

The Better Outcomes in Mental Health Care Initiative

**Evaluation of the Access to Allied Health Services
Pilot Voucher System**

**Otway Division of General Practice
(Referred to as the Division)**

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Executive summary

The Otway Division of General Practice launched its pilot 'Access to Allied Health Services' program and voucher system in February 2004. This was almost identical in structure to the pilot launched a year earlier by the Geelong Division of General Practice with whom it jointly developed the program. Not surprisingly then, this evaluation of the Otway Division's implementation of the program has repeated many of the findings previously made. The model was cost-effective and achieved its aims of increasing the access of the target patient population to allied mental health services, and of supporting General Practitioners (GP's) in their treatment of patients with mental health issues.

The voucher system was an efficient method of tracking GP, Allied Health Practitioner (AHP), and patient involvement in the pilot, while maintaining patient confidentiality and anonymity. The Division was able to successfully implement the pilot within the budget, to the satisfaction of the GP's, AHP's and consumers. Furthermore the Division was responsive to both consumer and service provider requests and queries and demonstrated a flexible approach within the constraints imposed on the pilot.

In the first twelve months nineteen GP's had registered with the pilot program and fifty patients had been provided with treatment. These patients were largely belonging to the target population envisaged: of low income, with mild-moderate mental illness, between 30 and 60 yrs old, without a tertiary qualification. The most common reasons for referral were depression and anxiety, and there were a substantial number of dual diagnoses. GP's and AHP's both agreed that these patients might otherwise have had difficulty accessing treatment.

The program was successful in terms of its clinical outcomes. Patients were overwhelmingly convinced of the merits of the program, their improved medical condition(s) and ability to manage their condition(s), and were satisfied that they had been treated with a sufficient level of respect and

confidentiality. They were equally satisfied with the timeliness and location of service, and the working relationships that developed between their referring GP and the AHP. The flexibility afforded in being allowed to re-refer patients for a second lot of counselling sessions was also seen as a substantial improvement by practitioners. Registered GP's and AHP's were also quite open in their praises about the benefits that had been delivered for patients through their increased collaboration; objective clinical data regarding improvements in the patient's condition was unfortunately not available. GP's were also very satisfied with the quality of care offered by the AHP's; recruitment of AHP's applied strict eligibility criteria which appear to have been rewarded. However, the Division has not as yet implemented a supervision system for ensuring continued professional development.

The main reservations expressed by GP's and AHP's regarding the pilot revolved principally around the constant theme of administrative constraints imposed upon the program, and the excessive amounts of bureaucracy. The time commitment involved in training and paperwork was frequently cited as a problem; non-participating GP's in particular were quick to cite this as the main barrier to participation. Other administrative constraints that were mentioned included the following:

- The referral and feedback processes were seen to be somewhat impractical and often inappropriate.
- The limited number of referrals per registered GP allowed by the budget was a disincentive to become involved.
- Lack of flexibility with regard to claiming fees; GP's were not able to claim higher fees for the three step mental health process if the patient failed to return for the third (review) session, as was regularly the case.
- A small number of trained and registered GP's were unable to refer to the program for a long period because their original practice dissolved and they were no longer seen to be practicing from an accredited clinic.
- Difficulty encountered by the Division in setting up a separate model for Aboriginal patients.

The identity of registered GP's was kept confidential and this was also somewhat contentious among AHP's. They were very keen to be proactive in directing their own patients towards the program but were not allowed. Conversely, registered GP's pointed to the added burden imposed by having previously unknown patients referred to them from other doctors so that they could avail of the program. This issue might be relieved by having a greater number of GP's registered with the program. Another shortcoming of the current program is the failure to meet the needs of the local Aboriginal population. It must however be recognised that this has been a nationwide problem for this program, and that the Division has been continuing to work towards a successful outcome with local Aboriginal communities.

Both GP's and AHP's acknowledged the satisfactory manner in which the Division and project officer had implemented the pilot program in the Otway Division, and provided education and training support. The one reservation regarding the Division's capacity to manage this program is the fact that it relies so heavily on the performance of the project officer. Prior to the appointment of the current officer, this position was vacant for some time and resulted in the pilot running significantly behind schedule.

Sustainability of the pilot will depend upon the Division being able to reduce the time commitments of registered GP's and AHP's by streamlining the education and paperwork requirements of the pilot. It will also depend on an increased number of practitioners registering with the program and the certainty that future funding for the program will be sufficient to allow registered doctors an appropriate number of referrals.

Chapter 1: Introduction

The Better Outcomes in Mental Health Care Initiative

The Better Outcomes in Mental Health initiative was instigated by the Commonwealth Department of Health and Ageing in 2001. The major aim of this initiative was to develop locally-appropriate referral services for general practitioners that would increase access to allied mental health services for mentally-ill patients being seen by general practitioners. There were five major components to this initiative:

- Incentive payments for general practitioners
- Education and training for general practitioners
- Medicare Benefits Schedule Items for general practice focussed psychological strategies
- Access to allied health services
- Medicare Benefit Schedule Item for psychiatrist case conferencing

A sum of \$120.4m was set aside over 4 years to develop a series of local pilot programs within general practice Divisions. The Geelong and Otway Divisions of General Practice made a successful joint application to develop the 'Access to Allied Health' component within their respective Divisions and have since developed such referral systems.

The Geelong Division of General Practice had completed it's first year of operation in February 2004 and has had a full 12-month evaluation undertaken by this Department **(1)**. The corresponding program for the Otway Division of General Practice (ODGP), which began in February 2004, is now being reported in this document. This program has largely been constructed with the same format, and hence its background, aims and objectives, and procedural requirements are quite similar to those in Geelong. This report will therefore try not to be repetitious in its description of the common aspects of

the program, and will also make a conscious effort to identify relevant issues and features that appear to be specific to the Otway Division (“The Division”) and program.

Operation of the Access to Allied Health Services Pilot Voucher System

The model provides that GP’s registered with the HIC for Level 1 of the BOMHi can refer their patients to a participating Allied Health Professional (AHP) for six sessions of FPS with the option of another six sessions if indicated on review by the referring GP. When completing the referral the GP must phone the Division to get a voucher number and patient identification code. These numbers are written on the referral form, the consent, the voucher and the minimum data set and then sent to the AHP. The AHP also writes these numbers on the consultation report (sent to referring GP) and reimbursement claim form (sent to the Division). This allows the Division to track each referral as a de-identified form.

The Otway Division of General Practice

The following is a concise overview of the Otway region and GP Division, as described by John Menzies, former medical director of the Otway Division of General Practice (ODGP). It underlines the more rural nature of the region when compared to the Geelong area from which the program was transferred:(2)

“The Otway Division began with a coming together of the tribes associated with the Colac district (Colac-Birregurra-Lorne-Apollo Bay and Winchelsea) and the Camperdown district (Camperdown-Terang-Mortlake-Cobden-Timboon and Lismore). Subsequently Port Fairy, Koroit and Penshurst joined in, then Warrnambool, Portland and Macarthur, and most recently Hamilton.

So now our Division extends from Winchelsea and Aireys Inlet in the east across to Portland, Heywood and the South Australian border. The sea forms our southern boundary and the Grampians/Great Dividing Range our northern one. The area is served by 110 (*now 115*) GP's of whom 108 are financial members. The population is 117,000. Medical services are largely delivered by GP'S working in small country hospitals, with specialist back up principally from Warrnambool and to a lesser extent Hamilton, Colac and Geelong.

Farming is the dominant industry, with dairying and beef in the southern and central portions and sheep in the northern part, spread like layers of a cake, with a seaboard fringe of tourism providing the icing. Similarly spread in layers are doctors and their interest, with fishing and surfing types along the coast, farmers in the middle, and bird watchers and botanists in the north. All types of terrain (physical and metaphorical) are contained within."

The Otway Division Evaluation

Full details of the 'Access to Allied Health Services' model developed by the Otway and Geelong Divisions of General Practice are described in Chapter 2.

This evaluation, carried out by the Greater Green Triangle University Department of Rural Health, has been conducted largely in the same format as that for Geelong. Minor changes have been made to the evaluation process in consultation with the Otway Division, as a result of findings from the initial report from Geelong and minor differences that have evolved between the two programs.

Chapter 2: Access to Allied Mental Health Practitioners- Development of a Model of Care

The ODGP mission statement is as follows:

"Otway Division of General Practice seeks to preserve and enhance the health of its community and to maintain and improve the standards of General Practice."

The Access to Allied Health Services Pilot, with the following aim, was seen to have the potential to integrate well with the aims of the Division as a whole:

"to provide a range of high quality mental health related allied health services to patients of GP's registered with the Better Outcomes in Health Care Initiative."

This aim translated into the following objectives for the Access to Allied Health Services Pilot:

- To provide improved health outcomes for people with a mental health disorder who have been referred by their GP using specified allied health services.
- To provide an effective model for referring people with a mental disorder to Allied Health Professionals (sustainable / transferable)
- To provide an allied health model which results in a more integrated primary care system between local Mental Health agencies (MAHS, BOMH, PMHCT, AMHS)
- To have the Division of GP be able to act as a successful fundholder for the purchase of allied health services
- To identify what benefits and disadvantages barriers and enablers there are to the Geelong and Otway Divisions in the undertaking of the pilot project

- To identify if Divisional intervention has impact on uptake and implementation of the BOMHi item numbers.
- To provide convenient cost effective and quality outcomes for GP's and allied health staff.
- To provide a cost effective model for purchasing allied health services in different geographical areas.
- Provide GP's with skills and systems to access BOMH pilot (item numbers/ services)
- Provide Allied Health workers with skills and systems to work within the BOMHi framework
- To provide effective outcomes of Koori mental health interventions.

Target population

The target population for the Access to Allied Health Services Pilot is “all patients with a mental illness, including those with co-morbidity who present in the general practice setting” In this context “mental illness” is defined as “a significant impairment of an individuals cognitive or affective and / or relational abilities which may require intervention and be a recognised medically diagnosable illness or disorder (as defined by WHO International Statistical Classification of Diseases and Related Health Problems: chapter v, Classification of Mental and Behavioural disorders: Primary Health Care Version, 2000). Within this population low income earners will be targeted.

The two main types of patients the pilot will target are:

1. Individuals who can be diagnosed with a high prevalence disorder who are not requiring a referral for direct intervention, but where the GP feels that more information is needed to complete the assessment and draw up a mental health plan. The GP will refer the patient for a session at the end of which the allied health professional will provide feedback to the GP on a feedback form. The GP may or may not sit in

on the session and will gain extra information needed to complete the assessment and formulate a mental health plan with the patient.

2. Individuals who could have a high prevalence disorder with complicating factors, which may require more intensive intervention. In this instance the GP may refer the patient to the allied health professional for a series of six sessions of Focussed Psychological Strategies (FPS), with the option of a further six sessions upon review of the patient.

Patients contraindicated for the pilot are those with delirium, dementia, tobacco use, alcohol misuse, a mental retardation, or those of low intelligence. Good candidates for the pilot are described as:

- Patients with insight into their condition
- Patients with anxiety disorders and depression, and with a K10 score of less than 15 (not severe)
- Patients with good motivation to change
- Patients experiencing a situational event
- Patients who are psychologically minded.

It was also intended to have specific structures in place to facilitate treatment of Koori patients.

Service model: registered GP's

In order to participate in the Better Outcomes in Mental Health Care initiative, GP's must meet certain training requirements, in accordance with guidelines provided by the Australian Divisions of General Practice (ADGP) and the General Practice Mental Health Standards Collaboration (GPMHSC)¹. The Otway Division provides Familiarisation Training (aimed at familiarising GP's with the initiative in general and with the 3 Step Mental Health Process in particular) and Level 1 training including SPHERE. Divisional GP's who

¹ The GPMHSC is a collaboration of the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine, the Royal Australian and New Zealand College of Psychiatrists, the Australian Psychological Society, and the Mental Health Council of Australia

complete this training and register with Level 1 of the BOMHi are eligible to refer their patients to the Access to Allied Health Services Project. Registered GP's are also eligible to receive the Service Incentive Payment under the Medicare Benefits schedule.

Service model: registered Allied Health Professionals

For the purposes of the Better Outcomes in Mental Health Care Initiative the definition of Allied Health included the professions of psychology, mental health nursing, occupational therapy, social work and Aboriginal and Torres Strait Islander health workers. The evidence based Focussed Psychological Strategies to be used by the Allied Health Practitioner included:

- Psychoeducation
- Cognitive Behavioural Therapy, including behavioural interventions, cognitive interventions, relaxation strategies, and skills training.

Letters were sent to local Allied Health Professionals and an advertisement was placed in the paper inviting Allied Health Professionals with skills in FPS's to participate in the pilot. To competently provide services under the initiative the Allied Health Professionals required the appropriate:

- Knowledge (including theory underpinning evidence based interventions, and research into their effectiveness):
- Skills (in delivering best practice, evidence based effective interventions): and
- Experience in assessing and treating patients with the range of mental Health problems to be targeted.

Interested Allied Health Professionals were required to apply in writing to the Division and to provide evidence of current qualifications, professional registration and professional indemnity insurance. The Otway Division

imposed the additional requirement that each AHP should have two years experience of working within that particular field. In some instances clarification of the applicant's qualifications or experience was sought in a telephone interview. Only those who met the appropriate criteria were offered contracts.

Educational criteria were to be met through the provider's educational qualifications and ongoing professional development. Allied Health Professionals were expected to sign a MOU with the Division to this effect. As a condition of employment the Allied Health Professionals were expected to provide their own professional support opportunities and supervision.

Method of referral to the Allied Health Professional

All GP's who register with the BOMHi were provided with a list of the Allied Health Professionals contracted under the pilot. Patients were referred using the Mental Health Assessment form from the 3 step Mental Health Process.

The GP was required to explain the 3 Step Mental Health process to the patient and get a consent form for release of information signed by the patient. Copies of the consent form were given to the patient and the Allied Health Professional and a copy of the Mental Health Assessment was also sent to the Allied Health Professional. A copy of the minimum data set was sent to the Division. The GP was also required to phone the Division to get a patient code and voucher number for the patient. The code and voucher number were then used on all patient forms as deidentifiers in accordance with the privacy act. The patients were also provided with an information brochure and instructed to contact the Allied Health Professional for an appointment.

Once the GP completed the referral it was sent to the chosen Allied Health Professional. Patients were encouraged to make their own appointments with

the AHP. This was deliberately incorporated into the referral strategy as a means of encouraging patients to take their some ownership in finding a solution to their mental health issues and thereby acting as a step in the therapy. The Allied Health Professional was required to provide a verbal report to the GP after the second session with the patient. After the requested number of sessions was completed the AHP was then required to complete a consultation report form and forward it to the GP. The AHP was also required to complete a minimum data set and reimbursement claim form and forward these to the Division

The process of referral is simplified in the following two tables, (table 1. and 2.).

<p><i>Path A Simple referral</i></p> <ol style="list-style-type: none"> 1. Complete mental Health Assessment, pt consent, and minimum data set. 2. Phone Division to get pt code and voucher number. 3. Send assessment, consent, voucher, and minimum data set to allied health professional 4. Fax Minimum data set to Division 5. Pt sees allied health professional 6. Allied health professional sends feedback form to GP 7. Allied health professional sends reimbursement claim form and minimum data set to Division 8. GP reviews pt and can refer for another six sessions if required.

Table 1.Path A. Simple referral

<p>Path B. 3 Step Mental Health Process</p> <ol style="list-style-type: none"> 1. Complete Mental Health Assessment (Step 1), pt consent, and minimum data set. 2. Phone Division to get pt code and voucher number. 3. Prepare Mental Health Plan (step 2) Include referral to allied health professional in action task section. 4. Send assessment, consent, voucher, and minimum data set to allied health professional 5. Fax Minimum data set to Division 6. Pt sees allied health professional 7. Allied health professional sends feedback form to GP 8. Allied health professional sends reimbursement claim form and minimum data set to Division 9. GP completes mental health review (Step 3) 10. GP can refer pt for another six sessions if required

Table 2: Path B. 3 Step Mental Health Process

How the Allied Health Services were purchased

Private Allied Health Practitioners provided services to patients on a sessional basis and were paid via a referral and claim back system to the Otway Division. Sessions were generally of sixty minute duration dependent on the needs of the patient. A standard reimbursement claim form was completed by the AHP and then forwarded to the Division. The Division then forwarded payment to the AHP. Allied Health Professionals were reimbursed by the Division at a rate of \$100 per session for each Allied Health worker (increased from \$80 shortly after commencement of the pilot). The Allied Health Professionals were expected to cover their own professional supervision costs from their own funds. Patients were not required to provide a co-payment.

Location of Service Provision

Service provision took place in the private rooms of the Allied Health Professional. In order to keep track of the number of referrals and to avoid a blow out in costs GP's were requested to first seek approval from the Division. Consumer progress is evaluated using the Kessler Psychological Distress Scale (K10), the Suicide risk assessment, and the Mini Mental State Examination. Baseline data was collected by the GP at assessment and again at review.

Quality control

Controlling the quality of services provided to consumers has been facilitated through;

- training for GP's and Allied Health Professionals;
- strict employment criteria for Allied Health Professionals ensuring only adequately trained Allied Health Professionals were contracted for the pilot;

- requirement for Allied Health Professionals to engage in ongoing professional development;
- requirement for Allied Health Professionals to feedback to the GP's after two sessions with the patient;
- provision of a GP resource kit providing standardised forms for assessment and referral, along with clear instructions for the procedures of the pilot, and
- Use of a patient code and the vouchers to maintain patient confidentiality.

Governance and Management

A steering committee was set up to administer the pilot. The Otway Division of General Practice was responsible for:

- Being the principle contact with the Department of Health and Ageing, and for assuming responsibility to the Department for compliance with the applicable terms and conditions of the prevailing agreement
- Maintaining the financial accountability of the project
- Provision of the office and equipment for the project worker
- Appointment of the project worker
- Encouraging GP's to register for the BOMHi and provide ongoing education for the participating GP's
- Appointment and education of Allied Health Professionals to provide focussed psychological strategies to patients
- Liaising with the GP's / Allied Health Professionals to ensure a coordinated approach
- Internal analysis and evaluation of the project.
- Provision of data for the external evaluation of the project.

Chapter 3. The Evaluation Process and Methodology

Background

The evaluation team met with the project team on several occasions prior to an evaluation plan being agreed upon. Because the process had already been undertaken at the Geelong Division for the same model of delivery, the main purpose of these meetings was to confirm the applicability of a similar evaluation in the Otway Division. These local aims and objectives of the pilot for the Otway Division, and the framework for the program's evaluation, are outlined below and are consistent with those for the Geelong program.

A time frame for the implementation and progression of the pilot was also decided.

Evaluation Purpose

- To improve the effectiveness of the Access to Allied Health Services Pilot
- To inform the broader national evaluation of the initiative, including the appropriateness of the Access to Allied Health Services component.

Evaluation Questions

Nine evaluation questions were outlined by the Better Outcomes in Mental Health Cares initiative's Evaluation Working Group in the 'Access to Allied Health Services Pilots Evaluation' document:

1. Does the allied health model result in a more integrated primary care system?
2. What are the most cost-effective models for purchasing allied health services in different geographical locations?
3. What are the infrastructure costs required to support the different models for purchasing allied health services?
4. Are Divisions of General Practice able to act as fund holders for the purchase of the allied health services?
5. Do the specific allied health services available need to be different for Aboriginal and Torres Strait Islander and trans-cultural populations?
6. What are the most effective locations for the delivery of the allied health services and how does the location affect outcomes for consumers and the partnership between the GP and the allied health provider?
7. Do the specific allied health services available result in improved health outcomes for people with a mental disorder who have been referred by their GP?
8. Can computer based therapy and other self help models of treatment result in improved health outcomes for people with a mental disorder who have been referred by their GP?
9. What are the most effective models for referring people with a mental disorder to Allied Health Professionals?

It is anticipated that these nine questions will be responded to in the National evaluation of the BOMHi. Therefore, a separate list of evaluation questions was agreed upon with the Geelong and Otway Divisions which would be guided by the questions listed above for the national evaluation framework, but which would also address the need to evaluate local aims and objectives.

This list of questions developed for the evaluation of the local pilot is outlined below. Some additional questions have been added which do not correspond directly to the aims of the project but which inform the evaluation process.

1. Is this model an effective method for referring people with a mental health problem to an allied health professional?

- Does the voucher system work efficiently?
- Are the protocols for referral and feedback between the GP's and Allied Health Professionals useful?
- Are GP's and Allied Health Professionals satisfied with the model?
- Are GP's and Allied Health Professionals satisfied with the referral and feedback processes in place?
- Has the development of a steering committee and project board been useful?
- Is the resource kit useful?
- Were appropriate program records of activities developed and maintained?
- Has the cost of the model been affordable within the funding for the pilot?
- Has the Division been able to adequately act as a fundholder?
- Is this model sustainable?
- Is this model transferable?
- Has there been a change in the quantity and quality of the referrals over the life of the project?
- How have patients been tracked throughout the system?

2. Does the BOMHi enable the provision of high quality mental health allied health services to patients of GP's registered with the BOMHi?

- Was the formation of the recruitment committee timely?
- Were the members of the recruitment committee suitably qualified to form a recruitment committee?
- Were the Allied Health Professionals recruited suitably qualified?
- Was a system of supervision for the Allied Health Professionals instigated?
- Is care provided in six sessions?
- Is care evidence based?

- Were the Allied Health Professionals informed of the procedures of the BOMHi?
- Was the list of participating Allied Health Professionals distributed to all GP's in a timely manner?
- Were the Allied Health Professionals participating in the program adequately promoted to the GP's?
- Were the Allied Health Professionals and GP's satisfied with the referral and feedback process?
- Were patients satisfied with the quality of care?
- Is there improved patient outcomes post care?

3. Was patients' access to mental health allied health services improved?

- Did the proportion of GP's registered with the BOMHi increase (to 20%)?
- Did the GP's registering with the BOMHi all refer patients?
- Were the GP's and Allied Health Professionals satisfied with the education process (mail-outs and information sessions)?
- Were the GP's and Allied Health Professionals satisfied with the education content (mail-outs and information sessions)?
- Were the AMHS and the other mental health service providers (PMHCT, MAHS) satisfied with the information they received regarding the BOMHi?
- Did the education and training assist GP's to make referrals?

4. How were ATSI populations targeted for inclusion in the pilot and was this successful?

- Were meetings organised and attended by the ATSI populations?
- When the meetings held and what were their agenda?
- How were culturally sensitive GP's encouraged to register with BOMHi and participate in the pilot?

5. Did the BOMHi provide an allied health model, which resulted in a more integrated primary care system than MAHS, PMHT, or AMHS?

- Were PMHT, AMHS, and MAHS aware of the BOMHi aims, objectives and roles?
- Did the PMHT, AMHS, and MAHS service providers perceive a duplication of services?
- Did the GP Divisions perceive a duplication of services between the BOMHi and the other services?
- Were the PMHT invited to the information sessions regarding the BOMHi?
- Did the GP's and Allied Health Professionals meet to discuss the pilot at regular intervals during the pilot?

The data to be collected for the minimum data set was specified by the Commonwealth by the Better Outcomes in Mental Health Care's initiative's Evaluation Working Group in the 'Access to Allied Health Services Pilots Evaluation' document. This minimum dataset allowed a socio-economic, clinical and treatment profile of patients, and also a brief description of the GP practices.

Data Collection

Both qualitative and quantitative methods were used to evaluate the pilot. Because of the relatively small numbers of practitioners and patients involved in the program, findings were validated using a process known as *triangulation*. Triangulation involves the simultaneous assessment of multiple results as a means of validating individual findings or conclusions. In this report we have used both *data triangulation* and *hypothesis triangulation*. With data triangulation, multiple sources of data are assessed simultaneously and observed for complementary findings (e.g. postal surveys and interviews both indicating the same finding for the same topic), while hypothesis triangulation looks at findings across a range of different questions which allow overarching conclusions to be reached.

Qualitative data methods

Key Informant interviews

A series of Key Informant interviews were conducted in March and April 2005 to gather views of both the implementation and the concept of the pilot. In total, 11 face-to-face interviews were conducted. Taped interviews were transcribed and analysed for themes using standard qualitative techniques.

The 11 Key Informant interviews were conducted with;

- 2 GP's participating in the pilot (appendix A)
- 2 GP's who had decided not to participate in the pilot (appendix B)
- 2 representative from each of the other mental health service agencies (PMHCT, AMHS) (appendix C)
- 3 allied health professionals participating in the pilot. (appendix D)
- 2 patients (Appendix E)

Quantitative data methods

Surveys

Three surveys were designed and distributed. Surveys were sent to the participating GP's (appendix F), participating Allied Health Professionals (appendix G), and to consumers (appendix E, same format as interviewed patients). The surveys to the consumers were distributed via their Allied Health Professional at the end of their final therapy session in order to maintain confidentiality. Stamped reply envelopes were provided with all surveys to ensure respondents confidentiality.

Of the 16 surveys sent out to participating GP's 6 (38%) were returned, 9 (69%) of the 13 distributed to Allied health professionals were returned, and 5 consumer surveys were returned. It is not known how many consumer surveys were distributed due to the method by which they were distributed.

Minimum dataset and referral data

The information gathered for the Commonwealth minimum data set was also analysed for process information such as numbers of participants and referral patterns. Referral data was also collected by the Division in the distribution of vouchers and patient identifying codes.

Health outcomes data

Individual consumers were to be evaluated at baseline and follow up using the K 10, the Suicide risk assessment and the Mental Health Examination. Unfortunately most of the patients did not return for their review visit with the GP and therefore this outcome data was not available. Moreover, it was not possible to enter this information online as part of the minimum database. This meant that it would not be possible to provide an objective assessment of improvements in the patient's condition.

Data Analysis

Qualitative data was analysed using standard qualitative techniques. Quantitative data was analysed using only descriptive statistics due to the small sample sizes.

Strengths and Weakness of the Evaluation Methodology

The main strength of the evaluation was that a variety of methods were used to collect data from a range of different sources. This allowed us to conduct the triangulation process with data, whereby findings from one information source are interpreted only with consideration of related findings from other components of the evaluation. This compensates for the limitations resulting from having to rely on relatively small numbers of practitioners and patients for information to some extent. A secondary strength of the evaluation was that data was collected in collaboration with the GP Division. This process ensured that questions asked on surveys or Key Informant interviews were

appropriate, and comprehensive. It also enabled the Division to add any questions they thought might be appropriate, or have been missed by the evaluators.

Weaknesses of the methodology were as follows:

Small sample size for surveys due to the limited pool of patients and practitioners.

The refunding of the program in its current format prior to and without reference to the local evaluation has left certain stakeholders feeling that contributing to this evaluation would serve little purpose.

The implications of these weaknesses are that it is difficult to draw conclusions from small sample sizes and that much of the qualitative information gained is based on subjective opinion.

Chapter 4: Is this model an effective method for referring people with a mental health problem to an Allied Health Professional?

Does the voucher system work efficiently?

GP's feedback in surveys suggests that mixed feelings exist regarding the voucher system, with 3/6 GP's reporting that the system has been easy to use and two respondents reporting that the voucher system had not been easy to use. Quite significantly, all five GP respondents agreed that the voucher system had increased their access to AHP's.

The general attitude from many involved GP's and AHP's was that all such initiatives were to be supported regardless of minor inefficiencies because of the benefits to the patient. Both of the interviewed GP's quickly dismissed any notion of difficulty, and this attitude is typified by the following AHP comment:

AHP: "I think any funding that accesses or increases access to counselling is essential and it should, you know, be supported and endorsed and, you know, all be it whatever shortcomings there might be, or barriers ... the quibbles about the paper work are insignificant relative to or compared with... the difference that it can make in people's lives".

However, one of the AHP's did identify the voucher system as creating a barrier to the efficient running of the pilot:

AHP: "Well, I think... the voucher system itself ... really slows up the whole process and makes it complicated."

One of the surveyed GP's also identified a simpler voucher system with less paperwork as a means of improving the program. Just 2/5 GP's reported the process of claiming payments as easy, and this was reflected in comments such as the following during stakeholder interviews:

GP: "They've (GP practice administration) had one rejected they tell me... that was for a patient who had a second lot of six sessions and I saw them, obviously, for the assessment at the end of the six sessions and I saw them again and must have done another assessment and then saw them again at the end and I was told, I wasn't sure if you were allowed to claim again for that second lot and it was very nebulous as to what requirements you had to do to make a second claim."

The other interviewed GP also felt there were initial difficulties in actually getting patients to attend the third session so that extra payments could be accessed:

GP: "At the beginning there were a few that didn't come back and have follow up, but the psychologists are certainly pushing them to come back now. So I think I see a higher percentage back."

GP's access their fees through the HIC and not the GP Division. The system for accessing fees was covered in the familiarization training run by the Otway Division. This was supplemented by individual support sessions and advice provided by the Division's project manager for GP's about to commence involvement with the scheme.

Key informant interviews suggest that this problem was in part is due to very few patients returning for their final review visit and changed fees were not able to be accessed until the third review visit had been completed. The AHP's seemed to be more satisfied with the payment system, with 6/9 (67%) reporting that it was easy to claim payments:

AHP: *“Yes. It was quite good, nice and simple, nice and straight forward. One single form”*

One interviewee did indicate some unnecessary duplication in their work by having to fill out a specific form:

AHP: *“it was a duplication of information, because in my ... administrative practices I had to generate a receipt anyway for, you know, so I have to then duplicate all of that information on a form that they wanted me to fill out.”*

None of the patients indicated any problem or inconvenience with the voucher system during their feedback.

Are the protocols for referral and feedback between the GP’s and AHP’s useful?

The protocols for referral and feedback between the GP’s and the AHP’s specify that the GP’s send the Mental Health assessment, signed patient consent form, and minimum data set information, to the AHP, including the voucher number and ID number on each form. The AHP’s then see the patient and are required to provide an oral report to the GP after the patient’s second session, and provide a completed feedback form to the GP after the final (sixth) session.

Only 3/6 (50%) GP’s responding to the survey thought the referral forms were clear and easy to complete. Furthermore just a single GP reported being able to complete the referral forms quickly. Three of the six GP’s reported the protocols for referral were not easy to use, and 4/6 (67%) respondents that the protocols were not time effective. There was a poor assessment of these protocols with 5/6 (83%) GP respondents reporting them to be unclear.

Most GP's were in agreement that the assessment forms were appropriate – these assessment protocols included the Mental Health Assessment 4/6 (67% agreeing it was appropriate), and the K10 and the Suicide Risk Assessment 4/6 (67%) and 5/6 (83%) respectively agreeing they were appropriate assessments). At the receiving end, 7/8 (87.5%) AHP's reported that the referral information they received was quite clear and 5/8 reported that the referral information was complete. Despite this clarity of referrals, there were doubts as to the usefulness of the information being specified on the protocol documentation. The inference was that they were designed with reporting rather than treatment concerns in mind, making them inflexible and impractical:

GP: *"I must say I don't use the forms that they gave me. I'm not a form person. I tend to write them a brief letter. So my referral process to them, to the psychologist, I'll dictate a letter and include the ID numbers in it."*

Allied health practitioners concurred with this:

AHP: *"Give me an opportunity to write some things in there rather than prescribe the boxes that I fill in, because the trouble with the boxes of course is that if the patient doesn't fall into those boxes. I mean I know that for statistical purposes at the end may be some summary boxes ... but the information flow needs to be from the doctor to me and from me to the doctor, not just about (reporting of statistics) you know, as much as I realise that that's an important part of the whole process."*

AHP: *"No, the official form I thought was fairly inadequate. I mean even to sort of say, you know a tick box that says depression or anxiety isn't sufficient. I mean the doctor knows lots of information about this patient, it would be really helpful if the form had some provision that said let's start by sharing this information, so I don't have to start from scratch."*

Are GP's and AHP's satisfied with the model?

GP's and AHP's were largely satisfied that this model achieved beneficial outcomes in terms of patient and GP support, and in terms of enhancing the working relationship of the two parties. There remains however a number of criticisms relating the effort and bureaucracy involved in achieving this.

All 6 GP survey respondents indicated that the pilot has increased the amount of support they have in working with the specified client group. There was also a unanimously positive response from the six GP's when asked if they felt that the model used had assisted in the referral of patients. Half (3/6) of the GP's reported that they thought the BOMHi service model was a better option than those currently available to them. One GP expanded upon this point during an interview, saying that all such models which increased the ability of GP's to treat such patients were to be encouraged.

GP's appeared very happy with the administration of this model by the Division and current project officer also, with all 6 respondents reporting satisfaction.

A major source of dissatisfaction for the GP's was the amount of paperwork involved in the pilot, with just 2/6 (33%) of the GP's stating that the amount of paperwork was appropriate for the service and just 1/6 (17%) of the opinion that the amount of paperwork was appropriate to the income. In asking what barriers existed to the pilot working effectively, and what improvements need to be made, 5/6 (83%) GP's commented on the excess of paperwork as a major issue, despite contentment otherwise with the scheme. This common attitude is typified by the comments of one GP respondent:

GP: "I don't care about being paid any more. I just don't have time for all the paperwork- which probably isn't even looked at by anyone and certainly doesn't help the patient. The time involved- I could have seen the patient for ~3 long sessions which may be more useful".

That the amount of paperwork may also be a barrier to GP's becoming involved in the program as a similar theme emerged with the GP's who elected not to participate in the pilot. In the face of other competing programs and a high workload, this model which was perceived as excessively bureaucratic seems to have been disregarded as a non-starter for a number of practices:

NGP: "...you've got to remember that ... there's also initiatives to do with other things, diabetes and asthma, the collaborative program... we're always being employed to do private research and we do a bit of that here. So this is yet another one which happens to me, in my view, although I haven't done the training, has a reputation for being very heavily administration based and I don't think we need that at the moment."

This notion that current workloads and the perceived workload associated with the program has had a serious impact on uptake of the program, was reinforced while trying to recruit interviewees from general practice. Many GP's were unable to put time aside for an interview but did cite workload problems as the simple explanation of their non-participation- both in the program and its evaluation. On the plus side, those GP's who did get involved were very happy with the fact that the new model created a much better working relationship with allied health professionals:

GP: "Oh, for sure, I think it means that, it's been excellent that way. And I do value very much the feedback I get from the psychologist. It's been interesting, initially we, traditionally we've had very, very little feedback from psychologists whenever we've referred ... and suddenly I've had this rush of wonderful letters from them. But I assured them that we actually do like that and we learn a lot from it too and 'cause I would like to be a better counsellor, but both my skills and more particularly my time restrains, prevent that a lot. And I do find it helpful to get their feedback letters and find out how they go about a lot of their work."

There was also quite a high level of satisfaction among AHP's, with 5/8 (63%) reporting satisfaction with the manner in which it was implemented, 7/7 (100%) reporting that their patients had benefited, and 5/7 (71%) feeling that the Division had adequately administered the pilot. As with the GP's, they held mixed feelings about the level of paperwork required: just 5/9 (56%) felt that it was appropriate for the service, but 6/8 (75%) felt that it was appropriate for the income.

AHP's were asked if the BOMHi service model was a better option than those currently available to their client; 4/6 (67%) respondents agreed it was a better model while 3 respondents declined to comment. Significantly, all 7 who responded thought their patient had benefited from involvement with the pilot, and 8/9 thought that the pilot offered value for money for their clients:

AHP: "(GP's)... wanted another way to provide that treatment (counselling) and often people can't afford to do it themselves. There are no publicly funded psychologists available in this area, other than for crisis work. So if all you have is depression, then you can't get treatment unless you're prepared to pay for it. So this was one way of making sure that people who need that assistance can get it."

Key Informants suggested that the benefits of the pilot were the opportunity it provided for networking of services:

GP: "I'd give them a nine or ten out of ten for the quality of care I get from the psychologists"

A source of dissatisfaction to the AHP's was that there were not enough doctors registered with the service, with 3/9 AHP's listing this as a barrier to the pilot working effectively, and 3/9 also recommending that more doctors be trained in order for the system to work more effectively.

AHP: "Get a lot more GP's involved in it. I'd like to see all GP's involved in it, every single one of them. I think that that's absolutely imperative."

This AHP interview also raised the idea of expanding the scheme to include other health practitioners: “...it should be that the referral can come from any number of sources and I don't know why for instance a dentist couldn't refer somebody to a GP and say look could you organise for this person to have a referral to a psychologist for problems that I picked up as a dentist or a physiotherapist, or anybody else for that matter. I think the source, the visible source of information about the program should be able to come from anywhere, be given to the patients, say please go along and have a talk to your doctor about the appropriateness or otherwise and making the referral under the program for appropriate.”

A few AHP's also raised their frustrations about being unable to access a list of BoMH registered GP's.

Importantly, the patients themselves appear to be happy with the treatment model. All four patients who responded felt that the GP and AHP worked well together to help the patient, all five respondents indicated that they were treated with confidentiality and respect, and 4/5 (80%) reported not having to wait for an AHP appointment (the fifth respondent waited 7 days). When asked, none of the patients indicated that they would like to see any improvements. All of these views were reiterated and reinforced by the two patients interviewed.

Are GP's and AHP's satisfied with the referral and feedback processes in place?

All 6 GP's reported the AHP reports received were both clear and adequate in content. All 6 GP's also reported that final reports were received in a timely manner after the patient had completed their final session. Unfortunately only 3/6 (50%) GP's reported that they consistently received a follow up call to discuss the intervention plan after the patient's second visit.

Four of the six GP's (67%) reported that the AHP's were easy to access, 5/6 report that AHP speed of response was adequate, and all 6 felt that the locations of AHP's were suitable. Importantly, communication between the GP's and AHP's was perceived as open with all 6 GP's reporting open communication with AHP's.

Seven of the eight AHP's (88%) responding to the surveys reported that they thought the referral forms were easy to understand, and 6/8 (75%) thought the proforma for reporting back to the GP's was easy to complete.

There was mixed opinion from AHP's about their ability to meet reporting guidelines established and agreed to in their Memorandums of Understanding (MOU) with the Division. Four of the seven respondents had been able to meet the reporting guideline of a phone call to the GP after the second visit, while another two indicated that they could not achieve this all the time. All 8 AHP's who responded had managed to report to GP's on their patients at the end of the six sessions however. Key informants suggested it was not the concept of contacting the GP's after the second session with the client but rather the difficulty of having both practitioners available to talk at the same time:

AHP: "I tend to do the reporting in writing rather than oral. Simply because I know doctors are busy and I'm damn near impossible to get onto as well, and I would often find for instance, that I would ring the doctor and he'd have a patient so he'd say well give me some time and I'll ring back and then he'd ring back and I'll have a patient."

The need to provide a session-by-session feedback has also been criticized on the grounds that it is difficult to prepare, not all relevant to the GP, and not in a format that is useful to the GP:

AHP: "Well the feedback form that we required here to fill in to the doctor has got session by session notes and I've had a lot of dilemmas about that. Number one, it seems to me from the group discussions I've had with doctors

that doctors just haven't got time to read that material anyway and that it's too detailed for them. And then secondly there are issues about what's appropriate to pass onto a doctor and what isn't."

AHP: "I found it (feedback) actually time consuming and quite a challenge to...condense it into a session by session breakdown, whereas generally speaking when I give feedback it's (centred) more ...around, you know goal treatment and ...degree of success in achieving those goals and things like that. So kind of helpful, but I found it quite time consuming."

Has the development of a steering committee and project board been useful?

The Steering Committee and Project Board were appointed prior to the commencement of the project. Because it was a collaborative project in conjunction with the Geelong Division of General Practice, much of the groundwork (such as policies, development of protocols) had already been prepared and all that was required was for the Steering Committee to endorse this and effect its implementation. One of the shortcomings of the Steering Group is the inability to date to recruit a consumer representative. Numerous approaches were made both to mental health advocacy groups and liaison services within the Division, and it is now planned to advertise the position more widely.

It did not prove feasible for the geographically-dispersed groups to meet as a group after the initial meetings to set-up. Direction for the project was given where necessary through informal communication. This does not appear to have hindered the implementation of the project locally, but has resulted in less recording of the decision-making processes.

Is the resource kit useful?

Four of the six GP (67%) survey respondents reported the resource kit had been useful, and 2/6 (33%) reported it had not. The content of the resource kit

was considered to be relevant by 4/6 (67%) of the respondents, and the content of the kit to be adequate by 5/6 (83%) respondents to the question.

Were appropriate program records of activities developed and maintained?

- The informal nature of much of the communication for the Steering Committee and Project Board for this project has resulted in poor records of decision-making procedures and agenda items for communication.
- A GANTT chart was developed along with a task list of who does what
- All referrals sessions payments etc were entered into an excel spreadsheet.
- The specified data from the minimum data set was collected and entered onto the Commonwealth program database as it became available.
- Invoices from AHP's were documented so that patient progress through the treatment process could be tracked.

Has the cost of the model been affordable within the funding for the pilot?

It was hard to establish the pattern for referrals in the first 12 months of this program due to the relatively small numbers involved, so it is subsequently difficult to assess how future demand will grow. However, the Division has had a limited number of GP's registered so this has taken a lot pressure from the budget. It has also allowed the Division to permit extra referrals for individual doctors above their initial referral quota. Future funding for service provision would need to match any increase in the number of registered GP's so that participation remained worthwhile.

The issue of fees paid to AHP's did not appear to be as contentious an issue as it was in the Geelong Division. AHP's were paid \$80 for each session

completed, and this figure was increased to \$100 just two months into the program. A payment of \$20 is payable if the patient did not present for the appointment but to date no such payment has been claimed. Three of the nine AHP survey respondents (33%) felt that this program incurred more costs than other mental programs with which they were involved.

In response to the question as to whether accessing the pilot has resulted in a change in fees the AHP can access just 3/8 (38%) respondents reported that they had been able to access a change in fees for these clients. Moreover 6/9 (67%) respondents reported that claiming the money had been an easy process, while 3/9 (33%) reported it had not. Of concern 3/9 (33%) respondents reported that participating in the pilot had incurred more costs for their clinic compared to other mental health services. In response to the question as to whether it had been cost effective to become involved in the pilot, those AHP's interviewed were quite happy with the amount being paid.

GP's were less positive regarding the cost effectiveness of the model. When asked if the pilot was cost effective compared to other mental health services they could access just 2/5 (40%) GP's reported the model was cost effective while 3/5 (60%) reported it was not cost effective. In addition half of the respondents - 3/6 GP's - reported that participating in the pilot had incurred more costs for their clinic in comparison with other mental health services. Much of the cost-effectiveness of the program from a GP's perspective relied on the receipt of a \$150 bonus payment given for completion of three sessions with the GP by the patient. Because the final GP session occurred after the six AHP sessions, the ability to complete to claim this payment therefore relies on (a) the patient completing six sessions, and (b) the patient's own motivation to return to their GP after six sessions. This is outside of the control of the GP, and interviews with GP's revealed dissatisfaction regarding this uncertainty about the final payment:

GP: "We probably do get (paid appropriately), as long as we (receive)... the bonus PIP payment at the end. Assuming I get that, if I get that on top of my, you know, other standard fees, I'd probably vaguely do (get paid

appropriately), but it is, it's a lot harder work for me to do a, you know, to see someone for a mental health assessment than it is for, you know a standard C consultation. Yeah, so I think I definitely deserve the bonus at the end and I think it's probably debatable whether we're really reimbursed for it."

Has the Division been able to adequately act as a fund holder?

All 6 GP's responded to this question and agreed that the GP Division had administered the pilot adequately. AHP's were generally satisfied with the implementation and administration of the pilot with 5/6 (83%) respondents reporting that they were satisfied with the implementation of the model and that they felt that the GP Division had administered the pilot adequately. The main reservation to this end stemmed from a substantial delay in its implementation brought about by a period where there was no project officer.

AHP: "It seemed very slow to get off the ground. As I said, I was chasing it for eighteen months"

Is this model sustainable?

A number of core requirements will need to be in place for the Access to Allied Health program to be sustainable: these include patient acceptance of the process, and willingness to participate by a sufficient numbers of GP's and AHP's.

Consumer feedback on the pilot was highly positive: all five survey respondents considered it value for money, and felt that the GP and AHP had been able to meet all their mental healthcare needs. The two patients interviewed had not yet completed the process but felt that it was making definite progress. AHP's and GP's were similarly enthusiastic in their praise of the concept of the pilot and the benefits it is bringing to patients.

However, these comments hide the fact that so many GP's did not register with the program, and subsequently restricted the number of patients who could access the program. The level of uptake by GP's must be increased if it is to remain sustainable. At the moment, it appears that patients are being sent by other doctors to registered GP's in order to access the scheme. This has serious workload implications for the small number of registered doctors if they are required to assess a disproportionate number of patients about whom they have no prior knowledge:

GP: "I do see a fair number of patients for this process who are actually referred from other doctors because there are not many doctors that are actually involved in the program, so I have had quite a few come to me because they hear that I do the program and that is a bit frustrating when you're already busy in your own practice and then you know you're not really going to probably see those patients long term. You're seeing them, you know, from scratch, you know so there not patients you know well and, you know, you do all this assessment and send them and they get seen, but, I mean, it's nice for them , but it's, that is an imposer on our time when we're already booked out. So it would be much nicer if a lot more doctors actually were part of the program."

The decision by individual GP's not to participate seems mostly to have been made on a personal cost-benefit analysis of the scheme, where the acknowledged benefits of participation for patients were weighed against the costs to the GP in participation: as stated elsewhere, these included the amount of training required to register, the relatively large amount of paperwork, difficulties with fees and getting paid, uncertainty about the future of the scheme, and the limited number of patient referrals allowed. If these issues can be addressed so that the burden of involvement is seen to be outweighed by the patient benefits then this program would be far more likely to succeed at a local level. Most of these issues need to be addressed at a national level.

Is this model transferable?

Generally yes, this has been successfully transferred from the Geelong Division.

Has there been a change in the quantity and quality of the referrals over the life of the project?

A total of 50 patients were referred to Allied Health Practitioners through the program between 15th February 2004 and 23rd February 2005. Ten of these patients had repeat referrals requested on their behalf. One referral equals six individual one hour sessions, comprising a total request for 360 sessions in this time period. At the end of the reporting period a total of 171 sessions had been booked and paid for, and there were a further 171 sessions booked. The fluctuation in referral patterns during this first year makes it difficult to assess whether the level of demand for AHP services is set to substantially increase beyond this period. See table 3. Numbers of Referrals per month.

Month	Number of referrals	Month	Number of referrals
March '04	4	September '04	6
April '04	4	October '04	4
May '04	1	November '04	7
June '04	7	December '04	2
July '04	3	January '05	0
August '04	4	February '05	6

Table 3. Numbers of referrals per month

Given the time GP's put into becoming trained for the pilot it is likely they will continue to want to refer patients in an attempt to recoup their own training costs. However some GP's also expressed concern that word of mouth by patients may create a potential explosion of referrals and that an excess patient load of mental health patients would be stressful. The issue of patients gaining access to registered GP's was raised by several of the AHP's as GP's did not want to be advertised as registered in case they were inundated with a mental health caseload. In addition to being stressful, this would further limit the number of referrals they could make for their own existing patients.

Referral patterns

Information regarding type of referrals has been collected on the minimum data set. A breakdown of referrals by diagnosis for those patients whose data has been entered on the minimum data set appears in table 4. All patients were under 60yrs of age, and just 7/33 (21%) were under 30 years of age. Eighty-one percent (29/36) of patients were female, and just 8/28 (29%) had a tertiary education. Almost one-third of patients lived alone (11/34, 32%) and in keeping with the target population for the program, 28/34 (82%) of reported cases were judged by their GP's to be of low income. The majority of patients referred did have depression (see table 4); seventeen of the 37 patients for whom there is data had a dual diagnosis, the most prevalent being a combination of depression and anxiety disorders (13 cases). There were no referrals for psychoses or substance misuse as these patients were specifically excluded from the program. There were no known Aboriginal patients.

There has been no distinguishable change in the nature of referrals over the twelve month period when looked at in terms of the features outlined above. However, the numbers involved in any given month are quite small so it is difficult to make an accurate analysis.

Table 4. Types of each diagnosis referred by patient number.

Diagnosis	Numbers of patients referred (N=37*)
Alcohol and amphetamine: Drug Use	0
Psychotic disorders	0
Depression	30
Anxiety Disorders	17
Unexplained Somatic	4
Other	1
Unknown	1

*Patient data was not available from the minimum dataset for 11/48 documented referrals.

How have patients been tracked throughout the system?

Patients are tracked throughout the system via the ID numbers and Patient vouchers. The only way the Division had of tracking the patients involved in the three-step mental health process was from HIC data recording how many of the higher payments were triggered. There has been difficulty tracking how many patients started, but did not complete, the three step mental health care process, because unless the patient returned for the third review session with the GP the higher payments were not triggered. In the first 12 months of the program, 35 patients have completed the 3 step mental health program. The Division cannot currently access data regarding how many patients have started the process. Furthermore not all GP's choose to complete the three-step Mental Health process, despite referring the patients to the Access to Allied Health Services pilot, and other patients opt themselves not to return for their final GP visit. These patients cannot be tracked, via HIC data as the GP does not access the higher payments for the patient. The Division is able to

track these patients via the voucher. An additional problem with the review consult is that the consult is a level C (20 minutes) or a level D (40 minutes) which is too long if the person is well and requires no further intervention or counseling.

Chapter 5: Does the BOMHi enable the provision of high quality mental health allied health services to patients of GP's registered with the BOMHi?

Was the formation of the recruitment committee timely?

The formation of the recruitment committee was completed in February 2004, one month after the commencement of the pilot. The recruitment committee consisted of 1 allied health professional, 1 GP, and the program supervisor for the Division; the Division project officer was present in an advisory capacity. Expressions of interest from suitably qualified Allied Health Professionals were sought the same month. The initial recruitment of AHP's was completed in February 2004, but there have been meetings of this committee for subsequent recruitment.

Were the members suitably qualified to form the recruitment committee?

The Otway Division appointed the recruitment committee. The AHP on the committee was highly experienced and had been involved in the similar BOMHi program undertaken in Geelong. The project supervisor has a position on the Division Board and was able to represent their concerns. It is reasonable to assume that the GP recruited to the committee had the appropriate experience for this role based on his years of working as a GP within the Otway Division, a special interest in mental health issues, and his participation as a registered GP within the local BOMHi program.

Were the AHP's recruited suitably qualified?

In response to the question as to if the specific AHP's available were suitable to address the needs of their clients, all 6 GP's responded positively.

However, two of the six GP's reported that the list of participating AHP's was inadequate.

All AHP's appointed to the pilot met the list of 'Skills required to deliver services' as outlined by the Commonwealth. The AHP's were not interviewed individually by the recruitment committee, rather their CVs were examined and any questions arising from the CV, regarding the applicant's suitability or qualifications, were clarified via a phone interview. One issue which did arise in the Otway pilot was the attempt by one counselling organization to be accredited as an organization. The recruiting committee declined this application on the basis that each AHP should be able to demonstrate their qualification on an individual basis. One application by an individual was deemed inappropriate, and was rejected. Two other applications lacked sufficient information and the individuals involved declined to resubmit. Thirteen allied health professionals were eventually recruited before commencement of the programme.

Was a system of supervision for the AHP's instigated?

No system for supervision of the AHP's was enforced by the Division. While the maintenance of professional development was a requirement in the AHP Memorandum of Understanding, it was not enforced by the Division.

Is care provided in six sessions?

This was thought to vary from patient to patient. The Division introduced extra six sessions and this was found to accommodate most patients. As previously

stated, an extra six sessions were sought for 10 of the 50 patients referred in the first year.

The GP's and AHP's participating in the pilot were positive about the flexibility of the pilot allowing an extra six sessions if needed, arguing that this system allowed a reasonably comprehensive treatment of most patients:

AHP: "Initially we were told just six, but what we found was that the six plus an option of six, and I think in ninety percent of cases that was quite satisfactory. I can think of a couple of cases where it wasn't, but mostly they were satisfactory."

The problem of not enough sessions per client may relate to inappropriate referrals rather than numbers of sessions allowed. A number of the AHP interviews indicated that the counselling process uncovered more complex cases and previously unknown issues that subsequently required management.

Is care evidence based?

This has not been well monitored in the pilot, with reliance for evidence based practice being placed on the AHP. A summary of the evidence based focused psychological interventions provided by the Commonwealth was given to all AHP's at the commencement of the pilot and it was made clear that all interventions should be evidence based. At the request of the Division AHP's have used pre and post testing on their clients, unfortunately not all AHP's complied with the request and the tools used varied, making comparison of data impossible. The Commonwealth minimum data set did not ask for pre and post intervention scores.

Were the AHP's informed of the procedures of the BOMHi?

Each AHP was individually visited by the project officer once they had agreed to participate. The processes and procedures of the BOMHI initiative were outlined at these meetings, and a resource kit with written details was also supplied. This was complemented by a well-attended group meeting in November 2004. All AHP's were notified of any changes to the procedures in writing during the course of this program.

This view is supported by results from the AHP survey, where 7/9 (78%) AHP's surveyed reported they felt adequately informed of the pilot, 6/7 (86%) felt that the number of training sessions was adequate for their needs and all 8 respondents to this question felt that the contents of information sessions were sufficient.

Was the list of participating AHP's distributed to all GP's in a timely manner?

The list of participating AHP's, along with specialty details, was initially distributed at the information session on the pilot for GP's in February 2004 along with their resource kits. Recruitment of AHP's was completed in the same month, and an information session for all participating AHP's was held individually. GP education regarding how to complete the 3 step mental health examination was completed in 2003.

Were the AHP's participating in the program adequately promoted to the GP's?

All GP's received a list of participating AHP's in their resource kits. AHP's were invited to describe their specialty area for inclusion in the kit and this description was used in the resource kit.

Were patients satisfied with the quality of care?

All of the relevant indicators measured (table 5, N=6) suggest that patients were very satisfied with the quality of care provided by the BOMHi program. This satisfaction with the care given by the GP's and AHP's, and with the communication between the two parties, was reiterated by the two interviewed patients. A couple of patients did indicate lower levels of satisfaction with the amount of time and number of sessions with the GP.

Table 5. Patient satisfaction with the quality of care

Level of Satisfaction with:	Range	Mean	Median
Number of times you had to visit your GP	5-10,	7.8	8
Amount of time spent with you by your GP	4-10,	7.6	9
Amount of time spent with you by your AHP	5-10,	8.6	9
Location of AHP	6-10	8.8	10
Mental Health Care	7-10	8.8	9

Table 5. Consumer ratings of satisfaction levels.

All five patients responding to the survey reported their confidentiality was respected during their involvement with the program, that their GP had treated them respectfully. All five respondents also reported their AHP had treated them respectfully, and that their mental health needs had been met. Importantly from the program's point of view, all five also indicated that the GP and AHP had worked well together in treating the patient. Again, these views were emphatically endorsed by the two interviewed patients.

Are there improved patient outcomes post care?

GP's surveyed were positive regarding the benefits of the pilot to their patient with all six survey respondents reporting that their patients had benefited from

involvement in the pilot. Most (5/6) GP's also perceived the pilot as cost effective for the patient. 6/7 (86%) AHP's also reported that their patients had been informed regarding the pilot by their GP's.

Consumers surveyed reported improved outcomes post care, with all five respondents reporting that their condition had improved, and that they had learned to manage their condition. The interviewed patients indicated that they were still learning to manage their condition but that there was definite progress being made.

Objective outcomes are difficult to assess given that different AHP's have used different assessment tools. No field was entered into the minimum data base to evaluate improvement in outcome score (Yes/No). Moreover, it is believed that many patients did not return to their GP after six AHP sessions because they felt that there was no need. This obviously made it impossible for the GP to assess any improvement in the patient.

Chapter 6. Was patient's access to mental health and allied health services improved?

The issue of equity of access to the service was of common concern to the AHP's surveyed. There were reports of clients having difficulty accessing registered GP's and frustration with the Division that it was not able to supply lists of registered GP's. GP's on the other hand expressed concern at being inundated with mental health patients if it was openly advertised that they were registered for the pilot.

GP1: "One thing I probably haven't mentioned is that I do see a fair number of patients for this process who are actually referred from other doctors because there are not many doctors that are actually involved in the program, so I have had quite a few come to me because they hear that I do the program and that is a bit frustrating when you're already busy in your own practice and then you know you're not really going to probably see those patients long term."

There was a conflicting desire among AHP's, typified by the following comment, to know who was registered with the program so that they also could encourage patients into the program:

AHP: "There are a couple of significant barriers, not least of which is, I think in this area there are only something like nineteen GP's who were registered for it. That was the biggest barrier. And the second biggest barrier was nobody could tell us who the nineteen were."

Despite the difficulty of not knowing which GP's were registered it appears that the pilot has increased accessibility to mental health services:

GP: "As I said before, it's just that most of the people that would benefit from one on one psychological counselling, can't afford it privately and often they can't access it through other structures and so they basically, either have

substandard counselling or else they just don't have it at all. So I think any system which provides funding options for people that have such counselling has got to be worth looking at."

Did the proportion of GP's registered with the BOMHi increase (to 20%)?

There are estimated to be 115 GP's practicing in the Otway Division of General Practice, and 19 of these (17%) had registered with the BoMHi scheme by February 2005. Four of these GP's have either left the area during the first year, while another four are currently awaiting familiarization training to allow the to become registered.

When asked why they decided not to register with the pilot the Key Informants were in agreement that it was the time commitment of the pilot that had prevented them.

Did the GP's registering with the BOMHi all refer patients?

Eleven of the 19 (58%) registered GP's referred patients in the first year of operation, according to the minimum dataset. As stated above, a couple of GP's moved from the area early in the program. Other GP's were unable to refer because the dissolution of their practice meant that they were subsequently working in practices that were not registered with the scheme.

Were the GP's and AHP's satisfied with the education process? (Mail outs and information sessions)

Seven out of nine AHP's (79%) responding to the survey reported they felt adequately informed regarding the pilot. Six out of seven of these respondents also reported the information sessions were adequate in number.

While there were no complaints from the registered GP's, the two non-registered GP's interviewed indicated that the perceived level of training requirements was an impediment to their getting involved in their overworked environments.

Were the GP's and AHP's satisfied with the education content (Mail outs and information sessions)?

Eight out of nine (89%) AHP's thought the education sessions were adequate in content. Both of the registered GP's that were interviewed did not hesitate to indicate their satisfaction with the program. One of the unregistered GP's indicated a fear that there would be an emphasis on procedural rather than clinical content.

Were the other mental health service providers (PMHCT, MAHS) satisfied with the information they received regarding the BOMHi?

The two representatives interviewed had certainly been informed about the advent of BOMHi. However, it would appear that there was very little direct interaction between these services with BoMHi, and this has possibly made the exact structure and purpose of the BoMHi become a little unclear over time, apart from knowing that it is a potential option for clients not suited to their own service.

Did the education and training assist the GP's to make referrals?

In response to the question as to whether the pilot has increased willingness to participate in primary mental health care, 5/6 (83%) of the GP's reported that it had while just 1 respondent indicated that it had not. One GP was very

emphatic about the positive impact it had had when asked if it encouraged involvement in mental healthcare:

GP: "Oh, for sure, I think it means that, it's been excellent that way. And I do value very much the feedback I get from the psychologist... traditionally they never, you know, give us any feedback and suddenly I've had this rush of wonderful letters from them... we actually do like that and we learn a lot from it too."

Chapter 7. How were Aboriginal and Torres Strait Islander populations targeted for inclusion in the pilot and was this successful?

None of the GP respondents reported participation in the program through their clinic by people with Aboriginal and Torres Strait Islander heritage. This was confirmed by the available data from the minimum dataset.

GP opinion regarding the need for Allied health services to be different for Aboriginal and Torres Strait Islander and transcultural populations was divided. While none of the GP's stated that services do not need to be different, just 2 of the GP's asserted that services do need to be different, while three of the GP's declined to respond and another indicated uncertainty. AHP opinion was similarly divided with 3/8 (38%) respondents stating services do not need to be different, and 5 (63%) respondents stating services do need to be different for Aboriginal and Torres Strait Islander and transcultural populations.

Were meetings organized and attended by Aboriginal and Torres Strait Islander populations?

Multiple meetings between representatives of the Division and local aboriginal co-operatives failed to reach agreement upon an acceptable model of care for Aboriginal patients. Both parties agreed that the preferred model of care would not require patients to visit an unfamiliar doctor outside the co-operative setting. Unfortunately, at this time the co-operatives were not registered as health centres from which this service could be provided and none of the co-operatives directly employed doctors. A request to the Commonwealth Department of Health and Ageing for permission to develop a separate model of care for Aboriginal patients was declined.

When the meetings held and what were their agenda?

In total, six meetings were held with representatives of the various local Aboriginal communities throughout 2004 – two in April, two in June, one in July, and one in December. These meetings largely focused on mechanisms to implement Better Outcomes in a manner that would benefit and would be acceptable to Aboriginal communities. There were two additional meetings conducted with Aboriginal and Divisional representatives from other GP Divisions in July 2004 examining the potential of different models of mental health care.

How were culturally sensitive GP's encouraged to register with BOMHI and participate in the pilot?

In the absence of a service model which was acceptable to local aboriginal co-operatives, the Division did not specifically pursue culturally sensitive doctors during the first 12 months of operation.

Chapter 8. Did the BOMHi provide an allied health model, which resulted in a more integrated primary care system than MAHS, PMHT, and AMHS?

Were the PMHT, AMHS, MAHS aware of the BOMHi aims objectives and roles?

It was difficult to assess the extent to which this was the case based on the two interviews carried out. These organizations were at some stage given relevant information directly through the Division and also via professional networks; indeed, representatives from the PMHT were involved in the establishment of the BOMHi project. During the first 12 months however, there appears to have been a low level of direct interaction between clinicians from the different services, and there has also been changes to some key personnel. This may result in other services not maintaining as acute a knowledge of the BoMHi service as they had at the outset.

Did the PMHT, AMHS, MAHS service providers perceive a duplication of services?

Neither of the two interviewed service provider representatives felt that their own service overlapped to any substantial extent with the service provided by the BoMHi.

Did the GP Divisions perceive a duplication of services between the BOMHi and the other services?

All 6 survey respondents felt that the model helped to refer selected patients. However, one of the interviewed GP's did suggest that while the procedures for the two services were quite distinct, the target population may have overlapped:

GP: "I've often, yeah they're very similar people and so it's wonderful, it's almost amazing that at the same time we've got primary mental health team and better outcomes in mental health setup at the same time. I would, I find my referral patterns are fairly similar. The biggest difference between primary mental health team is that I don't have to go through a formal assessment before I refer them on. So if they were more available I would probably use them an awful lot more, because it's such an easy system."

Did the GP's and AHP's meet to discuss the pilot at regular intervals during the pilot?

GP's and AHP's met to discuss the pilot in Nov 2004. There was also a separate case presentation session in April 2004 to which both GP's and AHP's were invited.

Chapter 9. Discussion and recommendations

The clinical successes of the *Access to Allied Health* pilot observed in the Geelong Division appear to have been successfully reproduced in transferring the program to the Otway Division. GP's, and AHP's were in the main extremely satisfied with the new service this model provided, as were consumers. It has seen a successful multidisciplinary collaboration between individual GP's and Allied Health Practitioners which resulted in increased access to appropriate mental health services for the target population. This is particularly important in the largely rural Otway Division because of the large numbers of people falling into the target population and for whom appropriate services did not previously exist.

The program has also facilitated the delivery of an improved standard of care: GP's have availed of increased educational opportunities, while the referred patients were able to access local counselling services which they were previously unable to afford. This has added significance in the rural context given the generalist nature of medical and health services and the shortage of appropriate specialist care. The Division has administered this program in an efficient and proactive manner that minimised, within the constraints of the program, the administrative workload involved.

As with Geelong, the main barriers to the sustainability of the model from the GP and AHP point of view are the high cost of being involved due to the amount of paperwork and the time taken to do the required paperwork. GP's were also concerned about the time taken to train to become registered. A shortage of GP's in the Otway region has left most doctors feeling overworked already. The result is that it makes it difficult to encourage GP's to undertake training for a program with a perceived high level of administration. Higher fees were not always accessible if clients dropped out of therapy or failed to return to the GP for their review meeting, something over which the GP has no control.

If the BOMHi does not become more cost effective for experienced practitioners there is a threat that only novice practitioners trying to establish their practice will become involved. The budget will obviously have a dramatic effect on the sustainability of the program. This needs to increase as the number of registered GP's rises so that the same number of referrals per practitioner (if not more) becomes available. A decreased number of referrals would make the training and administrative input into the program less cost-effective.

Although not a barrier to the sustainability of the service, equity of access was an issue for both consumers and AHP's, both of whom reported difficulties accessing GP's who were registered. Understandably marketing of registered GP's poses a threat to GP's already participating in the program who do not want to be inundated with mental health referrals. This may become less of an issue as more GP's become registered and load can be more evenly spread, and also as the registered GP's become known to referral sources and consumers via word of mouth publicity.

Recommendations

Recommendations for the Otway Division's program are largely in keeping with those for Geelong.

1. Reduce time constraints on GP's through:

- Simplifying the training process to register for the pilot
- Reducing the amount of paperwork required
- Streamlining the amount of paperwork required by using the information GP's are already recording on their computer program Medical Director. In this way the same information does not have to be recorded twice.

2. Reduce the time constraints on AHP's by

- Increasing AHP's access to GP's for follow up phone calls after the second session with the patient, or by allowing

individual AHP's and GP's to decide upon their own feedback mechanisms,

3. Increased flexibility with fees

- GP's to be able to claim higher fees after second visit
- AHP's to be able to negotiate their own fees with the Division based on experience, numbers of referrals etc.

4. Development of a model of care that is acceptable to Aboriginal consumers and communities; this may need to differ from the model already in place.

5. Supervision sessions should be organised such that the intervention for any given consumer is discussed at least once and preferably twice: once after their first therapy session (to present the evidence-based treatment plan, including treatment goals) and again before their last session (to review progress and support appropriate transfer back to the referring GP). A working party with representatives from the Division and the Commonwealth should be established to investigate cost effective options for supervision.

Chapter 10: Conclusions

As a pilot the Access to Allied Health Voucher system was both cost effective and convenient for the GP Division to manage. Patients were able to be tracked through the system while their confidentiality was protected.

Collaboration and increased communication between GP's and AHP's was facilitated, while quality of the program was ensured through the thorough GP education and recruitment of well-qualified AHP's. The overall program referral structure is welcomed by GP's, AHP's and patients alike. As the number of consumers who are aware of the pilot increases and demand for services increases the GP Division will have to modify aspects of the existing program to ensure ongoing cost containment and quality service.

The service currently provided will inevitably need to be capped if costs are to be contained. Moreover, costs of the current program could be minimised by streamlining the paperwork and amount of time required by health professionals to participate in the program.

The quality of the existing program will need to be ensured through ongoing supervision and flexibility of fee structures for AHP's. The ability for both the GP to claim parts, or payments after each session should also be examined in the light of new funding for the initiative. Streamlining the paperwork and standardising the assessment tools used by AHP's and GP's should also assist with quality control, and collaboration between GP's and AHP's.

Accessibility for consumers needs to be increased through increased recruitment of GP's, a corresponding increase in program funding, and marketing of registered GP's. This could potentially be done through AHP's who would then be able to refer patients to a registered GP. If more GP's are encouraged to participate in the initiative then there is less likelihood of one GP being swamped by mental health referrals?

The procedural changes suggested in this evaluation should assist in ensuring the ongoing sustainability of the Access to Allied Health Services Voucher system.

References

- (1) **Dunbar J, Reid C.** The Better Outcomes in Mental Health Care Initiative: The Access to Allied Health Services Pilot Voucher 12-Month Evaluation Report, GP Association of Geelong. Greater Green Triangle University Department of Rural Health. Warrnambool, February 2004.
- (2) **Menzies J.** Otway Division of General Practice website: Introduction section. <http://www.otway.asn.au/>. Accessed June 2005.

Appendices

Appendix A. Key informant interviews. (GPs)

- How did you become aware of the BOMH pilot?
- Why did you choose to become involved in the BOMH pilot?
- What do you consider a barrier to this pilot working effectively?
- What improvements can you suggest to making this pilot work more effectively?
- Has this pilot increased your willingness to participate in primary mental health care?
- Is the protocol for referral to the BOMH pilot easy to use? Y/N If not why not?
- Are you satisfied with the voucher system?
- Were the education sessions useful?
- What did you think about the amount of paperwork?
- Were you satisfied with the: K 10 Assessment
 - suicide risk assessment
 - mental health assessment
- Were you adequately reimbursed for your involvement in this pilot?
- What other information would you like to see included on the patient's minimum data set?
- For what proportion of the patients you referred did you complete a 3 step MH process?
- Did the patients attend for the third session thereby enabling you to access the extra payment
- What information would you like to see added to the three step mental health process?
- What information would you like to see deleted from the three step mental health process?
- Did you complete a MH assessment on the form provided for every patient referred?
- If you did not complete a MH assessment on the form provided for some patients referred what information did you record and in what format?
- If you could include anything else in the resource kit what would it be?

- How does the BOMH service model compare to other mental health service options currently available to you?
- On a scale of 1-10, 1 being not satisfied and 10 being extremely satisfied, how satisfied are you with the model BOMH pilot?
- Do you have any other comments regarding the BOMH pilot?

Appendix B. Key Informant Interview Questions: Non participating GPs

- Do you feel well supported in working with mental health clients? Y/N
- Were you aware of the BOMH pilot? Y/N
- Are you BOMH registered? Y/N
- Does your client caseload lend itself to being involved in the BOMH pilot?
Y/N
- Do you consider it necessary to do extra training to make referrals to the BOMH service? If not why not?
- If you chose not to participate in the pilot, Why did you choose not to participate?
- What improvements can you suggest to the BOMH model for accessing AHP services?
- What do you consider the barriers to participating in the BOMH pilot?
- How does this model compare to other allied health mental health services (MAHS, AMHS, PMHT)?
- Do you have any other comments regarding the BOMH pilot?

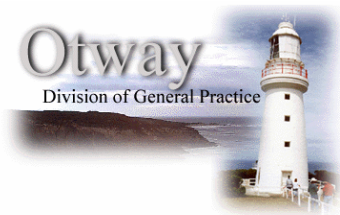
Appendix C. Key informant interviews: Other Mental Health Services (MAHS, PMHT, AMHS)

- How did you become aware of the BOMH pilot?
- How does the BOMH pilot fit with the MAHS, PMHT, AMHS aims objectives, and roles?
- Was it clear how your clients could access the BOMH pilot? Y/N
- How do you think the BOMH pilot could work more effectively?
- Do you think there is duplication of services between your service and the BOMH pilot?
- Were you satisfied with the information you received regarding the BOMH pilot?
- Do you have any other comments regarding the BOMH pilot?

Attachment D: Key informant interviews: Allied Health Professionals

- How did you become aware of the BOMH pilot?
- Why did you decide to participate in the pilot?
- Has this pilot assisted your clients? Y/N
- Were you satisfied with the manner in which the pilot was implemented?
Y/N
- Were the information sessions adequate in number? Y/N
- Were the information sessions adequate in content? Y/N
- What do you consider a barrier to this pilot working effectively?
- What improvements can you suggest to making this pilot work?
- Was it cost effective to be involved in the BOMH pilot? Y/N
- Was the reimbursement claim form clear and easy to use? Y/ N
- Was the referral information you received clear? Y/N comprehensive Y/N
- Did you find the proforma for the consultation report useful in reporting back to the GPs? Y/N
- Is there any other information which you think should be included in the referral forms? Y/N If so what is it?
- Was the number of treatments allowed in this pilot adequate? Y/N
- Is there any other information which you think should be included in the AHP minimum data set? Y/N If so what is it?
- Was the amount of written reporting appropriate?
- Was the amount of oral reporting appropriate?
- On a scale of 1-10, 1 being not satisfied and 10 being extremely satisfied, how satisfied are you with the BOMH pilot?
- Do you have any other comments regarding the BOMH pilot?

Appendix E. Consumer Survey



Flinders University and Deakin University
PO Box 423, Warrnambool, Victoria 3280
Tel: (03) 55633315 Fax: (03) 55633144

Consumer Survey

The Better Outcomes in Mental Health Care initiative (BOMHCi) is a new government program. General Practitioners who are registered with the program have the option to refer people with a mental health disorder to allied health services for specific time limited treatment. The allied health services are evidence based and provided at no cost to people with a mental health problem.

This survey forms part of the evaluation of this new initiative, as a consumer of the service your opinions are important to us. Completion of the survey is entirely voluntary, and you may choose not to participate. If there is any question you do not want to answer on the survey for any reason just leave it blank.

This is an anonymous survey and does not include your name or any other information that could identify you individually. The survey can be mailed directly to the university in the return address envelope provided to ensure anonymity. If you choose not to complete the survey please also return the blank survey. By returning the survey directly to the

university your individual responses will remain unknown to your GP and psychologist/ social worker.

The information provided in the surveys will remain confidential and no individual will be able to be identified from the surveys or from the information presented from the surveys.

Most of the questions to follow are in Yes/ No format. Please respond by circling the number which best describes your answer. Some questions may require a brief response. Please write your answer in the space provided.

1. Do you have a GP whom you see regularly?

No..... 0

Yes..... 1

2. Was your GP registered with the BOMHC initiative?

No..... 0

Yes..... 1

3. If your GP was not registered with the BOMHC initiative did you find it easy to get to see a GP who was registered?

No..... 0

Yes 1

NA..... 2

4. How did you find a GP registered for the BOMHC initiative?

5. How did you find out about the BOMHC initiative?

6. Did you have to wait to access the BOMH service?

No..... 0

Yes..... 1

If yes how long? _____ days

7. Was the information about the BOMH project clearly conveyed to you by your GP?

No 0

Yes 1

8. How many times did you need to visit your GP?

9. After seeing your GP did you have to wait long before getting an appointment to see a psychologist / social worker?

No 0

Yes 1

If yes how long? _____ days

10. Was your confidentiality respected during your involvement with this program?

No..... 0

Yes..... 1

11. Did your GP treat you respectfully?

No 0

Yes 1

12. Did your psychologist/social worker treat you respectfully?

No 0

Yes 1

13. Did the GP and psychologist / social worker together meet all your mental health needs?

No 0

Yes 1

Please explain:

14. Does this service offer value for money?

No 0

Yes..... 1

15. Has the condition for which you were referred improved as a result of your psychologist / social workers intervention?

No..... 0

Yes..... 1

16. Have you learned to manage the condition for which you were referred as a result of your psychologist / social workers intervention?

No..... 0

Yes 1

17. How would you like to see this service improved?

The following questions relate to your level of satisfaction with the service you received. Please circle the number on the scale from 1-10 which corresponds to how you felt about the service, with one equalling not at all satisfied and 10 equalling extremely satisfied.

18. Were you satisfied with the number of times you had to visit your GP?

Not at all satisfied

Extremely satisfied

1 2 3 4 5 6 7 8 9 10

19. Were you satisfied with the amount of time spent with you by your GP?

Not at all satisfied

Extremely satisfied

1 2 3 4 5 6 7 8 9 10

20. Were you satisfied with the amount of time spent with you by your psychologist/social worker?

Not at all satisfied

Extremely satisfied

1 2 3 4 5 6 7 8 9 10

21. Were you satisfied with the location of your psychologist / social worker?

Not at all satisfied

Extremely satisfied

1 2 3 4 5 6 7 8 9 10

22. Were you satisfied with your mental health care.

Not at all satisfied

Extremely satisfied

1 2 3 4 5 6 7 8 9 10

Thank you for taking the time to complete this survey.

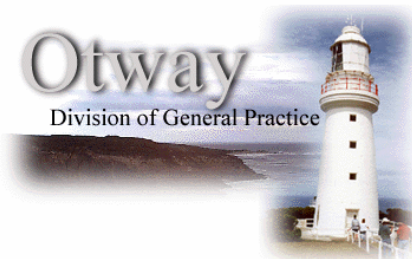
Please return your completed survey form in the reply paid envelope provided.

Appendix F: GP survey



Flinders University and Deakin University
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Otway
 Division of General Practice



Better Outcomes in Mental Health GP survey

This survey is designed to provide a broad overview of attitudes toward, and knowledge of, the BOMH pilot. Details about the following responses will be gathered in a series of Key Informant Interviews. The information gained from these surveys will assist in tailoring the BOMH scheme to your needs in the future.

<i>Please tick the most appropriate response</i>	Yes	No
Cost efficiency / Accessibility		
Compared to the other mental health services you can access (Primary Mental Health Care Team, More Allied Health Services, Area Mental Health Service) has the BOMH model been cost effective for you?		
Compared to the other mental health services your patient can access (PMHT, MAHS, AMHS) has the BOMH model been cost effective for your client?		
Has accessing the BOMH pilot resulted in a change in the fees you can claim for seeing these clients?		
Has the process of claiming this money been easy?		
Has participating in the BOMH pilot incurred more costs for your clinic compared to other mental health referral processes?		
Has the voucher system been easy to use?		
Does the voucher system increase your access to AHPs?		
Cultural appropriateness		
Did any people from Aboriginal and Torres Strait Islander and transcultural populations participate in the program through your clinic?		

Do the specific allied health services available need to be different for Aboriginal and Torres Strait Islander and transcultural populations?		
Were you satisfied with the manner in which the pilot was implemented?		
Please tick the most appropriate response	Yes	No
Paperwork		
Is the protocol for referral to the BOMH project easy to use?		
Are the protocols time effective?		
Are the protocols clear?		
Is the amount of paperwork appropriate to the service being provided?		
Is the amount of paperwork appropriate to the income?		
Were the referral forms clear, / easy to complete?		
Were the referral forms able to be completely quickly?		
Do you consider the evaluation forms appropriate? – K10,		
-Suicide risk assessment		
- Mental health assessment		
Did the resource kit assist with the referral process?		
Was the content of the resource kit relevant?		
Was the content of the resource kit adequate?		
Allied Health Providers (AHPs)		
Were the specific AHP providers available, suitable to address the needs of your clients?		
Was the list of participating AHPs adequate?		
Did you find the AHPs easy to access?		
Was the speed of response of the AHP to your referral adequate?		
Was communication between yourself and the AHP open?		
Were the reports you received from the AHPs clear?		
Were the reports you received from the AHPs adequate?		
Was the location of the AHPs suitable?		
Did you receive reports in a timely manner from the AHP after your patient had finished the six sessions?		
Did the AHP phone you after the patients' second visit to provide feedback?		

General Satisfaction		
Did your patient's mental health benefit from involvement in the BOMH project?		
Has the GP Division administered this pilot adequately?		
Do you feel the BOMH pilot has increased the amount of support you have in working with this client group?		
Has the BOMH model assisted you in referral of selected patients?		
Is the BOMH service model a better option than those currently available to you (PMHT, MAHS, AMHS)?		

What do you consider a barrier to this pilot working effectively?

What improvements can you suggest to making this pilot work more effectively?

Has this pilot increased your willingness to participate in primary mental health care?

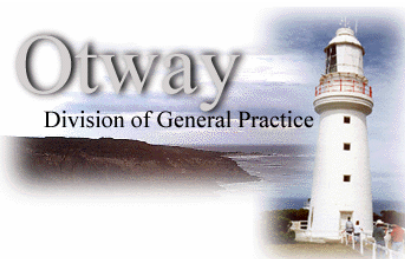
Do you have any further comments?

Thank you for your time in participating in this survey. Please place the survey in the attached envelope and return it to Kevin McNamara

Appendix G: AHP survey



Flinders University and Deakin University
 PO Box 423, Warrnambool, Victoria 3280
 Tel: (03) 55633315 Fax: (03) 55633144



Better Outcomes in Mental Health AHP survey

This survey is designed to provide a broad overview of attitudes toward, and knowledge of, the BOMH pilot. Details about the following responses will be gathered in a series of Key Informant Interviews. The information gained from these surveys will assist in tailoring the BOMH scheme to your needs in the future.

<i>Please tick the most appropriate response</i>	Yes	No
Cost efficiency		
Compared to the other mental health services your patient can access (PMHT, MAHS, AMHS) does the BOMH model offer value for money?		
Has accessing the BOMH pilot resulted in a change in the fees you can claim for seeing these clients?		
Has the process of claiming this money been easy?		
Has participating in the BOMH pilot incurred more costs for your clinic compared to other mental health services?		
Communication		
Was the referral information you received clear?		
Was the referral information you received always complete		
Was your patient informed about the BOMH pilot?		
Were you able to meet the reporting guidelines?		
-phone call to GP after second visit		
-report to GP on patients completion of six sessions		

Cultural appropriateness		
Did any people from Aboriginal and Torres Strait Islander and transcultural populations participate in the program through your clinic?		
Do the specific allied health services available need to be different for Aboriginal and Torres Strait Islander and transcultural populations?		

<i>Please tick the most appropriate response</i>	Yes	No
Paperwork		
Is the amount of paperwork appropriate to the service being provided?		
Is the amount of paperwork appropriate to the income?		
Do you consider the patient evaluation forms appropriate? -K10, -Suicide risk assessment -Mental health assessment		
Were the referral forms easy to understand?		
Was the proforma for reporting easy to complete?		
Education		
Do you feel adequately informed about the BOMH pilot?		
Were the number of information sessions adequate for your needs?		
Was the content of the information sessions sufficient?		
General satisfaction		
Were you satisfied with the manner in which the pilot was implemented?		
Did your patient benefit from involvement in the BOMH project?		
Has the GP Division administered this pilot adequately?		
Is the BOMH service model a better option than those currently available to your client (PMHT, MAHs, AMHS)?		

What do you consider barriers to this pilot working effectively?

What improvements can you suggest to making this pilot work more effectively?

Any Comments?

Thank you for completing the survey. Please return it to Kevin McNamara in the reply-paid, addressed envelope provided