



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

Third interim evaluation report

Benefits and barriers associated with different models of service delivery

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Executive summary

Background

The 2001-2002 Federal budget initiative Better Outcomes in Mental Health Care has taken up the challenge of improving the mental health care available to the general population, specifically acknowledging the key role of GPs in mental health care. A key component of the initiative is the Access to Allied Health Services component, which permits appropriately-trained GPs to refer consumers to allied health professionals, via projects being run through Divisions of General Practice. To date, 102 such projects have been funded.

The Program Evaluation Unit of The University of Melbourne's School of Population Health has been charged with the task of undertaking a specific program of work around the evaluation of these projects. To date, the Program Evaluation Unit has synthesised information from local project evaluation reports and from a purpose-designed minimum dataset, with a view to providing ongoing lessons about how the projects are going, who they are reaching, the type of care they are providing, and whether specific models of service delivery seem to be particularly effective in particular circumstances.

With regard to the latter issue, the first and second interim evaluation reports^{1,2} produced by the Program Evaluation Unit provided a conceptualisation of the dimensions on which models of service delivery differ. This conceptualisation suggested that the models differed in terms of: (a) the means of retaining allied health professionals (i.e., contractual arrangements or direct employment); (b) the location of allied health professionals (i.e., GPs' rooms, own rooms or other location; and (c) the referral mechanisms used (i.e., voucher systems, brokerage systems or register systems).

The current report explores these models in greater depth via an Evaluation Forum held in Victoria on 9 September 2004.

Method

Evaluation Forum participants represented 17 of the 25 Access to Allied Health Services projects being conducted in Victoria (68%). In addition, one Tasmanian project was represented.

The Evaluation Forum ran for 90 minutes, and took the form of an interactive discussion designed to explore the following questions:

- Do models of service delivery differ from the conceptualisation outlined in the first and second interim evaluation reports, and, if so, how?
- What are the benefits and barriers (for Divisions, allied health professionals and consumers) associated with the means of retaining allied health professionals?
- What are the benefits and barriers (for GPs, allied health professionals and consumers) associated with the various locations from which allied health professionals deliver services?
- What are the benefits and barriers (for GPs, allied health professionals and consumers) associated with the different referral mechanisms?

Results and discussion

The Evaluation Forum provided support for the validity of the conceptualisation of the different models of service delivery put forward in the early evaluation reports.^{1,2} It confirmed that the means of retaining allied health professionals falls into two camps – contractual arrangements with individual allied health professionals or with agencies such

as community health centres, and direct employment of allied health professionals. It also confirmed that in the majority of projects, allied health professionals provide focussed psychological services within their own rooms or co-located in GPs' practices. Finally, it provided support for the originally-proposed referral mechanisms (the voucher system, the brokerage system, and the register system) but suggested that a fourth system (the direct referral system) is also in operation.

The major focus of the Evaluation Forum was in determining the benefits and barriers associated with the dimensions of the models. Forum participants provided considerable detail in this regard. Often, the benefits of one model address barriers to another, and vice versa. So, for example, projects in which the allied health professionals operate from their own rooms may have benefits for GPs in terms of access to a range of providers, but may present problems associated with reduced opportunities to collaborate. Conversely, projects in which the allied health professionals are co-located with GPs may have advantages for GPs in terms of communication, collaboration and potential for knowledge transfer, but the downside may be a reduced range of providers to whom referrals can be made.

The fact that each model has pros and cons highlights the need to take into account contextual variation. Divisions undertaking Access to Allied Health Services projects have considered the benefits and barriers, and chosen the model that is best suited to the local context, sometimes modifying it over time to address difficulties that could not be foreseen from the outset. For example, a number of projects that began by adopting a simple voucher system have modified their approach to incorporate the addition of a register system, thereby improving the match between consumers' needs and allied health professionals' skills and expertise. In weighing up the benefits and barriers, Divisions have taken into account contextual variations such as the level of engagement of GPs, the number of GPs participating, the number of participating practices, the availability of allied health professionals, the number and quality of existing linkages with local mental health agencies, and the range and severity of conditions presenting to general practice. A one-size-fits-all model for the Access to Allied Health Services projects would miss the local variation and context and Divisions have appropriately tailored their service delivery models to local needs.

Conclusion

The original conceptualisation of the dimensions of models of service delivery proposed in the first and second interim reports appears to be valid, although it does not capture all of the nuances of service delivery 'on the ground'. The dimensions of the models are not mutually exclusive, and are often used in combination. There are benefits and barriers to each of these dimensions, and no one model appears to be suited to all contexts. Further work is needed to determine whether particular models are most effective in particular circumstances.

Chapter 1: Background

The Better Outcomes in Mental Health Care initiative

The Better Outcomes in Mental Health Care initiative has taken up the challenge of improving the mental health care available to the general population, specifically acknowledging the key role of GPs in mental health care. It began in July 2001 as a four-year initiative, funded at \$120.4 million by the Commonwealth Department of Health and Ageing.^{3,4}

The initiative comprises five components, namely: (1) Education and training for GPs; (2) The 3 Step Mental Health Process; (3) Focused Psychological Strategies; (4) Access to Allied Health Services; and (5) Access to Psychiatrist Support. These five components have been described in detail elsewhere,^{3,4} and an overview is provided at Appendix 1. This report focuses on the Access to Allied Health Services component.

The Access to Allied Health Services component

Through this component, projects are being conducted by Divisions of General Practice that permit appropriately-trained GPs to refer consumers to allied health professionals. For the purposes of the initiative, the Department of Health and Ageing defines allied health professionals as psychologists, mental health nurses, occupational therapists, social workers and Aboriginal health workers. The Department of Health and Ageing provides Divisions with guidelines⁵ regarding the selection of appropriately qualified allied health professionals, but ultimately these decisions are made by the Division, taking into account the local context (e.g., availability of particular types of professionals in rural areas).

The allied health professionals provide diagnostic assessment and evidence-based, focused psychological strategies for consumers with high prevalence disorders such as depression and anxiety, who would otherwise experience difficulties in accessing care. The care is delivered in six sessions, with a further six sessions being available following a review by the GP. The interventions that the Department of Health and Ageing considers to constitute 'evidence-based, focused psychological strategies' include:

- Psycho-education, including motivational interviewing
- Cognitive behavioural therapy, including behavioural interventions (e.g., behaviour modification, exposure techniques, activity scheduling) and cognitive interventions (e.g., cognitive therapy)
- Relaxation strategies, including progressive muscle relaxation and controlled breathing
- Skills training, including problem solving and skills training, anger management, social skills training, communication training, stress management and parent management training
- Interpersonal therapy (especially for depression)⁵

Since the initiative began, 102 Access to Allied Health Services projects have been funded in three major funding Rounds (see Appendix 2 for a complete list). In Round 1, 15 pilot projects received funding between June and August 2002, and a further 14 supplementary projects received funding between January and March 2003. In Round 2, 40 additional projects received funding after July 2003. A third funding in July 2003 saw the commencement of 33 new projects. Appendix 2 details these projects.

Evaluation efforts

Evaluative efforts related to the Better Outcomes in Mental Health Care initiative in general, and the Access to Allied Health Services component specifically, are overseen by an Evaluation Working Group (chaired by Professor Ian Hickie). On the recommendation of the Evaluation Working Group, two sets of activities have been undertaken with regard to the evaluation of the initiative.

In 2003, the Program Evaluation Unit of The University of Melbourne's School of Population Health was appointed to develop an evaluation framework for the overall initiative, and to undertake a specific program of work around the evaluation of the Access to Allied Health Services component. The latter included providing support to local project evaluations, developing a minimum dataset, and synthesising information from the local evaluation reports and the minimum dataset. In this way, the Program Evaluation Unit is providing ongoing lessons about how the Access to Allied Health Services projects are going, who they are reaching, the type of care they are providing, and whether specific models of service delivery seem to be particularly effective in given circumstances. Findings from these evaluation activities have been disseminated through two interim evaluation reports,^{1, 2} three journal articles,^{4, 6, 7} and a range of presentations at conferences and other forums,⁸⁻²⁵ and via the Primary Mental Health Care Australian Resource Centre (PARC) website and newsletter.²⁶

Complementing the above evaluation activities, Healthcare Management Advisors were contracted in 2004 to conduct an evaluation of the overall Better Outcomes in Mental Health Care initiative. This evaluation has been completed, but the final evaluation report is not yet publicly available.

Focus of the current report: Service delivery models

As noted above, two previous interim evaluation reports have been produced.^{1, 2} Together, these draw on information from the local project evaluation reports and the minimum dataset to answer a number of questions, one of which related to the models of service delivery being used by the projects. The reports concluded that the projects are operating under a range of different models, with many drawing on elements from several models. The models differ in terms of means of retaining allied health professionals, location of allied health professionals and referral mechanisms. Later projects have drawn on the lessons learned in earlier projects, adapting models to suit their own contexts. The variation on these dimensions is summarised in Table 1.

Table 1. Dimensions on which models of service delivery differ: Original conceptualisation

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

Source: Adapted from Pirkis et al¹ and Morley et al²

Data from the local evaluation reports and the minimum dataset provide a broad overview of these models, but desirably this would be complemented by qualitative data that provide an in-depth picture of the advantages and disadvantages of the different types of models. An evaluation forum, attended by representatives of Victorian Divisions conducting Access to Allied Health Services projects, provided an opportunity to explore the benefits and barriers associated with the different models in more detail.

The current report presents the findings from this forum.

Chapter 2: Method

Evaluation forum participants

The Evaluation Forum was held on 9 September 2004 as part of a regular meeting of Victorian Divisions implementing the Access to Allied Health Services Projects held by General Practice Divisions Victoria (GPDV).

Participants represented 17 of the 25 Access to Allied Health Services projects being conducted in Victoria (68%) – 3 of the 5 Pilot projects (60%), 4 of the 5 Supplementary projects (80%), 6 of the 9 Round 2 projects (67%), and 4 of the 6 Round 3 projects (67%). In addition, one Round 2 project from Tasmania was represented.^a

Evaluation forum process

The Evaluation Forum ran for ninety minutes and took the form of an interactive discussion led by a facilitator from the Program Evaluation Unit.

The aim of the evaluation forum was to explore the advantages and disadvantages of the different models of service delivery being implemented by Divisions. Divisional representatives were presented with a written description (see Appendix 3) of the different variations of service delivery models being implemented by Divisions nationally, as reported in the first and second interim evaluation reports.^{1,2} They were asked to comment on this conceptualisation and to describe ways in which their own service delivery models fit within this conceptualisation. They were then asked to discuss the benefits and barriers of each of the different models, for GPs, allied health professionals and consumers.

Evaluation questions

Specifically, the forum explored the following questions:

- Do models of service delivery differ from the conceptualisation outlined in the first and second interim evaluation reports, and, if so, how?
- What are the benefits and barriers (for Divisions, allied health professionals and consumers) associated with the means of retaining allied health professionals?
- What are the benefits and barriers (for GPs, allied health professionals and consumers) associated with the various locations from which allied health professionals deliver services?
- What are the benefits and barriers (for GPs, allied health professionals and consumers) associated with the different referral mechanisms?

Data recording and analysis

The discussion that ensued was recorded by a note-taker from the Program Evaluation Unit.

The notes were subsequently examined to identify major content and themes, and then individual responses were classified according to these themes. The intention was to present 'typical' responses, while at the same time indicating the range of views presented within a given theme. Responses were considered for the projects as a whole, and placed in the context of the way the models of service delivery were conceptualised

^a It should be noted that attendance did not necessarily equate to contribution, so these figures do not reflect equal input from all Divisions.

in the first and second interim evaluation reports.^{1,2} Wherever possible, consideration was given to the extent to which the projects have evolved over time.

Chapter 3: Do models of service delivery differ from the conceptualisation outlined in the first and second interim evaluation reports, and, if so, how?

Forum participants suggested that, in the main, their models of service delivery fit within the conceptualisation outlined in the first and second interim evaluation reports.^{1,2} There are, however, some elements of models that are not particularly well captured by this conceptualisation.

Correspondence with the original conceptualisation

Means of retaining allied health professionals

With regard to the means of retaining allied health professionals, most projects contract allied health professionals, and some employ them directly. There are also examples of projects where the allied health professionals are neither contracted nor employed by the Division, but the Division has a contract with the allied health professional's employer. So, for example, in one project, allied health professionals are employed through the local community health service, and the Division has a contract with that service. All of these approaches are consistent with the original conceptualisation.

Location of allied health professionals

In terms of location of allied health professionals, the majority of projects involve allied health professionals operating out of GPs' rooms or their own rooms, consistent with the original conceptualisation. The remainder of projects involve allied health professionals providing services from other locations, again consistent with the original conceptualisation. Examples of these include rooms rented from the local hospital, on-site accommodation at the Division's premises, and space made available at Centacare (an organisation which provides counselling, mediation, accommodation and training).

Referral mechanisms

The majority of projects have developed referral mechanisms that rely on voucher, brokerage or register systems, or a combination of these, as indicated in the original conceptualisation. However, a proportion of projects have also adopted a direct referral model, in which the GP refers directly to the allied health professional. Often this takes place in the context of the allied health professional being co-located with the GP. However, there are exceptions, where the allied health professional is located elsewhere (e.g., in the above project where allied health professionals are employed through the local community health service, GPs send referral forms directly to the allied health professionals). There are other subtle ways in which referral mechanisms also vary, including the involvement of other professionals in the referral process (e.g., a pilot is currently underway in one Victorian Division to employ a mental health nurse to work in conjunction with GPs in referring consumers to allied health professionals).

A modified conceptualisation

Table 2. Dimensions on which models of service delivery differ: A modified conceptualisation

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

Source: Adapted from Pirkis et al¹ and Morley et al,² and modified on the basis of findings from the Evaluation Forum

A note on contextual factors influencing models of service delivery

There are some contextual factors specific to the state of Victoria that have influenced the choice of service delivery model for Victorian Divisions. In particular, the operation of the Primary Mental Health Teams, which focus on the management of high prevalence disorders and the provision of training and support to primary care providers, has had implications for the way in which some Victorian projects operate. Several Victorian Divisions have established links with the PMHT operating in their catchment and in one instance, the PMHT acts as the point of triage in a brokerage model of service delivery.

Other contextual factors are not specific to Victoria, but may also influence elements of the models under which given projects operate. So, for example, rural Divisions may differ from metropolitan Divisions in the selection of service delivery models as a result of the operation of the More Allied Health Services program in their catchment areas. As with the Primary Mental Health Teams, the More Allied Health Services program has a focus on the management of high prevalence disorders within primary mental health care, although it concentrates on provision of support to providers rather than on treatment for consumers.

An illustration of the way in which these contextual factors might operate is provided by the example of one Victorian Division which employs a model involving the integration of funding from the Access to Allied Health Services project, the Primary Mental Health Team, and More Allied Health Services program. The resultant model involves an integrated team, where the GP directly refers to the allied health professional who is

employed directly by the Division and provides psychological services from their own premises. Although the project's basic model fits within the original conceptualisation, it clearly has additional complexities that are not encompassed by the conceptualisation.

Chapter 4: What are the benefits and barriers associated with the means of retaining allied health professionals?

As noted, most projects contract the services of allied health professionals (either directly, or through their employing agency), and some employ them through the Division. This aspect of the service delivery model is one that directly affects Divisions and allied health professionals, indirectly affects consumers, and has fewer implications for GPs. This chapter considers the relative merits of contracting arrangements and direct employment from the perspective of Divisions, allied health professionals and consumers.

Contractual arrangements

Divisions

Retaining allied health professionals under contract has several benefits for Divisions. In particular, it provides Divisions with access to a range of service providers with varying skills and expertise to cater to the needs of the broad range of consumers accessing services through the projects. The volume of allied health professionals available to provide services as a result of contracting results in decreased waiting lists. Contracting service providers also allows Divisions to set costs on a 'per hour' basis and avoid financing additional project-related costs such as supervision and travel. Retention of allied health professionals under contract provides Divisions with generally greater flexibility in terms of the provision of focussed psychological services to consumers.

However, retaining allied health professionals under contract imposes some constraints, resulting in the need to 'ration' the number of sessions of psychological services provided to consumers through the project. Contracting allied health professionals can also pose an impediment to quality assurance, providing fewer opportunities for monitoring the services being provided. In particular, the feedback process whereby the Division receives information with regard to quality is slower (in some cases taking several months).

Allied health professionals

A contract model of service delivery appears to provide fewer benefits to allied health professionals than the model of direct employment by Divisions. While contracting provides opportunities for a greater number of allied health professionals, there is evidence to suggest that the quality of the experience for individual providers may be reduced under this model. Contracted allied health professionals are required to provide their own infrastructure, insurance and supervision. There is often a perceived lack of support from the Division, associated with limited attempts at relationship-building. In addition, while the contract model is able to provide allied health professionals with a source of income, it does not guarantee regular or ongoing work.

Consumers

Many of the above benefits of contractual arrangements for Divisions and allied health professionals have flow-on effects for consumers. The fact that contracting allows the Division to offer access to a greater number and range of providers means that consumers are more likely to be provided with psychological services that are well-matched to their needs, and means that they are less likely to experience long waits for

care. It should be noted, however, that where funding is depleted, waiting lists may become an issue.

Direct employment

Divisions

Divisions which employ allied health professionals report that this model allows them to 'make the limited funds available stretch a bit further'. It gives Divisions greater control over the quality of services provided, because it fosters stronger relationships between the allied health professional and the Division, and allows information regarding service quality to be quickly fed back to the Division.

On the other hand, direct employment can be costly. Divisions employing allied health professionals must provide the necessary support and infrastructure to allow clinicians to provide services to consumers. For example, they must establish, finance and monitor ongoing supervision arrangements for allied health professionals. They must also reimburse providers' travel costs, which can be financially burdensome in rural areas where large distances are often covered in order to provide services across the catchment area.

Allied health professionals

The above provision of support and infrastructure by Divisions under the direct employment model translates into benefits for allied health professionals. In particular, the provision of services such as supervision, which lead to increased skill development and reduced isolation, are favoured by allied health professionals. Direct employment also fosters relationships between the Division and allied health professionals, as well as between allied health professionals themselves. In addition, it provides allied health professionals with ongoing work and a clear indication of the requirements of the role. It has been suggested that direct employment may allow for greater continuity of care by allied health professionals and greater trust by GPs, with the implication being that this model may therefore better support the provision of treatment to consumers with greater severity of symptoms and/or more complex presentations.

Consumers

Many of the advantages and disadvantages for Divisions and allied health professionals of the direct employment model have flow-on effects for consumers. On the plus side, the quality assurance and monitoring that is facilitated by the direct employment model provides consumers with access to high quality focussed psychological strategies. This is balanced against a more limited choice of allied health professionals to whom the consumer can be referred, which may decrease the likelihood of a good match being achieved between the expertise of the allied health professional and the needs of the consumer.

Chapter 5: What are the benefits and barriers associated with the various locations from which allied health professionals deliver services?

As indicated earlier, the majority of projects involve allied health professionals operating out of GPs' rooms or their own rooms, with a small minority providing services from other locations, again consistent with the original conceptualisation. The benefits and barriers (from the perspective of GPs, allied health professionals and consumers) associated with allied health professionals providing services from GPs' rooms are discussed below, as are the benefits and barriers associated with their providing services from their own premises. The benefits and barriers of other arrangements are not discussed, since the examples of these are few, and difficult to generalise to other settings.

GPs' rooms

General practitioners

Co-location of allied health professionals with GPs facilitates the establishment of mutually satisfying relationships between all providers. This relationship-building confers additional benefits, providing the opportunity for direct communication, both formal and informal, between GPs and allied health professionals. Communication allows for the provision of feedback directly from the GP to the allied health professional and vice versa. Any queries or concerns can be quickly and easily resolved via direct communication. For example, the allied health professional may have a query in relation to the consumer assessment conducted by the GP and co-location provides the opportunity to discuss the information directly with the GP. This feedback loop also results in increased skill development for GPs in the area of mental health. As well, co-location allows providers to share client files and promotes a streamlined service system in terms of scheduling of appointments and billing processes.

GPs see co-location as advantageous, because it means that consumers can be directly referred to allied health professionals. The flip-side of this, however, is that where referrals are made exclusively to the allied health professional(s) operating within the practice, the GP has access to only a limited array of expertise, and this may mean that the needs of some consumers may not be met.

The provision of space to allied health professionals can also represent a barrier for GPs, particularly if space is at a premium within the practice. Even where space is available, there may be an opportunity cost since revenue that would be generated if a GP were using the room is forfeited.

Allied health professionals

Just as GPs report that co-location confers benefits of increased collaboration and resultant skill development, so too do allied health professionals. However, some also report that co-location can have its downside, creating the potential for GPs to pressure them into skipping the prescribed referral process or to undertake tasks that fall outside the remit of the Access to Allied Health Services project (e.g., conducting assessments in conjunction with the GP, or accepting referrals through the More Allied Health Services program). Other problems with co-location, from the perspective of the allied health professional, include receipt of a limited range of referrals beyond those provided by the practice (in turn resulting in limited opportunities for ongoing skill development), and

logistical difficulties with room arrangements. Some have also commented that co-location favours the allied health professionals operating within the practice, creating inequities for the allied health professionals as a group.

Consumers

Co-located service provision is beneficial to consumers in that it provides the convenience of no additional travel or the need to negotiate a new location. Some argue that the co-location model is less likely to create stigma, since, to an observer, the consumer is merely visiting his or her GP's practice, rather than a mental health specialist. Others disagree, however, suggesting that the presence of an allied health professional in the GPs' practice can foster stigma, by decreasing the opportunities for maintaining anonymity. Stigma may be a particularly important issue in small rural communities.

The co-location model highlights to the consumer the shared responsibility for their care between the GP and the allied health professional, and feedback from consumers to Divisions suggests that this instils confidence in the consumer.

Own rooms

General practitioners

Where allied health professionals provide mental health services from their own premises, GPs tend to have access to greater range of referral options. However, the provision of services remote from the GP practice fails to provide important opportunities for relationship-building and knowledge transfer between GPs and allied health professionals, a crucial component of the initiative.

Allied health professionals

Providing focussed psychological strategies from their own premises allows allied health professionals to receive referrals from all GPs registered with the Better Outcomes in Mental Health Care initiative within the catchment, thereby maintaining diversity and encouraging skills development.

This model also confers on allied health professionals a large degree of independence and influence over the provision of mental health services as part of the initiative. However, with this independence comes a lack of opportunity for relationship-building, a sense of isolation, costs associated with provision of their own space (e.g., administrative support).

Similarly, providing services from their own rooms affords a convenience for some allied health professionals (particularly those who are engaged in service provision for the Access to Allied Health project part-time, and are operating a private practice that takes referrals from other sources the remainder of the time), but may also create location-related barriers. So, for example, attend case conferences with the GP (and other professionals) may require them to travel some distance from their premises.

Consumers

Accessing mental health services at the allied health professional's own premises provides consumers with a range of choices in terms of location at which to attend treatment, which in turn facilitates access to treatment. Some have argued that this choice also maximises anonymity, although others have suggested that in small rural areas attending an allied health professional's practice poses a greater threat to anonymity than attending a GP's practice where a variety of services is available.

The provision of services from different locations may hamper communication between the GP and allied health professional, and this may jeopardise continuity of care. Doubling-up of information sought from the two providers may result in the requirement that the consumer reiterate aspects of his or her story, which can lead to frustration and disenchantment with the treatment process on the part of the consumer.

The need to travel to the allied health professional's own premises can pose a barrier for consumers with a mental health problem, particularly in rural areas where this travel may involve large distances.

Chapter 6: What are the benefits and barriers associated with the different referral mechanisms?

The majority of projects have developed referral mechanisms that rely on voucher, brokerage or direct referral systems (the latter with or without registers of available allied health professionals). Each of these referral mechanisms is explored below in terms of their associated benefits and barriers.

The voucher system

Under this system, the Division provides participating GPs with vouchers that can be given to consumers. Consumers then present these vouchers when they visit eligible allied health professionals. Allied health professionals can then redeem the vouchers for payment from the Division.

General practitioners

GPs appreciate the fact that the voucher system involves a minimum of paperwork and 'red tape', factors which have consistently been reported as barriers to participation in the Access to Allied Health Services projects.^{1,2} They are also positive about the fact that the voucher system is simple and flexible, and minimises confusion because there is no requirement for them to consult with the Division (or another third party) or the allied health professional during the referral process.

However, this simplicity comes at a price. The lack of any requirement for the GP to communicate with other personnel has contributed to a number of problems. The passage of vouchers from GP to consumer to allied health professional is difficult for Divisions to track referrals (although some Divisions have introduced innovative methods to help in this regard, such as voucher numbering systems), which has flow-on effects for GPs. GPs do not receive feedback with regard to consumers who fail to commence treatment, which has led to some GPs in some Divisions scheduling the first appointment with the allied health professional on behalf of the consumer. GPs may not even receive feedback once the consumer enters treatment, which can pose difficulties in terms of payment, particularly if the consumer does not return for the review session which activates the Service Incentive Payment.

Additionally, the voucher system does not provide GPs with any information about the skills and expertise of the allied health professionals to whom they are referring. This has been identified as a particular problem in rural areas where there is often some distance between the locations from which GPs and allied health professionals are operating, but is also a problem in metropolitan areas where there are numerous providers. GPs are expected to make referrals in the absence of this information, which may lead to inappropriate referrals that are problematic for both the allied health professional and the consumer. Some Division implementing a voucher systems have found that registered GPs only refer to allied health professionals whom they know. Other Divisions have chosen not to go down this route at all, arguing that GPs can and should be given the decision making authority in matching allied health professional and consumer at the point of referral and preferring a direct referral approach (see below).

Allied health professionals

The voucher system confers an element of control on consumers that translates into benefits for allied health professionals. Allied health professionals report that consumers

are more invested in treatment and willing to work at treatment, which is rewarding for them as providers.

Having said this, the voucher system confers fewer other benefits on allied health professionals than other models, creating disincentives for them to participate in projects operating under such systems. As noted above, the model can result in inappropriate referrals.^b This may even be perpetuated by the allied health professionals, who may be reluctant to suggest that a referral is outside their skill base in the event that this might jeopardise future referral opportunities. Regardless of how they occur, inappropriate referrals are unlikely to lead to a positive experience for the allied health professional, and have led to calls for allied health professionals to be more involved in the referral process.

Despite the claim that the voucher system should decrease waiting times because of the direct progression from the point of referral, many allied health professionals suggest that with the onus almost entirely on the consumer, the voucher system can lead to delays in initiating treatment. This creates frustrations for allied health professionals, who find it difficult to track referrals and to gauge their workloads.

Consumers

The voucher system provides consumers with greater involvement and control in terms of the treatment process, providing them with some choice in terms of the allied health professional they attend and allowing them to initiate treatment when they are ready. This system may also promote anonymity, by giving consumers the option of seeking treatment from an allied health professional who does not operate close to where they live and/or does not know them.

The brokerage system

Under this system, the Division or a third party provides a point of triage. GPs refer to this broker, which then allocates the referral to a specific allied health professional, sometimes using prioritisation and matching criteria.

General practitioners

The brokerage system has the advantage of providing GPs with opportunities for collaboration with and support from mental health professionals who are best-placed to provide care for the consumer in question, which can lead to increased skill development and confidence in managing consumers with mental health problems. The brokerage system may also save the GP time, in terms of finding the most appropriate allied health professional to suit the consumer's needs.

However, some have argued that the brokerage system takes control of the referral process away from the GP, particularly where the broker operates outside of the practice. The training required for registration with the initiative has been shown to increase GPs knowledge and confidence in the area of mental health, and taking the referral decision away from the GP would seem to defeat the purpose of requiring such training. It may also suggest to GPs a lack of confidence in their ability to make appropriate referral decisions, and may inhibit ongoing skill development.

In addition, while the brokerage model may save time for GPs at the point of referral, it usually means an extended waiting period for the referral process to move from the point

^b This is clearly not true in all cases, however. A representative from one Division at the Evaluation Forum noted that the Division had received only one report of an inappropriate referral, despite approximately 200 referrals being made to date under a voucher system.

of referral to the consumer receiving treatment, because of the involvement of the third party in matching the consumer with the appropriate allied health professional.

Allied health professionals

The brokerage model strives to ensure that referrals received by allied health professionals are appropriate to their skills and expertise. Ideally, this should mean that particular providers are not favoured for referrals based on existing relationships with given GPs. However, there has been some suggestion that the brokerage model may result in some providers being favoured over others by the broker making the referral decisions.

The intervention of a third party in the referral and treatment process diminishes the opportunity for relationship-building, collaboration and knowledge transfer between GPs and allied health professionals. A representative from one Division at the Evaluation Forum suggested that in some cases allied health professionals may not wish to receive referrals from a third party for this reason, and may therefore be less likely to participate.

Consumers

The brokerage model provides a co-ordinated approach to care that helps to ensure that treatment is tailored to the needs of the consumer. This is thought to lead to high quality mental health care and increased satisfaction with care. However, as discussed earlier, implementation of this referral mechanism can often mean delays for consumers in receiving treatment following referral by their GP, as a third party assesses and refers the consumer to an appropriate provider. Where there is a waiting list and the consumer is not deemed to be a high priority, waiting times can be even longer.

Of particular concern is the need created by the brokerage system for 'multiple assessment' by different clinicians before the consumer receives treatment. This often requires the consumer to re-tell his or her story, which may create an obstacle to seeking care. This is likely to increase the number of missed appointments at this crucial early stage before the consumer is engaged in the treatment process, and thereby act as a barrier to accessing treatment for some consumers. The involvement of a third party in the treatment process may also cause the consumer to question his or her confidentiality (although it should be stressed that ways of maintaining privacy, confidentiality and anonymity have been carefully considered by the brokerage models that are currently operating). It has even been suggested that the requirement of involvement of a third party associated with this referral mechanism may detract from the consumer's trust in the GP.

The register system

Under the register system, participating GPs are provided with profiles of eligible allied health professionals, allowing them to make their own, informed decisions about referral. In many cases, the register system has evolved in response to criticisms of the voucher system or the brokerage system, and is seen as a compromise between the two. For example, a number of Divisions that began operating voucher systems have now augmented these with a register so that a GP can actively recommend that a given consumer might benefit from using his or her voucher to see a particular allied health professional, chosen on the grounds of the match between the consumer's needs and allied health professional's skills. Mixing and matching referral mechanisms in this way combines the simplicity and ease of implementation of the voucher system with tailored referral and potential for monitoring promoted by the register system.

General practitioners

The register system provides several benefits to GPs registered to refer through the initiative. In particular, the provision of information with regard to the skills and expertise of a wide range of participating allied health professionals gives GPs the knowledge to make informed referral decisions.

Allied health professionals

Giving allied health professionals the opportunity to highlight their particular skills and expertise reduces the likelihood of their receiving inappropriate referrals, and may increase their chances of building up a specialist referral base in their particular area(s) of interest.

Consumers

The informed referral decisions facilitated by the register model have flow-on effects for consumers, in that they are more likely to be referred to an allied health professional who can meet their mental health treatment needs, and less likely to be dissatisfied and seek treatment from an alternative provider or abandon treatment all together.

The register model provides access to a broader range of allied health professionals than consumers would have been likely to have had available to them in the past, particularly in rural areas. In the main, this is obviously a good thing. However, it may have incidental negative consequences, such as creating a need to travel to access psychological services. Some consumers may also feel that the register model jeopardises their anonymity, since they are dependent on the GP for referral to a particular allied health professional.

Direct referral

A number of Divisions have adopted a direct referral model where GPs refer straight to the allied health professional, usually but not always, in a co-located practice setting.

General practitioners

The direct referral approach allows ease of referral for GPs as it does not require intervention by the Division or a third party before the referral can progress to the allied health professional. It results in improved collaboration between GPs and allied health professionals and promotes communication, both formal and informal, between the two providers. However, this approach may limit the range of allied health expertise to which GPs have access, particularly in a co-located practice setting where GPs may consistently provide referrals directly to just one or two allied health professionals.

Allied health professionals

The communication and collaboration promoted by the direct referral approach is also of benefit to allied health professionals, in that it facilitates knowledge transfer and skill development for both parties. However, because it relies on the GP knowing the allied health professional, it may also result in referrals that are based on familiarity and ease of access, rather than suitability.

Consumers

The direct referral approach promotes a co-ordinated approach to care for consumers which may lead to higher quality care and increased consumer confidence. This approach also reduces waiting time for the consumer given the direct progression of

referral between providers. However, the selection of allied health professional to whom to refer based on ease and familiarity may not provide the optimal match between consumer and provider.

Chapter 7: Summary and conclusions

Summary and interpretation of findings

Since the Better Outcomes in Mental Health Care initiative began, it has been evident that Divisions have taken different approaches to the Access to Allied Health Services projects. By taking into account contextual factors and sharing learnings, the Divisions have put forward a range of models of service delivery. The first and second interim evaluation reports posed a classification of these models that varied on three dimensions – means of retaining allied health professionals, location of allied health professionals, and referral mechanisms.^{1,2}

The Evaluation Forum provided support for the validity of the conceptualisation of the different models of service delivery put forward in these early evaluation reports.^{1,2} It confirmed that the means of retaining allied health professionals falls into two categories – contractual arrangements with individual allied health professionals or with agencies such as community health centres, and direct employment of allied health professionals. It also confirmed that in the majority of projects, allied health professionals are providing focussed psychological services from their own rooms or co-located in GPs' practices. Finally, it provided support for the originally-proposed referral mechanisms (the voucher system, the brokerage system, and the register system) but suggested that a fourth system (the direct referral system) is also in operation.

Certain interdependencies between and within the different dimensions of the models became apparent through the Evaluation Forum. Between dimensions, for example, the voucher, brokerage and register systems make most sense in the context of allied health professionals being located in their own rooms and contracted by the Division, whereas the direct referral system is usually more relevant in the context of allied health professionals being co-located in GPs' rooms (either under a direct employment or a contractual arrangement). Likewise, within dimensions, a number of Divisions have augmented the voucher system with the register system, in order to provide GPs with a more informed basis upon which to make referrals.

The major focus of the Evaluation Forum was teasing out the benefits and barriers associated with the dimensions of the models. Forum participants provided more detailed information in this regard than was available to the first and second interim evaluation reports, and the benefits and barriers are summarised in Table 3. Often, the benefits of one model address barriers to another, and vice versa. So, for example, projects in which the allied health professionals operate from their own rooms may have benefits for GPs in terms of access to a range of providers, but may present problems associated with reduced opportunities to collaborate. Conversely, projects in which the allied health professionals are co-located with GPs may have advantages for GPs in terms of communication, collaboration and potential for knowledge transfer, but the downside may be a reduced range of providers to whom referrals can be made.

Table 3. Summary of benefits and barriers regarding dimensions of different models of service delivery

			Divisions	GPs	Allied health professionals	Consumers	
Means of retaining allied health professionals	Contractual arrangements	Benefits	<ul style="list-style-type: none"> • Volume and range of allied health professionals • No supervision, support and infrastructure costs • Flexibility 	• N/A	<ul style="list-style-type: none"> • Number of allied health professionals with opportunity to participate 	<ul style="list-style-type: none"> • Volume and range of providers available means that services are likely to be matched to needs and waiting lists likely to be short 	
		Barriers	<ul style="list-style-type: none"> • Need to 'ration' number of sessions • Fewer opportunities for monitoring and quality assurance 	• N/A	<ul style="list-style-type: none"> • Need to provide own infrastructure, insurance and supervision • Limited relationship-building • No guarantee of ongoing/regular work 	<ul style="list-style-type: none"> • Waiting lists may become an issue if funding becomes depleted 	
	Direct employment	Benefits	<ul style="list-style-type: none"> • Can make limited funding 'stretch a bit further' • Relationships between allied health professionals and Divisions • Quality assurance • Feedback of information to Division 	• N/A	<ul style="list-style-type: none"> • Supervision • Skill development • Reduced isolation • Relationships between allied health professionals and Divisions and between allied health professionals themselves • Ongoing work • Clarity re. requirements of role • Greater trust by GP • Improved continuity of care 	<ul style="list-style-type: none"> • Quality assurance and monitoring promotes high quality care 	
		Barriers	<ul style="list-style-type: none"> • Supervision, support and infrastructure costs 	• N/A	<ul style="list-style-type: none"> • None identified 	<ul style="list-style-type: none"> • Limited choice of allied health professionals for referral • Decreased likelihood of good match between consumer's needs and allied health professional's skills 	
	Location of allied health professionals	GPs' rooms	Benefits	• N/A	<ul style="list-style-type: none"> • Mutually satisfying professional relationships • Direct communication • Skill development • Sharing of files and appointment/billing systems 	<ul style="list-style-type: none"> • Mutually satisfying professional relationships 	<ul style="list-style-type: none"> • Convenience • Possible stigma reduction • Confidence in shared care arrangements

			Divisions	GPs	Allied health professionals	Consumers
		Barriers	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • Limited array of expertise • Issues re. space 	<ul style="list-style-type: none"> • Pressure to circumvent referral process and/or take on tasks outside remit of project • Receipt of a limited range of referrals • Limited opportunities for skill development • Logistical difficulties with room arrangements • Inequities for those outside practice 	<ul style="list-style-type: none"> • Possible stigma generation
	Own rooms	Benefits	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • Access to greater range of referral options 	<ul style="list-style-type: none"> • Greater range and number of referring GPs • Greater diversity of referrals • Skills development • Independence and influence • Convenience 	<ul style="list-style-type: none"> • Choice of locations • Ready access to treatment • May increase anonymity
		Barriers	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • Fewer opportunities for relationship-building and knowledge transfer 	<ul style="list-style-type: none"> • Lack of opportunity for relationship-building • Costs associated with provision of own space • Location-related barriers (e.g., travel to take part in case conferences) 	<ul style="list-style-type: none"> • May threaten anonymity • Poorer continuity of care • Need to 're-tell story' • Travel barriers
	Other location	Benefits	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • N/A
		Barriers	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • N/A
Referral mechanisms	Voucher system	Benefits	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • Simplicity, minimal paperwork • Flexibility 	<ul style="list-style-type: none"> • Control vested in consumers makes them rewarding to work with 	<ul style="list-style-type: none"> • Greater control and choice • Increased anonymity
		Barriers	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • Lack of feedback re. consumers' attendance and progress • Lack of information re. skills and expertise of allied health professionals to whom referrals are being made • Inappropriate referrals 	<ul style="list-style-type: none"> • Inappropriate referrals • Difficulties in tracking referrals and gauging workloads 	<ul style="list-style-type: none"> • None identified

			Divisions	GPs	Allied health professionals	Consumers
	Brokerage system	Benefits	• N/A	<ul style="list-style-type: none"> • Collaboration with and support from allied health professionals who are best-placed to deal with the consumer in question • Skill development • Increased confidence • Time saving at point of referral 	<ul style="list-style-type: none"> • Appropriate referrals 	<ul style="list-style-type: none"> • Care tailored to consumers' needs • High quality care
		Barriers	• N/A	<ul style="list-style-type: none"> • Lack of control of referral process • Delays between referral and treatment 	<ul style="list-style-type: none"> • Favoured providers • Diminished opportunity for relationship-building, collaboration and knowledge transfer with GPs 	<ul style="list-style-type: none"> • Delays between referral and treatment • Need to 're-tell story'
	Register system	Benefits	• N/A	<ul style="list-style-type: none"> • Information upon which to make informed referral decisions 	<ul style="list-style-type: none"> • Reduced likelihood of inappropriate referrals • Increased chances of building up a specialist referral base 	<ul style="list-style-type: none"> • Care tailored to consumers' needs • High quality care • Access to broad range of providers
		Barriers	• N/A	<ul style="list-style-type: none"> • None identified 	<ul style="list-style-type: none"> • None identified 	<ul style="list-style-type: none"> • Potential for increased travel • Potential for decreased anonymity
	Direct referral	Benefits	• N/A	<ul style="list-style-type: none"> • Ease of referral • Collaboration between providers • Good communication 	<ul style="list-style-type: none"> • Collaboration between providers • Good communication • Skill development • Knowledge transfer 	<ul style="list-style-type: none"> • Co-ordination of care • Quality of care • Reduced waiting times
		Barriers	• N/A	<ul style="list-style-type: none"> • Limited range of allied health professionals 	<ul style="list-style-type: none"> • Referrals may be based on familiarity, rather than skills and expertise 	<ul style="list-style-type: none"> • Limited number of allied health professionals may result in sub-optimal match between consumer and provider

The fact that each model has pros and cons highlights the need to take into account contextual variation. Divisions undertaking Access to Allied Health Services projects have weighed up the benefits and barriers, and chosen the model that is best suited to the local context, sometimes modifying it over time to address difficulties that could not be foreseen from the outset. So, for example, a number of projects that began by adopting a simple voucher system have modified their approach to incorporate a register system, thereby improving the match between consumers' needs and allied health professionals' skills and expertise. In weighing up the benefits and barriers, Divisions have taken into account contextual variations such as the level of engagement of GPs, the number of GPs participating, the number of participating practices, the availability of allied health professionals, the number and quality of existing linkages with local mental health agencies, and the range and severity of conditions presenting to general practice. A one-size-fits-all model for the Access to Allied Health Services projects would miss the local variation and context and Divisions have appropriately tailored their service delivery models to local needs.

Some caveats

It is acknowledged that the current interim evaluation report is based on responses from 17 Victorian Divisions and one Tasmania Division. Clearly, it would have been desirable to consult more broadly, but this was beyond the scope of the funding available for the current evaluation work. The opportunity to conduct the Evaluation Forum arose in Victoria quite opportunistically, and it is considered that the decision to take advantage of this opportunity was justified. The 18 Divisions represented include a mix of Round 1 pilot and supplementary projects, Round 2 projects and Round 3 projects, and constitute 18% of all projects funded across Australia. The projects being conducted by these Divisions are operating under a range of models (although it must be acknowledged that the full range was not represented at the Evaluation Forum – for example, there was no representation from a project operating under the brokerage model). It is acknowledged that some caution must be exercised in generalising the findings to other Australian Divisions, particularly since local factors in the Victorian context (e.g., the operation of Primary Mental Health Teams) has shaped the projects in this state. Ongoing national evaluation work will continue to expand on this information and will indicate the extent to which these results can be generalised.

Implications for ongoing evaluation efforts

In addition to determining whether the benefits and barriers associated with each of the various models can be generalised to divisions operating across Australia, there is a clear need to explore the effectiveness of these models, using objective criteria. Conclusions can not be drawn about the effectiveness of particular models without consideration of consumer outcome data. A set of fields is currently being developed for incorporation into the minimum dataset, which will allow outcome data to be collected. Once such data are available, it will be possible to explore whether particular models tend to lead to better or worse outcomes for consumers. Having said this, it is unlikely that the evidence will come down on the side of one model over another in all circumstances; it is much more likely that it will point to different models working best in certain contexts.

Conclusion

The original conceptualisation of the dimensions of models of service delivery proposed in the first and second interim reports appears to be valid, although it does not capture all of the nuances of service delivery 'on the ground'. The dimensions of the models are not mutually exclusive, and are often used in combination. There are benefits and barriers to each of these dimensions, and no one model appears to be suited to all contexts.

Further work is needed to determine whether particular models are most effective in particular circumstances.

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

Component 1: Education and training for GPs

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

Component 2: The 3 Step Mental Health Process

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

Component 3: Focused Psychological Strategies

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

Component 4: Access to Allied Health Services

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

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

Component 5: Access to Psychiatrist Support

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

Appendix 2: Access to Allied Health Services projects

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

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

Round	State	Division(s)
3	QLD	Brisbane North Division of General Practice Association Inc.
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	VIC	West Vic Division of General Practice
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.

Appendix 3: Focus group questions

Aim

To explore the advantages and disadvantages of the different models of service delivery being implemented by Divisions.

From the local evaluation reports, it has been concluded that the models to vary on three factors:

1. Referral mechanisms
2. Location of allied health professionals
3. Means of retaining allied health professionals

A further breakdown has been conceptualised as such:

1. Referral mechanisms

- a. Voucher system
- b. Registers that profiles allied health professionals in terms of their skills, thereby enabling GPs to make informed referral decisions
- c. Division or other agency acts as a broker allocating referrals using prioritization and matching criteria.

2. Location of allied health professionals

- a. GP's rooms
- b. Own premises
- c. Other location

3. Means of retaining allied health professionals

- a. Retained under contract
- b. Directly employed by the Division

Questions

1. Do the models of service delivery differ from the conceptualisation outlined, and, if so, how?

2. What are the benefits and barriers associated with different referral mechanisms, locations of allied health professionals and means of retaining allied health professionals?

- a. For Divisions?
- b. For GPs?
- c. For allied health professionals?
- d. For consumers?