



**Evaluating the Access to Allied  
Psychological Services component of the  
Better Outcomes in Mental Health Care  
program**

*Tenth Interim Evaluation Report*

**Progressive achievements over time**

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**November 2007**

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# Executive summary

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## ***Background***

The Better Outcomes in Mental Health Care program aims to improve consumers' access to high quality primary mental health care, and was introduced in July 2001. The program has sought to achieve this by offering GPs training, systemic and professional support, and financial incentives via a number of interlocking components, including 111 Access to Allied Psychological Services projects being conducted by Divisions of General Practice. These projects enable GPs to refer consumers to allied health professionals (predominantly psychologists) for six sessions of evidence-based mental health care, delivered in six time-limited sessions with an option of a further six sessions following a mental health review by the referring GP.

In recent times, a second primary mental health care initiative has been introduced which complements the Access to Allied Psychological Services projects. The Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule program (the Better Access program) was introduced in November 2006 as a cornerstone of the Council of Australian Governments (COAG) reform package, and includes the addition of a set of item numbers to the Medicare Benefits Schedule (MBS) that make the services of registered psychologists (and selected social workers and occupational therapists) eligible for a rebate. Under these new item numbers, a GP can refer a consumer to a psychologist for 12 individual sessions per calendar year, delivered in two groups of six with a review by the referring GP after the first six. Psychologists can directly bill Medicare Australia (the body that administers the MBS) or can bill the consumer who can then obtain a partial rebate from Medicare Australia.

## ***Method***

The current report is the tenth in a series of interim evaluation reports, produced as part of the ongoing evaluation of the Access to Allied Psychological Services projects. The report draws on data from the projects' minimum dataset and MBS data supplied by the Medicare Benefits Branch of the Department of Health and Ageing, and considers the progressive achievements of the projects via the following evaluation questions:

*Evaluation Question 1:* Has participation in the projects by GPs and allied health professionals changed over time?

*Evaluation Question 2:* Has the profile of consumers varied over time, and has the care they are receiving changed?

*Evaluation Question 3:* Have there been changes in the level of uptake of services provided by the projects following the introduction of the Better Access program?

*Evaluation Question 4:* Are the projects achieving positive outcomes for consumers?

## ***Key findings***

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

Between 1 July 2003 and 31 December 2006, 6,082 GPs referred consumers to 2,220 allied health professionals. There has been a consistent 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), 449 GPs made referrals to 135 allied health professionals; in the most recent quarter for which complete data were available (July-September 2006), the equivalent figures were 2,451 and 1,225, respectively.

### **Has the profile of consumers varied over time, and has the care they are receiving changed?**

Between 1 July 2003 and 31 December 2006, 72,409 consumers were referred to the Access to Allied Psychological Services projects. The number of consumers referred to the projects has increased on a quarter-by-quarter basis, beginning at 1,180 (546 urban; 634 rural) in July-September 2003 and peaking at 8,955 (5,113 urban; 3,842 rural) in July-September 2006. The profile of these consumers has remained fairly consistent over time overall and in urban and rural areas, 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 306,419 (188,179 in urban areas and 118,240 in rural areas). Once again, there is a clear increase in the number of sessions provided over time, rising from 4,020 (2,062 urban; 1,958 rural) provided in the July-September 2003 quarter to peak at 37,892 (22,884 urban; 15,008 rural) in the July-September 2006 quarter. In the main, the profile of these sessions has not changed over time in either urban or rural areas, with the majority being individually-based, 46-60 minutes 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 urban and rural 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 \$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 there been changes in the level of uptake of services provided by the projects following the introduction of the Better Access program?**

It was hypothesised that the introduction of the new MBS item numbers for psychologists and other allied health professionals under the Better Access program might reduce demand for allied health services provided through the Access to Allied Psychological Services projects. Divisional-level analysis of the number of sessions provided through both programs in the five months since the introduction of the Better Access program (1 November 2006) provided little overall support for this hypothesis. The uptake of the Better Access program has been dramatic, particularly in urban areas. However, there has not been a commensurate decrease in the number of sessions provided through the Access to Allied Psychological Services projects, except for a small early drop in the number of sessions provided in urban projects, which has now levelled out. The correlations between the number of sessions provided by both programs overall and in rural areas were not significant. In urban areas, however, a small significant negative correlation was observed. This suggests that in general the two programs are operating relatively independently of each other in terms of session provision, but that in urban Divisions there may be something of a move toward services provided through Better Access. Having said this, it should be noted that the two programs are not operating in isolation from each other in practical terms. Anecdotally, for example, some Divisions are providing support to GPs wishing to refer to the Better Access program, and some allied health professionals are providing services under both programs.

## **Are the projects achieving positive outcomes for consumers?**

The projects are using a range of different measures to assess outcomes for consumers. When available pre- and post-treatment scores on these outcome measures were reduced to a single metric, namely an effect size, the projects were shown to be achieving positive outcomes of large or medium magnitude.

### ***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. In the main, the profile of consumers they are treating and the nature of sessions they are providing have both reached a point of consistency.

The introduction of the Better Access program does not seem to have reduced the demand for psychological services provided through the Access to Allied Psychological Services projects, although there has been a slight shift in towards Better Access in urban Divisions. This may reflect the fact that there was an excess demand for psychological services that could not be met by the projects due to the capped nature of their funding, which is now being addressed, at least to some extent, by psychologists and allied health professionals providing care through the Better Access program.

Perhaps one of the reasons for the ongoing high demand for services provided through the Access to Allied Psychological Services is the fact that they are achieving positive consumer outcomes. There is good evidence that the projects are receiving positive results for consumers, in terms of alleviating symptoms, improving levels of functioning, and impacting on general wellbeing.

The Access to Allied Psychological Services projects appear to have become a crucial part of the mental health care landscape in Australia, and there continues to be a high demand for their services despite alternative avenues of service provision having been made available. They are reaching more and more people who may previously have had difficulty accessing services, and are providing high quality care in a consistent fashion. Most significantly, they are achieving their desired results.

# Chapter 1: Background

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## ***Primary mental health care reform in Australia***

Since the late 1990s, Australia has seen significant changes in the way in which mental health care is delivered in Australia. There has been increased recognition that disorders such as depression and anxiety are prevalent; the 1997 National Survey of Mental Health and Wellbeing showed that 6% of Australian adults (around 1,299,600) experience an affective disorder in a given 12-month period, and 10% (around 778,600) experience an anxiety disorder.<sup>1</sup> There has also been increased acknowledgement that many people with these high prevalence disorders receive no treatment or ineffective treatment,<sup>2</sup> and that those who do receive treatment tend to utilize GPs rather than providers like psychologists (29% utilise the former; 7% the latter<sup>3</sup>). GPs are well-placed to assess people with these disorders, who often present with a mix of physical and psychological symptoms, but they have traditionally been ill-equipped to provide effective psychological treatment (particularly non-pharmacological therapies<sup>4</sup>), citing barriers such as lack of training and time constraints.<sup>5</sup> By contrast, psychologists' training and mode of service delivery equips them well to provide treatment for common disorders such as depression and anxiety, but their services have tended to be out of the reach of many individuals, due to barriers of cost.

Two major initiatives have been introduced in response to these concerns. The first is the Better Outcomes in Mental Health Care program. The second is the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule program (the Better Access program). These complementary initiatives are both designed to improve consumers' access to high quality mental health care. Each includes a component which enables GPs to refer consumers to psychologists (and other relevant providers) for low-cost, evidence-based sessions of mental health care. Key components of both programs are described in more detail below.

### ***The Better Outcomes in Mental Health Care program***

The Better Outcomes in Mental Health Care program aims to improve consumers' access to high quality primary mental health care, and was introduced in July 2001. The program has sought to achieve this by offering GPs training, systemic and professional support, and financial incentives via a number of interlocking components (described in more detail in Appendix 1).<sup>6</sup>

Key among these components is the Access to Allied Psychological Services component, which supports GPs and allied health professionals (predominantly psychologists, but also social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers) to work together to provide optimal mental health care. Specifically, this component enables GPs to refer consumers to allied health professionals for six sessions of evidence-based mental health care, delivered in six time-limited sessions with an option of a further six sessions following a mental health review by the referring GP.

This collaborative approach to mental health care is occurring through 111 Access to Allied Psychological Services projects being conducted by Divisions of General Practice and funded in four funding rounds: 18 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 six from July 2005 (Round 4 projects). Appendix 2 provides a full list of these projects.

## ***The Better Access program***

The Better Access program was introduced in November 2006 as a cornerstone of the Council of Australian Governments (COAG) reform package of \$1.9 billion over five years. The Better Access program is designed to improve access for people with high prevalence disorders to a range of providers via a series of new Medicare Benefits Schedule (MBS) item numbers.<sup>7</sup>

Amongst the modifications to the MBS was the addition of a set of item numbers that make the services of registered psychologists (and selected social workers and occupational therapists) eligible for a rebate. Under these new item numbers, a GP can refer a consumer to a psychologist for 12 individual sessions per calendar year, delivered in two groups of six with a review by the referring GP after the first six. Psychologists can directly bill Medicare Australia (the body that administers the MBS) or can bill the consumer who can then obtain a partial rebate from Medicare Australia.<sup>7</sup>

## ***The current report***

The current report is the tenth in a series on the ongoing evaluation of the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program. The reports have sought answers to a variety of evaluation questions, drawing on information from projects' local evaluation and project implementation reports, a purpose-designed minimum dataset, a Divisional forum, and one-off surveys.<sup>8-16</sup> The focus of each of these reports is summarised in Table 1.

The current report considers the progressive achievements of the projects over time. Specifically, it looks at whether participation by GPs and allied health professionals has changed, whether the profile of consumers has shifted, and whether the services provided to consumers have altered. Where relevant, it compares these patterns for urban and rural projects. It also examines changes in the level of uptake of services provided by the projects following the introduction of the Better Access program.

**Table 1: Summary of focus of evaluation reports**

<b>Report</b>	<b>Projects included</b>	<b>Data sources</b>	<b>Evaluation questions</b>
First Evaluation Report <sup>8</sup>	Round 1 pilot projects – Australia	<ul style="list-style-type: none"> <li>Local evaluation reports</li> </ul>	<ul style="list-style-type: none"> <li>What models of service delivery are being used by the pilots?</li> <li>What is the uptake of the pilots?</li> <li>What are the advantages and disadvantages of the pilots?</li> </ul>
Second Evaluation Report <sup>9</sup>	Round 1 pilot and supplementary projects – Australia	<ul style="list-style-type: none"> <li>Local evaluation reports</li> <li>Minimum dataset</li> </ul>	<ul style="list-style-type: none"> <li>What models of service delivery are being used by the projects?</li> <li>What is the level of uptake of the projects?</li> <li>Who is accessing services through the projects?</li> <li>What services are consumers receiving through the projects?</li> <li>What are the advantages and disadvantages of the projects?</li> </ul>
Third Evaluation Report <sup>10</sup>	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects – Victoria and Tasmania	<ul style="list-style-type: none"> <li>Evaluation forum</li> </ul>	<ul style="list-style-type: none"> <li>Do models of service delivery differ from the conceptualisation outlined in the First and Second Interim Evaluation Reports?</li> <li>What are the benefits and barriers associated with the means of retaining allied health professionals?</li> <li>What are the benefits and barriers associated with the various locations from which allied health professionals deliver services?</li> <li>What are the benefits and barriers associated with the different referral mechanisms?</li> </ul>
Fourth Evaluation Report <sup>11</sup>	Round 1 pilot and supplementary projects, Round 2 projects – Australia	<ul style="list-style-type: none"> <li>Local evaluation reports</li> <li>Minimum dataset</li> </ul>	<ul style="list-style-type: none"> <li>What models of service delivery are being used by the projects?</li> <li>What is the level of uptake of the projects?</li> <li>Who is accessing services through the projects?</li> <li>What services are consumers receiving through the projects?</li> <li>What are the benefits and barriers associated with the projects?</li> <li>What lessons have been learned from the early experiences of the projects?</li> </ul>
Fifth Evaluation Report <sup>12</sup>	Round 1 pilot and supplementary projects, Round 2 projects – Australia	<ul style="list-style-type: none"> <li>Survey of models of service delivery</li> </ul>	<ul style="list-style-type: none"> <li>What is the profile of models of service delivery across the Access to Allied Psychological Services projects?</li> </ul>

Report	Projects included	Data sources	Evaluation questions
			<ul style="list-style-type: none"> <li>• Are particular models associated with differential levels of consumer access to services?</li> </ul>
Sixth Evaluation Report <sup>13</sup>	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects – Australia	<ul style="list-style-type: none"> <li>• Local evaluation reports</li> <li>• Minimum dataset</li> </ul>	<ul style="list-style-type: none"> <li>• Has participation in the projects by GPs and allied health professionals changed over time?</li> <li>• Has access to and the nature of mental health care for consumers changed over time?</li> <li>• Have the experiences of GPs, allied health professionals and consumers changed over time?</li> <li>• Are the projects achieving positive outcomes for consumers?</li> </ul>
Seventh Evaluation Report <sup>14</sup>	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects – Australia	<ul style="list-style-type: none"> <li>• Minimum data</li> <li>• Survey of models of service delivery</li> <li>• Case studies</li> </ul>	<ul style="list-style-type: none"> <li>• What models of service delivery are being used by the rural and urban projects?</li> <li>• What is the level of uptake of the rural and urban projects?</li> <li>• Who is accessing services through the rural and urban projects?</li> <li>• What services are consumers receiving through the rural and urban projects?</li> <li>• What are the outcomes for consumers through the rural and urban projects?</li> <li>• What are the issues associated with the rural and urban projects?</li> </ul>
Eighth Evaluation Report <sup>15</sup>	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 projects – Australia	<ul style="list-style-type: none"> <li>• Minimum data</li> <li>• Survey of models of service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• What is the level of consumer outcomes within and across projects?</li> <li>• Does the level of consumer outcomes vary depending on the model of service delivery?</li> </ul>
Ninth Evaluation Report <sup>16</sup>	Round 1 pilot and supplementary projects, Round 2 projects, Round 3 and Round 4 projects – Australia	<ul style="list-style-type: none"> <li>• Survey of demand management strategies</li> </ul>	<ul style="list-style-type: none"> <li>• How many projects are using demand management strategies?</li> <li>• What demand management strategies are being used within projects?</li> <li>• Which demand management strategies have been found to be most useful?</li> <li>• What features of any demand management strategy have worked well and not worked well?</li> </ul>

# Chapter 2: Method

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## ***Evaluation questions***

This report considers the progressive achievements of the Access to Allied Psychological Services projects over time, via the following evaluation questions:

*Evaluation Question 1:* Has participation in the projects by GPs and allied health professionals changed over time?

*Evaluation Question 2:* Has the profile of consumers varied over time, and has the care they are receiving changed?

*Evaluation Question 3:* Have there been changes in the level of uptake of services provided by the projects following the introduction of the Better Access program?

*Evaluation Question 4:* Are the projects achieving positive outcomes for consumers?

## ***Data sources***

Evaluation Questions 1, 2 and 4 were addressed using data from the previously-mentioned minimum dataset, which captures de-identified, consumer-level and session-level information. Data from the minimum dataset were available for the fourteen quarters from 1 July 2003 (when the minimum dataset was first 'rolled out') to 31 December 2006. Ninety nine per cent of all projects submitted data to the minimum dataset during this period – 32 (100%) of the Round 1 projects, 40 (98%) of the Round 2 projects, 32 (100%) of the Round 3 projects and six (100%) of the Round 4 projects. Data were extracted from the minimum dataset on the numbers of GPs and allied health professionals providing services through the projects (Evaluation Question 1), the number and profile of consumers accessing these services (Evaluation Question 2), the number and nature of these services (Evaluation Question 2), and the consumer outcomes associated with these services (Evaluation Question 4).

Evaluation Question 3 required data from the minimum dataset to be combined with supplementary MBS data on services rendered by psychologists (and occupational therapists and social workers) under the Better Access program, made available by the Medicare Benefits Branch of the Department of Health and Ageing. Specifically, the Medicare Benefits Branch extracted monthly postcode-level session data, aggregated these data so that all of the postcode areas within a given Division were combined for a given month, and provided the evaluation team with Division-level data. The numbers of sessions provided by Better Outcomes in Mental Health Care allied health professionals and Better Access allied health professionals were calculated at a Divisional level for each month from 1 November 2006 to 31 March 2007,<sup>a</sup> and correlations between the two were examined.

## ***Data analysis***

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<sup>a</sup> Note that the data cut-off for the analyses associated with Evaluation Question 3 differed from that for the analyses associated with Evaluation Questions 1, 2 and 4. This was because the analyses associated with Evaluation Question 3 were conducted later, once the Better Access program had been in place for a period of several months.

Simple frequencies and percentages were calculated in order to answer Evaluation Questions 1 and 2.

Correlation analyses were conducted to answer Evaluation Question 3. Specifically, Pearson's  $r$  was used to assess the linear relationship between the monthly number of sessions provided through the Access to Allied Psychological Services projects and Better Access program, since the introduction of the latter.

More complex analysis was required to address Evaluation Question 4. Specifically, effect sizes were calculated in order that outcomes could be presented in a standardised form to allow combination and comparison across multiple projects. More detail on the calculation of effect sizes is provided at Appendix 3.

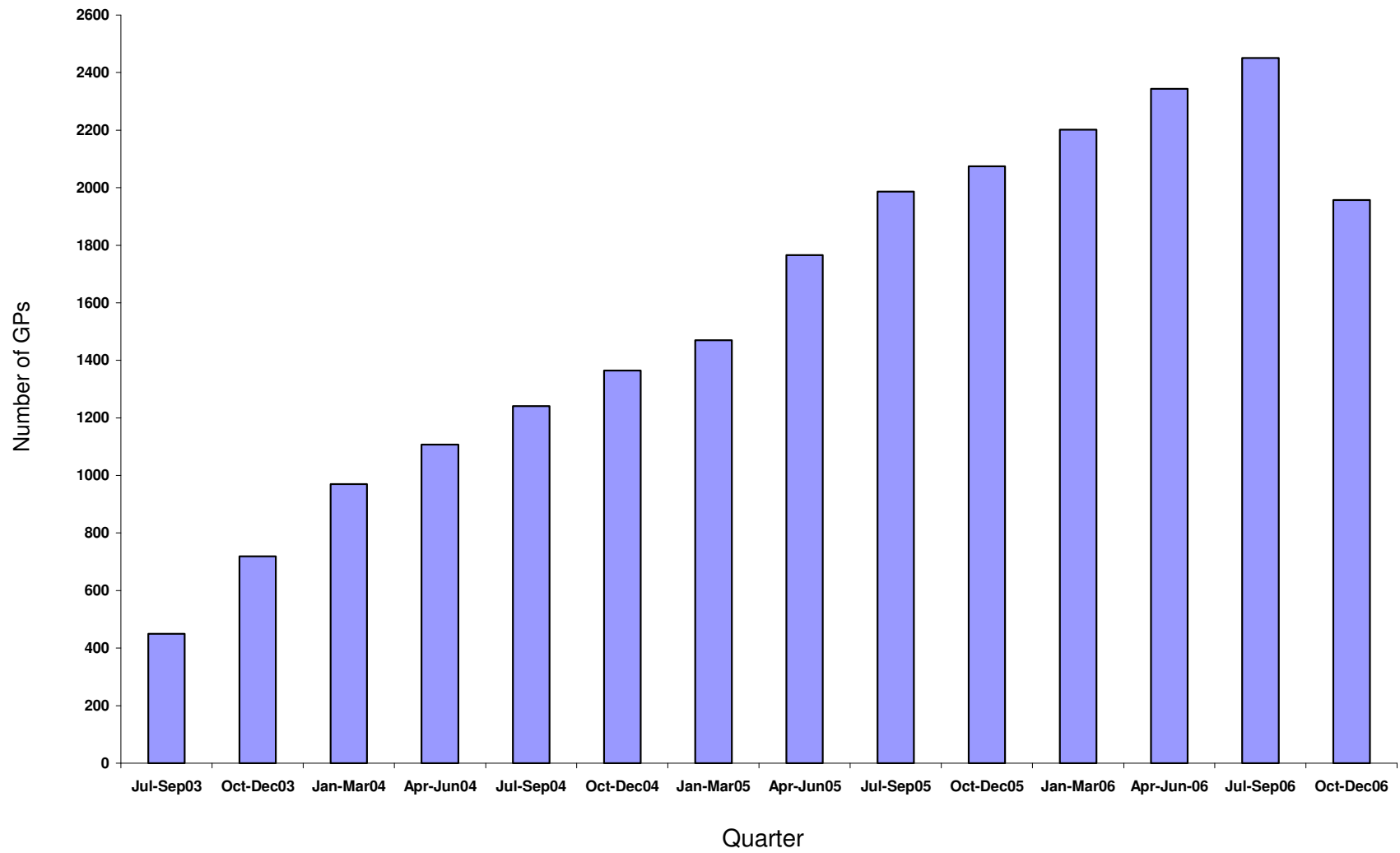
## **Chapter 3: Has participation in the projects by GPs and allied health professionals changed over time?**

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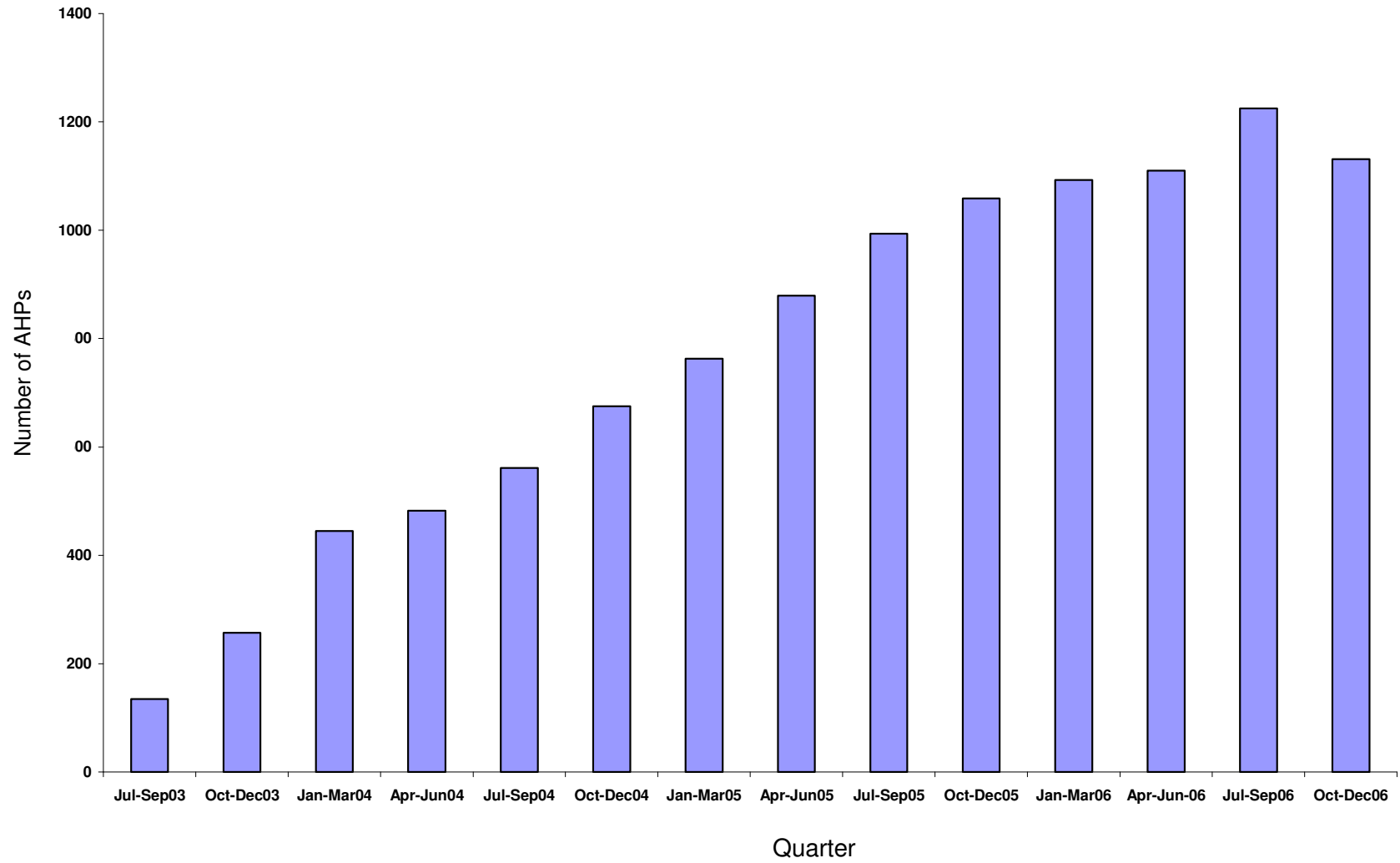
Between 1 July 2003 and 31 December 2006, 6,082 GPs referred consumers to 2,220 allied health professionals through the Access to Allied Psychological Services projects. Figures 1 and 2 provide a breakdown of the number of GPs making referrals and the numbers of allied health professionals providing services in each quarter, respectively.

The numbers of referring GPs rose steadily from 449 in the July-September 2003 quarter to a peak of 2,451 in the July-September 2006 quarter, reflecting the fact that existing projects became more established and additional projects came 'on board'. A similar pattern of increase is also apparent for allied health professionals, with 135 providing services in the July-September 2003 quarter, and 1,225 doing so in the July-September 2006 quarter. The numbers of participating GPs and allied health professionals dropped slightly (to 1,957 and 1,131, respectively) in the October-December 2006 quarter. These drops are likely to reflect a lag in data entry into the minimum dataset at the time of data extraction.

Figure 1: Number of GPs participating in the Access to Allied Psychological Services projects, by quarter



**Figure 2: Number of allied health professionals participating in the Access to Allied Psychological Services projects, by quarter**



# Chapter 4: Has the profile of consumers varied over time, and has the care they are receiving changed?

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## *Overview of consumers and sessions*

Between 1 July 2003 and 31 December 2006, 72,409 consumers were referred to the Access to Allied Psychological Services projects (40,955 to urban projects and 31,454 to rural projects). Figure 3 shows that the number of consumers referred to the projects has increased over time, rising from 1,180 in July-September 2003 to a peak of 8,955 in July-September 2006. Figures 4 and 5 provide a breakdown of this increase by urban and rural projects, where the figures for the same period were 546 to 5,113 and 634 to 3,842, respectively. All three figures show a drop in the final quarter (to 5,807 overall, and to 2,895 and 2,912 in urban and rural areas, respectively). As with the GP and allied health professional data presented in Chapter 3, these drops are likely to reflect a lag in data entry into the minimum dataset.

Figures 3, 4 and 5 also show the number of sessions of care provided to consumers between 1 July 2003 and 31 December 2006. In total, 306,419 sessions of care were provided through the projects (188,179 in urban areas and 118,240 in rural areas). Overall, the sessions have increased over time, rising from 4,020 in July-September 2003 to a peak of 37,892 in July-September 2006. The same pattern was apparent for urban and rural projects; the equivalent figures were 2,062 and 22,884 for urban projects and 1,958 and 15,008 for rural projects. Again, a drop is apparent in the final quarter of the observation period.

Taking the consumer data and the session data presented above together, it is possible to determine the average number of sessions per referred consumer. The average has remained relatively consistent over time, at 4.23. It should be noted, however, that these averages include all referred consumers in the denominator, and not just those who actually took up services. In total, 63,499 consumers used services. Using these figures as the respective denominators, the average number of sessions provided to those consumers who used services was 4.83.

## *Profile of consumers*

Table 2 summarises some of the key characteristics of the consumers receiving care through the projects, and provides a quarterly 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 approximately 41 years. The majority (around two thirds) are on low incomes. About half have no previous history of mental health care. Most have been diagnosed with depression (between 86-91%) or anxiety disorders (75-89%).

Tables 3 and 4 provide a breakdown of these data for urban and rural projects. In the main, the profiles of urban and rural consumers are similar, and generally parallel the data from all projects in terms of trends over time.

## **Profile of sessions**

Table 5 summarises some of the key features of the sessions of care provided to consumers, profiling changes over time. In general, the profile of these sessions has not changed greatly since the Access to Allied Psychological Services projects began. Sessions of 46-60 minutes 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. The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 75% and 70% of sessions, 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 profile of consumers).

Table 5 shows that the only notable change over time has been in the charging of a co-payment. In 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 incurred 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 charged 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 2006 quarter, 19% of sessions involved a co-payment, with only 3% being greater than \$20. Anecdotal evidence suggests that these fluctuations over time may 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.<sup>16</sup> They may also reflect the view that a small co-payment may encourage greater commitment to treatment on the part of the consumer.

Tables 6 and 7 summarise some of the key features of the sessions of care provided to consumers through urban and rural projects, respectively. In the main, the profile of these sessions has remained fairly constant over time in each area, and mirrors that of projects overall, but there are some nuances. For example, although the majority of both urban and rural sessions have consistently been 46-60 minutes in length, a slightly higher proportion of rural sessions have been under 45 minutes. Similarly, although CBT-based cognitive and behavioural interventions have dominated as the therapy of choice in the majority of both urban and rural sessions since the outset, the proportion of sessions at which these interventions are delivered has always been slightly higher in rural sessions.

Again, the exception to the rule relates to co-payments. Both urban and rural projects follow the consistent pattern described above, with relatively small proportions of sessions being associated with co-payments early on and in recent times, and relatively greater sessions incurring a cost to the consumer in the middle period. However, the picture is more exaggerated for urban projects, with proportionally more sessions involving a co-payment at each point in time, and higher average levels of co-payment being charged. For example, in urban projects in July-September 2005, a co-payment was charged at 32% of sessions, and in 4% of sessions this was over \$20. In the same quarter in rural projects, a co-payment was charged at 16% of sessions, and in 1% of sessions this was over \$20. It is also worth noting that the manner in which co-payments are charged and entered into the minimum dataset may affect the observed co-payment distribution; anecdotally some projects report charging a one-off co-payment for the *total number of sessions*, which is entered into the minimum dataset as a *single session* co-payment.

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

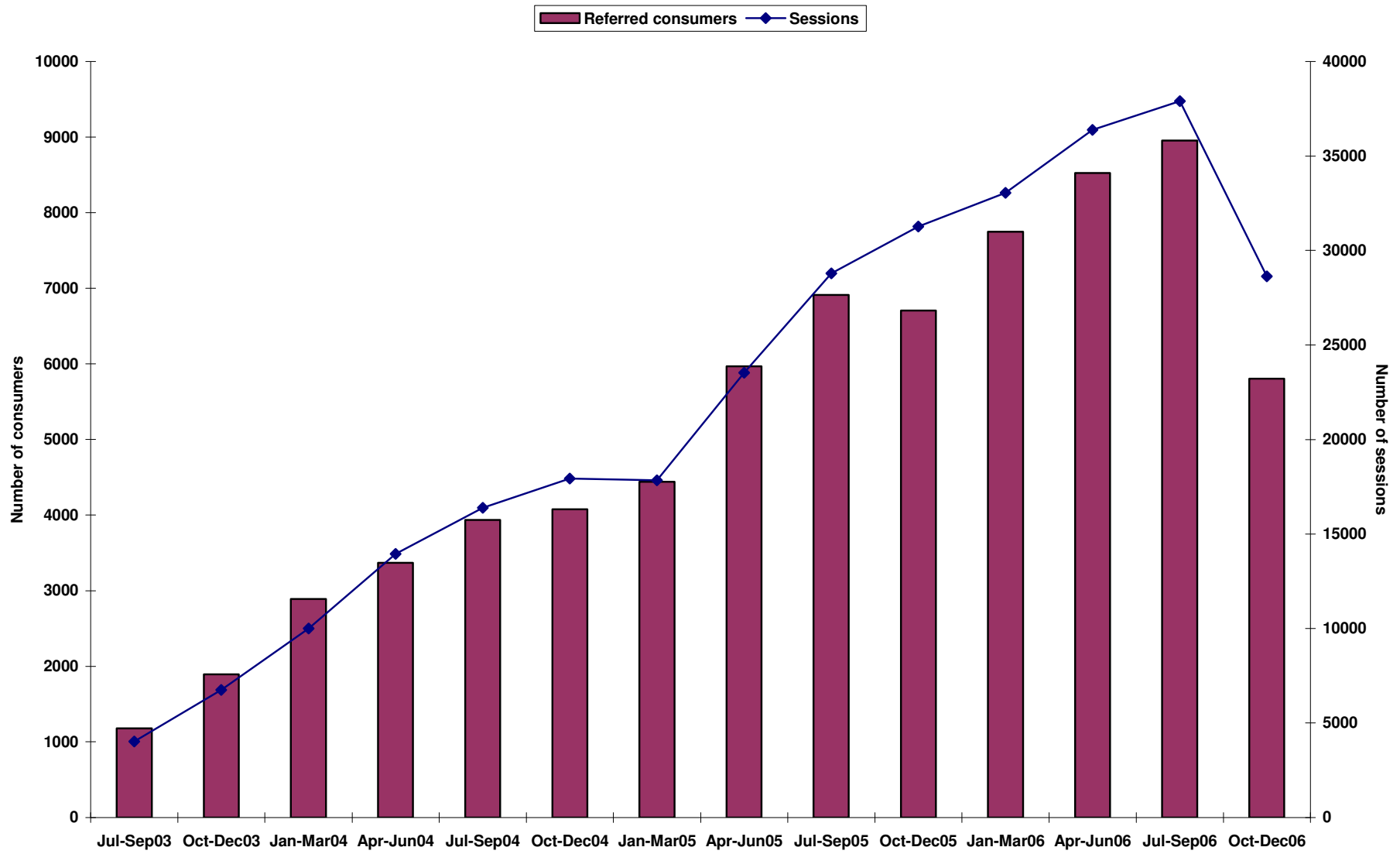


Figure 4: Consumers accessing sessions of care through the Access to Allied Psychological Services projects over time (urban projects)

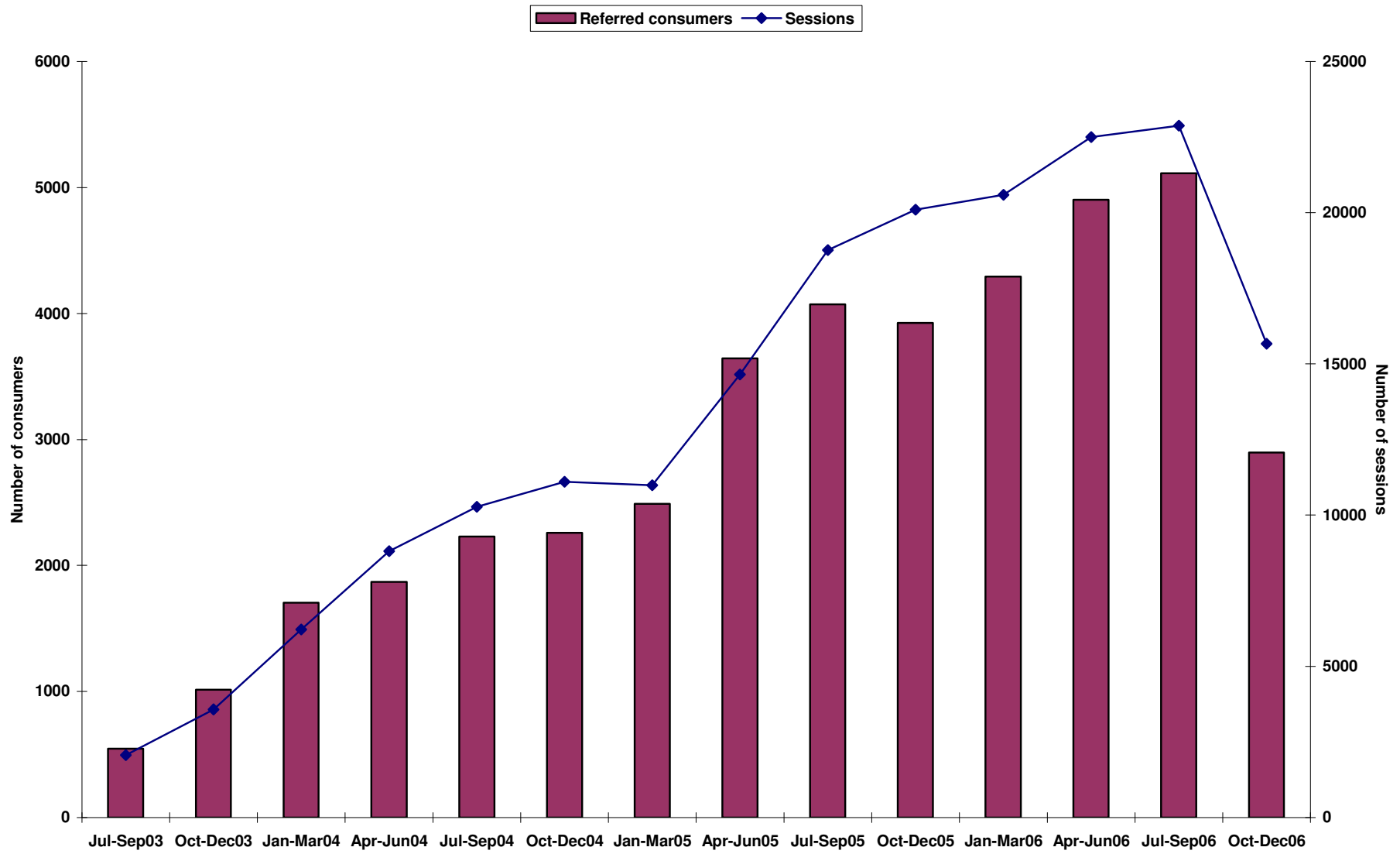
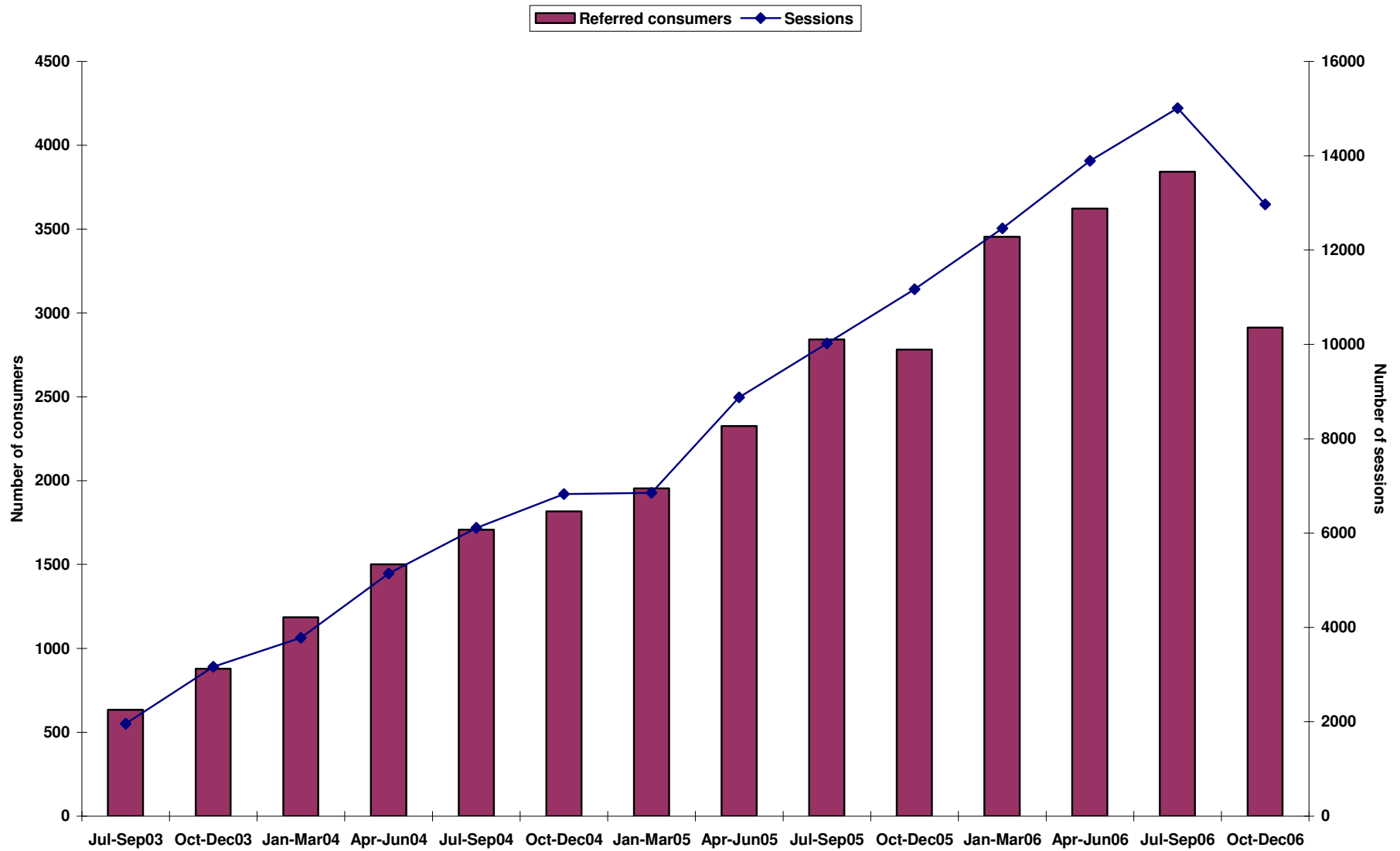


Figure 5: Consumers accessing sessions of care through the Access to Allied Psychological Services projects over time (rural projects)



**Table 2: Summary characteristics of consumers receiving care through the Access to Allied Psychological Services projects over time (all projects)**

	Jul-Sep03	Oct-Dec03	Jan-Mar04	Apr-Jun04	Jul-Sep04	Oct-Dec04	Jan-Mar05	Apr-Jun05	Jul-Sep05	Oct-Dec05	Jan-Mar06	Apr-Jun06	Jul-Sep06	Oct-Dec06
Gender														
• Female	72%	77%	73%	73%	74%	72%	73%	73%	71%	73%	73%	73%	72%	70%
• Male	28%	23%	27%	27%	26%	28%	27%	27%	28%	27%	27%	27%	28%	30%
Mean age	43	43	42	42	41	42	41	41	40	40	40	40	39	39
Low income														
• Yes	54%	59%	57%	63%	62%	62%	61%	63%	64%	62%	62%	63%	63%	60%
• No	21%	23%	26%	22%	21%	23%	25%	25%	24%	26%	26%	26%	23%	24%
• Unknown	25%	18%	17%	15%	17%	15%	14%	12%	12%	12%	12%	11%	14%	16%
Previous psychiatric service use														
• Yes	31%	34%	37%	40%	37%	40%	41%	41%	40%	40%	46%	43%	41%	44%
• No	40%	46%	49%	49%	49%	45%	47%	47%	49%	49%	50%	47%	48%	46%
• Unknown	29%	20%	14%	11%	14%	15%	12%	12%	11%	11%	4%	10%	11%	10%
Diagnosis <sup>a</sup>														
• Alcohol and drug use disorders	17%	16%	21%	23%	22%	22%	21%	23%	24%	22%	25%	22%	17%	19%
• Psychotic disorders	3%	6%	8%	7%	7%	7%	6%	7%	8%	7%	7%	6%	5%	5%
• Depression	89%	89%	91%	88%	86%	86%	88%	89%	89%	87%	89%	87%	87%	87%
• Anxiety disorders	78%	81%	82%	89%	78%	77%	79%	80%	82%	81%	82%	77%	78%	75%
• Unexplained somatic disorders	9%	10%	13%	12%	9%	9%	11%	12%	11%	10%	11%	7%	8%	8%
• Unknown	17%	14%	12%	12%	11%	10%	7%	7%	8%	10%	9%	6%	6%	6%

a. Multiple responses permitted

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

	Jul-Sep03	Oct-Dec03	Jan-Mar04	Apr-Jun04	Jul-Sep04	Oct-Dec04	Jan-Mar05	Apr-Jun05	Jul-Sep05	Oct-Dec05	Jan-Mar06	Apr-Jun06	Jul-Sep06	Oct-Dec06
Gender														
• Female	75%	77%	73%	73%	75%	74%	73%	73%	73%	73%	73%	73%	72%	71%
• Male	25%	23%	27%	27%	25%	26%	27%	27%	27%	27%	27%	27%	28%	29%
Mean age	43	42	42	42	41	41	41	40	40	39	39	39	39	38
Low income														
• Yes	61%	64%	67%	68%	66%	67%	66%	68%	68%	65%	66%	66%	65%	62%
• No	21%	18%	19%	18%	19%	20	22%	22%	22%	26%	25%	24%	20%	21%
• Unknown	28%	18%	14%	14%	15%	13%	12%	10%	10%	9%	9%	10%	15%	17%
Previous psychiatric service use														
• Yes	31%	33%	38%	41%	37%	41%	41%	43%	40%	41%	42%	44%	41%	44%
• No	40%	43%	50%	46%	49%	44%	48%	48%	51%	51%	50%	47%	49%	47%
• Unknown	29%	24%	12%	13%	14%	15%	11%	9%	9%	8%	8%	9%	10%	9%
Diagnosis <sup>a</sup>														
• Alcohol and drug use disorders	9%	8%	18%	20%	18%	15%	16%	17%	17%	17%	20%	16%	13%	15%
• Psychotic disorders	1%	6%	6%	5%	5%	4%	4%	4%	6%	5%	5%	4%	3%	3%
• Depression	86%	85%	87%	85%	84%	82%	82%	85%	84%	82%	84%	81%	83%	80%
• Anxiety disorders	76%	76%	78%	77%	74%	72%	72%	74%	77%	74%	76%	70%	72%	64%
• Unexplained somatic disorders	11%	10%	12%	14%	9%	6%	8%	9%	8%	8%	6%	4%	7%	5%
• Unknown	3%	6%	7%	7%	3%	3%	3%	3%	5%	5%	5%	3%	3%	3%

a. Multiple responses permitted

**Table 4: Summary characteristics of consumers receiving care through the Access to Allied Psychological Services projects over time (rural projects)**

	Jul-Sep03	Oct-Dec03	Jan-Mar04	Apr-Jun04	Jul-Sep04	Oct-Dec04	Jan-Mar05	Apr-Jun05	Jul-Sep05	Oct-Dec05	Jan-Mar06	Apr-Jun06	Jul-Sep06	Oct-Dec06
Gender														
• Female	70%	76%	72%	71%	72%	72%	72%	73%	71%	72%	72%	70%	73%	68%
• Male	30%	24%	28%	29%	28%	28%	28%	27%	29%	28%	28%	30%	27%	32%
Mean age	43	43	43	42	41	42	42	41	41	40	40	40	39	40
Low income														
• Yes	49%	55%	54%	57%	57%	57%	54%	55%	58%	59%	58%	59%	60%	58%
• No	20%	27%	29%	26%	24%	26%	29%	29%	27%	26%	27%	28%	27%	25%
• Unknown	31%	18%	17%	17%	15%	13%	17%	16%	15%	15%	15%	13%	13%	17%
Previous psychiatric service use														
• Yes	29%	35%	36%	37%	36%	38%	40%	38%	40%	38%	39%	42%	42%	43%
• No	42%	50%	50%	51%	48%	47%	46%	47%	46%	46%	48%	46%	47%	44%
• Unknown	29%	15%	14%	12%	16%	15%	14%	15%	14%	16%	13%	12%	11%	13%
Diagnosis <sup>a</sup>														
• Alcohol and drug use disorders	29%	27%	32%	35%	42%	48%	40%	55%	52%	40%	43%	37%	33%	34%
• Psychotic disorders	6%	6%	14%	10%	17%	20%	14%	23%	21%	16%	18%	16%	15%	10%
• Depression	92%	93%	96%	92%	90%	91%	96%	98%	97%	96%	96%	97%	96%	97%
• Anxiety disorders	78%	87%	91%	87%	83%	87%	93%	94%	93%	93%	93%	92%	92%	92%
• Unexplained somatic disorders	6%	10%	18%	10%	10%	17%	26%	29%	28%	18%	27%	20%	7%	18%
• Unknown	36%	27%	26%	27%	36%	35%	24%	30%	24%	31%	25%	15%	17%	18%

a. Multiple responses permitted

**Table 5: 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	Oct-Dec05	Jan-Mar06	Apr-Jun06	Jul-Sep06	Oct-Dec06
<b>Duration</b>														
• 0-30 mins	7%	5%	4%	3%	3%	3%	3%	2%	2%	1%	1%	1%	1%	1%
• 31-45 mins	7%	7%	10%	10%	10%	10%	6%	4%	7%	4%	5%	6%	5%	5%
• 46-60 mins	81%	78%	76%	75%	75%	74%	75%	80%	82%	83%	81%	82%	83%	83%
• Over 60 mins	5%	10%	10%	12%	11%	14%	16%	14%	9%	12%	13%	11%	11%	11%
<b>Type</b>														
• Group	0%	2%	3%	2%	2%	3%	3%	2%	3%	2%	2%	2%	2%	2%
• Individual	100%	98%	97%	98%	98%	97%	97%	98%	97%	98%	98%	98%	98%	98%
<b>Interventions<sup>a</sup></b>														
• Diagnostic assessment	36%	44%	54%	59%	53%	47%	45%	47%	48%	44%	44%	52%	50%	45%
• Psycho-education	48%	56%	64%	70%	59%	55%	51%	56%	60%	55%	53%	60%	60%	58%
• CBT-Behavioural interventions	58%	65%	69%	77%	75%	73%	66%	70%	70%	68%	66%	74%	75%	72%
• CBT-Cognitive interventions	63%	75%	80%	85%	83%	81%	75%	79%	77%	76%	72%	79%	81%	78%
• CBT-Relaxations strategies	42%	53%	59%	63%	61%	58%	50%	53%	52%	51%	47%	55%	56%	53%
• CBT-Skills training	46%	52%	55%	60%	57%	55%	50%	51%	52%	48%	44%	53%	54%	54%
• Interpersonal Therapy	39%	50%	57%	63%	59%	55%	51%	56%	54%	53%	52%	61%	60%	57%
<b>Co-payment</b>														
• \$0	91%	81%	64%	59%	59%	62%	71%	76%	78%	75%	78%	81%	81%	81%
• \$1-5	5%	5%	8%	7%	6%	6%	6%	7%	4%	5%	5%	3%	2%	2%
• \$5-10	4%	8%	13%	17%	20%	13%	7%	5%	5%	9%	8%	7%	8%	6%
• \$11-15	0%	1%	3%	2%	2%	1%	1%	1%	1%	1%	1%	1%	1%	1%
• \$16-20	0%	4%	5%	6%	7%	13%	11%	9%	11%	7%	6%	5%	5%	6%
• \$21-25	0%	0%	4%	5%	4%	3%	2%	1%	1%	1%	1%	2%	2%	2%
• \$26-30	0%	0%	2%	2%	1%	1%	0%	0%	0%	1%	1%	1%	1%	1%
• >\$30	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%

a. multiple responses permitted

**Table 6: Urban 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	Oct-Dec05	Jan-Mar06	Apr-Jun06	Jul-Sep06	Oct-Dec06
<b>Duration</b>														
• 0-30 mins	0%	1%	1%	1%	2%	2%	2%	2%	1%	1%	1%	1%	1%	1%
• 31-45 mins	9%	8%	12%	11%	11%	11%	6%	4%	3%	3%	3%	4%	4%	4%
• 46-60 mins	87%	81%	77%	76%	76%	76%	79%	82%	82%	85%	84%	85%	85%	85%
• Over 60 mins	4%	10%	10%	12%	11%	11%	13%	12%	14%	11%	12%	10%	10%	10%
<b>Type</b>														
• Group	1%	0%	2%	2%	2%	2%	3%	4%	2%	2%	1%	2%	2%	3%
• Individual	99%	100%	98%	98%	98%	97%	96%	98%	98%	98%	99%	98%	98%	97%
<b>Interventions<sup>a</sup></b>														
• Diagnostic assessment	39%	51%	51%	52%	44%	38%	36%	39%	40%	36%	34%	45%	44%	36%
• Psycho-education	55%	67%	62%	66%	57%	52%	48%	54%	52%	44%	41%	49%	51%	45%
• CBT-Behavioural interventions	58%	69%	57%	73%	69%	66%	59%	63%	63%	61%	58%	68%	69%	62%
• CBT-Cognitive interventions	64%	73%	76%	81%	78%	75%	69%	73%	72%	69%	64%	74%	76%	70%
• CBT-Relaxations strategies	41%	57%	54%	57%	52%	48%	41%	45%	45%	42%	35%	46%	44%	40%
• CBT-Skills training	36%	43%	46%	53%	48%	46%	41%	44%	46%	41%	34%	44%	45%	42%
• Interpersonal Therapy	47%	54%	58%	59%	51%	46%	39%	48%	45%	42%	40%	52%	52%	48%
<b>Co-payment</b>														
• \$0	91%	83%	63%	59%	57%	59%	60%	67%	68%	69%	71%	75%	76%	74%
• \$1-5	5%	4%	6%	5%	5%	4%	4%	6%	7%	6%	7%	3%	1%	3%
• \$5-10	4%	9%	17%	21%	23%	18%	20%	13%	11%	13%	9%	9%	9%	8%
• \$11-15	0%	1%	3%	2%	2%	2%	2%	1%	1%	1%	1%	1%	3%	3%
• \$16-20	0%	1%	3%	4%	5%	11%	9%	9%	8%	8%	8%	7%	6%	8%
• \$21-25	0%	1%	5%	7%	5%	4%	3%	2%	2%	1%	2%	3%	2%	3%
• \$26-30	0%	0%	2%	3%	2%	2%	1%	1%	1%	1%	1%	1%	1%	1%
• >\$30	1%	0%	1%	0%	1%	1%	1%	1%	1%	0%	1%	1%	1%	1%

a. multiple responses permitted

**Table 7: Rural 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	Oct-Dec05	Jan-Mar06	Apr-Jun06	Jul-Sep06	Oct-Dec06
<b>Duration</b>														
• 0-30 mins	14%	9%	9%	7%	7%	5%	5%	3%	4%	3%	2%	2%	2%	2%
• 31-45 mins	5%	5%	5%	8%	7%	6%	5%	5%	6%	7%	8%	8%	7%	6%
• 46-60 mins	74%	76%	75%	73%	75%	74%	76%	79%	78%	78%	75%	77%	79%	79%
• Over 60 mins	6%	9%	11%	12%	11%	14%	14%	13%	12%	12%	15%	13%	12%	13%
<b>Type</b>														
• Group	0%	3%	3%	3%	2%	3%	1%	2%	3%	2%	2%	2%	2%	2%
• Individual	99%	97%	97%	97%	98%	97%	99%	98%	97%	98%	98%	98%	98%	98%
<b>Interventions<sup>a</sup></b>														
• Diagnostic assessment	33%	39%	58%	73%	75%	75%	72%	70%	76%	72%	72%	69%	64%	64%
• Psycho-education	40%	44%	68%	81%	85%	84%	81%	81%	84%	82%	80%	79%	78%	77%
• CBT-Behavioural interventions	59%	60%	72%	84%	86%	89%	84%	86%	88%	86%	85%	85%	87%	87%
• CBT-Cognitive interventions	63%	76%	88%	93%	92%	92%	89%	91%	91%	90%	88%	88%	91%	91%
• CBT-Relaxations strategies	43%	50%	66%	77%	83%	83%	76%	77%	79%	77%	74%	74%	78%	76%
• CBT-Skills training	55%	59%	68%	75%	80%	80%	73%	71%	75%	74%	71%	71%	75%	76%
• Interpersonal Therapy	30%	44%	56%	74%	79%	81%	77%	78%	81%	82%	83%	80%	75%	72%
<b>Co-payment</b>														
• \$0	100%	88%	82%	83%	81%	81%	83%	85%	84%	86%	88%	89%	88%	90%
• \$1-50%	0%	2%	6%	5%	5%	5%	6%	7%	5%	3%	3%	3%	3%	2%
• \$5-10	0%	1%	1%	4%	7%	7%	4%	3%	3%	4%	5%	5%	5%	3%
• \$11-15	0%	0%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
• \$16-20	0%	7%	9%	6%	6%	6%	7%	5%	6%	5%	3%	2%	3%	4%
• \$21-25	0%	0%	0%	0%	0%	1%	0%	0%	1%	1%	1%	1%	0%	1%
• \$26-30	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
• >\$30	0%	2%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

a. multiple responses permitted

# **Chapter 5: Have there been changes in the level of uptake of services provided by the projects following the introduction of the Better Access program?**

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## ***Hypothesised changes***

As noted in Chapter 1, the Better Access program was introduced in November 2006, after the Better Outcomes in Mental Health Care program had been running for nearly five and a half years. By the time the Better Access program was introduced, the majority of the Access to Allied Psychological Services projects were well established. The two programs are complementary, with both being designed to improve access to mental health care providers for people with high prevalence disorders. There have been suggestions, however, that the introduction of the new MBS item numbers for psychologists and allied health professionals under the Better Access program will gradually reduce demand for allied health services provided through the Access to Allied Psychological Services projects.<sup>17</sup> There is a perception, for example, that GPs may favour the Better Access program because they may find the referral process simpler. Similarly, it has been suggested that psychologists may prefer to provide services through the Better Access program because they may have greater autonomy.

For the above reasons, it was hypothesised that there might be a reduction in the number of sessions provided through the Access to Allied Psychological Services projects after 1 November 2006, and that the magnitude of this reduction would be commensurate with the degree of uptake of the Better Access program in Divisions.

## ***Comparing the number of sessions provided through the Access to Allied Psychological Services projects and the Better Access program***

Divisional-level data on the number of sessions provided through the Access to Allied Psychological Services projects (from the minimum dataset) and the Better Access program (from the Medicare Benefits Branch of the Department of Health and Ageing) were available from 1 November 2006 to 30 April 2007. In both cases, data from April 2007 were excluded from the analysis because of the potential for lags in data provision and data entry. For the purposes of the current analysis, therefore, reliable data were available for the five month period from 1 November 2006 to 31 March 2007. It should also be noted that the analysis dataset only included data from 105 Divisions where both Access to Allied Psychological Services and Better Access data were available.

In total, 39,040 sessions were provided in the five month observation period through the Access to Allied Psychological Services projects, and 220,522 were provided through the Better Access program. Fifty two per cent of the Access to Allied Psychological Services project sessions were provided in urban areas, compared with 83% of the Better Access program sessions.

Figure 6 shows the overall monthly breakdown of sessions provided under each program. It indicates that although the monthly number of sessions provided by the Better Access program has increased dramatically since its introduction, the monthly number of sessions provided by the Access to Allied Psychological Services projects have remained fairly constant since 1 November 2007, showing a marginal decrease at most.

**Figure 6: Overall number of sessions provided through Access to Allied Psychological Services projects and Better Access program, 1 November 2006 to 31 March 2007**

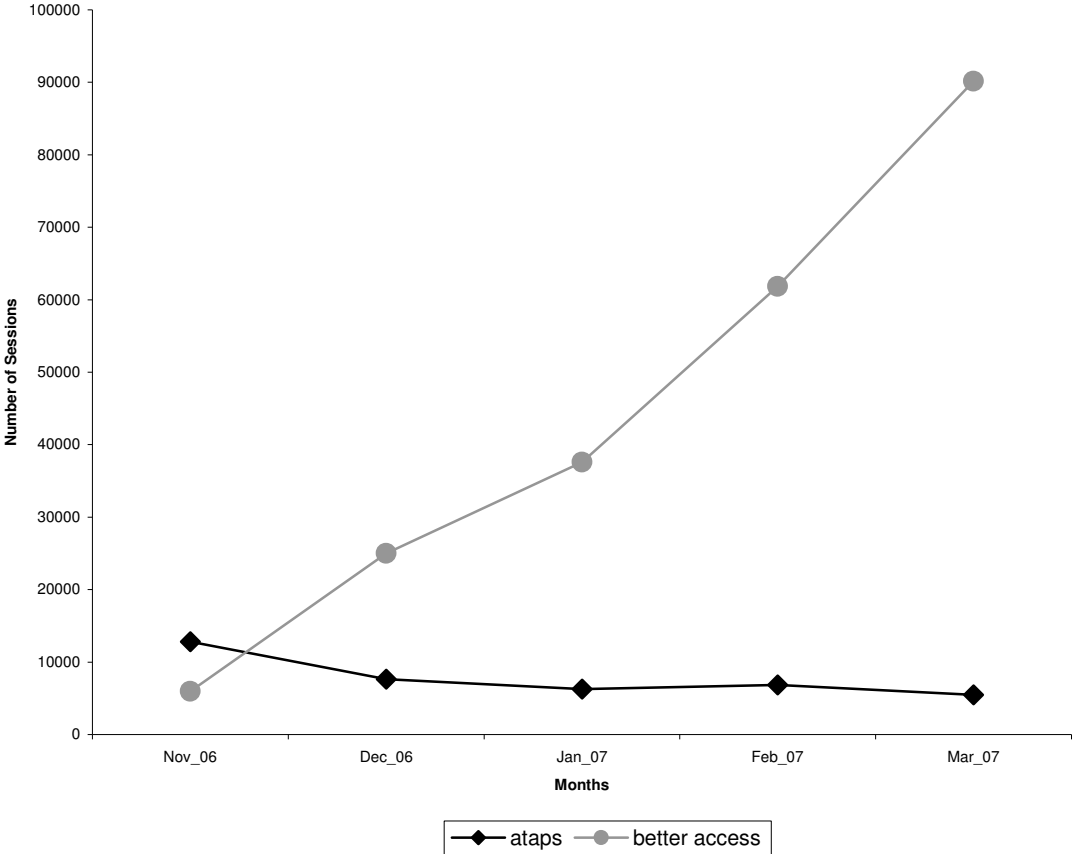
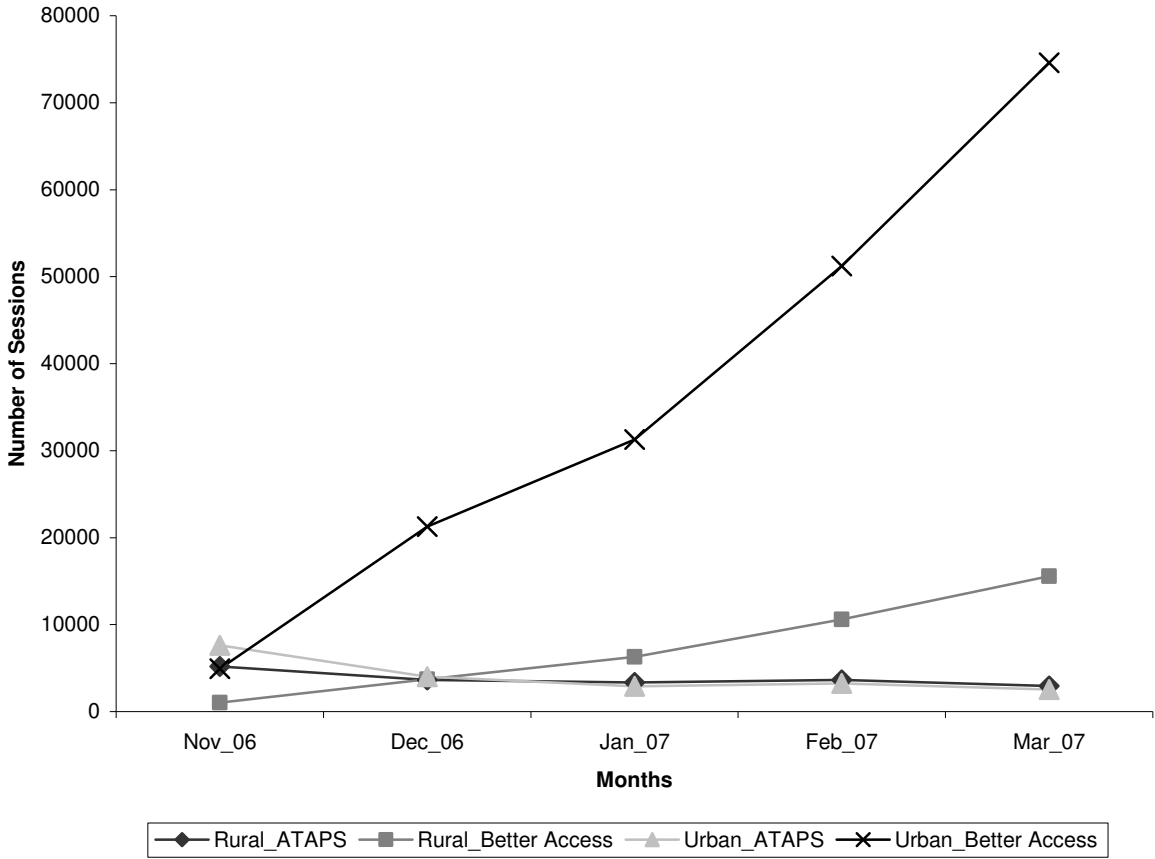


Figure 7 provides a more detailed picture of the sessions provided by the two programs, breaking them down by urban and rural area. It shows that the increase in number of sessions provided under the Better Access program has been most pronounced in urban areas, where there appears to have been an early decrease in the number of sessions provided through the Access to Allied Psychological Services projects which has then levelled out. It also shows that the increase in number of sessions provided under the Better Access program has been more gradual in rural areas, where the number of sessions provided by Access to Allied Psychological Services projects has decreased only marginally.

**Figure 7: Number of sessions provided through Access to Allied Psychological Services projects and Better Access program (rural and urban areas), 1 November 2006 to 31 March 2007**



Correlation analyses were conducted to assess the relationship between the number of sessions provided through the Access to Allied Psychological Services projects and Better Access program, per Division, per month. Three separate analyses were conducted – one for all areas combined, one for rural areas, and one for urban areas. The analyses found small, non-significant negative correlation overall ( $r = -.078$ ,  $p = .074$ ). For rural areas the correlation was positive but also non-significant ( $r = .024$ ,  $p = .703$ ). For urban areas there was a significant negative correlation ( $r = -.142$ ,  $p = .019$ ). This indicates that the number of sessions being provided at a Divisional level through the Access to Allied Psychological Services projects in rural areas are not being influenced by the number of sessions being provided through the Better Access program. However, in urban areas there may be a slight move towards sessions provided by Better Access.

# Chapter 6: Are the projects achieving positive outcomes for consumers?

## *Availability of outcomes data*

Access to Allied Psychological Services projects were included in the analysis of consumer outcomes if they had supplied pre- and post-treatment scores on a given outcome measure for at least five consumers to the minimum dataset. Forty two projects had entered sufficient data to be included in the analysis, and provided data for a total of 5,288 consumers. This represents an increase from the equivalent analysis conducted for the Eighth Interim Evaluation Report,<sup>15</sup> where 29 projects had supplied data for 2,007 consumers, but it is acknowledged that it still only represents 38% of projects and 7% of consumers.

Pre- and post-treatment outcome scores were available from 12 different measures, namely the Kessler 10 (K-10), the Beck Anxiety Inventory (BAI), the Beck Depression Inventory (BDI), the Hospital Anxiety and Depression Scale (HADS), the Depression Anxiety Stress Scales (DASS), the Health of the Nation Outcome Scales (HoNOS), the General Well Being Index (GWBI), the State Trait Anxiety Inventory (STAI), the Behaviour and Symptom Identification Scale (BASIS-32), Self-Rating Depression Scale (SDS), Outcome Rating Scale (ORS), and the General Health Questionnaire (GHQ-28). It should be noted that a decrease in score from pre- to post-treatment represents an improvement on all of these measures except the GWBI, where an increase represents an improvement.

The number of projects using each outcome measure is shown in Table 8, as is the number of consumers for whom each measure was used. Note that the totals exceed 42 and 5,288, respectively, because some projects used more than one outcome measure for the same consumer.

**Table 8: Consumer outcome measures used by the Access to Allied Psychological Services projects**

Outcome Measure	Projects (n=42)		Consumers (n=5,288)	
	Frequency	Percent	Frequency	Percent
K-10	26	32.9	2,384	45.1
DASS-42 - Depression, Anxiety Stress	16	20.3	814	15.4
DASS-21 - Depression, Anxiety Stress	14	17.7	625	11.8
BDI	6	7.6	273	5.2
BAI	5	6.3	198	3.7
HADS	4	5.1	143	2.7
HONOS	2	2.5	491	9.3
GWBI	2	2.5	158	3.0
BASIS-32	1	1.3	174	3.3
GHQ-28	1	1.3	12	0.2
STAI	1	1.3	9	0.2
ORS	1	1.3	7	0.1

N.B. Multiple responses permitted

## ***Mean pre- and post-treatment effect sizes***

The mean pre- and post-treatment effect size, weighted for sample size, for consumers across projects is 1.10 (95% CI = 1.00 -1.20). This indicates that, at worst, the effect size is 1.00. Based on Cohen's interpretation of effect size, this indicates a large positive effect ( $d > 0.80$ ).<sup>18</sup>

Table 9 shows the effect sizes for the 42 (de-identified) projects. The point estimates of effect size are all positive, indicating that all projects are achieving improved consumer outcomes. Shading indicates those projects with effect sizes that are bounded by positive 95% confidence intervals (i.e., positive worst- and best-case scenarios). Thirty-eight projects (90%) demonstrate positive 95% confidence intervals. Thirty-two (84%) show large positive effects at worst, and six (16%) show medium positive effects at worst. This interpretation is conservative, because, as noted, the point estimates are all positive, and the projects with confidence intervals bounded by negative lower limits tend to be those with small sample sizes.

**Table 9: Mean pre- and post-treatment effect sizes and 95 % confidence intervals by projects (n=42)**

Project	Effect Size ( <i>d</i> )	95% CI	
		Lower	Upper
1	0.93	0.78	1.07
2	0.84	0.68	1.01
3	1.07	0.79	1.35
4	0.71	0.55	0.87
5	0.93	0.57	1.3
6	1.24	0.98	1.5
7	0.66	0.17	1.14
8	1.54	0.15	2.93
9	1.95	1.32	2.58
10	0.95	0.19	1.72
11	1.07	0.42	1.72
12	2.59	1.47	3.7
13	0.22	-0.84	1.28
14	1.01	0.58	1.44
15	1.12	0.92	1.32
16	0.62	0.04	1.2
17	1.7	1.45	1.95
18	0.81	-0.64	2.27
19	1.08	0.92	1.25
20	1.27	1.02	1.52
21	1.43	1.14	1.72
22	0.95	0.78	1.11
23	1.24	1.01	1.47
24	1.36	-0.36	3.07
25	1.22	0.95	1.5
26	1.23	0.4	2.07
27	0.81	0.42	1.2
28	1.23	1.07	1.39
29	-0.22	-1.23	0.79
30	0.73	0.48	0.98
31	1.01	0.65	1.37
32	1.29	1.04	1.54
33	0.76	0.13	1.39
34	1.34	0.89	1.79
35	1.11	0.91	1.3
36	1.32	0.21	2.44
37	1.24	0.66	1.82
38	0.67	0.39	0.95
39	1.95	0.19	3.72
40	1.76	0.45	3.07
41	1.5	1.26	1.74
42	1.37	1.06	1.68
<b>Overall</b>	1.10	1.00	1.20

## **Chapter 7: Discussion and conclusions**

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

The current report focussed 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?**

Between 1 July 2003 and 31 December 2006, 6,082 GPs referred consumers to 2,220 allied health professionals. There has been a consistent 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), 449 GPs made referrals to 135 allied health professionals; in the most recent quarter for which complete data were available (July-September 2006), the equivalent figures were 2,451 and 1,225 respectively.

#### **Has the profile of consumers varied over time, and has the care they are receiving changed?**

Between 1 July 2003 and 31 December 2006, 72,409 consumers were referred to the Access to Allied Psychological Services projects. The number of consumers referred to the projects has increased on a quarter-by-quarter basis, beginning at 1,180 (546 urban; 634 rural) in July-September 2003 and peaking at 8,955 (5,113 urban; 3,842 rural) in July-September 2006. The profile of these consumers has remained fairly consistent over time overall and in urban and rural areas, 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 306,419 (188,179 in urban areas and 118,240 in rural areas). Once again, there is a clear increase in the number of sessions provided over time, rising from 4,020 (2,062 urban; 1,958 rural) provided in the July-September 2003 quarter to peak at 37,892 (22,884 urban; 15,008 rural) in the July-September 2006 quarter. In the main, the profile of these sessions has not changed over time in either urban or rural areas, with the majority being individually-based, 46-60 minutes 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 urban and rural 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 \$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 there been changes in the level of uptake of services provided by the projects following the introduction of the Better Access program?**

It was hypothesised that the introduction of the new MBS item numbers for psychologists and other allied health professionals under the Better Access program might reduce demand for allied health services provided through the Access to Allied Psychological Services projects. Divisional-level analysis of the number of sessions provided through both programs in the five months since the introduction of the Better Access program (1 November 2006) provided little overall support for this hypothesis. The uptake of the Better Access program has been dramatic, particularly in urban areas. However, there has not been a commensurate decrease in the number of sessions

provided through the Access to Allied Psychological Services projects, except for a small early drop in the number of sessions provided in urban projects, which has now levelled out. The correlations between the number of sessions provided by both programs overall and in rural areas were not significant. In urban areas, however, a small significant negative correlation was observed. This suggests that, in general, the two programs are operating relatively independently of each other in terms of session provision, but that in urban Divisions there may be something of a move towards services provided through the Better Access program. Having said this, it should be noted that the two programs are not operating in isolation from each other in practical terms. Anecdotally, for example, some Divisions are providing support to GPs wishing to refer to the Better Access program, and some allied health professionals are providing services under both programs.

## **Are the projects achieving positive outcomes for consumers?**

The projects are using a range of different measures to assess outcomes for consumers. When available pre- and post-treatment scores on these outcome measures were reduced to a single metric, namely an effect size, the projects were shown to be achieving positive outcomes of large or medium magnitude.

### ***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.

There are known lags in data entry for both the Access to Allied Psychological Services projects and the Better Access program. In the case of the Access to Allied Psychological Services projects, some Divisions do not enter session data into the minimum dataset until all six (or 12) sessions have been completed for a given consumer. In the case of the Better Access program, some psychologists and other allied health professionals may gather a 'batch' of claims before they submit them to Medicare Australia for reimbursement. These data entry lags would be expected to have an impact on the veracity of later data, which is why the September-December 2006 quarter was treated with caution in all descriptive analyses, and why March 2007 was selected as the 'cut-off' point for data used in the analyses that compared the Access to Allied Psychological Services projects with the Better Access program. Despite this, the true magnitude of achievements by the Access to Allied Psychological Services projects may have been underestimated, as may the number of sessions provided through the projects and under the Better Access program.

### ***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 greater 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.

The introduction of the Better Access program does not seem to have reduced the demand for psychological services provided through the Access to Allied Psychological Services projects. This may reflect the fact that there was an excess demand for psychological services that could not be met by the projects due to the capped nature of their funding, which is now being

addressed, at least to some extent, by psychologists and allied health professionals providing care through the Better Access program. This interpretation is consistent with other findings of the current evaluation, such as the fact that many Divisions have had to institute demand management strategies to deal with excess requests for services.<sup>16</sup>

Perhaps one of the reasons for the ongoing high demand for services provided through the Access to Allied Psychological Services is the fact that they are achieving positive consumer outcomes. There is good evidence that the projects are receiving positive results for consumers, in terms of alleviating symptoms, improving levels of functioning, and impacting on general wellbeing.

The Access to Allied Psychological Services projects appear to have become a crucial part of the mental health care landscape in Australia, and there continues to be a high demand for their services despite alternative avenues of service provision having been made available. They are reaching more and more people who may previously have had difficulty accessing services, and are providing high quality care in a consistent fashion. Most significantly, they are achieving their desired results.

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

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## ***Education and training for GPs (Component 1)***

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

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

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

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

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

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

The GP Mental Health Care Plan was included in the Better Outcomes in Mental Health Care program to provide a framework for the management of mental health problems and mental illness in a primary care setting, by encouraging effective and longitudinal care of consumers. Originally known as the 3 Step Mental Health Process, it included: (a) an assessment (Step 1); (b) preparation of a mental health plan (Step 2); and (c) a review of the mental health plan (Step 3). GPs were reimbursed for providing the 3 Step Mental Health Plan via a blended mechanism of

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

payment. When they registered with Medicare Australia, they were paid a sign-on Service Incentive Payment of \$150. The GP then billed Medicare Australia under normal attendance items (Level C or D) for the assessment and the mental health plan. He or she used a specific item number to bill Medicare Australia for the review (Items 2574, 2575, 2577, 2578, 2704, 2707, 2705 or 2708), and this triggered the payment of a Service Incentive Payment (\$150 per 3 Step Mental Health Process per consumer per year) in addition to attracting a Medicare rebate for the consumer.

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

### ***Focussed Psychological Strategies (Component 3)***

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

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

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

### ***Access to Allied Psychological Services (Component 4)***

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

### ***Access to Psychiatrist Support (Component 5)***

The Access to Psychiatrist Support component of the Better Outcomes in Mental Health Care program has two sub-components, both of which broaden the role of psychiatrists in providing mental health care. The first involves a series of Medicare Benefits Schedule rebates which enable psychiatrists to organise or take part in case conferences on a consumer's behalf (Items 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838, 855, 857, 858, 861, 864 and 866).

The second involves the provision of consultancy assistance to GPs by psychiatrists via GP Psych Support, a service that was originally provided by McKesson and Educational Health Solutions and is now being provided by the Royal Australian College of General Practitioners. GP Psych Support provides GPs with telephone, fax and email access to quality management advice from a psychiatrist within 24 hours, seven days a week.

## Appendix 2: Access to Allied Psychological Services projects

Round	Division(s)	State	Urban/Rural
1 (pilot)	Central Coast	NSW	Urban
1 (pilot)	NSW Central West	NSW	Rural
1 (pilot)	NSW Outback	NSW	Rural
1 (pilot)	Top End Div of GP	NT	Rural
1 (pilot)	Logan Area	QLD	Urban
1 (pilot)	SE Alliance of GP Bris (Ass of Bayside)	QLD	Urban
1 (pilot)	Sunshine Coast	QLD	Rural
1 (pilot)	Toowoomba & District (Now GP Connections)	QLD	Rural
1 (pilot)	Adelaide Nth Div of GP	SA	Urban
1 (pilot)	Bendigo & District	Vic	Rural
1 (pilot)	Dandenong Div of GP(Greater SE Div)	Vic	Urban
1 (pilot)	East Gippsland Div of GP (fund holder for Sth Gipp & Central West Div)	Vic	Urban
1 (pilot)	General Practice Alliance - South Gippsland Limited	Vic	Rural
1 (pilot)	Knox	Vic	Urban
1 (pilot)	NW Melbourne	Vic	Urban
1 (pilot)	Central West Gippsland	Vic	Rural
1 (pilot)	Fremantle	WA	Urban
1 (pilot)	Perth & Hills	WA	Urban
1 (supplementary)	ACT Division of GP	ACT	Urban
1 (supplementary)	Hastings Macleay	NSW	Rural
1 (supplementary)	Mid North Coast	NSW	Rural
1 (supplementary)	Riverina	NSW	Rural
1 (supplementary)	Nth & West QLD Primary Health Care	QLD	Rural
1 (supplementary)	Southern Division of GP SA	SA	Urban
1 (supplementary)	Ballarat & District	Vic	Rural
1 (supplementary)	Central Highlands	Vic	Urban
1 (supplementary)	General Prac Ass of Geelong (fund holder for Otway Div of GP)	Vic	Urban
1 (supplementary)	Mornington Peninsula	Vic	Urban
1 (supplementary)	NE Victoria	Vic	Rural
1 (supplementary)	Otway	Vic	Rural
1 (supplementary)	GP Down South (Peel SW)	WA	Rural
1 (supplementary)	Greater Bunbury (split from Peel SW 01.07.04)	WA	Rural
2	Blue Mountains	NSW	Urban
2	Canterbury	NSW	Urban
2	Dubbo / Plains	NSW	Rural
2	Illawara	NSW	Urban
2	Murrumbidgee	NSW	Rural

<b>Round</b>	<b>Division(s)</b>	<b>State</b>	<b>Urban/Rural</b>
2	Nepean Div of GP	NSW	Urban
2	New England	NSW	Rural
2	NW Slopes	NSW	Rural
2	Sthrn Highlands	NSW	Rural
2	Sutherland	NSW	Urban
2	Sydney South West GP Network Ltd (Fairfield)	NSW	Urban
2	Brisbane South	QLD	Urban
2	Capricornia	QLD	Rural
2	Central QLD Rural	QLD	Rural
2	Far Nth QLD Rural	Qld	Rural
2	Gold Coast/Tweed Valley Div of GP	QLD	Urban
2	Ipswich/West Moreton	QLD	Urban
2	Mackay	QLD	Rural
2	Townsville	QLD	Rural
2	Adelaide Central and Eastern Div of GP	SA	Urban
2	Adelaide Hills Div of GP	SA	Rural
2	Adelaide NE Div of GP	SA	Urban
2	Adelaide Western Div of GP	SA	Urban
2	Limestone Coast Div of GP	SA	Rural
2	Murray Mallee Div of GP	SA	Rural
2	GP North (Nth Tas)	Tas	Rural
2	NW Tasmania	Tas	Rural
2	Southern Tasmania	Tas	Urban
2	Central Bayside	Vic	Urban
2	Inner Eastern Melbourne DGP	Vic	Urban
2	Melbourne	Vic	Urban
2	Monash (Moorabbin)	Vic	Urban
2	Murray Plains	Vic	Rural
2	NE Valley	Vic	Urban
2	Southcity GP Services (Inner SE Melb)	Vic	Urban
2	Western Melbourne	Vic	Urban
2	Westgate	Vic	Urban
2	Whitehorse Div of GP (Inner East Melb)	Vic	Urban
2	Canning	WA	Urban
2	GP Coastal (Perth Central Coast)	WA	Urban
2	Great Southern	WA	Rural
2	Osborne	WA	Urban
3	Barrier	NSW	Rural
3	Barwon	NSW	Rural
3	Central Sydney	NSW	Urban
3	East Sydney Div of GP (SE Div)	NSW	Urban
3	Hornsby Ku-ring-gai Ryde	NSW	Urban
3	Hunter Rural	NSW	Rural

<b>Round</b>	<b>Division(s)</b>	<b>State</b>	<b>Urban/Rural</b>
3	Hunter Urban	NSW	Urban
3	Macarthur	NSW	Urban
3	Northern Rivers	NSW	Rural
3	Nth Sydney	NSW	Urban
3	SE NSW	NSW	Rural
3	Shoalhaven	NSW	Rural
3	St George	NSW	Urban
3	Went West	NSW	Urban
3	GP Partners (Bris Nth)	QLD	Urban
3	Sthrn QLD Rural	QLD	Rural
3	Wide Bay	QLD	Rural
3	Barossa Div of GP	SA	Rural
3	Eyre Peninsula Div of GP	SA	Rural
3	Flinders and Far Nth	SA	Rural
3	Mid Nth Rural Div of GP	SA	Rural
3	Riverland Div of GP	SA	Rural
3	Yorke Peninsula Div of GP	SA	Rural
3	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	Urban
3	Central Wheatbelt (Wheatbelt GP Network)	WA	Rural
3	Eastern Goldfields	WA	Rural
3	Mid West	WA	Rural
3	Rockingham Kwinana	WA	Urban
4	Bankstown	NSW	Urban
4	Hawkesbury Hills	NSW	Urban
4	Liverpool	NSW	Urban
4	Central Aust Div of Primary Health	NT	Rural
4	Cairns	QLD	Rural
4	Redcliffe Bribie Caboolture	QLD	Urban

## Appendix 3: Calculating effect sizes

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A single-group pre-post measurement design across multiple projects was used in order to calculate effect sizes. This approach was chosen to cater for the naturalistic nature of the study, and the range of outcome measures being used within and across projects.

Effect sizes ( $d$ ) were chosen as the key metric as they present outcome in a standardised form to allow combination and comparison across multiple measures and studies, or in this case, projects. For repeated measures, Cohen's  $d$  provides a reasonably accurate effect size estimate.<sup>19</sup> Cohen's  $d$  was calculated as the difference between pre- and post-treatment scores divided by the pooled pre- and post- standard deviations.<sup>20</sup> As effect sizes provide a slight overestimate of the true population effect, an adjustment was applied to remove this bias<sup>20</sup> (p20, Equation 8 using adjustment provided by Equation 11). Variance around  $d$  was calculated using an equation appropriate for repeated measures studies with very small sample sizes<sup>20</sup> (p21, Equation 9 using adjustment provided by Equation 11).

The goal of the analysis was to produce one effect size ( $d$ ) per project across all available measures, and one aggregate  $d$  across all projects. The analysis employed a random effects model,<sup>c</sup> and was conducted in the following steps:

1. *An effect size was calculated for each outcome measure, for each project.* This was restricted to consumers with both pre- and post-treatment values on any given measure.  $d$  was calculated for each measure using pre- and post-treatment means and standard deviations. In the case of the DASS sub-scales, one  $d$  was obtained from correlated subscales by averaging.<sup>21</sup>
2. *A combined effect size was calculated within projects.* (a) Where there was one measure per consumer per project (e.g., K-10 scores only), the single  $d$  calculated for that measure was used. (b) In cases where there was more than one measure per consumer (e.g., K-10 and HoNOS scores for the same consumer), the measures were averaged. This was done on the grounds that the measures were correlated, all measures were of interest and projects had medium to small sample sizes.<sup>18 21</sup> (c) In a single case where different measures were provided for different consumers (e.g., K-10 scores for five consumers and HoNOS scores for six), the standard meta-analysis formula described below was used, on the grounds that there was no overlap and these scores were analogous to independent estimates from different studies.
3. *Effect sizes were combined across projects.* A single weighted average  $d$  was obtained using the standard meta-analysis formula for independent estimates, using the weighted inverse variance method for random effects.

Cohen's 'rule of thumb' was used for interpreting the resultant standardised effect sizes (small effect  $d=0.20$ , medium effect  $d=0.50$ , large effect  $d=0.80$ ).<sup>18</sup> It should be noted, however, that  $d$  is based on single-group paired pre- and post-treatment scores in the current analysis, and pre-post effect sizes from single groups will generally be larger than post-treatment differences between independent groups.

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<sup>c</sup> A random effects model assumes the variability between effect sizes is due to sampling error plus variability in the population (i.e., that projects are measuring different, but related, effects) and provides the average treatment effect. A random effects model was used in the present study to cater for the presence of heterogeneity. To calculate a random effect, a weight incorporating the standard error adjusted for heterogeneity was applied to each individual project effect size.