NSW	St George District Division of General Practice Inc.
3	NSW	The Northern Sydney Division of General Practice Inc.
3	NSW	The Shoalhaven Division of General Practice Inc.
3	NSW	The South East NSW Division of General Practice Ltd.
3	QLD	Brisbane North Division of General Practice Association Inc.

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