PROGRAM EVALUATION UNIT

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

Fifth interim evaluation report

Models of service delivery: Profile and association with access

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

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Executive summary

Background

The Better Outcomes in Mental Health Care program seeks to improve the mental health care available to Australians. A key component of the program is the Access to Allied Psychological Services component, which permits eligible GPs to refer consumers to allied health professionals who deliver focused psychological strategies (namely psycho-education, cognitive behavioural therapy and interpersonal therapy) in six sessions with a following six sessions available upon GP review. Since the initiative began, 102 Access to Allied Psychological Services projects have been funded in three major funding rounds. These projects are conducted by Divisions of General Practice.

National evaluation work in relation to the Access to Allied Psychological Services projects has shown that they are operating under a range of different service delivery models. These models differ in terms of: (a) the means of retaining allied health professionals (i.e., contractual arrangements, direct employment, other); (b) the location of allied health professionals (i.e., GPs' rooms, own rooms, other); and (c) the referral mechanisms used (i.e., voucher systems, brokerage systems, register systems, direct referral, other).

Although it has highlighted the range of models and their advantages and disadvantages, to date the evaluation has not been able to quantify the employment of different models across projects. Nor has it been able to determine whether particular dimensions of the models are associated with differential levels of access for consumers. The current report explores these issues.

Method

A survey was sent to Divisional representatives responsible for each of the projects, and survey data were combined with routinely-collected data on the numbers of consumers accessing the projects. Together, these data were used to answer the following research questions:

- What is the profile of models of service delivery across the Access to Allied Psychological Services projects?
- Are particular models associated with differential levels of consumer access to services?

Key findings

The survey showed that there is considerable variability across the Access to Allied Psychological Services projects with regard to the models of service delivery being implemented:

- In 76%, allied health professionals are retained under contractual arrangements; in 28% through direct employment; and in 7% by other means (e.g., arrangements with supervised postgraduate psychology students);
- In 63%, allied health professionals provide services from GPs' rooms; in 63% they do so from their own rooms; and in 42% they do so from some other location (e.g., Divisional rooms, community health centres, hospitals and other general health and mental health facilities, other community agencies, and universities); and
- In 27%, voucher systems are used; in 24% brokerage systems are used; in 25% register systems are used; and in 51% direct referral systems are used.

Many projects have modified their models over time and have developed 'combination' models, adopting several options within a dimension (e.g., entering into contractual arrangements with some allied health professionals and directly employing others), and/or 'mixing and matching' across dimensions.

When the survey data were combined with access data from the minimum dataset, no models emerged as being associated with high levels of access. In other words, all models appear to be performing equally well in terms of enabling consumers to receive free (or low cost), evidence-based mental health care.

Conclusion

To conclude, the Access to Allied Psychological Services projects are operating under a range of service delivery models which have been adapted over time to best meet local needs. As a consequence, different models appear to be equally successful in different contexts at improving access to mental health care for consumers. Further work is needed to determine whether different models are associated with better or worse consumer outcomes, but in the meantime there is no evidence to suggest that Divisions should be modifying their locally-tailored models to adopt a more uniform approach.

Chapter 1: Introduction

The Better Outcomes in Mental Health Care program[a] seeks to improve the mental health care available to Australians. The Australian Government initially provided $AUD120.4 million for four years from July 2001, and has recently committed further funds for the continuation ($AUD102 million over four years) and expansion ($AUD42.6 million over five years) of the program.

The Better Outcomes in Mental Health Care program comprises a number of interlocking components, summarised in Appendix 1. One of these is the Access to Allied Psychological Services component,[b] which permits eligible GPs to refer consumers to allied health professionals who deliver focused psychological strategies (namely psycho-education, cognitive behavioural therapy and interpersonal therapy) in six sessions with a following six sessions available upon GP review. Since the program began, 102 Access to Allied Psychological Services projects have been funded in three major funding rounds. 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 round saw the commencement of 33 further projects in July 2004. More recently, additional funding was provided for the expansion of some of these projects. Appendix 2 provides a list of the funded projects.

For the past two years, the Program Evaluation Unit from The University of Melbourne's School of Population Health has been synthesising evaluation evidence from these projects, drawing on information from projects' local evaluation reports, a purpose-designed minimum dataset, a Divisional forum, and one-off surveys. Progressively, four interim evaluation reports have been produced, all of which are available on the Primary Mental Health Care Australian Resource Centre (PARC) website (http://som.flinders.edu.au/FUSA/PARC/alliedhealthmain.html).[1-4]

Running in parallel to the program in this way, the evaluation has shown that the projects have gone from strength to strength in terms of providing access to high quality mental health care for consumers who would otherwise experience difficulties in accessing such care. The evaluation has highlighted that the projects are operating under models that vary on several dimensions (which are not mutually exclusive, are often used in combination, and have advantages and disadvantages). They differ in how they retain allied health professionals – under contractual arrangements or via direct employment. They differ in terms of the location of allied health professionals – some are co-located with GPs, some provide services from their own premises, and others operate from a third location. They also differ in terms of the referral mechanism used – with some using simple voucher systems, others using brokerage systems, others using register systems, and still others using direct referral. Table 1 provides a summary of the dimensions on which the models of service delivery differ.

To date, however, there have been some gaps in the information that the evaluation has been able to provide. Although it has highlighted the range of models and their advantages and disadvantages, it has not been able to quantify the employment of different models across projects. So, for example, it has not been able to comment on the relative popularity of retaining allied health professionals through direct employment compared with doing so under contract. In addition, the evaluation has not been able to determine whether particular dimensions of the models are associated with differential levels of access for consumers.

[a] Formerly the Better Outcomes in Mental Health Care initiative
[b] Formerly Access to Allied Health Services projects

Table 1. Dimensions on which models of service delivery differ

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: Morley et al[3]

The current report addresses these knowledge gaps, via a survey administered to Divisional representatives responsible for each of the projects. Data from the survey were combined with routinely-collected data on the numbers of consumers accessing the projects, in order to answer the following two research questions:

- What is the profile of models of service delivery across the Access to Allied Psychological Services projects?
- Are particular models associated with differential levels of consumer access to services?

Chapter 2: Method

In late April 2005, a brief survey was emailed to the person responsible for each of the 102 Access to Allied Psychological Services projects (usually the Project Manager or Project Officer, but in the absence of these, the Divisional Chief Executive Officer or equivalent). Respondents were asked to complete the survey and return it by email or fax. Reminder phone calls were made as necessary, and the cut-off for returned surveys was late June 2005.

The survey sought information on the models of service delivery being utilised by the given project, in line with the conceptualisation presented in the previous chapter. Specifically, the survey sought information on the project's method of retaining allied health professionals, the location from which allied health professionals were providing services, and the referral process. Changes in each of these dimensions over time were explored. Appendix 3 contains the full survey instrument.

The overall analysis was conducted in two stages. The first stage involved only the survey data, and employed simple descriptive analyses which focused on profiling the projects in terms of the models of service delivery being utilised. These analyses are presented as simple frequencies and percentages, as appropriate.

The second stage involved combining the survey data with data from the minimum dataset (as at 24 June 2005). The minimum dataset is a repository for consumer-level and session-level data from the projects, and regression analyses were conducted which considered whether particular dimensions of the different models were associated with varying levels of access to services by consumers.

All data analyses were conducted using SPSS (Version 12.0.2).[5]

Chapter 3: Results

Models of service delivery: Profile

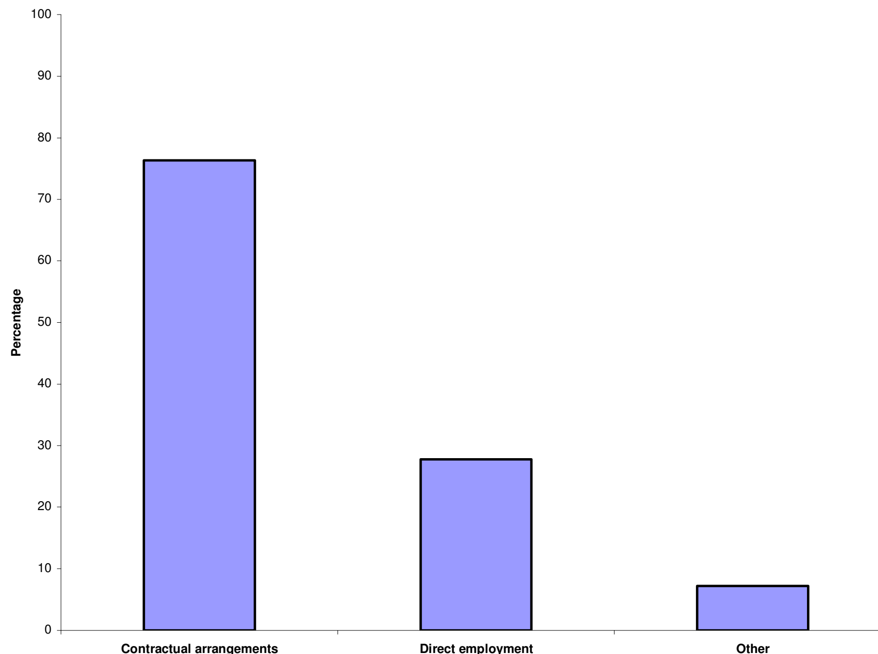
Availability of data

Survey data on models of service delivery were available from 97 Access to Allied Psychological Services projects (95%): 14 Round 1 pilot projects (93%); 14 Round 1 supplementary projects (100%); 39 Round 2 projects (98%); and 30 Round 3 projects (91%).

Means of retaining allied health professionals

Figure 1 provides a breakdown of the means of retaining allied health professionals adopted by the projects (note that some projects are using more than one means, so the total exceeds 100%). Of the 97 projects for which survey data were available, 74 (76%) are retaining their allied health professionals under contract and 27 (28%) are utilising a direct employment model. Seven (7%) indicated that they are using some other means. According to free text responses, this most commonly involves arrangements with postgraduate psychology students who are neither contracted to nor directly employed by the Division, but rather provide services in a supervised manner as part of their course requirements.

Figure 1: Means of retaining allied health professionals

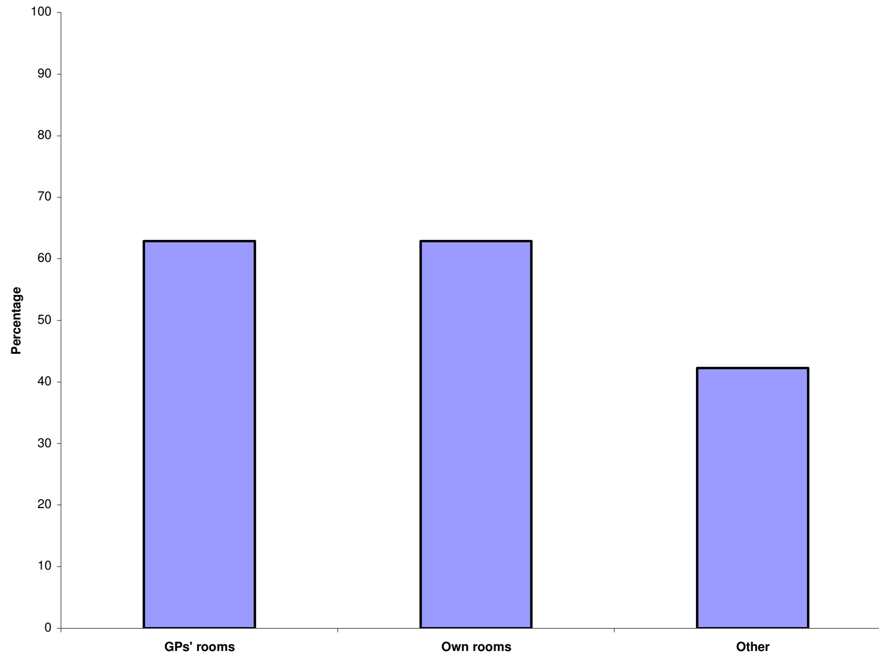


The surveys indicated that 11 (11%) of projects have changed their means of retaining allied health professionals since they began. Some have moved from the direct employment model to contracting with individual providers (or external agencies); others have done the reverse. Several have shifted from using postgraduate psychology students to employing or contracting with established providers (e.g., because of low student intakes). Others have introduced greater flexibility (e.g., options for part-time work) or improved working conditions (e.g., additional mentoring and support, study leave and opportunities to develop further skills, above-award wages), in an effort to attract more (and/or better qualified) allied health professionals into the program and improve the quality of care.

Location of allied health professionals

Figure 2 shows the different locations from which allied health professionals are providing services (again, it should be noted that a given project might be using more than one location, so the total exceeds 100%). The allied health professionals in 61 projects (63%) are providing services from GPs' rooms, under co-location arrangements. In the same number of projects, allied health professionals are providing services from their own rooms. In 41 projects (42%), allied health professionals are delivering sessions from some other location. These other locations are many and varied, according to free text survey responses. A number are providing services from Divisional rooms (either located at the Division, or located elsewhere and rented by the Division for this specific purpose). Other commonly-used locations include: community health centres, hospitals and other general health and mental health facilities; other community agencies; and universities. In some projects, allied health professionals are sometimes seeing consumers in their own homes, although this is generally not the norm.

Figure 2: Location of allied health professionals



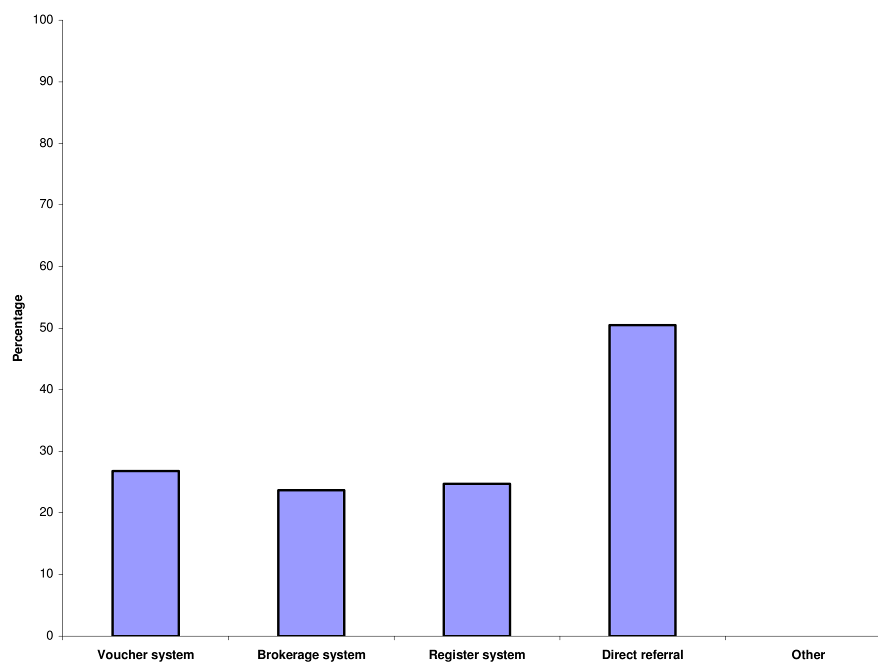
In 23 projects (24%), the location of service delivery has changed since the project began. According to free text survey responses, this has generally been in an effort to expand the service to additional areas or to provide after-hours services, and/or because circumstances have changed. A number of projects that originally provided services exclusively from GPs' practices are now offering services from allied health professionals'

rooms as well, and vice versa. Several have terminated arrangements with external agencies (e.g., because rooms provided at these agencies were required by other services), and a number have entered into new arrangements to improve the capacity of the allied health professionals to provide care (e.g., relocating to settings with increased space and better access to resources).

Referral mechanisms

Figure 3 shows the referral mechanisms that are being used in the projects. As with the data on allied health professionals' retention and location, it should be noted that given projects are often using a combination of referral mechanisms, so the total exceeds 100%). The most common referral mechanism, direct referral, is being used in 49 projects (51%). The voucher system has been taken up in 26 projects (27%), the brokerage system in 23 (24%), and the register system in 24 (25%). Survey respondents were given the opportunity to indicate whether any other referral mechanisms are being used in their respective projects, but no new ones were indicated (although several respondents described multiple referral mechanisms being used alongside each other).

Figure 3: Referral mechanisms



In 13 projects (13%), the referral mechanism has changed since the project's inception. In the main, these changes have been fairly minor and have simply involved refining the referral form or the steps involved in the referral process, often with a view to simplifying the tasks required by the GP and/or keeping better track of referrals. More major changes have tended to see projects move from voucher or brokerage systems to direct referral or register systems.

Model combinations

Many of the above models are being used in combination, both within and across dimensions. Table 3 indicates the extent of these combinations, and shows that a plethora of different model combinations are being implemented. Some patterns emerge – for example, where allied health professionals are retained under contract, there is a

greater tendency for them to operate from their own rooms than from GPs' premises – but there is considerable variability.

Table 2: Number of projects using given model combinations

REFERRAL MECHANISMS	**MEANS OF RETAINING ALLIED HEALTH PROFESSIONALS**	**LOCATION OF ALLIED HEALTH PROFESSIONALS**						
		GP	OWN	OTH	GP+OWN	GP+OTH	OWN+OTH	GP+OWN+OTH
VCH	CON		5		4			2
	EMP			1				
	OTH		1					
	CON+EMP	1						
BRK	CON	2	2	2	2	2		1
	EMP	1				2		1
	CON+EMP			1				1
REG	CON		3		3			4
	EMP					1		
	OTH		2					
DIR	CON	2	4	4	3	2	2	1
	EMP	4		3		3		
	OTH	1						
	CON+EMP	1			1	1		
	CON+OTH					1		
	EMP+OTH			1				
VCH+REG	CON		1		1			
VCH+DIR	CON		2		1			
	CON+EMP							2
BRK+REG	CON				1			
	CON+EMP							1
BRK+DIR	CON		1		1			1
REG+DIR	CON				2			
VCH+REG+DIR	CON		1		2			1
VCH+BRK+REG+DIR	CON+EMP							1

LEGEND:

Referral mechanisms
VCH: Voucher system
BRK: Brokerage system
REG: Register system
DIR: Direct referral

Means of retaining allied health professionals
CON: Contractual arrangements
EMP: Direct employment
OTH: Other

Location of allied health professionals
GP: GPs' rooms
OWN: Own rooms
OTH: Other

Comments on different models of service delivery

Survey respondents were invited to provide any overarching comments in free text. Typically, respondents who provided comments took the opportunity to describe the advantages (and, to a lesser extent, disadvantages) of elements of their models. Several observations can be made about these comments.

Firstly, the advantages and disadvantages identified mirrored those which were noted in the more comprehensive exploration of benefits and barriers undertaken via a forum that

was reported in the Third Interim Evaluation Report.[3] In other words, no new advantages or disadvantages were identified.

Secondly, approaches that were seen as advantageous in one project were seen as disadvantageous in another, and vice versa, depending on the local context. An illustration is provided below, in the form of comments from two respondents, the first of whom favoured co-locating allied health professionals in GPs' rooms, and the second of whom favoured allied health professionals providing services from their own rooms.

> *'Evaluations have overwhelmingly supported co-location with GP as a preferred model for patients (decreases stigma in country town; less 'scary'), GPs and psychologists (build collegial relationships; better understanding of each other's role and skills; improved collaborative care for pt). All our services now prioritise co-location and collaborative care.'*

> *'Our service delivery model has been specifically set up to meet the needs of the region as the demands change or premises location may change. Locating rooms within a GP's practice was decided against as there are too many competing locations in this area and we did not want to encourage doctor hopping.'*

Finally, sound rationales were provided for using particular elements of the models in combination (both within and across dimensions), again related to local needs. An example is provided below, in the form of comments from a respondent whose project involved contracting some allied health professionals and employing others.

> *'Flexible model; reduces possible waiting lists by having both a directly employed and contracted list of allied health professionals; very quick pick up of referrals by allied health professionals and contact with patient; large range of allied health professionals to choose from; if GPs don't nominate a specific allied health professional we are able to introduce them to an allied health professional they may not have utilised before to increase the scope of referral options for them.'*

Association between models of service delivery and access to services by consumers

Availability of data

Service models data and minimum dataset data were available for 78 projects (76%): 11 Round 1 pilot projects (73%); 10 Round 1 supplementary projects (71); 37 Round 2 projects (93%); and 20 Round 3 projects (61%). The lower proportion of Round 3 projects reflects the fact that because some have only just reached the stage of implementation, a reduced number have begun to enter data into the minimum dataset.

Access to services by consumers

According to the minimum dataset, as at 24 June 2005, the 78 projects had provided access to allied psychological services for a total of 18,770 consumers. The median was 166.5, and the inter-quartile range was 74.0 to 349.8.

To cater for the fact that projects in different funding rounds had potentially different windows of opportunity within which to provide access to services, the total number of consumers per year of project implementation was estimated. To do this, the total number of consumers was divided by 3, 2.5, 2 and 1 in the Round 1 pilot projects, the Round 1 supplementary projects, the Round 2 projects and the Round 3 projects, respectively. By this calculation method, the median number of consumers per year of project implementation was 93.3 and the inter-quartile range was 44.5 to 161.2.

Predictors of service access related to models of service delivery

The objective of the regression analysis was to determine which, if any, dimensions of the models of service delivery were independently predictive of higher levels of access per year of project implementation, after adjustment for all other variables. For simplicity, the dependent variable, access, was binarised, with the access level for a given project being denoted as 'low access' (i.e., lower than the median level) or 'high access' (the median level or higher).

All dimensions of the models were included as covariates in the analysis. Although the influence of funding round was catered for to some extent by using access per year, rather than overall access, as the dependent variable, it was considered important to include funding round as a covariate, in case there were other residual effects of this variable. In other words, the analysis considered whether given dimensions of service delivery were independently predictive of levels of access per year of project implementation if funding round (and other dimensions of service delivery) were effectively held constant.

Table 3 shows the results, revealing none of the dimensions of the models to be predictive of high levels of access (as indicated by consistent p values of > 0.05).

Table 3: Predictors of access

		OR	95%lo	95%hi	p
Funding round	Round 1 pilot projects	3.92	0.71	21.65	0.117
	Round 1 supplementary projects	5.49	0.87	34.43	0.069
	Round 2 projects	3.30	0.95	11.53	0.061
Method of retaining allied health professionals	Contractual arrangements	0.40	0.06	2.82	0.355
	Direct employment	1.54	0.32	7.40	0.592
	Other	0.33	0.02	6.89	0.475
Location of allied health professionals	GPs' rooms	1.56	0.54	4.55	0.412
	Own rooms	1.73	0.44	6.78	0.432
	Other	0.78	0.26	2.31	0.656
Referral mechanisms	Voucher system	1.40	0.38	5.17	0.615
	Brokerage system	0.56	0.14	2.33	0.426
	Register system	0.84	0.21	3.31	0.798
	Direct referral	1.04	0.33	3.23	0.950

Chapter 7: Discussion

The survey data collected for the current report suggest that there is considerable variability across the Access to Allied Psychological Services projects with regard to the models of service delivery being implemented. Some features are particularly popular – for example, three quarters of the projects have entered into contractual arrangements with their allied health professionals, and half of all projects are using direct referral as their referral mechanism of choice. Others are more evenly distributed – for instance, equal numbers of projects have their allied health professionals delivering services from GPs' rooms and their own rooms.

Perhaps more striking than the above findings, however, is the fact that many projects have developed 'combination' models, adopting several options within a dimension (e.g., entering into contractual arrangements with some allied health professionals and directly employing others), and/or 'mixing and matching' across dimensions. This, and the fact that many of the projects have modified their models of service delivery over time, suggests that Divisions are responding to local needs by seeking solutions that work within their own context.

The purpose of the current report was to provide a profile of the models of service delivery that have been adopted by the projects, rather than to identify the advantages and disadvantages of different models. Advantages and disadvantages have been extensively explored in earlier reports, and a summary table from the Third Interim Evaluation Report[3] is provided at Appendix 4. Having said this, it is worth noting that where survey respondents provided free text comments about their particular models, they were generally positive and noted similar advantages to those that have been previously identified.

When the survey data were combined with access data from the minimum dataset, no models emerged as being associated with high levels of access. In other words, all models appear to be performing equally well in terms of enabling consumers to receive free (or low cost), evidence-based mental health care. Again, this suggests that some models may work best in one context, and others may work best in another, and that Divisions have adopted the most appropriate model (or combination of models) for their local environment.

Clearly, there is a need for further work in this area. Improving access is a salient indicator of success, which is why the current report explored the relationship between the various models and different levels of access. However, other indicators are also important, with the ultimate arbiter of success being whether consumer outcomes are improved. Recent modifications to the minimum dataset have meant that Divisions are now able to enter data on consumer outcomes, derived from a range of outcome measures administered to consumers at assessment and review. Future work will combine the survey data on models of service delivery with the minimum dataset data on consumer outcomes, in order to determine whether particular models are associated with an increased likelihood of improved outcomes.

To conclude, the Access to Allied Psychological Services projects are operating under a range of service delivery models which have been adapted over time to best meet local needs. As a consequence, different models appear to be equally successful in different contexts at improving access to mental health care for consumers. Further work is needed to determine whether different models are associated with better or worse consumer outcomes, but in the meantime there is no evidence to suggest that Divisions should be modifying their locally-tailored models to adopt a more uniform approach.

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

Component 1: Education and training for GPs

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

Component 2: The 3 Step Mental Health Process

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

Component 3: Focused Psychological Strategies

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

Component 4: Access to Allied Psychological Services

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

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

Component 5: Access to Psychiatrist Support

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

Appendix 2: Access to Allied Psychological Services projects

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

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

Models of service delivery used in Access to Allied Health Services Projects

As part of our role in synthesising evaluation information from the Access to Allied Health Services projects, we have developed a conceptual framework to describe the models of service delivery being used by the projects. The models differ in terms of means of retaining allied health professionals, location of allied health professionals and referral mechanisms (see Box 1).

Box 4: A framework to describe the models of service delivery being used by the projects

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

To date we have not been able to quantify the extent of variation in the models being used by projects, nor to answer the question of whether some models work better than others in particular contexts. We are not even certain that the framework is exhaustive; there may be other models operating of which we are unaware. In an effort to further clarify the range of models being used, we are conducting a brief survey to establish the models of service delivery that projects are currently implementing.

We would appreciate it if you would spend a few minutes completing the 1-page survey overleaf. Once you have completed the survey, please return it by email or fax to:

Belinda Morley (if you're in Vic, SA, Tas or NT)
Email: bcmorley@unimelb.edu.au
Fax: 03 9348 1174

Fay Kohn (if you're in Qld, NSW, WA or ACT)
Email: fkohn@unimelb.edu.au
Fax: 03 9348 1174

1. Name of Division(s) conducting Access to Allied Health Services project:

2a. Which of the following means of retaining allied health professionals is currently being used in your Access to Allied Health Services project? ***Please tick appropriate response(s)***

☐ **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.

☐ **Other** [Please specify]

2b. Has the means of retaining allied health professionals changed since the project began? ***Please tick appropriate response***

☐ Yes If yes, how?

☐ No

3a. From which of the following locations are allied health professionals currently providing services in your Access to Allied Health Services Project? ***Please tick appropriate response(s)***

☐ **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** [Please specify]

3b. Has the location of allied health professionals changed since the project began? ***Please tick appropriate response***

☐ Yes If yes, how?

☐ No

4. Which of the following referral mechanisms is currently being used in your Access to Allied Health Services Project? ***Please tick appropriate response(s)***

☐ **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 to the allied health professional being co-located with the GP. However, there are exceptions, where the allied health professional is located elsewhere.

☐ **Other** [Please specify]

4b. Has the referral mechanism changed since the project began? ***Please tick appropriate response***

☐ Yes If yes, how?

☐ No

5. Additional comments regarding service delivery models:

Thank you for taking the time to complete this survey.

Appendix 4: Summary of the advantages and disadvantages of different models of service delivery

			Divisions	GPs	Allied health professionals	Consumers
Means of retaining allied health professionals	**Contractual arrangements**	**Benefits**	• Volume and range of allied health professionals • No supervision, support and infrastructure costs • Flexibility	• N/A	• Number of allied health professionals with opportunity to participate	• Volume and range of providers available means that services are likely to be matched to needs and waiting lists likely to be short
		Barriers	• Need to 'ration' number of sessions • Fewer opportunities for monitoring and quality assurance	• N/A	• Need to provide own infrastructure, insurance and supervision • Limited relationship-building • No guarantee of ongoing/regular work	• Waiting lists may become an issue if funding becomes depleted
	Direct employment	**Benefits**	• Can make limited funding 'stretch a bit further' • Relationships between allied health professionals and Divisions • Quality assurance • Feedback of information to Division	• N/A	• 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	• Quality assurance and monitoring promotes high quality care
		Barriers	• Supervision, support and infrastructure costs	• N/A	• None identified	• 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	• Mutually satisfying professional relationships • Direct communication • Skill development • Sharing of files and appointment/billing systems	• Mutually satisfying professional relationships	• Convenience • Possible stigma reduction • Confidence in shared care arrangements
		Barriers	• N/A	• Limited array of expertise • Issues re. space	• 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	• Possible stigma generation

			Divisions	GPs	Allied health professionals	Consumers
	Own rooms	Benefits	• N/A	• Access to greater range of referral options	• Greater range and number of referring GPs • Greater diversity of referrals • Skills development • Independence and influence • Convenience	• Choice of locations • Ready access to treatment • May increase anonymity
		Barriers	• N/A	• Fewer opportunities for relationship-building and knowledge transfer	• 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)	• May threaten anonymity • Poorer continuity of care • Need to 're-tell story' • Travel barriers
	Other location	Benefits	• N/A	• N/A	• N/A	• N/A
		Barriers	• N/A	• N/A	• N/A	• N/A
Referral mechanisms	**Voucher system**	**Benefits**	• N/A	• Simplicity, minimal paperwork • Flexibility	• Control vested in consumers makes them rewarding to work with	• Greater control and choice • Increased anonymity
		Barriers	• N/A	• 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	• Inappropriate referrals • Difficulties in tracking referrals and gauging workloads	• None identified
	Brokerage system	**Benefits**	• N/A	• 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	• Appropriate referrals	• Care tailored to consumers' needs • High quality care
		Barriers	• N/A	• Lack of control of referral process • Delays between referral and treatment	• Favoured providers • Diminished opportunity for relationship-building, collaboration and knowledge transfer with GPs	• Delays between referral and treatment • Need to 're-tell story
	Register system	**Benefits**	• N/A	• Information upon which to make informed referral decisions	• Reduced likelihood of inappropriate referrals • Increased chances of building up a specialist referral base	• Care tailored to consumers' needs • High quality care • Access to broad range of providers
		Barriers	• N/A	• None identified	• None identified	• Potential for increased travel • Potential for decreased anonymity

			Divisions	GPs	Allied health professionals	Consumers
	Direct referral	**Benefits**	• N/A	• Ease of referral • Collaboration between providers • Good communication	• Collaboration between providers • Good communication • Skill development • Knowledge transfer	• Co-ordination of care • Quality of care • Reduced waiting times
		Barriers	• N/A	• Limited range of allied health professionals	• Referrals may be based on familiarity, rather than skills and expertise	• Limited number of allied health professionals may result in sub-optimal match between consumer and provider

Source: Morley et al[3]